Collaborate for care: Integrating hospice within the SNF

The hope and goal is that the vast majority of individuals who enter a SNF will receive the skilled services they need and then be able to return to the community. The reality, however, is that some residents will enter a facility and never leave.

While most hospice services are provided in the beneficiary’s home, palliative care is also needed within SNFs. Eighteen percent of people receiving hospice care in 2010 died in a nursing home, according to the National Hospice and Palliative Care Organization’s 2011 Hospice Care in America report. That number has increased in recent years, according to a 2010 study led by SC Miller titled The Growth Rate of Hospice Care in U.S. Nursing Homes, which examined the growth of Medicare-certified hospices providing hospice care in the nursing home from 1999 to 2006.

Miller’s research, which used MDS data, determined that the proportion of nursing home decedents who received hospice care rose from 14% (1999) to 33.1% (2006). “Our statistics support this finding,” says Christina Della Croce, MBA, OT/L, vice president of marketing, sales, and business development at Hospice of the North Shore & Greater Boston (HNSGB), which serves 87 Massachusetts communities and had over 500 admissions by nursing homes as a referral source in 2011. “As the number of hospice providers in the state of Massachusetts has increased, so has hospice utilization in SNFs. We are also seeing the growth of for-profit hospice organizations that are owned and operated by nursing home chains.”

This trend may be spreading or already exist in other parts of the country, but the more common SNF-hospice

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“We see ourselves as one team. It’s not us and them. We’re one team and we want to provide the best services while the patient is alive, as well as bereavement services afterwards for residents and the community.” —Laurie Farmer
partnership remains contractual arrangements between two private providers.

Merrimack County Nursing Home (MCNH) in Boscawen, N.H., makes use of just such an arrangement. The 290-bed facility contracts with a few different hospice agencies in the area, but works predominantly with Concord (N.H.) Regional Visiting Nurse Association (CRVNA).

In 2008, MCNH introduced a new hospice unit. Since then, the facility has seen an overall increase in the number of residents who receive palliative care.

“What seems to be changing within the industry is having palliative care liaisons in the hospital,” says Debra Thorne, RN, RAC-CT, reimbursement coordinator at MCNH. “So oftentimes the hospice consults are starting in the hospital prior to our residents returning or for new residents who are on our admissions list.”

Whereas previously the industry was concerned almost entirely about the restorative focus for anyone in long-term care, according to Thorne, people are beginning to accept the importance of palliative care and making sure those needs are met, she says.

The most important step, she adds, is recognizing as a caregiver when it’s appropriate to offer a family or resident palliative care—and that becomes much easier when the hospice agency and SNF exercise a communicative relationship built on trust and collaboration.

“We see ourselves as one team,” says Laurie Farmer, hospice manager for CRVNA. “It’s not us and them. We’re one team and we want to provide the best services while the patient is alive, as well as bereavement services afterwards for residents and the community.”

The first step in establishing that team mentality is a structured contract that details the responsibilities of both parties, as well as the reimbursement parameters for services rendered.

### The contract content

The Medicare hospice benefit covers end-of-life services for beneficiaries with life expectancies of six months or less (if the illness runs its normal course), who are no longer receiving curative treatment of their terminal illness and elect hospice services. At times, it can be difficult to differentiate between what classifies as meeting the terminal illness needs and what is considered providing personal care or nonrelated skilled care, which the SNF remains responsible for. Consequently, the contract between a hospice agency and SNF should be precise, as Medicare will cover the skilled and hospice needs of a resident only if the two are unrelated.

“Our contracts outline very specifically the responsibilities of the hospice agency and what services they’re going to provide, and it also speaks very specifically to the services that our skilled facility will be accountable for,” says Thorne.

MCNH uses an inpatient services agreement that covers the level of care coverage. An addendum to the inpatient services for general inpatient care clarifies up...
front which services are provided and what might be excluded, Thorne explains.

“For instance, hospice would provide the inpatient services; however, the facility may pay for room and board and the medications that aren’t related directly to the palliative care diagnosis,” she says. “The facility clearly is responsible for part of the billing portion.”

The written agreement, of course, is not limited to liability in terms of roles and responsibilities for care, as Medicare billing and reimbursement must be properly stipulated for the SNF and the hospice agency.

Most of the language used in the contract can be pulled directly from CMS, says Farmer. CMS’ SNF regulations and palliative care directives are integral to each provider’s individual governance, but are also meant to help guide the two in a collaborative, contracted relationship.

