

# Provider

## LONG TERM & POST-ACUTE CARE

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### Minding MDS Accuracy

An expert offers some tips for building a strong MDS team and avoiding Medicare default payments.

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Near the top of the list of an administrator's worst conversation starters with a minimum data set (MDS) coordinator is: "I'm sorry, I missed a Medicare assessment, and we won't get paid." Unfortunately, refrains like this one are occurring on a regular basis in nursing homes across the country.

The difficulty of accurately scheduling End of Therapy (EOT), EOT with Resumption, and Change of Therapy (COT) assessments can make the MDS team crazy, not to mention the time intensiveness of getting it right.

Every day on the 12,000-member American Association of Nurse Assessment Coordination (AANAC) community discussion groups, MDS coordinators submit questions and challenges concerning the scheduling of their MDS assessments. On far too many occasions, their situations result in loss of payment.

#### Default Payments Can Be Avoided

Among the most common reasons that a facility receives default payments is for late or missed EOT or COT assessments. This occurs when communication breaks down between therapy and the MDS scheduling coordinator.

Many times, each one is relying on the other to track the MDS schedule, and assessments fall through the cracks. An example that illustrates this is a therapist not notifying the MDS nurse that a resident has missed therapy or has ended therapy coverage, resulting in the assessment not being started in a timely manner.

Sometimes, the cause of a scheduling error is simply miscounting the days of missed therapy for the EOT or being off-count for the seven-day rolling COT. For example, one MDS nurse continued to count the rolling seven-day COT from the most recent 14-day assessment when there was an intervening Significant Change of Status Assessment completed, which reset the COT count.

Other errors occur when the MDS that is scheduled has the wrong reason code for the assessment type, such as when a coordinator codes a 30-day assessment when it should have been coded as a COT. These errors result in default payments if they are noticed and corrected while the resident is still on Medicare.

#### Provider Liability Risks

Once the resident is discharged from Medicare, however, it's a whole different story. When a prospective payment system assessment is missed and the resident has already been discharged from Medicare, the facility cannot receive payment for the days that the assessment covers (there are few exceptions).

If a resident has been discharged from Medicare when it is discovered that a submitted MDS contains an error that cannot be corrected using the modification process, the facility cannot collect payment for those days.

There are five reasons that an MDS has to be inactivated instead of modified: incorrect information for the type of assessment, wrong assessment reference date (ARD), the wrong type of provider, an incorrect entry date on an entry tracking record, or an erroneous discharge date on a discharge record.

### The Result Is Nonpayment

In these situations, the Resident Assessment Instrument (RAI) User's Manual states, "The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements" (RAI Manual [v1.08] Errata [v4], April 2012, page 8).

The result of this inactivation process is nonpayment. Facility staff are then required to submit a claim to the fiscal intermediary, indicating that the resident used the Medicare days. However, the days are recorded as provider liability, and the facility receives no payment for the care provided.

Even the most knowledgeable, savvy, and detail-oriented clinicians can make mistakes and miss information when scheduling MDS. Administrators can support their teams by helping them create facility MDS systems that share the burden and improve accuracy.

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