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MDS Alert

Medicare Compliance: Know The ABCs Of Part A Medical Necessity For Your Pneumonia Patients

There's more to skilling a resident for pneumonia than coding it on the MDS.

Pneumonia is one of those "ka-ching" diagnoses that can automatically RUG a resident into clinically complex--or into special care if the resident has pneumonia and a fever.

Pneumonia is also a diagnosis that fiscal intermediaries may scrutinize on medical review. So you need to dot your i's and cross your t's when using pneumonia as the primary reason a resident requires a Part A stay.

Since checking pneumonia at I2e can start the clinical RUG ball rolling, make sure you're following the RAI manual rules for coding diagnoses. The RAI manual defines pneumonia checked at I2e as "inflammation of the lungs, most commonly of bacterial or viral origin," notes **Cheryl Field, MSN, RN**, a consultant with **LTCQ Inc**. in Lexington, MA. Capture "any upper or lower acute respiratory infection other than pneumonia" at I2f, according to the RAI manual.

Code a diagnosis in Section I if it affects the resident's current ADL status, cognitive status, mood, behavior, medical treatment, nursing monitoring or risk of death. "To code pneumonia, you need a written physician diagnosis or use the one from the hospital," says Chicago consultant **Joan McCarthy.**

Don't Misuse Presumption of Coverage

Say a resident treated for pneumonia in the hospital stay is admitted to the SNF and classifies into a clinical RUG on the 5-day assessment. "A resident who goes into one of the top 35 RUGs is presumed skilled until the assessment reference date of the 5-day assessment," says **Diane Brown, CEO** of **Brown LTC Consultants** in Boston. (If the ARD were on day three of the stay, for example, you could bill Medicare for days one through three under the presumption of coverage.) Even so, the resident must require daily skilled care during that time. And the facility must provide and document that care. After the ARD, you'd keep the person on Part A if he continued to require daily skilled nursing care and had Medicare days available.

Example: A resident admitted to the SNF had pneumonia in the hospital treated with IV medications. He remains unstable and requires daily skilled nursing monitoring for respiratory status. Based on the IV med in the hospital, the resident would RUG into extensive services if he had an ADL score of at least 7. The pneumonia diagnosis coded in Section I would also qualify the resident for clinically complex, which will add a point to the extensive count determination. The best practice for assessing the pneumonia would include looking at the person's clinical signs and symptoms daily. "These include vital signs, auscultation of lung sounds, oxygen saturation, and assessment of pulmonary function [in conjunction] with ADLs," says Field.

Determine When the Resident Is Stable

To determine when the resident with pneumonia has stabilized, consider a number of parameters, advises **Evelyn Hutt, MD**, with the **Veterans Affairs Medical Center** in Denver, who has helped develop evidence-based guidelines for managing nursing-home-acquired pneumonia. Hutt suggests you might consider a resident to be stable if he or she:

• has an oxygen saturation above 90 percent on room air or on his/her usual amount of oxygen at sea level.

• isn't hypotensive and has a respiratory rate less than 30.

• requires less than 3 liters of oxygen per minute. "Patients often stay on oxygen for a time after their other symptoms resolve," says Hutt. "And someone with COPD might require 3 liters at baseline, but generally not 4."

• has a pulse under100. "Some people with COPD have chronically elevated pulse rates," adds Hutt, "so you'd have to consider the person's baseline."

• has returned to his cognitive baseline if the infection affected his cognitive functioning.

• is afebrile.

"Anyone receiving parenteral (IV, IM) antibiotics should" remain on skilled nursing care, adds Hutt.

Good question: How long would the resident need to be stable before taking him off Medicare Part A? Under the old Medicare utilization guidelines, no one had a problem saying that if someone were stable for 48 to 72 hours, it was appropriate to consider taking him off daily skilled monitoring and resuming usual patterns of observation, says Sheryl Rosenfield, RN, a consultant with Zimmet Healthcare Group in Morganville, NJ.
Of course, you "evaluate each case individually," advises Brown. "A resident's pneumonia may have stabilized, but he may have a comorbidity [such as congestive heart failure] affected by the pneumonia that requires further daily observation and assessment. Or a resident could stay on skilled care a little longer if the staff were doing teaching and training for discharge," Brown says.

Rehab Low Plus Extensive Services a Potential Option
Some residents with pneumonia require rehab therapy for their condition. But the facility should "look at care delivery to residents with pneumonia or another episodic illness" who receive high rehab services for one to two months, advises Rosenfield.
"A QA review of several residents with the same diagnosis may help facilities to better determine other choices for the type and delivery of care," she says. Rosenfield notes, for example, that facilities often overlook rehab low plus extensive services, which she views as a "good category for residents admitted or readmitted from a hospital stay for pneumonia who aren't ready for intensive rehabilitation services."