“Many of our contracts are generated in response to strong relationships with Boston-area and community-based hospitals. The patients are often seen by our or the hospital’s palliative care team, and in turn are recommended for hospice in a facility,” says Della Croce. “This ensures a comfortable and considerate transition for the patient from the hospital to the skilled nursing setting.”

The transition is also assisted when SNF staff members are aware of a new hospice patient’s medical condition, prepared for their responsibilities, and familiar with the general policies outlined in the agreement.

“Because nursing isn’t just a day shift only, we’ve involved all staff within the facility on the hospice education piece, so they all know the protocol for notification of hospice if there’s a change in a resident’s condition,” says Thorne. “They’re aware that, as part of the contract, they need to notify hospice of any resident status changes.”

**Maximizing the relationship for the resident’s benefit**

A facility’s ability to make the most of its relationship with hospice providers does not just serve the reimbursement needs of the SNF. More importantly, it offers palliative care patients the most complete and thorough care possible.

Developing an effective partnership takes time and effort on both sides, says Della Croce. “While we may technically be a contract service, we see them as elder care experts,” she says.

In that light, HNSGB provides the necessary end-of-life expertise while working closely with the SNF to meet the patient’s needs. The root of the relationships fostered by the providers’ staff members is a true investment in caring for the patients.

“The team can work together to develop a plan of care for ADLs, nurturing family concerns, and ensuring that patients are comfortable by extending their quality of life,” says Della Croce.

The plan of care, developed by the SNF, should be coordinated with the hospice agency and the family. Communication is critical, which means the lines between the facility and the agency must be kept open at all times.

“Keep each other informed about how things are going emotionally. Even with family issues, I try to keep that line open,” says Cindy Edgecomb of MCNH social services. “With care plan meetings, we always try to include family as best as we can. That seems to be very helpful. So we’re building a relationship with the family and with the resident.”

The cornerstone of collaboration between a SNF and its contracted hospice agency is often the hospice liaison. The liaison becomes well known by the facility staff, who should have his or her contact information and be able to reach that individual at all times.

When possible, providing a consistent hospice aide or facility liaison is the first of many best practice tips provided by HNSGB for agencies to consider in their interaction with a SNF. The others include:

➤ Communicate the hospice aide/liaison’s schedule with the SNF
➤ Schedule regularly occurring team meetings with the hospice staff and SNF interdisciplinary team
➤ Ensure hospice documentation in the SNF patient record
Have hospice physicians and/or nurse practitioners available for on-site consultation and face-to-face visits

Offer specialty programs based on the type of facility (e.g., dementia unit, cardiac care, or oncology care)

Offer joint family support groups

Provide family and SNF staff education with opportunities for end-of-life education

Consider the need for hospice following significant change documented on the MDS (e.g., weight loss, decrease in ADLs, change in dementia status)

Implement advance directive planning

For SNFs, education and support should be two of the top priorities. The facility social worker can get a lot out of meeting weekly with the hospice liaison. In addition, weekly administrative team meetings provide the opportunity to review the status of current hospice residents and to determine if there are any additional patients who may need to be monitored for the potential for palliative care services, says Thorne.

The best possible experience for residents and families

In most cases, the better the relationship between a SNF and hospice agency, the better the experience for a resident and his or her family, who pick up on the attentiveness and thoughtfulness of all staff members interacting with their loved one.

“We have a lot of family members who come in on a regular basis and they get to know the residents and the families and the caregivers,” says Amy Nichols, RN, MCNH assistant DON. “They see the role hospice plays on other people’s lives within the facility. I think that has opened a lot of people’s eyes, so when their mom or dad or loved one gets to that point, they say, ‘That’s something I think I want to consider.’ ”

For MCNH, which continues to shape its now four-year-old hospice unit, the experiences shared between outside agencies and facility staff spark new ideas for improvement and serve as anecdotes when familiarizing new residents and families with palliative care.

“I think growing together as a group and having been in this process almost from the conception, it became very apparent to me over time of how to expose people to hospice, how to explain it better, and how to describe what it is,” says Nichols. “It’s always something that has been there, but it has not been at the forefront of the medical field. I think it’s coming forward more, and as more of us get educated on what it is, we’re better able to describe it to families and residents so they can see what a beneficial process it can be.”

That education began with the MCNH staff assigned to the hospice unit, which was designed in collaboration with outside hospice agencies, Thorne says. Residents who begin palliative care in the facility can choose to stay in their current unit or move to the hospice unit.

