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An Integrated Approach to the LTC Industry

PPS ALERT FOR LONG-TERM CARE

PPS payment update provides a slight increase, but few changes

Continuing Education | **Learning Objectives**

After reading this article, you will be able to:

- Identify the changes made by CMS to the SNF PPS for fiscal year 2013
- Describe the impact these changes may have on a facility's coding and billing practices
- Describe the impact these changes may have on a facility's documentation practices

There is a saying that goes "Something is better than nothing," which is the mantra SNFs should have for the 2013 fiscal year.

In July, CMS officially released an update notice regarding the SNF PPS for fiscal year 2013. CMS has issued a 1.8% increase to the market basket rate, a significant increase from last year's 11.1% Medicare reduction. The overall market basket increase is 2.5% for SNFs, but a 0.7% adjustment as part of the Affordable Care Act's 10-year plan to reduce Medicare knocks down the overall increase. CMS estimates this will translate to an influx of approximately $670 million.

Also of note, CMS decided to forgo the usual rule-making process by skipping the comment period and simply issuing the final rule in July. In April, CMS announced that rather than proposing new regulations that could radically affect payments, it would simply make statutory update adjustments to Medicare Part A, enabling it to forgo the comment period.

> **"The positive thing is that there is an increase. We never thought there would be one. Even though it's small, I think that's positive."**
>
> *—Bonnie G. Foster, RN, BSN, M.Ed.*

Although it's a fairly insignificant increase, SNFs should be relieved that it's not another year of drastic cuts, says **Bonnie G. Foster, RN, BSN, M.Ed.,** owner and president at Foster Consulting, Inc., in Columbia, S.C.

"The positive thing is that there is an increase," Foster says. "We never thought there would be one. Even though it's small, I think that's positive."

On the other hand, the slight increase reinforces the importance for facilities to focus on the accuracy of their coding and Medicare billing, as well as how patients are receiving therapy, an issue that CMS has been monitoring closely.

Watch your RUG rates

Ever since the Office of Inspector General (OIG) released the report *Questionable Billing by Skilled Nursing Facilities* in December 2010, CMS has been more actively involved in cracking down on facilities

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that may be getting inflated reimbursement. Looking at data from 2006 to 2008, the report found that SNFs increasingly billed Medicare for higher-paying RUG rates, even though patient characteristics remained largely the same. The report found that payments to SNFs with ultra-high therapy RUGs increased 90% during that time period, accounting for a $5 billion increase in payments.

As a result, OIG recommended that CMS monitor payments from SNFs, particularly those that are billing for higher-paying RUGs, and change the current method for determining how much therapy is needed to ensure appropriate payments.

"CMS has been closely monitoring the amount of individual, concurrent, and group therapy, so providers obviously need to provide what is most appropriate for the resident," says **Julia Hopp, MS, RN, NEA-BC,** executive vice president of reimbursement for Paramount Health Care Company in Garden Ridge, Texas.

With only a small increase to Medicare payments, SNFs may be tempted to find more revenue with RUGs, particularly involving therapy, but they should be very cautious in how those services are billed, Foster says.

In fact, many elderly patients may be too ill to do therapy, especially when they are first admitted to a SNF, and their care plan needs to reflect that.

"That has always been the concern of therapists," Foster says. "Our residents are sicker than they have ever been and the idea of taking someone who is 80 years old with a fractured hip to therapy—especially if they also have diabetes or congestive heart failure or dementia—taking them to therapy with the idea of getting a very high or ultra-high RUG is just not realistic."

Instead, SNFs should focus their attention on providing a complete and individualized care plan. For example, a younger patient who has just had a knee replacement and is only going to be in the facility for two to three weeks should receive as much therapy as possible. An older patient with multiple health issues may require less therapy, or more focused therapy.

"What you really need to work on is that you're providing the type of care that the residents need and also that you are reimbursed for the care that you're providing," Hopp says.

