MDS Alert

Payment and Regulatory Compliance: Keep Your RUGs Straight And Enjoy A Clean Compliance Slate

Jettison this dangerous idea about MDS accuracy.

Don't be misled: MDS undercoding can be a wolf in sheep's clothing.

"Most facilities know that upcoding patterns can lead to payment recoupments and even fraud investigations, but many tend to ignore undercoding because they believe it doesn't get them into compliance and fraud territory," comments **Ari Markenson, JD**, with **Epstein Becker & Green** in New York City.

Yet undercoding cuts your patient-care coffers and can bring surveyors and plaintiff attorneys stomping to the door. "If the MDS is wrong, then your care plan and services provided may be wrong," cautions Markenson.

The bottom line: Both under- and overcoding are equal opportunity troublemakers that you need to head off at the pass. These five strategies will help keep your MDS coding regulatory compliance on the straight and narrow - and your payment on the up and up.

1. Assign two people to do MDSs who develop expertise in assessment/coding following state-specific and Medicare requirements. "Then those MDS nurses can cross-check or spot audit each others' MDSs on a regular basis" (and serve as a back-up for each other for vacations or illness), suggests Markenson.

You might even consider having a third person with MDS know-how audit the two MDS coordinators doing the assessments, suggests **Susan Battaglia, RN,** a consultant with **MG Healthcare Solutions** in Orchard Park, NY. Whatever you do, don't assign one person the role of MDS guru. If you do, the facility could have a problem with MDS accuracy and not even be aware of it, says Battaglia.

2. Use the peer audits to identify areas where the MDS team disagrees over coding issues and seek definitive answers to resolve the issue. If the QA team can't figure out the answer by referring to the RAI user's manual and other written and expert sources, go to the horse's mouth, e.g., a government source - and get the answer in writing.

For example, if the RAI coordinator or your fiscal intermediary says to code an item or handle an issue in a certain way, confirm that in writing, even if it's by e-mail. Doing so could get you off the hook if the advice turns out to be wrong. "A provision in the new Medicare Modernization Act says that providers who rely on written advice from the FI or the **Centers for Medicare and Medicaid Services** can't be held liable for fraud," Markenson notes.

3. Spot audit the MDS and RUG before transmitting it to the state and before submitting the UB-92 to the FI. Again, you're looking for upcoding (an inflated number of rehab minutes, for example) but also case-mix drivers that the MDS coordinator or team may have missed.

For example, review your preadmission information, especially on the 5-day MDS with the hospital lookback, suggests **Patricia Boyer, RN, MHA,** a consultant with **BDO/ Heritage Healthcare Group** in Milwaukee. "See if you missed an IV or other service that would put the person into an SE3," she says.

Keep in mind that ADL scores are often off the mark - and not in the facility's favor. "Ask someone who knows the resident to spot check the ADL score to see if it sounds right," Boyer adds. "If you have a question about the ADL score accuracy, then dig into the individual components for the late-loss ADLs to see if they were assessed and coded

correctly," she counsels.

"For example, if you know a patient in RHA requires a lot of help with their ADLs, that could be a mistake, because a resident in that category is normally coded as fairly independent," Boyer adds. "So you'd look deeper at the assessment/coding accuracy."

Also check with clinical staff who know the resident, as they may be aware he received some oxygen therapy PRN during the assessment window, as an example, which could affect the person's RUG, cautions **Roberta Reed, MSN, RN**, a consultant with **Howard, Wershbale & Co.** in Cleveland.

Try this: Use the MDS software function (most computer systems have it) to generate a quick list of the clinical indicators that contributed to the RUG classification - for example, pressure ulcers with two or more treatments, tube feedings, etc., advises **Diane Brown, CEO** of **Brown LTC Consultants** in Boston. "Then check the documentation to see if those conditions and treatments are adequately recorded in the medical record."

As a final check, compare the UB-92 to the RUG scores and MDS before the facility bills, Brown suggests. "Double check the value in Section P (therapy minutes), the ADL scores and make sure the UB-92 includes ICD-9 codes that explain the medical necessity of services billed and required for the RUG."

Doing the audits can pay off big time, says Brown: "One facility that generates 5,000 MDSs a year found that simply double checking the UB-92s against the MDS/RUGs score rang up an additional $750,000 in one year."

4. Listen up if surveyors find problems with your MDS accuracy. The first sign that a fraud audit might be in your future may actually come from surveyors.

"Facilities often don't realize that if the survey agency concludes they have a systemic issue with their MDS accuracy, they also have a payment issue (and potential fraud allegations) on their hands," Markenson avers. "Surveyors are supposed to pass along such information to Medicaid or Medicare FIs or to CMS."

5. Follow the DAVE show. Tune in to the CMS-sponsored Webcast series that walks providers and surveyors through the top inaccuracies uncovered by DAVE in the program's prenational or pilot phase. In rank order these problem spots are Sections P, I, O, J and G. CMS will analyze DAVE findings resulting from offsite and onsite MDS reviews later this year.

To view the Aug. 27 Webcast on Section G (physical functioning), the Oct. 29 Webcast and the upcoming Feb. 28 one on Section P, go to www.cms.internetstreaming. (For highlights of the training effort, see the February, March and April MDS Alerts.)