All of the rooms are private and slightly larger than most normal rooms so as to accommodate visiting family members. The unit includes a designated family room with a kitchenette. Sleeping quarters can be set up in the family room in case family members wish to spend the night with their loved one.

Families also have access to a number of bereavement services at MCNH.

“In our collaboration together, we have some of the hospice spiritual care staff conduct quarterly memorial services. They work with social services at the facility in planning a memorial service facilitated by hospice staff that’s open to residents, staff, and families,” says Farmer. “We also offer bereavement support to other residents, in addition to providing support to the caregiving staff.”
In 2010, CRVNA and MCNH began offering a “Lights of Life” ceremony in December at the facility. Invitations are sent out to family members who lost a loved one at MCNH. Staff members from both providers identify a family member who can speak during the ceremony about his or her experience with hospice and about the care received by his or her loved one at the facility. At the conclusion of the vigil ceremony, a tree is lit.

“As a healthcare provider to long-term care for over 30 years, it is wonderful to see that there are more end-of-life services for patients in SNFs,” says Della Croce.

In electing a SNF to work with, Della Croce says HNSGB will look at the facility’s end-of-life philosophy, death rate, hospital readmission rate, Medicare Part A recurrence rate, family satisfaction score, current use of palliative care, and the medical director’s affiliations.

CRVNA holds an end-of-the-year meeting during which information specific to each contracted facility is reviewed, says Farmer. That information includes:

- Length of patient stays
- Length of stay in terms of reimbursement
- Total patient days
- Median patient stay

In looking closely at the numbers, the agency can potentially determine if more hospice education is needed at the facility, or if there are certain reasons for inflated or deflated statistics.

In the end, the goal is the same for SNFs and their contracted hospice agencies: Improve care whenever and however possible, and provide patients and their families with the support that is both necessary and deserved in an individual’s final days.

“We feel that the success of our hospice unit is due to the collaboration that has been developed and continues to be developed,” says Thorne. “There has been no division in any of the decision-making. Everything is done with that team mentality and it’s done with the focus always on the resident and the families, meeting their needs and the needs of the community.”

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Physician certifications and recertifications: Myth or fact?

**Continuing Education | Learning Objectives**

After reading this article, you will be able to:

- Identify which clinicians are permitted to sign certifications and recertifications
- Explain how much time SNFs are allotted to sign the initial certification
- Describe the regulations involving specific form use
- Explain when recertifications are due
- Identify when delayed certifications are allowed

**Editor’s note:** The following article was written by **Elizabeth Malzahn,** national director of healthcare for Covenant Retirement Communities in Skokie, Ill.

There seems to be continued confusion surrounding the physician certification or recertification requirements in a SNF. A physician certification is needed for admission to a facility for post-hospital services that will be covered under Medicare Part A; several recertifications are also required for those same services to continue to be covered in the SNF.

Let’s take this opportunity to examine some of the common urban legends involving this topic and look to the regulation for guidance and a final answer. We will refer to Publication 100-02, *Medicare Benefit and Policy Manual,* as well as Publication 100-01, *Medicare General Information, Eligibility and Entitlement* for our answers.

**Urban legend (UL):** Only the physician can sign the certification or recertification.

**Elizabeth Malzahn (EM):** Myth. According to the Medicare guidelines (100-02, Ch. 8, §40.1):

*A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner [NP], a clinical nurse specialist [CNS] or, effective with items and services furnished on or after January 1, 2011, a physician assistant [PA]) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.*

For purposes of this article, all references to physicians will include physician extenders such as NPs, CNSs, and PAs.

**UL:** The SNF medical director can sign when the attending physician is unavailable.

**EM:** Fact. Provided that the medical director has knowledge of the resident and the specific case and is willing to sign, this practice is acceptable.

**UL:** The initial certification must be signed prior to, or upon a resident’s admission to the SNF.

**EM:** Myth. Per the Medicare guidelines (100-02, Ch. 8, §40.1), “Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable.”

A significant number of providers have adopted a rule that this initial certification is required within 72 hours of admission, and this has been considered an acceptable practice by CMS. However, the section goes on to further clarify that a routine admission order by a physician does not suffice: “There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.”

**UL:** A separate form is required to document physician certifications and recertifications.

**EM:** Myth. CMS allows autonomy to providers in this area. This documentation can be included in another form, notes, or other physician records. However, most providers find that having a separate form makes...
adhering to the requirements set forth in the regulation much easier.

