

Skilled Nursing Facility Myths and Misconceptions

By Jerry L. Rhoads, CPA, FACHCA, January 2007

(With an implementation plan for eradicating these from your SNF operation)

Myth #1

SNF Patients are getting their entitled Medicare Part A Benefits

After the advent of the Prospective Payment System (PPS), how could it happen that patients are not getting their entitled Medicare benefits, when Part A Medicare coverage criteria, by law, did not change? Because providers are using Minimum Data Set (MDS) and Resource Utilization Groups (RUGs) as a way to define skilled coverage and not utilizing Revision 262 of the Skilled Nursing Manual.

To be in full compliance with the Social Security Act, providers must turn to Transmittal 262 and the revised Skilled Nursing Manual to insure that beneficiaries receive their entitled coverage.

With the enactment of PPS and Medicaid cutbacks, it is becoming all the more important that SNF's develop expertise onsite for managing a growing segment of their business. The post hospital referrals are increasing by 25% each year. Therefore, SNF's must be adept at utilizing all 44 RUG's categories for Medicare reimbursement. Let's look at how a knowledge of Rev. 262 can double or triple your Medicare Part A days and distribute your RUG's days throughout the 44 groups.

In 1987, HIM-12 (Skilled Nursing Manual) was revised to more clearly present the requirements for coverage under Part A of the Medicare Program. The stated purpose by Health Care Financing Administration (HCFA) was to make it easier to identify covered care and ensure that claims are approved when the requirements for coverage are met.

Why would HCFA do this? A lawsuit required that the guidelines be revised. Under a court order, Transmittal 262 was issued to the Intermediaries, not the providers. If you have not heard of Rev. 262, you are not alone. Literally, thousands of providers are working under the old interpretative guidelines and are not aware of the revised definitions.

Following are a few clarifications that will destroy many, if not all, misconceptions and myths about skilled coverage:

The revision states in its preamble, as directive to the Intermediary reviewers, "Remember that you are reviewing for coverage. Look for evidence that services are covered, to approve the claim. If you can not find the evidence, than denial is appropriate. Do not approach a claim assuming it is uncovered and looking only for evidence to us in denying it."

"In short, you can use medical review screens to approve claims without in-depth individual review, but not to deny them. Any rule of thumb that would declare the level of care requirements not met and deny a claim on the basis of elements such as the patient's condition, restorative potential, ability to walk or degree of stability without individual review of all pertinent

facts to see if coverage could be justified is unacceptable. A medical denial decision should be based on a detailed and thorough factual analysis of the patient's total condition and needs."

Definition of Custodial Care: "Custodial care is excluded from coverage. Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medications that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision should be based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential." Everything else by definition is skilled!

Following are "Rules of thumb" or Medicare myths that were used to deny coverage in the past that are no longer allowed by HIM-12 due to 262:

- 1) Patients plateauing in therapy
- 2) Fractures above the waist
- 3) PO meds
- 4) No potential for recovery
- 5) Dying process or supportive
- 6) Psychiatric diagnosis or Alzheimer's cases
- 7) Skilled services require nursing and therapy seven days per week
- 8) Non-skilled services (never covered)
- 9) Potential for injury (never covered)
- 10) Skilled supervision, observation and management of care plan (not covered)
- 11) "Old Stroke" non-covered (262 says reviewer must address the services, not the diagnosis)
- 12) No coverage for maintenance or routine therapy
- 13) No coverage if there is no progress
- 14) Pain meds (not covered)
- 15) Generalized weakness (not covered)
- 16) Secondary and tertiary diagnoses do not justify further coverage
- 17) Complications do not justify further coverage

The following misconceptions have been coined by the Intermediaries over the years and shot down by Rev. 262:

- 1) Patients must progress for Medicare to pay. Not so. If coverage is only for rehab, then there needs to be progress. However, in nursing, the coverage is for improving the medical or mental status or preventing further deterioration and further injury.
- 2) Patients can waive their Medicare benefits. Not so if they are Medicaid. Medicare must be billed first, then Medicaid.
- 3) Patients need to be having therapy and nursing or they must be discontinued. Not so. It is nursing first and/or therapy that qualifies the patient for coverage.
- 4) Patients need to be having therapy and nursing or they must be discontinued. Not so. It is nursing first and/or therapy that qualifies the patient for coverage.
- 5) Skilling a patient is based on a certain diagnosis or nursing procedures. Not so. It is the daily nursing interventions that justify Medicare coverage, then therapy enters the picture as needed.