In many SNFs there is a struggle between the patient's schedule and the therapist's schedule. Therapists want to start at 8 a.m., but patients often want to sleep in, take a shower, and have breakfast before going to therapy. With more focus on resident satisfaction, says

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Questions? Comments? Ideas?

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Foster, the SNF will have to find ways to work around both schedules.

To resolve these issues, it's imperative that therapists are included in the care plan process, Foster says. With this approach, therapists can communicate with the doctors and nurses to determine what other health complications the patient is dealing with and they can push for restorative therapy programs so there is some continuity between what the therapist is doing and what the clinicians are doing.

In some facilities, therapists operate in their own bubble, which can cause confusion with nurses and nursing assistants.

"They are a really big part of the team," Foster says. "With this team approach the patient might actually need more therapy. There are solutions, but they have to be part of the team."

This confusion can also create discrepancies between the patient chart and billing and MDS forms. For example, an occupational therapist might be working with a patient to teach the patient to dress him- or herself, but in the nursing documentation the nurse would note that the patient dressed him- or herself, leading a Medicare auditor to question why the occupational therapist is getting paid to teach the patient what he or she already knows how to do. If the therapist were included in a meeting with the nurse, that detail could have been resolved.

"That could be a major monetary payback," Foster says. "You can't do anything about that because it's already charted. You can't go back and erase it or change it."

Triple-check your documentation

Many facilities are likely still feeling the impact of last year's Medicare cuts, as well as the Medicaid rates that were either cut or maintained at the state level. These payment decreases have only highlighted the need for accuracy so SNFs are fairly compensated for the care they provide. During a time of increased scrutiny from CMS regarding overpayment and Medicare fraud, SNFs need to be particularly aware of their billing and coding documentation, which is the backbone of a CMS audit.

"SNFs need to be monitoring the care that they are providing and making sure they are coding that care accurately, and triple-checking the billing with the MDS to make sure everything matches up correctly," Hopp says. "Providers really just need to continue doing what they have been doing, but just make sure everything is as accurate as possible."

Audits can be extremely nerve-racking for a facility, and the results can be equally detrimental, Foster says. Even the slightest discrepancy can affect reimbursement rates, particularly when it comes to therapy and RUGs.

"I don't think I've ever been through an audit where a facility didn't have to pay back some money, and we're talking thousands and thousands of dollars," Foster says.

However SNFs can minimize that damage by reinforcing a team-centered approach to patient care, and training clinicians and coders on the effects of improper documentation.

"The problem is that it's usually very simple stuff; stuff you don't even think about," Foster says. "But once you've been audited you're on their list, and then you're always on their list." ■

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ICD-10 postponed until 2014, giving facilities another year to prepare

Continuing Education | **Learning Objectives**

After reading this article, you will be able to:

- State the new compliance deadline for ICD-10, as established by HHS
- Discuss the reasons why HHS initiated a proposal for the ICD-10 compliance deadline delay
- Describe steps that facilities should take to prepare and implement a successful ICD-10 transition

In April, the U.S. Department of Health and Human Services (HHS) proposed an extension of the ICD-10 deadline for one year, from October 1, 2013, to October 1, 2014. On August 24, HHS issued the final ruling, confirming the one-year extension, which was instituted to allow more time for healthcare facilities—particularly smaller facilities—to adopt the new coding system.

"We believe the change in the compliance date for ICD-10 gives covered health care providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition by all covered entities," HHS said in the final published ruling.

Many facilities expressed concern with the 2013 deadline, pointing to the difficulty a variety of organizations had in meeting the compliance deadline for the Associated Standard Committee's X12 Version 5010 standards, which updated billing software and laid the groundwork to accommodate the longer and more detailed ICD-10 coding system.

In December 2011, CMS conducted a survey among 404 healthcare providers, 101 payers, and 90 vendors to determine how well prepared the industry was for these changes. CMS found that 83% of providers were aware of the upgrade to Version 5010, but only 64% indicated they would be compliant by the January 2012 deadline. Additionally, nearly a quarter of providers in the survey indicated they would not be ready for the ICD-10 October 1, 2013, deadline.