**UL:** A statement from the physician such as “continued extended care services are medically necessary” is adequate to document the need for SNF services.

**EM:** Myth. According to the Medicare guidelines (100-01, Ch. 4, §40), the requirements for the narrative for both certifications and recertifications, respectively, are:

- The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual’s need for skilled care on a continuing basis for any of the conditions for which he/she was receiving inpatient hospital services, including services of an emergency hospital.

- The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care.

**UL:** If the SNF uses a specific certification/recertification form, the physician may reference another section of the medical record, if he or she does not include a statement about the need for continued SNF services.

**EM:** Fact. This is an allowable practice, but many providers shy away from it because it is difficult to find the specific area in the record that is being referenced. Having all of the necessary information in one place allows for a cleaner medical record process.

**UL:** The physician can sign both the certification and first recertification at the same time.

**EM:** Fact. The physician may sign both the initial certification and recertification, normally due by day 14 of the stay, at the same time.

**UL:** The recertifications are due on days 14, 44, and 74 of the stay in all cases.

**EM:** Myth. According to the Medicare guidelines (100-01, Ch. 4, §40.4), “Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.”

A common pitfall is the assumption that the statement above indicates that recertifications are required by days 14, 44, and 74 of the stay in all cases. For additional clarification, let’s review the example below, which is an excerpt from the HCPro book *Long-Term Care Skilled Services: Applying Medicare Rules to Clinical Practice*:

*A resident is admitted on Oct. 1 and the initial certification and recertification are both signed on day three of the stay. Subsequent recertifications are required every 30 days and so in this instance the next recertification would be required by Nov. 1, which is 30 days from the initial recertification signed on Oct. 3, but only day 32 of the resident’s stay. If the SNF assumed that the recertification was due on day 44, the window would have been missed and there would be a gap in the recertification, resulting in services that cannot be billed to the program.*

Failure to obtain a certification or recertification precludes the SNF from being able to bill for the Medicare services. One of the four requirements for covering and billing Medicare Part A services in a SNF is that a physician has certified the need for such services.

**UL:** Delayed certifications are never allowed.

**EM:** Myth. According to the Medicare guidelines (100-01, Ch. 4, §40.5):

> Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an isolated oversight or lapse.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the skilled nursing facility considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.
Creating person-centered care planning

Editor’s note: This is an excerpt from the HCPro book MDS 3.0 Care Plans Made Easy, by Debbie Ohl, RN, M.Msc., PhD. For more information about this book or to order, call customer service at 800-650-6787 or visit www.hcmarketplace.com/prod-8700.

Person-centered care is an idealistic approach to resident care that became common around 1985. It was designed to allow people with developmental disabilities to have a voice in their lives and to facilitate self-determination. By the late 1990s, the concept had filtered into other areas of healthcare.

Person-centered care is an empathic, commonsense approach to personalize care and deinstitutionalize the environment that has been present in nursing facilities for decades. The irony of mandated requirements has driven facilities into a very structured system-centered approach to care in order to remain in compliance. At the same time, these mandates are now requiring flexibility and system changes to meet individual preferences by using the MDS 3.0 as the vehicle for change.

System-centered services rarely accommodate person-centered services (rising times, bedtimes, mealtimes, bath times, activities, etc.). In the person-centered model, the resident is in control. For example, if the person likes coffee on rising each day (rising on his or her schedule and not the facility’s) and prefers only toast rather than a complete breakfast prescribed by the dietitian, adjustments should be made to accommodate the individual. Obviously, when you multiply the number of residents who have their individual preferences, current systems will require many adaptations to provide this kind of diversity. Facilities using a neighborhood care model have been innovators, experimenting to improve responsiveness to individuals with good results.

Person-centered care isn’t about generating new forms or increasing workload. It is intended to shift the emphasis away from a paper-oriented process of care delivery. In the recent past, a concept for person-centered care plans was promoted in the form of “I” care plans. The idea of “I” plans is to improve communication with staff members about who the person is, to have staff members become more familiar with the resident, and to remind them that the resident is more than a room number or a diagnosis, thereby improving the quality of care that the resident receives.

The stated goals for using “I” plans are really no different than the expectations of any care plan format. The concept methodology certainly prompted additional discussion about giving the resident a voice. The “I” plans attempt to do this quite literally, with care plans written in the first person. Care planning is not about format. Care planning is a process rather than a physical item; it is a means to an end, rather than an end in itself. Person-centered care is more than delivering care or giving care plans a title; it is about being conscious of the person receiving the care, the human being.

