MDS Alert

MEDICARE: Steer Clear of Common Problems At P1a

Capture these treatments to keep your SNF fiscally healthy.

MDS teams that aren't up to speed in coding and documenting the numerous payment-related items in P1a can wave goodbye to accurate RUG placements.

The section includes four of the five extensive services, a slew of services that RUG residents into clinically complex -- and one that will RUG a resident into special care. It also contains medical review items that support a skilled level of care.

Boost your payment track record: These three steps will keep you on the road to PPS and compliance success.

1. Review the basic rules and exclusions for capturing clinical services in P1a. Code items in this section if the resident received the service even once in the past 14 days -- as long as it wasn't solely in conjunction with a diagnostic or surgical procedure and the immediate post-recovery period, advises **Christine Twombly, RN,** a consultant with **Reingruber & Company** in St. Petersburg, FL. Also, "you can't code IV medications or blood transfusions [in P1a] given in conjunction with chemotherapy or dialysis," Twombly cautions.

Tip: Develop standardized procedures that ensure you evaluate whether to code IV meds and other services in P1a provided in conjunction with surgery or a diagnostic procedure and the immediate recovery aftermath. For example, nurse consultant **Jan Zacny, RN**, with **BKD Southern Missouri** encountered a scenario in which a resident who received a minor laparoscopic procedure went into respiratory distress and had to go on a ventilator in the SNF for a day. While you can't code a vent provided as part of a surgical procedure, Zacny told the facility to capture it in this case because "it wasn't a part of the normal recovery period for the surgical procedure."

Another example: If a patient had surgery in the hospital and received an IV med for a day in the ICU unit due to an unexpected post-op complication, Zacny tells facilities to code it in the lookback.

Key coding tip: Code radiation therapy, chemotherapy and dialysis even though the services are excluded from consolidated billing. Chemo or dialysis will RUG a resident into clinically complex -- and radiation therapy will put him in special care.

2. Develop a surefire system for obtaining hospital documentation for extensive services. If the resident received a service coded in P1a before admission, you need documentation from the hospital to identify the date of services, says **Marilyn Mines, RN, BC,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. Other- wise, the facility will be out of luck -- and money -- if the FI asks for the back-up documentation.

Cautionary example: One facility put a resident with IV meds into SE2. "But the only documentation the facility had was a physician order sheet from the hospital saying to start an IV antibiotic," says Zacny. And "the FI said that just because the doctor ordered the medication doesn't mean the resident received it. So the FI dropped the resident down to a special care RUG. The facility obtained the hospital documentation after that and appealed and won," she adds. "But that's a lot of hassle."

Your best bet: Consultant **Diane Atchinson, MSN, RN-CS, ANP,** advocates that SNFs send someone to prescreen residents in the hospital and obtain the hospital documentation to justify MDS coding, including MARs and blood transfusions, etc. Once the hospital sends the chart to medical records, it's like "pulling teeth" to get the documentation you need, cautions Atchinson, president of **DPA Associates Inc**. in Kansas City, MO.

Proactive strategy: William O. Benenson Rehabilitation Pavilion obtains a copy of the MAR from the hospital that tells the last day of the IV medication, says **Nemcy Cavite Duran, RN, RAC-C,** director of MDS for the Flushing, NY facility. "We also ask our physicians to write in the admission note that the resident had IV medication in the hospital and to specify the condition the medication was used to treat -- for example, an antibiotic for pneumonia."

3. Double-check whether you've coded and documented items to justify a skilled level of care. For example, P1ae (monitoring acute condition) isn't a RUG driver, but it is a "medical review item," counsels **Diane Brown,** CEO of **Brown LTC Consultants** in Peabody, MA. "If the facility is skilling a resident for assessment and observation or evaluation of the care plan -- and you don't check that item -- the FI may ask why not?" she warns.

Another example: P1ad (intake and output). Doing I&O doesn't get the resident into a RUG. But it does help explain why you were skilling someone in the bottom 18 RUGs for acute monitoring, notes Atchinson.

You also need documentation to support that you were collecting I&O data and also using skilled nursing skills to determine if the resident had a potential fluid imbalance.

Editor's note: See the related reader question on whether you can code oral suctioning in Section P1a, p. 137. Also read "Breathe Easy When You Skill A Resident For Oxygen Therapy (P1ag)" in the January 2007 MDS Alert.)