Another survey conducted by the American Health Information Management Association in September 2011 had mixed results from 639 providers concerning compliance efforts with Version 5010 and ICD-10. Although 85% of inpatient facilities had begun preparing for the implementation of ICD-10, 39.3% of all other providers had not started planning at all. Furthermore, of the "other" providers that hadn't started implementation planning, 50.5% indicated they weren't sure when this planning would begin.

Lastly, according to a survey by the Workgroup for Electronic Data Interchange conducted in February, 50% of respondents indicated they didn't know when they would complete their impact assessment of the ICD-10 transition.

Even after the January deadline for Version 5010, healthcare organizations—particularly smaller organizations—continued to struggle. In February, the Medical Group Management Association sent a letter to HHS indicating that if the government didn't step in to help solve the problems with transitioning to 5010, physician practices would face operational difficulties and could even be forced to close their practices. Given the struggles the healthcare industry had with Version 5010, there were plenty of concerns among long-term care providers that implementing an even more complicated system in ICD-10 would be extremely difficult by the October 2013 deadline, says **Dawn Duchek,** industry initiatives coordinator for Gateway EDI in St. Louis.

"5010 had a much bigger impact to the industry than was expected," Duchek says. "The goal with ICD-10 is to have a much smoother transition and to better prepare for the potential bumps in the road."

From a financial perspective, a regulatory impact analysis conducted by HHS showed a cost avoidance of \$3.6–\$8 billion that would incur if healthcare providers

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and plans had to process claims manually, and smaller healthcare providers would have to take out loans as a result of delayed payments.

A new date with the same changes

Aside from the date, nothing has changed in terms of the impact of the transition from ICD-9-CM to ICD-10-CM. These new diagnosis codes are still much more specific than the ICD-9 version. ICD-9 codes are three to five characters, whereas ICD-10 codes are three to seven characters and alphanumeric, offering more detail and specificity for certain conditions. For example, under ICD-9, pressure ulcers were coded as 707.0x and 702.2x in order to define the scope and stage. ICD-10 gets far more specific with more than 100 codes for pressure ulcers that define the location, laterality, and stage of the wound.

Once implemented, the specificity of ICD-10-CM coding will paint a fuller and more detailed picture of the resident in the UB-04 form, which should ultimately reduce the number of denials to SNFs. The system will also be able to better handle the transition to electronic medical records (EMR) by providing more current information on a resident's condition, and staying current with terminology and clinical concepts.

Although the transition to ICD-10 is on the horizon, facilities still need help fully understanding the current ICD-9 system, says **Marilyn Mines,** senior manager of clinical services for FR&R Healthcare Consulting, Inc., in Deerfield, Ill. These misconceptions will only make the transition more difficult.

"There's a lot involved in ICD-10 that is not understood," she says. "I'm not sure how SNFs are going to be able to move to the specificity of this coding when the current coding is not always being done correctly."

Approaching the change

The following are suggested steps facilities can take to facilitate a smooth transition to ICD-10:

➤ **Assemble a steering committee.** The first step in making the transition to ICD-10-CM is to assemble a steering committee made up of representatives

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from coding, billing, and IT, as well as doctors and nurses who can help with the specific clinical translations, Duchek says. This committee should look at ways the new system will affect software, hardware storage, and paper processes, how patients will be impacted, and where their facility is in terms of making this switch.

