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MDS Alert

Medicare Payment : Troubleshoot These 5 Areas On The UB-92 And MDS

Here's where the 'twain must meet if you want to get paid.

If your MDSs and UB-92s aren't in sync with each other, and with Medicare requirements, your SNF will have a trail of denied claims that could end in focused medical review -- or worse.

The good news: You can ward off a chronic case of the billing snafus and fiscal blues by making sure your SNF is on top of the following five common problem areas.

1. The assessment reference date (ARD) for the MDS is recorded on the UB-92. The ARD set by nursing goes on the UB-92 as the service date, notes **Jan Zacny, RN**, consultant with **BKD Inc.** in Springfield, MO. She has seen facilities put the date of admission as the service date, which makes it appear as if the facility gave seven days of therapy in one day.

Also make sure that nursing and therapy are working with the same ARD. **Tip:** Show the therapy department the ARD for the MDS and the RUG generated to make sure they are on the same page, which is how **Glenburn Home** in Linton, IN, handles the issue, according to MDS nurse **Chris Smith, BSN, RN**.

2. The HIPPS codes on the UB-92 reflect the correct RUG and assessment type. Nursing has to communicate to billing the RUG and assessment type, which comprise the Health Insurance PPS code (the three-letter RUG plus two-digit assessment modifier). That's important because "the modifier is not always the same two numbers that appear in section AA8a and b" of the MDS, says **Marilyn Mines, RN**, a consultant with **FR&R Healthcare Consulting** in Deerfield, IL. "For example, if the MDS were an OMRA that is combined with a 30-day MDS, AA8 a would be coded as 0 and the AA8b would be 8. The HIPPS modifier, however, would be 28, not 08."

Double check it: Have someone validate the two-digit assessment indicator that tells what type of assessment it is (the last two digits in the HIPPS code). "If someone isn't checking, the facility won't catch the little errors that people make," cautions **Diane Brown**, CEO of **Brown LTC Consultants** in Needham, MA.

3. The MDS coordinator lets the billing office know to bill off-cycle assessments (significant change in status or significant correction of a prior assessment). The MDS staff must let the billing department know to bill a new RUG rate generated by an off-cycle assessment beginning on the ARD of that assessment, counsels Brown.

Say you complete a significant change in status or a significant correction MDS for a Medicare Part A resident, and the ARD for this assessment is not within an assessment window for a required Medicare assessment, and there is a change in the RUGs category. You'd code the off-cycle assessment as a 3 (significant change) or 4 (significant correction) at AA8a, and an "8" at AA8b, says Mines. "But the HIPPS modifier would be a 30 or 40 and the change in reimbursement would start as of the ARD and end on the last day of the original cycle."

Try this strategy: MDS staff at Glenburn Home give billing a heads up about significant change in status or significant correction MDSs during the daily Medicare meetings attended by clinical and billing staff, reports Smith.

4. The diagnosis codes recorded on the UB-92 are correct (as specific and accurate as they can be) and correlate to diagnoses checked or coded on the MDS in Section I (I1, I2 orI3). Inappropriate or missing ICD-9-CM codes on the UB-92 are one of the top reasons for denied claims, cautions Zacny. "Put the code under primary diagnosis that explains the primary reason for providing and billing services for the Part A stay."

The claim must also include secondary diagnosis codes to further explain services provided and billed. For example, if

the patient is getting speech therapy and you just use the late-effect stroke code, that won't justify the need for speech therapy, says **Patricia Trela, RHIA,** a coding consultant in Quincy, MA. So you would want to include treatment codes, such as dysphasia (438.12), to explain the reason for services.

A treatment diagnosis is the impairment or disability related to a resident's function, explains **Yaffa Liebermann, PT, GCS,** owner of **Prime Rehabilitation Services Inc.** in Oakhurst, NJ. "A treatment diagnosis needs to be a disability that will justify skilled care," she says. And the diagnosis should be very specific. For example, treatment diagnoses would include "gait abnormality" (781.2) or "difficulty walking/hip" (719.75).

If the UB-92 includes certain supplies or pharmaceuticals, check to see that at least one of the ICD-9-CM codes explains why, advises Mines. "If you bill for a catheter, as an example, you need a diagnosis on the UB-92 to show why that item or service is required," Trela says.

You would expect to see the same diagnoses on the MDSs as on the UB-92 and vice versa, according to **Nancy Augustine, MSN, RN**, director of quality improvement and risk management services for **LTCQ Inc.** in Lexington, MA. "But if a resident were receiving eye drops for glaucoma or some other chronic condition that's not really the condition for which he's receiving skilled care, the diagnosis of glaucoma may be at the lower end of 10 diagnoses because it's not impacting his skilled care," Augustine says. "Yes, the resident is receiving medication and you're care planning for it due to peripheral vision loss, but that diagnosis wouldn't be at the top of the list on the UB-92 if the resident had suffered a CVA and was receiving rehab therapy for that, as an example," Augustine notes.

Beware: Some billing software packages reorder the ICD-9-CM code fields even when they are entered correctly in order of priority, cautions Augustine. If your software reorders the ICD-9 code fields, make sure the UB-92 includes the essential codes.

"The order of the codes is not as important as ensuring that everything 'billed'on the UB-92 has a treatment or diagnostic code to support its medical necessity," says Mines.

Another idea: Talk to your vendor about changing the software product to better meet your needs, suggests **Nathan Lake, RN**, a Seattle-based MDS and computer software expert. For example, you could ask the vendor to leave the codes in the order chosen by the user, or allow the user to assign a priority to each ICD-9 code and then place them in the bill based on priority, he says.

5. The MDS has been accepted into the state database before billing for the days covered by the MDS-generated RUG. "The billing department should actually look at the validation report from the state to see the MDS has been accepted," suggests Brown.