Codify
BY AAPC

MDS Alert

Payment: Ditch These 3 MDS Myths Before They Drive Medicare Revenues Into The Ground

The truth will allow you to capture fair payment for your SNF.

Myth-driven practices for setting assessment reference dates can be expensive. So don't let these three common mistaken beliefs ruin the fiscal show in your SNF.

Myth No. 1: Prescheduling the MDS process using a software program is the best way to know what to do when. That approach may keep the assessments on time -- but you can bet they won't be right on the money. For example, to get the MDS done within the acceptable RAI timeframe, some facilities "use Excel spreadsheets where they put in the resident's date of admission and calculate what's due when," observes **Nathan Lake, RN,** an MDS expert in Seattle. Other facilities preprogram their MDS software with "suggested reference dates that the staff take as the absolute dates," says **Sheryl Rosenfield, RN,** director of clinical services for **Zimmet Healthcare Services Group LLC** in Morganville, NJ.

The problem: If the facility puts a software program in charge of selecting ARDs, the interdisciplinary team loses the flexibility of setting the best assessment window for each assessment to capture the highest case-mix RUG, which pays the most under the RUG-53 system. For example, the facility might miss out on getting a resident into extensive services "because they go too far to the end of the assessment window to capture" IV fluids or IV medications, says **Marilyn Mines, RN, BC,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.

Solutions: By "establishing a case management approach to the assessment process and knowing the resident's clinical condition," the team can identify "key financial drivers," says Rosenfield.

You can enlist your software's help, of course. For example, some software offers the capability to help you select the ARD that will put the resident into the RUG with the highest case-mix, says **Peter Arbuthnot,** with **American HealthTech Inc.** in Jackson, MS. Some software programs also calculate information on the selected ARD and "flag" inconsistencies or MDS items that may have been improperly coded or that the team might look at for higher reimbursement, says Mines. But using such programs doesn't diminish the need for the RN assessment coordinator "to understand what's going on and why," she adds.

Myth No. 2: You shouldn't use grace days if you want to stay in the Centers for Medicare & Medicaid Services' good graces.

The problem: Refusing to use grace days means you lose the flexibility of capturing a resident's highest therapy use, ADL assistance and other key RUG drivers.

The solution: The rule is that you can use grace days but don't abuse them, advises **Jan Stewart, RN,** a consultant with Zimmet Healthcare. "It's perfectly safe to use them in order to get the resident into a higher paying RUG, if he requires and receives the services," she says.

"For example, you might use grace days to capture very high or ultra-high therapy minutes," adds Stewart. "Or you might use grace days" when a resident missed a day or two of therapy due to illness, she adds. In that case, "move the ARD forward in order to capture five days of therapy."

You can change the assessment reference date all the way up to the last available grace day in order to capture the resident's highest resource use, says **Maureen Wern, CEO** of **Wern and Associates** in Warren, OH.

Not recommended: One example that could be construed as misusing grace days might be a facility that always uses day 8 as the ARD for the 5-day MDS for no reason, says Stewart. You can project high rehab on the 5-day MDS, she says, so there's no reason to use grace days for that reason. "If a facility routinely used grace days due to an organization and time management problem -- that's also a problem," Stewart adds.

Using the grace days for the 5-day assessment under the presumption of coverage can be a problem if there's nothing else to skill the resident other than the IV in the lookback -- "and you discharge the person after that ARD," says **Roberta Reed, MSN, RN,** clinical care manager at **Legacy Health Services,** which operates nursing homes in Ohio. "If there's something else going on with the resident and you want to capture that by using a grace day -- for example, so the person goes into SE3 instead of SE2 or SE1 -- that would be OK," Reed adds.

Myth No. 3: You should always set the ARD in order to capture rehab plus extensive services rather than one of those "old RUGs." Facilities that blindly follow that policy will end up with a lower paying RUG in some cases.

Example No. 1: Ultra-high rehab (RUC and RUB) pay more than everything except for ultra-high rehab plus extensive services. Yet Wern has seen situations where nursing insists on using day 11 as the ARD to capture the hospital IV medication on the 14-day MDS when therapy is saying "if you give us three more days, we can put the person into ultra-high rehab."

The Medicare team should set the ARD to capture the optimal RUG group, stresses **Diana Johnson, RN,** a consultant with **Health Dimensions Group** in Minneapolis.

Example No. 2: SE3 pays more than low rehab plus extensive services (RLX), notes **Christine Twombly, RN,** a consultant with **Reingruber & Company** in St. Petersburg, FL. So say a frail elderly resident who had IV meds in the hospital lookback received enough therapy and restorative nursing to qualify for RLX on the 14-day assessment. If the resident also qualifies for SE3 (extensive services), the RUG grouper will select SE3, which has a higher case-mix index and pays more than RLX, says **Diane Brown,** CEO of **Brown LTC Consultants** in Boston. But if the resident qualifies for both RLX and SE3 and you set the ARD so one of the elements for SE3 drops out -- such as a condition required for impaired cognition or one that puts the person into clinically complex or special care -- then the person will go into RLX, Brown points out.

The dollars add up: RLX pays about $45 less a day than SE3 (federal unadjusted urban rates for fiscal 2007, effective Oct. 1, 2006).