- **Identify software needs.** Software upgrades may be necessary to house the additional 140,000 codes included in ICD-10, as well as the existing ICD-9 codes which will continue to be used for inpatients with a discharge date prior to October 1, 2014, or if there is an issue with rebilling. "Now is the time to look at the reports you're getting from your practice management system or EMR to identify the ICD-9 codes you use most often," Duchek says. "Identifying your top revenue codes is a good place to start with mapping ICD-9 to ICD-10. You will also want to confirm that your ICD-9 reports will be converted to ICD-10."
- **Establish a lead contact within the facility.** Facilities should also appoint a designated point person that is going to be the resident expert in the new system and lead the transition. MDS coordinators are typically the ones who handle the current ICD-9 system, so the responsibility will most likely fall to them, although a team approach may be necessary, Mines says. "With the new system, there might be the need to have an actual coder who is more educated in the system, one who can be more accurate," she says. "But I'm fearful that it is all going to fall to the MDS coordinators."
- **Examine internal processes.** Long-term care facilities in particular should also focus on their process for changing a resident's diagnosis, Mines says. The specificity of ICD-10 coding will allow for more timely adjustments as new issues arise or an existing diagnosis is resolved. For example, residents often come into a long-term care facility after having surgery for a fractured hip in the hospital. Even though it has been resolved, their diagnosis still reads, "fractured hip." A similar situation arises with pressure ulcers as they progress or regress to higher or lower stages. Facilities need to develop written policies that dictate an effective flow of information to input diagnostic changes as they arise. "This includes new diagnoses as they come up," Mines says. "The billers need to have a point person who is knowledgeable, that they can consult with in updating, changing, and eliminating diagnoses and conditions. The same diagnoses from the hospital stay should not continue from 10 years earlier if they are resolved."

Start sooner rather than later

"Pushing the ICD-10 back to 2014 shouldn't translate to an extra year of procrastination," Duchek says. Facilities should be using this additional time to begin the process of evaluating how they will make the transition.

"We had the interim final rule in February and now six months have gone by, so if you haven't done anything, what have you gained? You've only gained six months," Duchek says. "The longer you procrastinate, the less time you have to get ready. There are so many things that a facility or practice can do today that can help them with the processes right now and help them to understand the impacts of ICD-10."

Mines recommends initiating a task force at the beginning of 2013 to get the process started by identifying a few key leaders to look at how new codes will be implemented and how they will affect the facility's current billing system. This committee should also look at their percentage of rejections and appeals with ICD-9, whether those will increase or decrease with ICD-10, and how they can maximize reimbursement by accurately applying the new system.

"I would say right after the beginning of the year is when people should sit down with their teams and figure out what they're going to do and set up a schedule of events, so when the date actually comes they won't be out of their minds to figure out what to do," Mines says. ■

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CMS' *Nursing Home Action Plan* focuses on quality and patient care

Continuing Education | **Learning Objectives**

After reading this article, you will be able to:
- State the main objective of CMS' *2012 Nursing Home Action Plan*
- Describe the five approaches CMS suggests nursing homes should take to meet the plan's objectives
- Recognize the impact these objectives have on maintaining quality of care for nursing home residents

CMS has released its *2012 Nursing Home Action Plan,* which supports the three-part directive from the national organization to improve healthcare in the United States. The three objectives are:
- Improving the individual experience of care
- Improving the health of populations
- Reducing the per capita cost of care for populations

In an attempt to meet these three overall objectives, CMS has laid out five approaches for nursing homes to consider going into next year:
- Enhance customer engagement with relevant, timely information that can be accessed by the public
- Strengthen survey processes, standards, and enforcement by improving the way data is captured and improving the consistency with which nursing homes are regulated
- Promote quality improvement by reducing physical restraints, rehospitalizations, and the prevalence of pressure ulcers, as well as supporting institutional culture change
- Create strategic approaches through partnerships with the U.S. Department of Health and Human Services, Quality Improvement Organizations, and state survey agencies
- Advance quality through innovation and demonstration with projects such as the Nursing Home Value-Based Purchasing Demonstration, which attempts to prevent costly rehospitalizations through high-quality care

Aside from these direct objectives, the 2012 plan gives nursing homes and SNFs a broad idea as to what CMS surveyors will be focusing on and the direction they should take their facility to maximize their reimbursement.

Quality matters

Quality care and performance has been and continues to be a recurring theme, which means facilities should continue to pay particular attention to the quality measures released by CMS, says **Janet Potter, CPA, MAS,** manager of healthcare research at FR&R Healthcare Consulting, Inc., in Deerfield, Ill.

