MDS Alert

RAI Compliance: Get Your MDSs And Billing Ready For Inspection

Here's what the government is likely to target in 2004

Wherever the OIG plans to go, fiscal intermediary auditors and surveyors are sure to follow. And the Health & Human Services' **Office of Inspector General's** 2004 work plan casts a spotlight on - you guessed it - the MDS, as well as a number of billing and payment issues.

The OIG plans to examine MDS submissions and nursing home records for PPS patients, as well as the timeliness of MDS submissions for all nursing home residents. In other words, "the OIG work plan is the 'nail in the coffin' for the idea of the MDS as an original source document," says Washington-based attorney **Marie Infante**, a member of the board of the **American Nurse Assessment Coordinators**. (As you may recall, the **Centers for Medicare & Medicaid Services** said in a previous Q&A that "there is no federal requirement for a second source of documentation ... to substantiate the resident's status for each and every MDS item.")

The OIG may dovetail its MDS scrutiny at some point with the **Centers for Medicare & Medicaid Services'** national DAVE project (Data Assessment Verification), although there's no concrete evidence that collaboration is in the works. Yet DAVE will actually generate reports on specific MDS inconsistencies, inaccurate coding and potential fraudulent patterns, Infante notes. For example, DAVE may flag nursing facilities that show a pattern of not delivering projected therapy minutes.

What's one of the best ways to ensure your MDS and documentation are on the same track? Make sure they tell a consistent story about the resident's needs, resource utilization and progress. "Therapy and nursing notes or social work and nursing notes should not sound like they are talking about completely different people," Infante advises.

Also keep in mind that holes in the documentation are a problem from a survey perspective and also could bolster malpractice litigation, Infante cautions. "The facility should comply with the documentation systems the facility has in place - or streamline them to capture the critical information," she advises.

Target These Billing and Payment Areas

The OIG work plan emphasizes a number of specific billing and payment issues, as follows:

1. The three-day qualifying hospital stay for Part A SNF coverage. The OIG isn't letting up on this one: SNFs are ultimately responsible for ensuring beneficiaries spent three consecutive midnights as an inpatient in a hospital in order to qualify for a Part A-covered stay. "In the past, SNFs may have inadvertently admitted a resident who actually spent four or five days in the emergency room," notes **Darla Watson**, vice president of beneficiary support for Atlanta-based **Mariner Healthcare**.

   Strategy for Success: To validate a three-day stay, ask the hospital billing department how it's billing the hospital stay, suggests **Marilyn Mines**, a nursing consultant with **Frost Ruttenberg & Rothblatt** in Deerfield, IL. "Make sure the claim for the hospital stay was billed as an inpatient under Part A, rather than as an outpatient (Part B)," Mines says. Another, somewhat less effective option would be to ask the time and date the resident was admitted from the emergency room or observation bed to the hospital as an inpatient, she adds.

2. **Inappropriate Part B payments for Part A-stay residents.** The OIG says it will analyze Medicare Part B payments for nursing facility residents to determine whether "unbundling, payment for inappropriate services, or aberrant billing patterns occurred." That's not all bad news, actually. "On the one hand, the government is concerned about assuring

access to care and continues to revisit the issue of those services included in the Part A rate," says **Howard Sollins**, attorney with **Ober/Kaler** in Baltimore, MD. "But on the other hand, the plan reflects a concern about double payment for the same or overlapping services under Parts A and B," he adds.

Strategy for Success: Be very clear about what services are included in the daily PPS rate and whether the facility or ancillary suppliers can bill certain services under Part B, Sollins advises. And don't rely strictly on broad categories of exclusions from Part A consolidated billing, such as MRIs and CAT scans or radiation therapy. The SNF is responsible for paying for any of the latter if they aren't done in a hospital outpatient setting.

3. Billing for ineligible days of SNF coverage. The OIG will have its eye on SNFs that bill Medicare for the day of discharge or for days of care when residents otherwise in a Part A SNF stay are in the hospital, Sollins cautions.

4. Review of antipsychotic drugs prescribed for Medicaid nursing home residents. The OIG will be looking to see if residents receiving these medications have diagnoses of mental illness. Under OBRA, residents should not receive antipsychotic medications if they don't have schizophrenia or a number of other serious psychiatric diagnoses (see list below). **Tip:** The draft MDS 3.0 includes ICD-9-CM diagnoses for many of these mental illnesses (go to http://cms.hhs.gov/quality/mds30/DraftMDS30.pdf). Residents with dementia-related psychotic and/or agitated behaviors can receive antipsychotic drugs, if they meet certain criteria and the facility does the proper assessment and follow-up, according to **Sam Kidder**, PharmD and a long-term care ombudsman, in Silver Spring, MD, who helped CMS write the interpretive guidelines for antipsychotic drug use.

   For the specific criteria, go to www.cms.hhs.gov/manuals/pub07pdf/AP-P-PP.pdf, page 229.

Ensure Residents On Antipsychotic Meds Have One Of These 11 Diagnoses

Under OBRA (F tag 330), residents receiving antipsychotic drugs should have one or more of the following conditions documented in their clinical record:

1. Schizophrenia
2. Schizoaffective disorder
3. Delusional disorder
4. Psychotic mood disorders (including mania and depression with psychotic features)
5. Acute psychotic episodes
6. Brief reactive psychosis
7. Schizophreniform disorder
8. Atypical psychosis
9. Tourette's disorder
10. Huntington's disease
11. Organic mental syndrome (now called delirium, dementia and other amnestic and other cognitive disorders by the DSM-IV) with associated psychotic and/or agitated behaviors (additional criteria must be met to give antipsychotic meds for this diagnosis. See www.cms.hhs.gov/manuals/pub07pdf/AP-P-PP.pdf, p. 229).