Codify
BY AAPC

MDS Alert

Payment: Erase Default Rates For 5-Day MDSs, Demand Bills

Weigh carefully whether to do MDS assessments.

Think of the default rate as the bottom-rung RUG that can cause your SNF to loose its fiscal footing if you accrue too many.

Key example: Medicare will pay the default rate for a beneficiary who received skilled care and was either discharged or died on or before day eight of the SNF stay when the SNF didn't do a five-day MDS.

And "some facilities decide it's not worth the paperwork to do an MDS and [instead] bill the default rate using a HIPPS code of AA000," observes consultant **Jan Zacny, RN.** "But if you do that too many times, you're really losing money," cautions Zacny, with **Southern Missouri BKD** in Springfield, MO.

Instead: Zacny encourages SNFs to always do a 5-day MDS--even if the patient goes home or dies on day one or two. "The default rate is considerably lower than SE2 or SE3 for a patient who had an IV in the hospital," she warns.

And the actual monetary loss may be higher than you think due to direct-care costs. "It's a fair assumption," says **Joy Morrow, RN, PhD**, "that care costs are the highest for the first day or two of a resident's stay." That's because the "staff will be assessing the person and providing more assistance in most cases until the resident improves--or until they determine what level of help he needs," says Morrow, a consultant with **Hansen, Hunter & Co**., Beaverton, OR.

Master Demand Bills

SNFs also receive the default rate in demand bill scenarios where the facility doesn't submit an MDS for a resident and the FI determines the services met coverage criteria for skilled care.

Your best bet: Consultant **Joan McCarthy, MJ, LNHA**, thinks it's a good idea for SNFs to always do MDSs when residents or their representatives request the facility submit a demand bill to the FI.

"The resident might RUG into one of the upper 35 RUGs--for example, Clinically Complex for oxygen--but the facility didn't feel the resident required daily skilled care for the oxygen," says McCarthy, manager, health care, **RSM McGladrey Inc.** in Chicago.

Of course, usually, the resident will go into one of the lower 18 RUGs. Even so, those pay more than the default rate.

Morrow agrees, noting that FIs are deciding more cases in the beneficiary's favor, especially on the front end of a SNF stay when a patient has had a three midnight hospital stay.

But the FI is more likely to deny demand bills for services on the back-end of a skilled stay, Morrow finds.

Preempt this: "The most common reason a resident/representative requests a demand bill after Part A therapy stops is that the person doesn't feel ready to go home," says Morrow. But "in most cases, you don't have to discharge the person immediately," she notes.

"You can continue to skill the person if she still requires daily skilled nursing monitoring for a few days to make sure she is stable--and then decide prior to eight to 10 days after all therapy stops whether to do an Other Medicare Required Assessment," Morrow says.

You can also "talk to the resident/family about other care options after the Part A stay ends--for example, Part B therapy or home health services," Morrow notes.

Caution: If Part B therapy services will be rendered at a Medicare A level, the resident should not be discharged from Part A, adds **Marilyn Mines, RN, RAC-C, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.