"Long-term care facilities have had the stigma of

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poor quality hanging over them for decades," she says. "Possibly more than any other provider type, they have had to work harder to overcome the preconceived notion of poor quality that was prevalent on the consumer side. The long-term care industry had been concentrating on quality delivery of care and quality of life long before the mandates started coming from CMS. Now that quality measures will be added to the Nursing Home Compare website, a public venue, nursing homes will need to concentrate not only on quality of care in general, but specifically in those measures that will be included."

Quality care has always been a focus for long-term care facilities, but these objectives help bring it to the forefront, Potter says. Every facility has a different area to focus on in terms of improving quality care. If you already have an effective program, this action plan should prompt you to redefine the scope of your program or reveal additional weaknesses. For those that don't have a strong quality improvement program, this serves as a reminder that they may need to rebuild.

Specifically, organizations need to be looking at many of the same initiatives that have been highlighted by CMS all year, such as reducing rehospitalization rates, use of antipsychotic medication, and pressure ulcers, says **Maureen McCarthy, RN, BS,** vice president of clinical reimbursement for National Healthcare Associates and president of Celtic Associates, LLC, in Goshen, Conn.

McCarthy suggests breaking down specific sections of the plan to determine how those objectives relate to your particular facility. For example, what are your rates for antipsychotic drug use, and what should your rates be to achieve the 15% reduction CMS has requested? Where are patients being unnecessarily rehospitalized, and what can you do to improve that process or communication among clinicians?

"You need to know where you are before you know where you're getting to and how long that road is," she says.

As part of the Affordable Care Act, CMS has already launched its Quality Assurance and Performance Improvement (QAPI) project in nursing homes across four states (California, Florida, Massachusetts, and Minnesota) in order to test tools and resources and solicit feedback before the national rollout. Another program conducted at 182 SNFs in Wisconsin, New York, and Arizona yielded mixed results, leaving health officials unsure whether it would result in net savings or improved quality care.

This should be a warning shot for long-term care facilities if they want to remain financially viable, since quality will ultimately impact reimbursement rates, says **David Bufford,** an attorney at Hall, Render, Killian, Heath & Lyman, PSC, in Louisville, Ky.

"The future for nursing homes in general is they are going to be paid on a quality basis," Bufford says. "QAPI is really going to be the basis of how they are going to be reimbursed in the future. You are going to have to meet certain quality initiative guidelines to essentially achieve the same amount of reimbursement."

It's important that facilities also look at implementing an IT infrastructure that will allow them to effectively track quality data. Many of the national organizations have already invested in this so they can communicate better with acute care organizations, but many of the smaller "mom and pop" organizations still lag behind. If they don't get up to speed in the coming years, they will be swallowed up by the larger corporations, Bufford says.

"A lot of the national players already have quality trackers and they have the touch panels in the hallway

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where they can document the provisions of care to the residents," he says. "They are ahead of the curve because they are going to be able to approximate what CMS is going to look at and you can track that yourself. Instead of waiting for CMS to analyze your data and then give you back a score, you're going to be able to respond immediately and see what needs to be improved."

Improving the survey process

CMS recognizes that there needs to be more consistency with the way surveys are conducted nationally, so you can expect surveyors to come in with a much more defined role, with a focus on key areas.

"More than ever nursing facilities must be ready for survey at any time," Potter says. "In this industry we've always lived with the knowledge that surveyors could walk in at any moment. With more and more potential things to be reviewed and scrutinized, it is essential that facilities be proactive and prepared."

Everyone in the building, from the director of nursing to the billing office manager to volunteers, should be prepared to answer surveyors' questions. Potter suggests utilizing an outside consultant who will conduct an unbiased mock survey in order to highlight weaknesses.

