MDS Alert

Test Yourself: You Be The FI--Would You Pay These 2 Claims?

Find out whether you and CMS are on the same page.

Read the following cases and decide if you think the FI should pay or deny the claims (answers below).

Case No. 1:
Services Billed: RHC01 for days 1-14
Supporting Documentation:

MDS:
• Five-day assessment
• T1c indicated the projected therapies would total 10 days
• T1d indicated the projected therapies would total 900 minutes

Medical Record:
• The actual therapy minutes for this assessment were five days/450 minutes.
• ST, OT & PT each documented 30 minutes of treatment per day for five days.
• Doctor orders and plan of treatment were for all three therapies at five days each week.
• During the second week of treatment the resident became ill with nausea, vomiting and diarrhea and was unable to participate in therapies for two days.

Case No. 2:
Services Billed: RHB07 for days 15-30
Supporting Documentation:
MDS:
• 14-day assessment
• P1ba indicated speech therapy was provided five days/325 minutes

Medical Record:
• The resident was hospitalized as an acute care patient for an exacerbation of Chronic Obstructive Pulmonary Disease (COPD) for greater than three days. Upon admission to the SNF, speech therapy began treating the resident for a "speech impediment."

• Nursing notes, social services notes, and dietary notes indicated that the patient's speech was clear and coherent and he was able to make his needs known.

• The documentation did not establish the medical necessity for skilled speech therapy intervention, a skilled need for a condition treated during the resident's qualifying hospital stay--or skilled intervention for a condition that arose while in the facility as a result of a condition treated during the qualifying hospital stay. No other skilled needs documented.

ANSWERS: Case No. 1: The medical necessity of the therapy service is demonstrated at the level billed. The resident's illness was unforeseen. The documentation showed that the projection was made in good faith. The HIPPS code billed would be paid.
Case No. 2: The HIPPS code billed would be denied because the services were not reasonable and necessary.
Source: Transmittal 196 (www.cms.hhs.gov/manuals/pm_trans/R196CP.pdf)

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