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MDS Alert

Medicare:Preempt Payment Recoupments and Worse With This RAC Risk Management Plan

Your SNF could be more vulnerable than you think.

The Recovery Audit Contractors have been turned loose, and now's the time to troubleshoot problem areas likely to soon appear in the auditors' crosshairs.

Hindsight is 20/20: Taking lessons from the RAC demo, SNFs might bet on rehab therapy being a hot item on RACs' agendas. "RAC audits may also focus on rehab RUG categories, especially if residents are in those categories for long periods of time," cautions **Cindy MacQuarrie, RN, MSN**, managing partner for BKD Inc. in Kansas City, Mo. RAC reviewers will look at records to see if the rehab services were repetitive in nature and could have been provided by non-licensed personnel, says MacQuarrie.

A big fiscal pinch: In the demonstration project, the RACs recovered $16.3 million from SNFs, and some of the bigger recoveries in California related to failure of SNFs to meet Medicare criteria for skilled therapy, observes attorney **Steve Lokensgard**, special counsel with Faegre & Benson LLP in Minneapolis. And that means either the SNFs didn't have good documentation of physician orders for the therapy, or the therapy documentation didn't meet the relevant medical necessity criteria, he says.

Solution: "DONs and MDS coordinators, as well as nursing staff, need to evaluate residents to ensure that they need therapy services based on their current conditions," advises MacQuarrie. "State agencies and CMS have information about residents' ADL status, how much they are walking, and range of motion, etc.," she adds. And auditors can look at the facility's MDS data to determine whether the resident has changed as the result of therapy. "If there has not been any change, auditors may ask why the person is receiving therapy."

Smart moves: SNFs should correlate therapy services to rehab residents' ADL and mobility status on the MDS, and complete a significant change assessment if the person declines in two or more ADLs, MacQuarrie advises.

Focus on These Key Billing Issues

Other areas likely to appear on the RACs' radar include:

1. Part A consolidated billing. RACs will be focusing on consolidated billing issues and double billing of items to Part B for people in Part A stays, predicts **Betsy Anderson**, VP at FR&R Healthcare Consulting in Deerfield Ill. "That's fairly easy to identify because the RACs will have access to Part A and Part B claims."

Proactive strategy: "SNFs have to make a good-faith effort to notify an outside provider that a patient is in a Part A stay," advises **Elizabeth Malzahn**, manager with FR&R. "The SNF should have a good notification mechanism," she adds. "This is something CMS has been telling SNFs for a long time."

Double billing most often occurs when outside providers, such as lab companies, come to facilities to provide services to residents who they don't realize are on Part A, in Malzahn's experience. And "most of the time this is an honest mistake," she says. However, "basically what RACs are going to look at is those honest mistakes."

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2. Lack of a three-day qualifying inpatient hospital stay. SNFs get caught in the trap of not verifying a three-day

stay, says Anderson. Then they find out after providing SNF care that the person was really in the emergency department or on an observational unit for part of that time rather than in an inpatient bed. And "edits in the system can detect that type of thing even at the fiscal intermediary or MAC level," cautions Anderson.

Trouble brewing? RACs will probably be looking at the qualifying hospital stay not only for SNFs but also on the hospital side, in terms of the medical necessity of the stay, experts caution. And the latter could be a big problem for SNFs.

"If the hospital doesn't meet medical necessity criteria for the three-day hospitalization required for the SNF benefit, the RAC could deny the SNF stay, as well," predicts **Tim Johnson, MBA**, executive director of Castle Rock Medical Group, a Denver-based consulting firm. To counter this threat, the SNF might review the hospital H&P, discharge summary, and other clinical documentation to see if those meet the documentation requirements for medical necessity, Johnson suggests. "It's a bit testy to have a SNF evaluating the acute-care side of documentation, but the SNF's payment may be on the line related to that."

3. Billing compliance requirements. Watch out for compliance issues where, for example, the SNF doesn't submit benefits exhaust claims for patients who continue to receive tube feedings that keep them skilled, advises **Jennifer Wormington**, managing consultant for BKD LLP in Springfield, Mo. "The SNF has to submit benefits exhaust claims whether the resident is in a certified bed or not. The SNF doesn't have to submit a no-pay claim unless a person going off Part A remains in a certified bed."