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MDS Alert

Medicare Payment: Kick Your Medicare Skilled Coverage Determination And Documentation Skills Into High Gear

Cover the coverage triad and combat these 4 expensive myths.

Myths about Medicare skilled coverage will come back to bite the SNF's bottom line if the FI denies services - or when a beneficiary and SNF miss out on legitimate Part A coverage opportunities.

Below experts provide a quick walk-through of coverage requirements and debunk some common false beliefs that can trip up your Medicare SNF coverage.

Nail down the basics: Keep in mind that Medicare Part A SNF coverage includes three components, advises **Cheryl Field, MSN, RN, CRRN,** director of clinical and reimbursement services for **LTCQ Inc.** in Lexington, MA.

Eligibility. The patient has to have Part A Medicare benefits (and not all patients do). The patient also has to have had a three-day qualifying hospital stay within 30 days of admission (or admission to the SNF within 30 days of another SNF stay) and days left in his 100-day benefit.

Skilled level of care coverage requirement. Medicare Part A covers five categories of SNF care: (1) direct skilled rehabilitation services; (2) direct skilled nursing services; (3) management and evaluation of a patient care plan; (4) observation and assessment of a patient's condition; (5) teaching and training activities.

To review definitions and examples of these coverage categories, see chapter 8, pages 21 through 33 of the online Medicare Benefit Policy Manual at www.cms.hhs.gov/manuals/102_policy/bp102c08.pdf.

The RUG score (what the facility will be paid for the SNF services). That's where the MDS figures in the equation. "You have to do the MDS to determine the RUG score to see what the facility will be paid," says Field.

For example, if your facility forgets to do an MDS on a resident within the assessment reference period for a particular assessment, the best you can do is to bill a default rate. "So in that case, the resident would meet the top two criteria (eligibility and skilled level of care requirement) but not the third" in getting a fair RUG payment for the services provided, Field notes.

Base Your Decisions in Reality, Not Myth

To provide and get paid for necessary Medicare skilled care, shake loose these common misleading mindsets about Medicare skilled coverage:

Myth No. 1: A patient who falls in the upper 26 RUGs automatically qualifies for a Medicare skilled need. That's usually true, but you have to look more closely in each case, experts caution. Who might RUG into the upper 26, but not really require a skilled nursing service? One example might be a resident with COPD who is clinically stable and requires ongoing oxygen therapy for a chronic condition, says **Jane Belt, RN, MSN,** a consultant with **Plante & Moran Swartz Group** in Dublin, OH.

Even if a resident has a stage 3 pressure ulcer and two or more treatments coded on the MDS, which puts him in a special care category, he might not really qualify for Medicare skilled coverage, cautions **Rena Shephard, MHA, RN, FACDONA, RAC-C,** president of **RRS Healthcare Consulting** in San Diego.

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In such a case, "you have to look at whether the facility is providing a daily skilled service," she says. "The Code of Federal Regulations gives a clue about that issue when it talks about wound care requiring prescription medication and aseptic technique qualifying for skilled nursing care," Shephard adds.

"But the facility still has to provide the care daily," Shephard says. And dressings that aren't changed daily or that cover the wound completely and prevent daily wound assessment may not fit that bill.

In addition, "when providing a skilled nursing service for wound care, the care has to be related to the wound," to be covered under Part A, "which could include daily assessment for infection," Shephard adds. "But services designed to prevent further skin breakdown are not covered by Medicare," she cautions.

Be proactive: "If in doubt, call the FI and ask for its coverage policy related to wound care or other issues," Shephard suggests.

Myth No. 2: Forget skilling a resident who RUGs into one of the lower 18 RUGs. Not so fast, say experts. Residents can be skilled for restorative nursing alone - or even behavioral management if, for example, they are behaviorally unstable and require medication titration following a qualifying three-day psychiatric hospital stay. (For the details on restorative and behavioral management as stand-alone skilled services, see the March 2005 MDS Alert.)

Some facilities don't continue to skill people once therapy stops because they "don't understand that nursing could continue to provide observation and assessment or care plan management until the resident is clinically stable," Belt says.

Tip: Do an OMRA (Other Medicare Required Assessment) if the person coming off rehab therapy is not stable clinically - for example, the resident has developed an upper respiratory infection and fever, isn't drinking fluids well and needs daily nursing observation and assessment, advises **Roberta Reed, MSN, RN,** a consultant with **Howard, Wershbale & Co.** in Cleveland.

"The person may not even RUG into one of the upper 26 RUG categories, but the facility can still skill the person for daily observation and assessment, as an example, until he's stable," Reed says. "The OMRA covers the days until the next regularly scheduled MDS is due."

Myth No. 3: The facility has to document extensive assessments of the resident's condition and all care provided each shift to ensure Medi-care SNF coverage. That's not necessary, and facilities should avoid doing a lot of "garbage charting" that fills up the paper chart or electronic record, but doesn't build a case for skilled care, cautions Field.

On the other hand, the facility should definitely have daily documentation to describe the resident's skilled needs and skilled services provided. "You have to be able to tell from the documentation why the resident is skilled - otherwise, a medical reviewer may deny the claim," Belt advises.

In addition, the interdisciplinary team must document all three aspects of a resident's eligibility for the Medicare SNF stay: eligibility, skilled care requirement and the RUG level, advises Field. "The social worker may, for example, document eligibility by capturing the beneficiary's Social Security number, birth date, Medicare number and validating the three-day hospital stay," she says.

Therapy should document the resident's need for skilled therapy services and provide documentation to support what's coded on the MDS, including the number of therapy minutes and the resident's progress, Field adds.

Real-world example: To document skilled nursing coverage, Harbor **Villa Care Center** in Anaheim, CA uses a combination skilled care checklist and narrative Medicare daily skilled documentation form to capture skilled services (see Cliip 'N Save Combine A Skilled Care Checklist And Narrative Notes Form). "If the form doesn't take the nurse where she or he needs to go to support the skilled care being provided, then she can do a quick narrative note specific to the resident's skilled need," says **German Martinez**, a nurse and the facility's administrator.

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To make sure nurses know why the resident is being skilled, the facility also uses a form, which the nursing supervisor completes at admission. The form is then included in the resident's chart to give the nurses information about the skilled services required by the resident, Martinez explains. (See the related case study Ready, Set, Audit: Ensure Your Skilled Nursing Documentation Makes The Grade For Part A Coverage)

Myth No. 4: A Medicare beneficiary doesn't qualify for services unless he's had a three-day hospital stay within the last 30 days. Actually, a SNF can also reskill a resident within 30 days of his previous SNF stay. "Yet some SNFs miss out on the 30-day window where a resident who goes off skilled care can go back on for a condition treated during the SNF stay or resulting from the three-day qualifying hospital stay," notes **Helene Merlo, RN,** a consultant with **Parente Randolph** in Harrisburg, PA.

Facilities that track residents to see if they are eligible to come back on Medicare have the most success in reskilling residents within the 30-day window, Merlo observes. "Obviously, the resident would come back on Medicare under the same spell of illness," Merlo says, so make sure he has days left in the benefit period.

"But the resident doesn't need to go back in the hospital for Medicare to pay for the remaining days left in the benefit period - if the care is medically necessary based on Medicare criteria for SNF services."

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