MDS Alert

Payment & Compliance: Take Your Medicare Meeting Productivity to a New Level

Tip: Make sure someone at the meeting knows if the resident has a clinical need for skilled care after therapy stops.

Are your Medicare meetings a forum for getting the job done efficiently -- or do the meetings leave room for improvement?

That's the pivotal question addressed by **Marilyn Mines, RN, RAC-CT, BC,** in a popular session at the October 2010 American Association of Nurse Assessment Coordinators meeting.

"Ask are these meetings working for us -- or have they become this meeting place where everyone is thinking about everything else they should be doing other than sitting there and chatting?" To avoid that scenario, "have people stand during the Medicare meeting" so they will want to keep the meeting moving along by focusing on the Medicare issues, advised Mines, director of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

Address Meeting Frequency, Who Should Attend, Discussion Points

How often you meet depends on the facility's census and whether the facility conducts other meetings focused on Medicare issues, Mines said. "If you have 65 or 75 residents on Medicare at a time, you don't have to discuss every single resident at every meeting. You could have Tuesday/Wednesday for the Medicare meetings" for example. Just make sure the team touches base weekly at a minimum for each resident, she advised.

As for who should attend: The list includes therapists or a therapy representative and the social worker. "The social worker is critical for discharge planning," Mines noted. "Many facilities actually have their social worker give the generic and liability notices -- and the person has to know when to give them." Discuss generic and liability notices required for Part B residents, too, Mines advised. (For a comprehensive review of these notices and a handy chart to help you sort them out, see the next MDS Alert.)

The meeting should also include someone from billing or the business office. "The business office tracks the Medicare days," Mines noted. If the facility doesn't do so as part of a triple check meeting, discuss ICD-9 codes with the business office representative at the Medicare meeting, she advised. Look at whether the UB-04 appropriately identifies codes to support the ancillary charges. (For more information on ICD-9 diagnoses for rehab residents, see the article on page 20.)

Billers/business office people also know about the residents' secondary payers and whether an Additional Development Request (ADR) has been posted, Mines said. "They are the first to know about an ADR in most instances," which needs to be communicated "ASAP" so you can start collecting data and reviewing the medical record.

The administrator and nursing representatives should also participate. And make sure someone at the meeting knows the resident's clinical needs to determine if the resident qualifies for Part A coverage after therapy stops, Mines urged. "You need people who have done their homework and are going to shoot out the information ... about what makes the resident qualify for Medicare on a clinical basis," added Mines. She noted that many of the clinical RUGs now pay more than some of the rehab RUGs.

Also discuss the resident's disposition and how much longer he's going to be on Medicare. "If you only discuss this during the Medicare meeting, are there in-betweener meetings? How are you letting billing know when the person is no longer skilled?" Mines asked.

Billing tips: Once a resident is no longer skilled, the SNF must send a no-pay claim to the intermediary, if the person remains in a Medicare certified bed, Mines explains. You send the no-pay claim at least once a year, before Sept. 30, to notify the Common Working File that the resident is in a certified Medicare bed, she adds.

If the person has used up his Medicare days and remains skilled, the billing department must submit a benefit exhaust claim, Mines advises. Send the benefits exhaust claim monthly while the person remains at a Medicaredefined skilled level of care, she says. "This prevents a new benefit period from starting." Once the resident is nolonger skilled, you send the final benefit exhaust bill.

Consider These Additional Agenda Items

Mines also suggested covering these topics in the Medicare meeting:

Reason for Medicare coverage. Mines includes this item on a template for a Medicare meeting (see page 18). She prefers using one form per resident that includes the designated information from week to week. That way, "you can continue to track the resident over a period of time."

Physician certification/recertification. "One of the biggest reasons for technical denials is lack of certification and recertification," Mines cautioned.

The therapy start date. Under RUG-IV, the therapy start date (the date of the first therapy evaluation**)** is important in terms of whether you're re going to do a start of therapy OMRA, Mines pointed out.

The ARD window for the upcoming MDS assessment. Discussing this helps with ARD planning, including when you're doing an end of therapy OMRA, Mines counseled. Discussing the window "also allows staff to be more aware of the requirements for combining various assessments, since this is connected to the window for an acceptable ARD." For example, look to see if you can combine a start of therapy OMRA with a 14-day assessment.

The reason for doing the assessment and the correct assessment indicators. "The Medicare meeting is a good venue for talking about that," Mines said. "The assessment indicators are used for billing and to indicate why the assessment was completed." Depending on your software, you may sometimes have to make manual changes to the assessment indicators, she pointed out.

Part A consolidated billing. The nursing representative at the Medicare meeting can alert the biller or business office representative to look for an invoice from a provider for an X-ray, lab test, or other ordered ancillary service that falls under consolidated billing, Mines said. Otherwise, "if you have no other way of letting the billing office know to expect an invoice (other than the resident has an order for an X-ray, etc.), how are they going to know to look for one?"

The 30-day window. Track residents who have gone off Part A during the 30-day window to see if they are eligible to go back on Part A during that time period, Mines advised.