- 6) PPS changed the definition of skilled care. Not so. The definition of skilled care was established by the Social Security Act amendment in 1966 and has never changed. PPS merely changed the method of payment.
- 7) MDS and RAP's (Resident Assessment Protocol) are enough to support Medicare payment. Not so. The MDS and RAP's merely determine the level of care and payment. The documentation that must exist is quite extensive if you do not have a system to link MDS to the automatic responses by the nurses.
- 8) Narrative nurses' notes are adequate to prove and support daily skilled care. Not so. The narrative notes often state only what is not wrong with the patient, not the skilled services being done to support reimbursement. Whereas, P.I.E. (potential industry earnings) nurses' notes give the reviewers what they are looking for, and protect you, the provider, against false claims allegations and denials.
- 9) The number of covered Medicare days is a subjective nursing determination. Not so. The number of days a patient gets is based on the objective criteria for entitlement to insurance that is outlined in rev 262.
- 10) Medicare denials are the worst thing that can happen in Medicare. Not so. A denial only puts the provider on notice that the reviewer does not agree with the documentation of skilled services. After a denial, the provider can appeal, re-bill to Medicaid or have the ancillary providers bill Part B or insurance. The losses from a Medicare denial can be nominal.
- 11) Utilization review is no longer necessary. Not so. If you want to get the grace days associated with terminating cases, you must follow the UR (Utilization Review) protocols.
- 12) Therapists are experts in Medicare. Not so. Therapists are expert in how they get paid, not you.
- 13) If in doubt, you should call the Intermediary for answers. Not so. The Intermediary is a source of information, however, they interpret the regulations as directed by CMS, and have been chastised by the courts and found to be stretching the law at times.
- 14) A duly certified facility is the way to go. Not so. If the patient stays in the same bed after the skilled stay, the regulations presume that the level is still skilled until rebutted. This means that many beneficiaries will not get another 100 days, ever.

PPS has cut the average length of stay in half!

Why, when Rev. 262 states that Medicare coverage is to be based on nursing process, not a procedure or positive outcome?

Following are excerpts From Rev 262:

“The three factors for determining skilled level of care are:

- 1) The patient requires skilled nursing or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel. (see paragraph 3132.1 to 3132.3); requires the skills of qualified registered nurses, licensed practical/vocational nurses, physical therapists, occupational therapists, and speech pathologists or audiologists).
- 2) The patient requires these skilled services on a daily basis (see 3132.5) (daily is essentially a seven day a week basis, unless skilled rehabilitation services are not available on a seven day a week basis. In that case, the skilled rehab services can be provided five days a week). A combination of therapy and skilled nursing meets the daily definition (i.e., PT on Monday, Wednesday, and Friday and Nursing on Tuesday,

Thursday, Saturday and Sunday) If the services are dropped down to three visits per week with the restorative aides doing the exercises, further billing can be done under the Rehab Low categories for a period of time, then to full nursing restorative programs. This can occur as long as there is improvement or stopping of decline (the patient must be able to sustain that highest level of functioning or should not be discontinued until that level is attained).

- 3) As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF. (see 3132.6) The “practical matter” requirement, absent of evidence to the contrary, presumes that the requirement is met. It also must be feasible for the particular patient. The fact that the patient is granted an outside pass, short leave of absence, holiday, or family occasion, is not in itself evidence that the individual no longer needs to be in a SNF for skilled services.”

“In addition, the services must be furnished pursuant to a physician’s orders and be reasonable and necessary for the treatment of a patient’s illness or injury, his or her particular medical needs and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Skilled nursing services include:

- 1) Hands on treatments
- 2) Skilled observation of results of treatment to determine any changes in orders for possible complications
- 3) Skilled assessment of condition during and after treatment to determine a need to initiate additional medical procedures until the patient’s treatment regimen is essentially stabilized
- 4) Skilled management of evaluation of care plan for complications
- 5) Skilled teaching and training of self care and how to manage patient’s own treatment regimen
- 6) Culmination of unskilled services where the sum total of unskilled services, which are a necessary part of the medical regimen, considering the patient’s overall condition, makes the daily involvement of skilled nursing personnel necessary to promote the patient’s recovery and medical safety.”

“Other skilled nursing factors:

- 1) Complexity of the services due to medical complications must be considered
- 2) Medical instability is a justification for continuing coverage
- 3) Mental instability is a justification for continuing coverage
- 4) High risk for injury is a justification for continuing coverage
- 5) Even where a patient’s full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities.
- 6) The fact that there is no potential for such a patient’s recovery does not alter the character of the services and skills required for their performance.

PPS has shrunk the majority of coverage to a few higher intensity rehab categories:

“Skilled rehabilitation services:

- 1) The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a qualified therapist;
- 2) The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified therapist;
- 3) The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improved materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;
- 4) The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition;
- 5) The services must be reasonable and necessary for the treatment of the patient's condition. This includes the requirement that the amount, frequency, and duration of the services must be reasonable.
- 6) When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel.
- 7) Routine therapy can be covered as part of inpatient SNF care, but they do not qualify a patient for a SNF level of care because they are not skilled services."

" Common therapy modalities and procedures:

- 1) Assessment of a patient's rehabilitation needs and potential
- 2) Therapeutic exercises which must be performed by or under the supervision of the qualified therapist due to either the type of exercise employed or the condition of the patient, constitute skilled therapy
- 3) Gait training, range of motion, bed mobility, ultra sound, hot packs, etc.
- 4) Speech and occupational therapy are to meet the same standards.
- 5) Maintenance therapy – The specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician are achieved. Establishing such a program is a skilled services.

