MDS Alert

Payment, Compliance & Clinical News

Some SNFs are getting MAC letters about ultra high rehab. "Highmark, the MAC for J12, has started a comparative review where it's sending out letters to SNFs whose billing for 'higher paying RUGs' is above the J12 average, based on the MAC's analysis," reports attorney **Paula Sanders,** with Post & Schell in Harrisburg, Pa.

Sanders notes that the letter Highmark has sent to SNFs points to the OIG study showing that SNFs from 2006 to 2008 "increasingly billed for higher paying RUGs, even though beneficiary characteristics remained largely unchanged." The OIG report, "Questionable Billing by Skilled Nursing Facilities," is referring to ultra-high rehab.

The MAC letter typically says it contains "a summary of the RUG claims billed by your facility as compared to the J12 average," informing the SNF that "a list of the individual high-paying RUG claims billed by the facility is available upon request," Sanders says. "The MAC goes on to say [in the letter] that while it 'recognizes that not all of these claims may represent payment errors, we are asking in light of the OIG findings for you to review the data closely and conduct a self-audit of the associated claims,'" she adds.

Sanders says she knows that non-profit SNFs have received the letter -- "even though the OIG report quoted in the letter talked about for-profits being 'far more likely than nonprofit or government SNFs to bill for higher paying RUGs.'" But "the MAC isn't looking at the ownership status of SNFs," says Sanders. "It's looking at its data. Being a small-sized SNF or having a non-profit status won't insulate a SNF from reviews by the MAC."

More: Consultant **Judy Wilhide, RN, RAC-MT, C-NE,** in Virginia Beach, Va., reports that she's aware of four SNF providers in J11 (Palmetto) that have in the past six days received record requests for rehab ultra high.

Editor's note: For an in-depth look at ultra high rehab, including experts' suggestions for how to avoid denials for the service, see an upcoming issue of MDS Alert.

In the hospice section of its FY 2012 work plan, the OIG says it will "review hospices' marketing materials and practices and their financial relationships with nursing facilities." The focus of the new review, says the OIG, will be "hospices that have a high percentage of their beneficiaries in nursing facilities."

A July 2011 OIG report, "Medicare Hospices That Focus on Nursing Home Residents," identified what the agency calls "high percentage hospices," which were providing two-thirds or more of their hospice care to Medicare patients in nursing facilities in 2009. The agency's analysis found that such hospices "typically enrolled beneficiaries whose diagnoses required less complex care and who already lived in nursing facilities. Together, beneficiaries with ill-defined conditions, mental disorders, and Alzheimer's disease accounted for over half (51 percent) of the beneficiaries served by high-percentage hospices," the report states. "In contrast, 32 percent of all hospice beneficiaries had one of these three conditions as their terminal diagnoses; beneficiaries with these conditions typically received routine home care, which is less complex and costly than other levels of hospice care."

In the report, the OIG noted that "CMS stated that it will share the information in this report with Recovery Audit Contractors (RAC) and Medicare Administrative Contractors (MAC)."

The OIG data in the agency's report may not be an accurate representation of what's happening today, according to one industry expert. The OIG's data collection spanned from 2005 to 2009, but the new hospice Conditions of Participation only took effect in December 2008, and provided a lot of new requirements, including the face-to-face requirements for recertification, says **Jon Radulovic,** spokesperson for the National Hospice and Palliative Care Organization. (For more information on the hospice F2F requirement, see the article on page 124.)

Consultant **Beth Carpenter** also points out that "there's nothing wrong with providing care if it's done appropriately and people qualify" for the care. "And it's quite possible that's what's going on in the designated [high nursing home volume] hospices" identified in the OIG report. "It's just that the spotlight is now being put on this particular setting for hospice care," adds Carpenter, in Lake Barrington, Ill.

Cherry Meier, RN**, M**SN**,** senior VP of public affairs for VITAS Healthcare Corporation, which provides hospice services, notes that the eligibility requirements for hospice don't include diagnoses requirements. "The criteria state that the physician anticipates that the person has a six month prognosis or less if the disease follows its normal course." Thus, you have to look at each case independently, she adds.

"Just because someone has a primary diagnosis of dementia doesn't mean the person doesn't have other complicating factors," Meier says. "When you simply label people according to their diagnoses, you miss what they may actually require in terms of care. The OIG report focuses more on diagnoses rather than the complexities of the person that would make him or her eligible for hospice."

The various MACs/FIs do have local coverage decisions for hospice care, Meier says. "These are usually for non-cancer diagnoses where the MAC/FI provides guidelines to help hospice providers identify criteria that would qualify the patient," she says. "But the criteria are just guidelines -- they are not etched in stone anywhere. They help with your documentation, but if the physician finds the person is declining for other reasons, then they may be eligible for hospice," Meier adds.

CMS**recently posted "MD**S**3.0 R**AI**Manual V1.07 Errata" on its website.** The table includes a number of corrections to the RAI manual that the agency says will appear in the next version. For example, on "page 2-56 Section 2.11 Combining Medicare Assessments and OBRA Assessments: the text does not reflect the new PPS assessment schedule," CMS states in the table.

Another one: "On page 2-58, Section 2.12 Medicare and OBRA Assessment Combination: under Medicare-required 14-Day and OBRA Admission Assessment the second and third bullets do not reflect the new PPS assessment schedule."

Currently the manual reads as follows:

- "ARD (Item A2300) must be set on days 11 through 14 of the Part A SNF stay.
- ARD may not be extended from day 15 to day 19 (i.e., grace days may not be used)."

The edited version will be:

- "ARD (Item A2300) must be set on days 13 or 14 of the Part A SNF stay.
- ARD may not be extended from day 15 to day 18 (i.e., grace days may not be used)."

More: "Chapter 3, Section O Page O-39 Item O0600: Physician Examinations -- in the first bullet under Coding Tips and Special Populations, the last sentence 'Cannot be an employee of the facility' was added in error and should be ignored," states the information in the table. "Chapter 3, Section O Page O-39 Item O0600: Physician Examinations ��" in the first bullet under Coding Tips and Special Populations, the last sentence "Cannot be an employee of the facility" was added in error and should be ignored."

To read all of the errors and corrections, download the table at www.cms.gov/NursingHomeQualityInits/downloads/MDS30Errata.pdf.

Have your residents been taking any of these OTC supplements? High doses of vitamin A can cause hypercalcemia and make someone appear to have hyperparathyroidism, said **John Morley, MD,** in a talk at the March 2011 annual American Medical Directors Association meeting. "Watch for this -- it's very common," he said. "Some patients are taking four different vitamin A combinations a day. We see this all the time in my endocrine practice."

Also: "Ginseng causes hypertension. Get rid of ginseng and the blood pressure goes down," Morley reported. And "colloidal silver causes kidney damage."

Head off problems with intended weight loss. "You have to be careful with prescribing weight-loss diets for older people in nursing homes," says **John Morley, MD,** at St. Louis University School of Medicine. "Weight loss can increase hip fracture and lead to functional disability," he cautions. "When you lose weight, you lose 75 percent fat and 25 percent muscle and bone," he adds. "And when you are older and frail, loss of muscle and bone is a much bigger problem."

Remedy: "Exercise is a good way to lose weight," Morley tells MDS Alert. "If someone does need to lose weight, you should give a high essential amino acid diet and have the person in an exercise program. There are some great studies showing that people who do any resistance exercise and any aerobic exercise have amazingly good results."