More intensive focus on quality care and reducing readmissions means surveyors will likely be more diligent in their process, Bufford says. This will be particularly true in facilities where they have immediate access to electronic medical records where they can hone in on 12 patients with chronic obstructive pulmonary disease, or 12 patients on a feeding tube, rather than 12 random patient files.

"I think what we are going to see in the future is, because of the quality initiative requirements, they aren't going to just take the facility's word for it," Bufford says. "There is going to be a little more digging."

Survey preparation will be particularly important as CMS unveils more quality improvement surveys and reimbursement is tied to specific objectives.

Building a team approach

Long-term care facilities would be remiss not to use this action plan as an opportunity to improve upon all facets of their organization. Based on the objectives and approaches that CMS lays out, facility administrators can conduct a risk analysis of their entire facility, Potter says. This should include heavy involvement from the clinical team as to what areas need more attention, as well input from social workers, therapists, and dietary and environmental services employees.

"Improvement will only come from an interdisciplinary team approach to finding areas of weakness and turning them into strengths," Potter says.

In general, a multidisciplinary approach will bring a variety of perspectives and will help meet the goals that CMS has set forth in its action plan. ■

Learn how to run a successful SNF

The *Comprehensive Guide to Nursing Home Administration*, written by Dr. Brian Garavaglia, serves as a blueprint to managing staff, developing a budget, and navigating the ever-changing SNF regulatory environment. Complete with an emphasis on high-focus survey targets such as Medicare reimbursement, quality care, and documentation, this book also contains more than 850 downloadable test questions to ensure SNF administrators are well prepared to improve operational efficiency.

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MDS professor

Test your knowledge of the MDS and long-term care by answering the following questions:

1. When billing for pneumovac and/or influenza vaccines, which of the following revenue code(s) should appear on the claim?
   a. 771 administration
   b. 636 vaccine
   c. 771 and 636
   d. 250 pharmacy

2. Which of the following statements regarding Durable Medical Equipment Regional Carriers (DMERC) billing is not true?
   a. DMERCs are divided into four regions
   b. Only a DMERC can be billed for parenteral and enteral nutrition (PEN) and prosthetic and orthotic supplies
   c. A SNF may obtain a supplier number and be able to submit claims to the DMERC
   d. Submission of claims to the DMERC is done using a CMS-1500 form and appropriate HCPCS codes

3. Which of the following services requires a separate Certificate of Medical Necessity to be signed by the supplier before submitting a claim?
   a. Urological supplies
   b. Surgical dressing supplies
   c. Enteral therapy supplies
   d. Ostomy supplies

4. Which of the following diagnoses would meet the criteria for enteral therapy to be covered?
   a. Left hip fracture
   b. Pneumonia
   c. Blindness
   d. CVA with dysphagia

5. A facility has only 30 days to respond to an ADR or an automatic denial will occur.
   a. True
   b. False

6. Mrs. Anderson requires an indwelling Foley catheter due to urinary retention. Her physician has ordered a silicone-coated catheter, a bedside drainage bag, an insertion tray, and irrigations of normal saline every day. Which of these items will not be covered according to the medical policy for urological supplies?
   a. Silicone-coated Foley catheter
   b. Bedside drainage bag
   c. Insertion tray
   d. Irrigation tray with normal saline

7. Mrs. Anderson also requires dressings to both of her hips. The dressing to the right hip is Duoderm and is for a reddened area. The dressing to the left hip is a gauze dressing with hydrogel for a Stage 3 wound. Which of the following supplies are not covered?
   a. Duoderm
   b. Hydrogel
   c. Gauze
   d. Tape

8. Which of the following prosthetic supplies requires the test of permanence (condition for at least three months) to be covered by Medicare?
   a. Trach care supplies
   b. Ostomy supplies
   c. Urological supplies
   d. Surgical dressings

9. Medicare medical review can occur either post-payment or prepayment.
   a. True
   b. False

Answers to these questions are on p. 12. ■

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PPS Q&A

Editor's note: This month's PPS Q&A was written by ***Diane L. Brown, BA, CPRA.*** *To submit a question for upcoming issues, email Associate Editor Melissa D'Amico at* mdamico@hcpro.com.

