MDS Alert

Medicare: Proposed SNF PPS Rule Keeps Providers On Their Toes: Here's What You Need To Know

CMS explains default rate billing, RUG recalibration.

Be prepared: The FY 2009 proposed SNF PPS and consolidated billing rule contains provisions that could affect your SNF's bottom line depending on its MDS practices and case-mix. And there's a lot more lurking under the surface. So read on to find out what may be in store.

No assessment, no payment: For one, the final rule may settle that perplexing question about whether to bill the default rate for a missed MDS assessment. The proposed rule says that CMS' recent claims analysis has confirmed "confusion among providers" about when they can submit a claim using the Health Insurance Prospective Payment System (HIPPS) rate code of AAA00, which is the default code.

The proposed rule notes that when the SNF fails to comply with the assessment schedule, it must file a late assessment in order to be paid at a default rate. "Noncompliance with the schedule is determined by the assessment reference date (ARD) on the resident assessment."

The proposed rule says that program instructions also allow payment at the default rate in these limited circumstances when the SNF has failed to assess the beneficiary:

• When the stay is less than eight days within a spell of illness;

• The SNF is notified on an untimely basis or is unaware of a Medicare secondary payer denial;

• The SNF is notified on an untimely basis of the revocation of a payment ban;

• The beneficiary requests a demand bill; or

• The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

"In circumstances other than those described above," states the proposed rule, "no payment is available to the SNF where the SNF fails to assess the resident." Yet even though Medicare won't pay, the SNF must "nonetheless submit a claim using the HIPPS default rate code and an occurrence code 77 indicating provider liability in order to ensure that the beneficiary's spell of illness (benefit period) is updated," according to the proposed rule.

Unless CMS is convinced to do otherwise by comments on the proposal, it will go into effect on Oct. 1, 2008, says **Ron Orth, RN, NHA, CPC, RAC-CT**, president, **Clinical Reimbursement Solutions LLC** in Milwaukee.

A History of Conflicting Instructions

In Orth's view, the confusion over billing the default rate for a missed MDS assessment began with CMS' release of Transmittal 196 in 2007 (http://www.cms.hhs.gov/transmittals/downloads/R196PI.pdf). Since that time, CMS has made contradictory statements related to the proper billing of the default code, says Orth, noting that SNFs have always billed the default rate when staff forgot to do an MDS and could not do one after the fact. "This practice was in compliance with several [fiscal intermediary] documents as well as the CMS Web-based MDS training program," he points out.

CMS officials said in a SNF/LTC Open Door Forum last year that the practice of billing the default rate for a missed assessment was OK as long as it didn't reflect a pattern, Orth adds. "Based on the CMS Open Door Forum comments,

many providers continue to bill the default code in the rare occasion" where staff did not complete an MDS, Orth says.

RUG Recalibration Will Affect Some SNFs More Than Others

The proposal also includes recalibration of the RUG case-mix weights to make the RUG-53 system, implemented in 2006, budget-neutral.

In that regard, the rule has "been somewhat controversial," said **Sheila Lambowitz**, during a recent SNF/LTC Open Door Forum. Lambowitz noted that in expanding the RUG-III model from 44 to 53 RUGs, CMS expected a shift of only about 19 percent to the nine new rehab plus extensive services RUGs. But it actually turned out to be 30 percent, meaning the agency overpaid SNFs in 2006, 2007 and 2008, Lambowitz said. CMS isn't taking back the extra money, but moving forward, the agency is making the RUG system budget-neutral, she explained.

CMS proposed an adjustment of $770 million for FY 2009, so going forward the payments will be lower. That $770 million is offset by the market basket update of $710 million, leading to a $60 million reduction in payment.

Running the numbers: In analyzing the proposed rule, **Steve Jones, CPA**, with the Clearwater, FL, office of **Moore Stephens Lovelace**, notes that for the federal rates, the nursing index declined in all categories, from under 5.5 percent in some of the non-deemed categories (those in the lower 18 RUGs), to almost 8 percent for CC2.

"The nine new groups declined from just under 6.5 percent to 7.3 percent," he says. This means that "even with the market basket increase, the nursing component is declining in real terms," Jones adds.

From an operational standpoint, facilities that have higher percentages of residents in Extensive Services and Clinically Complex categories are going to be more adversely impacted than those with more rehab patients, Jones says.