Shifting emphasis from the mechanics of care plans and delivery to actually honoring the uniqueness of that human being who needs our assistance will hallmark the next evolution for nursing facilities. The road will be fraught with challenges as surveyors and facility operators, staff members, significant others, and those we are charged with caring for shift into this alternative.

Create a simple mission statement like, “listen, learn, and connect” and couple it with a vision statement encompassing what all that means to lay a foundation for the culture change that is sure to come. Create a vision for your organization. What does person-centered care look like when it’s achieved? How will you blend and promote standards of care for health conditions, potential risk, and an individual’s functional status while promoting the quality of life for each person in your care? What will the positive impact be for all stakeholders? Vision is the source of new models, images, and structures. Vision creates a picture in the present that directs us toward the future. Empower people to act in service of the vision. Remove obstacles to change—one at a time.
MDS professor

Test your knowledge of the MDS and long-term care by reading the excerpt below and answering the open-ended questions that follow. The scenario, questions, and answers were distributed as a Section Q case study by CMS during the MDS National Conference, March 8–9 in St. Louis.

Ms. V. is an elderly woman with mild dementia. She had previously been in a behavioral unit of a psychiatric hospital. She was hospitalized in an acute care hospital after a series of falls caused by a urinary tract infection, which exacerbated her dementia. She was then discharged to a nursing facility for rehabilitation. Ms. V. says she has recovered from her illness and is interested in returning to community living.

Ms. V.’s daughter lives 50 miles away and visits her mother monthly. The daughter had previously told the facility social worker that she was opposed to her mother leaving the facility to live in the community. She is concerned about her mother’s safety because of her previous wandering and multiple falls.

1. How would you approach and analyze item Q0100—Participation in Assessment? Is the individual able to understand and participate in the assessment process?
   a. How would you code Q0100?
   b. How would you code Q0500B?
   c. How would you code Q0600?

2. While there was nothing in the case description to indicate that the daughter is a legally appointed guardian or legally authorized representative (such a representative would be responsible for making decisions for the resident, including giving and withholding consent for medical treatment), for discussion purposes, let’s assume that she is the legally appointed guardian. If this is the case, what would need to be done?
   a. How would you code Q0100?
   b. How would you code Q0500B?
   c. How would you code Q0600?

3. If there is a court-appointed guardian, is it necessary to obtain permission from the guardian before interviewing the resident?

Find the correct answers on p. 10.

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MDS professor answer key

Below are the answers to the MDS professor on p. 9:

1. Except in unusual circumstances, such as if the individual resident is unable to respond or participate in the assessment proceedings, continue the assessment interview and code the responses accordingly.
   a. Code Q0100A = 1, Yes, resident participated in assessment; if the daughter also participated in the assessment, code Q0100B = 1, Yes, family participated in assessment.
   b. When Ms. V responded “yes” to item Q0500B, code Q0500B = 1, Yes. (Note: Review the previously recorded response to item Q0490—Resident’s Preference to Avoid Being Asked Question Q0500B in the resident’s clinical record or prior MDS assessment. Use this information in determining whether item Q0500B should be asked.)
   c. Code Q0600—Referral = 2, referral (of resident) made.

2. Continue the interview with the resident and record the individual’s responses in the resident’s clinical record. Contact the legal guardian to interview him or her, obtain responses for the MDS assessment, and record those on the MDS.
   a. Code Q0100C = 1, Yes.
   b. If the daughter/guardian responds “no” to item Q0500B, code Q0500B = 0, No.
   c. Code Q0600—Referral = 0, No, referral (of resident) not needed. Even though the daughter answered “no” to Q0500B, you may want to refer her to the local contact agency to obtain more information about the community living services and supports that are available for Ms. V. This will help her become fully informed about what her options are. This individual may or may not be able to successfully live in a less restrictive environment such as adult foster care or assisted living. The scope and intensity of supports and services (both formal and informal) that are available (or not) will be a major factor.

3. No. If the resident has a court-appointed guardian, the resident should still be asked the question (Q0500B) unless state law prohibits asking the resident. If the resident is unable to respond and participate in the assessment, then ask the family, significant other, or legal guardian. A guardian, family member, or legally authorized person should not be consulted to the exclusion of the individual resident.

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ADLs are key to your reimbursement!

