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MDS Alert

Reimbursement: The Stakes Are High For Avoiding These 3 Medicare Mistakes

Keep your SNF out of the fiscal pits with these coverage, ARD and billing management strategies.

Although an occasional Medicare misstep can cost your SNF a chunk of money, a pattern of problems docks the coffers on a regular basis.The good news is that you can keep your SNF on the right side of the payment, survey and compliance track by closing these money drains.

1. Taking residents off Part A prematurely. Too often, rehab drives the coverage decision -- so residents tend to go off Part A when therapy ends. And that is a big mistake, emphasized **Kristen Mastrangelo,OTR, MBA, NHA**, in an **Eli Research**-sponsored audioconference on Medicare.

Do the math: Suppose the patient's Medicare rate is $350 a day and Medicaid is $150 in a state, said Mastrangelo, president and CEO of **Harmony Healthcare International Inc.** in Topsfield, MA. If you take the patient off Medicare Part A too soon, the facility is receiving considerably less money per day for providing the same services -- that is, the nurse continues to observe and monitor the resident daily because he is still unstable and at risk for a relapse, she noted.

Solutions: The Medicare team needs to know the skilled coverage criteria, including the "slam dunk" daily direct nursing services that skill a resident, such as tube feedings or IVs, Mastrangelo suggested. The Medicare team should also review each patient whom the team is considering considering taking off skilled coverage.That's important to do because Mastrangelo often finds that a chart review in such cases will uncover clinical issues that show the resident still requires skilled services. Thus,the team needs "checks and balances including chart audits to make sure the treatment regimen has stabilized, she says.

The administrator should also attend the Medicare meetings to pose questions about why the team is taking a person off Part A, Mastrangelo suggested.

2. ARD management that undercuts the RUGs. The type of case management you want is where the nurse evaluator informs the team that Mr. Jones is going to be admitted as a rehab patient requiring very intensive therapy, said Mastrangelo.He received IV fluids and IV meds through the day of discharge from the hospital.

Then the team says, 'OK, I have to immediately initiate therapy to qualify for rehab ultra by day seven because the IV fluids give him the extra ADL points for eating to put him in RUX instead of RUL, she noted. But when the resident's therapy commences, rehab realizes that the MDS nurse can move the ARD to day 8 to achieve RUX. How so? The resident requires a two-person assist for his ADLs and will RUG into RUX without the extra ADL points provided by the IV fluids, which have a seven-day lookback. (The IV med, which has a 14-day lookback,will put the person in rehab plus extensive services.)

"This type of communication is key," stressed Mastrangelo.

An alternative scenario: Suppose Mr. Jones' only extensive service indicator is IV fluids, and the team needs to set the ARD for day 8 to capture ultra-high therapy. "It would be better to obtain a RUG level of RUC ersus RVX [because] RUC trumps RVX payment-wise,"explains **Elisa Bovee, MS, OTR/L**,director of education and training for Harmony Healthcare.

And from a case-management perspective, capturing that ultra level, if the resident needs and can tolerate that level of services, is important because the resident probably already received close to that RUG level, bovee tells **Eli.**

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Also,capturing that ultra RUG level and reporting it is a more accurate reflection of the resident's true service needs and provision, she adds.

Remember: You need hospital documentation of an extensive service indicator to code it on the MDS, reminds **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.

The team also has to be on the same page for using ARDs and know the lookback period for their MDS sections, says **Darlene Greenhill**, a nursing home consultant in Atlanta.

For example, when performing MDS audits, Greenhill finds that rehab or other team members sometimes only used six days of the seven-day lookback. The MDS team must also understand that the ARD ends at midnight, requiring the team to capture data until then, Greenhill adds. Omitting a third instance of weight-bearing assistance that occurred on the evening of the ARD or a fever, as examples, can cost your SNF a higher-paying RUG level.

3. Billing before you have everything in order to prevent payment recoupments. Cindy Fronning, RNC, CDONA, RACMT, has seen entire claims denied because the physician didn't sign the certification or ecertification. And you're not supposed to bill Medicare before the MDS is accepted in the state repository. So make sure the signed certs/recerts are in the chart, and that the MDSs have been transmitted and accepted by the state repository, advises Fronning, director of clinical reimbursement for **Pathway Health Services** in White Bear Lake, MN.

Remember: "The therapy plan of treatment also needs to be signed and dated prior to submitting the UB to the FI," says Mines.

Editor's note: Making mistakes with consolidated billing can also cost your SNF big time. For inside tips and handy tools for managing this major payment and compliance issue, see the next MDS Alert.

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