Functional Pathways™

Excellence in Rehabilitation

EXECUTIVE BRIEF

Medicare Denials: WHAT SKILLED NURSING FACIITIES SHOULD KNOW!

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We Make a Difference
in the lives we touch

Summary

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"*Money was never a big motivation for me, except as a way to keep score. The real excitement is playing the game.*" ~ Donald Trump

Skilled Nursing Facilities (SNF) strive for quality of care, quality of life, helping residents return to the community and providing compassion while helping those peacefully transition from this life. Our jobs are hard and the restrictions we have to work under are burdensome. So why do we do it? The real excitement for caregivers is helping those who cannot help themselves!

Improper Medicare payments to skilled nursing facilities have increased from 4.8% to 7.7% between 2012 and 2013 due to the SNF's failure to obtain physician and NPPs certification and recertification statements. If the physician/NPP certification and recertification process is not timely and does not provide all of the medical necessity statements by the physician/NPP justifying the need for the skilled level of care, SNFs will be at risk for improper payments when faced with an audit. Improper documentation practices will contribute to receiving a denial for medical necessity followed by facing the potential for the resident's entire skilled stay to be recouped.

Working through the appeal process takes an immense amount of time and attention to detail, not to mention resources to track and hike through the appeal process. Absence of a "clean claim" is most common reason for denials in SNFs. These oversights include missing modifiers, missing or inaccurate ICD-9 codes, improper coding, etc. Stopping the denials before they happen is the challenge we all face. In its' FY 2014 Agency Financial Report, The Department of Health and Human Services reported an overall fee-for-service error rate of 12.7 percent, representing $46.3 billion in improper payments. [1]

If an Additional Development Request (ADR) is made from the Medicare contractor, ensure you have a denials/appeal team established in the SNF to tackle the layers of the process. Including all necessary documentation for the auditor to review is crucial. Stopping a denial at the ADR level will preserve payments and avoid denials which could negatively affect your cash flow and increase resources for appeals.

Did you know that claim denial rates are projected to increase by 100% to 200% in the early stages of coding ICD-10?[2] Your nursing staff and therapy provider must be committed to transparency and working together to ensuring the nursing and therapy documentation supports medical necessity and reflects the skills of a nurse and therapist.

THE FINALE

Healthcare is a constantly changing world. Continue focusing on quality and value based service and at the same time, keep the dollars you rightfully deserve for the care provided. If you find you are constantly being reactive rather than proactive, stop the insanity and review systems. Continuing to do the same thing and expect different results is simply crazy.

THE SIGNPOSTS

- Be Proactive!
- Review nursing and therapy documentation frequently.
- Provide ongoing training to nursing staff regarding accurately recording ADLs.
- Supply ongoing training to therapy staff pertaining to accurately recording treatment provided.
- Ensure all necessary documentation is consistently placed in the medical record.

THE TAKEAWAY

- Establish a denial team in your facility.
- Commit to clean claim submission.
- Improve documentation quality.
- Demand compliance with an effective Triple Check Process.
- Build a committed partnership with Therapy!

[1]Connolly Healthcare: http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx
[2]Claim Denials: 15 ways to fight back; Medical Economics; http://medicaleconomics.modernmedicine.com/medical-economics/RC/claim-denials/claim-denials-15-ways-fight-back?page=full

Value in Commitment

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We are committed to doing everything we can to improve the lives of our residents. Being a part of a pro-active, transparent, and seamless team is vital to the success of our future caregiving abilities.

NURSING/FACILITY DOCUMENTATION REQUIREMENTS	THERAPY DOCUMENTATION REQUIREMENTS
Confirm documentation is in the medical record to support a medically necessary three day inpatient hospital stay.	Verify your therapists are creating a complete plan of care/plan of treatment which includes the therapist's signature, professional credentials, and the date the plan was established.
ADR TIP: Make sure to include the discharge summary from the hospital when submitting ADR	**ADR TIP**: Submit all therapy documentation, including orders and clarification orders that are legibly signed and dated by the physician.
Verify clinical staff effectively documents pertinent resident facts (resident condition, types of treatments provided, ADL flow sheets, physician notes).	Ensure therapists are documenting why the previous goals were not met or could not be met to support the modification of the plan.
ADR TIP: Review all medical diagnoses to ensure they are coded to the highest level possible for that code. This proactive review is completed during Triple Check process.	**ADR TIP**: Make sure to include supportive therapy documentation including individualized programs developed for the resident.
Ensure the skilled level of care is clearly documented by the physician to support the SNF admission and that care is vital and necessary for the treatment of the resident's condition.	Confirm the therapists/assistants are clearly documenting to support the therapy minutes billed. Make sure the treatment minutes are clearly documented in the patient's record; ensure time and untimed codes are billed appropriately.
ADR TIP: Accurate nursing ADL tracking is vital to accurate reporting of the acuity of care provided to the resident. Make sure all ADL documentation is provided when submitting an ADR packet to Medicare.	**ADR TIP**: Make sure to include all therapy service logs referencing units and minutes provided for the resident. The service logs support the RUG billed and Medicare cannot confirm the RUG billed without the therapy service logs.

ABOUT FUNCTIONAL PATHWAYS

Since 1995, Functional Pathways™ has consistently provided premier contract therapy services throughout the nation. Our mission has always been to provide ***Excellence in Rehabilitation***.

To-date, our continued relationships have been predicated on three unique features that set us apart from all other therapy providers: **Our Values**, **Our Promise**, and **Our Innovation**. Organizations that partner with us will also receive these as additional benefits within their own communitites. We understand that the synergies between these three core elements are philosophical to providing unique, yet customized therapy services across the entire continuum of care to help residents age in place healthy and securely while creating a more stable census and by providing properly documented therapy.

We encourage you to partner with us to ***Make a Difference in the Lives We Touch***.

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