Don’t let improper ADL coding put your facility at risk of significant revenue loss. Join HCPro on Tuesday, June 19, at 1 p.m. (Eastern) for the live 90-minute webcast “ADL Coding and the Impact on Your Facility’s Reimbursement.” Regulatory expert Diane L. Brown, BA, CPRA, introduces a valuable flow sheet to illustrate to MDS coordinators, DONs, and CNAs the correct way to document ADLs and code the MDS 3.0 with an eye on the bottom line. Specific examples from your peers will enable you to identify techniques to self-evaluate your current processes, align with corporate compliance mandates, and discover the benefits and limitations of software to help manage the job.

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For more information on “ADL Coding and the Impact on Your Facility’s Reimbursement,” visit www.hcmarketplace.com/prod-10366.
PPS Q&A

Editor’s note: This month’s PPS Q&A was modified from the HCPro book The Comprehensive Guide to Nursing Home Administration, by Brian Garavaglia, PhD, FACHCA. For more information about this book or to order, call customer service at 800-650-6787 or visit www.hcmarketplace.com/prod-10292. To submit a question for upcoming issues, email Editor Justin Veiga at jveiga@hcpro.com.

Q As the MDS coordinator at a small single-entity SNF, I often feel like I’m charged with far too many responsibilities. Some of those tasks should definitely belong to me, but others I am not so sure about. Can you break down the core responsibilities of an MDS coordinator in my situation?

A The MDS coordinator is responsible for ensuring appropriate coding and documentation of all residents as specified in the mandated guidelines.

Thus, the MDS coordinator must understand the MDS assessment process and address any inconsistencies that may exist within the MDS evaluation. For example, dietary and nursing may be addressing similar issues in various sections, yet the MDS may reveal a discrepancy in coding between the two disciplines. The MDS coordinator must not hesitate to question and evaluate any possible incongruent coding features. Since this is a federally mandated system, it is important that all information that is coded and provided by the MDS coordinator is accurate and that all data is submitted in a timely manner.

Reimbursement issues also are related to the MDS evaluation, and improper data could lead to reimbursement that is either too high or too low given the true status of the resident’s condition. This could lead to charges of fraudulent billing and claims submission, something that the MDS coordinator must guard against.

The MDS coordinator and the MDS system are the engines that drive much of the billing process, especially related to Medicare reimbursement. Therefore, the MDS coordinator must ensure that the respective disciplines complete thorough evaluations that justify the determined billing level, as well as any continuation of Medicare services and fund appropriation.

Providing prompt notification to families concerning any residents who can no longer be skilled under Medicare is an important task of the MDS coordinator. This task is shared with the social worker, the director of admissions, as well as the business office personnel. Other than for technical denials (denials based on exhaustion of benefits), the MDS coordinator, in collaboration with social services and admissions, should...
send letters stating that the nursing facility can no longer justify certification under Medicare and that the family has the right to appeal on the basis of demand billing procedures. If the family, resident, or other responsible party members feel they are entitled to further coverage, promptly notify the accountant or billing agency that works with your monthly Medicare so that all demand billings can be submitted to the fiscal intermediary for review. All requests for demand billing should be tracked and filed in collaboration with the director of admissions. It is important to note that during the demand billing process, until the fiscal intermediary renders a decision to the family, the facility can bill for only copayments and private charges.

In addition, MDS coordinators must remember that physicians have to continue to document at certain time intervals regardless of whether residents meet the Medicare criteria for skilled services. Therefore, the MDS coordinator often must inform the physician when certification and recertification need to be addressed.

The MDS coordinator is generally responsible for keeping a running log of which residents need annual or quarterly MDS evaluations or evaluations due to significant changes in status. They also typically coordinate the monthly care conference schedule, as well as conference scheduling for five- or 14-day conferences and conferences for quarterly, annual, and significant changes. The resident and his or her family are invited to these conferences, and the different disciplines or the interdisciplinary team discusses the resident’s status. The MDS coordinator should make sure all team members briefly document the issues discussed in the care conference as well as whether the resident or family members were in attendance. The MDS coordinator and social worker should make a concerted effort to always notify all cognizant residents of their right to attend their care conference and be fully informed of their current status and care plan treatment protocol in compliance with the Patient Self-Determination Act of 1990 and OBRA.

Care conference scheduling is based on assessment reference dates, or the dates during which the MDS needs to be completed on a respective resident, as well as grace time dates for completion of the information. The MDS coordinator must be aware of those dates because federal guidelines stipulate a time frame within which the MDS must be completed for each resident, along with a particular grace period.
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