Q I am a little confused on the significant change criteria and need some clarification. In MDS 2.0 the division of changes was 0,1,2 to a 3,4 and vice versa. Now with MDS 3.0 the division of changes is not clear. I know that it is always the team's decision if the residents have changed enough to impact their need for care, but has there been an ADL division? Doing a significant change for someone who goes from a 0 to 1 when even we can fluctuate in a day seems redundant. Any clarification will be greatly appreciated.

A Improvement or decline in two or more areas, such as decision-making or ADLs, are guidelines for your team to use to evaluate a situation rather than a mandate to always code these situations as a significant change. More important for you and your team is to determine the impact of such changes on the resident's condition. In Chapter 2 of the *MDS 3.0 User's Manual*, there are several pages and many examples of what may constitute a significant change of condition. A significant change in status assessment (SCSA) is not mandated just because ADLs improve or decline. SCSA decisions are not based on concrete criteria, but more broad-based criteria.

Guidelines for when a change in resident status is not significant include (this is not an exhaustive list):

- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and a comprehensive reassessment is not necessary to facilitate discharge planning.

Q CMS clarified that we do not have to do an End of Therapy (EOT) if a resident is discharged from the facility on day 3 after one to three days of no therapy. What if day 3 is the resident's last covered day? Are we required to complete an EOT?

A If the resident is discharged before midnight of the third day, you are not required to complete the EOT OMRA.

Q Does coding for IV fluids in Section K for the seven-day look-back period affect the RUG level and reimbursement rate?

A Yes, it does impact the RUG-IV level and reimbursement category. By checking IV fluids in MDS item K0510A, the beneficiary will classify into the Special Care High category (Hxx). Don't forget to review the instructions in the *MDS User's Manual* before checking this item to be sure the resident meets the requirements.

Q Regarding the ability to "make self understood and understanding others" (B0700, B0800), if the resident has one day in a seven-day period that he is acutely ill and has a decrease in his level of consciousness and was not able to communicate, would that be coded as 3 (rarely/never understood) or should the complete seven days be taken into consideration? The assessment is a discharge assessment and some think that the

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change in level of consciousness should be noted on the assessment somehow.

A Although ADLs code the worst moment that happens three or more times, other items, such as ability to make self understood, do not. It's looking at the entire seven days, rather than the one unusual day. Your documentation should include the one-day event, but your coding should look at all seven days.

Q If a resident is on IV therapy, should this information be coded in Section K under parenteral IV or is this for nutrition only?

A The question you need to answer is: Why is the resident on IV therapy? You can only code IV therapy that is provided for either nutrition or hydration (including prevention of dehydration). The *RAI User's Manual* states: "K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration." ■

MDS professor answer key

Below are the answers to the MDS professor on p. 10:

1. c. Both revenue codes should be billed.

2. b. Only PEN supplies must be billed to the DMERC. Prosthetic and orthotic supplies may be billed to the A/B Medicare Administrative Contractor (MAC).

3. c. Only enteral and parenteral therapy supplies require an additional document referred to as the Certificate of Medical Necessity. All other supplies require only the presence of a specific physician order.

4. d. A CVA with resulting dysphagia meets the coverage criteria described under the medical policy for enteral feeding. The diagnosis must relate back to the reason the patient cannot eat an oral diet.

5. False. If documentation is not received in 45 days, a medial review determination will be made on the information available, which could include a full denial.

6. d. Irrigations that are routine are not covered under the urological medical policy. Only irrigations that are nonroutine and are used for an acute problem, such as an acute blockage of the catheter, are covered.

7. a. Duoderm is a covered product under the surgical dressing benefit, but in this case it is being used on an area that is not a wound and has not met the debridement criteria as established in the surgical dressing medical policy.

8. a & c. Ostomy supplies and surgical dressings do not currently have this requirement.

9. a. True. Either can occur depending on the type of medical review.

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