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MDS Alert

WHAT DO YOU THINK?--Can You Implement Strategies To Help Prevent Additional Development Requests?

The answer is no ... and yes.

If you think of an additional development request (ADR) as the luck of the draw, you're right -- most of the time, anyway.

The mixed reality: "Most times, an ADR is random," says **Jane Blake, RN,** a consultant with **The Broussard Group** in Lake Charles, LA. "The Social Security Act required FIs to randomly review 1 to 3 percent of all Medicare claims to protect public trust," adds **Cheryl Field, RN, MSN,** a reimbursement expert with **LTCQ Inc**. in Lexington, MA.

But FI requests for additional documents may also be triggered by several events that savvy facilities attempt to preempt or at least be prepared to explain to the FI, including the following:

• **RUG patterns or other trends that diverge from the beaten path in the SNF industry.** "For example, compared to your 'peers,' you may be consistently treating at an extremely high level of therapy when everyone else is treating at an 'average' level," says Blake.

The bottom line: If the FI starts noticing more people in higher paying RUGs, longer lengths of stay, or more people in the lower 18 RUGs -- it will start looking at claims and then start picking ones for ADRs, says **Joan McCarthy, MJ, LNHA,** manager, healthcare, **RSM McGladrey Inc.** in Chicago.

Be proactive: Facilities should track their therapy and RUG patterns, and if they see a change, be prepared to explain that. "In a cover letter accompanying the ADR materials, the facility can explain a change in care patterns," suggests McCarthy. For example, "perhaps the organization has had a change in case-mix related to referral patterns or a change in mission" where it is providing more subacute care or intensive levels of rehab, she notes.

• **Certain billing scenarios.** One key example would be billing Part A for skilled services when a resident is receiving the hospice benefit, according to **Joel Van Eaton, BSN, RN, CRNAC,** reimbursement clinician for **Care Centers Management Group** in Johnson City, TN.

In such a scenario, the documentation should support the Part A services as being unrelated to the patient's terminal condition requiring hospice services, he says.

• **Improper diagnosis coding** that fails to explain the reason for the resident's Part A stay can lead to an outright claims denial or an ADR.

Remember: "The primary diagnosis for skilled care has to reflect the diagnosis for which the resident received treatment in the hospital stay -- or it can be a diagnosis that arose during the SNF stay for the hospital-related condition," says McCarthy.

Example: If the FI sees a resident in a rehab RUG received speech therapy, and dysphagia is listed fourth or fifth as a diagnosis code, that might trigger an ADR, says **Pauline Franko, PT,** principal of **Encompass Education** in Tamarac, FL.

"If speech is working on swallowing and communication, then you'd need two diagnoses to support that -- dysphagia and aphasia or dysphasia, etc.," adds Franko.

Documentation tip: The medical record should reflect the resident's need for various therapy disciplines. For example, a resident who has suffered a CVA may initially need more speech therapy to help him with a swallowing problem as a priority before PT and OT become more involved, says Franko.