Some nonskilled services are being denied and should be covered!

"In special cases, the ordinary view of a service as non-skilled can be overturned because of the patient's condition. This means that a service which ordinarily is considered non-skilled, under the general requirements for skilled therapy, can be treated as a skilled service in these special cases. However, two requirements must be met:

- 1) The level of the services or the condition of the patient, must require the skills of a physical therapist; and
- 2) There must be a reasonable expectation of improvement in the patient's condition, or the services must be needed to establish a maintenance program."

“Non-skilled services that normally are not skilled: 1) Still can be covered as a part of inpatient care and 2) Do not qualify a patient for SNF level of care unless a documented special medical complication makes skilled performance necessary:

- 1) Oral medications, eye drops and ointments
- 2) General maintenance care of colostomy and ileostomy
- 3) Routine maintenance of catheters
- 4) Changes of dressings for non-infected postoperative or chronic conditions
- 5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems
- 6) Routine care of incontinent patients, including use of diapers and protective sheets
- 7) General maintenance care in connection with a plaster cast unless there are complications
- 8) Routine care of braces and similar devices unless there are complications
- 9) Use of heat as a palliative and comfort measure, such as whirlpool or steam pack
- 10) Routine administration of medical gases after a regimen of therapy has been established after patient has been taught how to institute therapy
- 11) Assistance in ADL's
- 12) Periodic turning and positioning in bed
- 13) General supervision of repetitive exercises to maintain function unless the skills of a licensed therapist are involved to assess the patient's condition.”

Editorial Comments by Jerry L. Rhoads, CPA, FACHCA:

Providers tend to fall into three categories in managing their Medicare business.:

- 1) Act passively. No interest in the complexities of Medicare, but dabble in it while seeking nominal help from their accounting firm. They may have two to four patients on Medicare on any given day and do not see it as a vital part of their finances.
- 2) Finds Medicare a challenge but overwhelming and takes some risks only because they have to. Most of these providers belong to a chain operation that employees accountants in their reimbursement department. Since the home office accountants are not clinically oriented and the clinicians are not schooled in Medicare coverage, the number of days per case will hover around 15 to 25 with an average of five to seven patients per day on Medicare.
- 3) See Medicare as an opportunity and seek onsite help to manage the complexities. They recognize that PPS Medicare is more complex and must embrace the nursing department, as well as accountants and therapists. These are SNF's that have sought training on Revision 262 and have implemented systems that integrate 262 documentation into their MDS processing. As a result, the Medicare business becomes at least 10% of the census every day and 40% of the revenues. Not only does this improve cash flow immensely, but also enables the staff to improve outcomes because all of the nursing RUG's groupers are being actively used to improve patient functioning over a longer period of time.

My company, Caregiver Management Systems, Inc. specializes in Medicare processing and documentation systems. If you find yourself in the first two categories, we can get you to the third category in 90 days or less. If you are in the third category, you probably need better documentation systems. Call Jerry L. Rhoads, CPA, FACHCA, at 847/517-6710. Don't wait another day, for Medicare done the right way can save that day.

MYTH #2

We are Short Staffed



The clock ticked 11:00PM and still no nurse for the Medicare unit. The agency called and said the last bill had not been paid and they would not staff that shift. The DON was called and was going to work that unit to cover the shortfall. This is the sixth time this month that there was a crisis on the night shift. All kinds of incentives are being used to get staff to show up. Shift differentials, 40 hours paid for 26 hours worked, sign on bonuses, days off for days worked, free passes to ballgames and movies, more money per hour for working off shifts. Nothing seems to work for any length of time.

Sound familiar?. When I was running nursing homes, this was occurring and that was 10 years ago. Every one said it was because of a nurse shortage. Nothing has changed. In effect, there was no shortage. The nurses and aides just did not want to work in a nursing home. How could we restructure staff so this does not occur? Is it possible to improve morale and attitudes to impact retention and attendance? The answer is an empathic yes! Is it more money? Is it more time with the resident? Is it more authority? Is it better benefits? Is it more status? Is it a better future? Is it better tools to get the work done? Is it knowing what the workload will be when I get there? Or, is it just plain liking the job better? The experts indicate that it is all of these, but one will stand out as the primary impetus to cutting turnover and call-ins. That is the workload and the worker's capacity to get it done to management's satisfaction.

It is my experience in turning around two very poor performing facilities, that the worker's attitude towards their work was impacted more by how we delegated the tasks than anything else. When the method of assigning the work was restructured, the facility that had been decertified for poor quality turned around immediately. In three months, we went from being targeted for closure to getting five of the six stars of quality given by the surveyors.

This new structure has been refined over the last ten years, as we have taught facilities how to organize the work and delegate the tasks. In essence, the technique is called Activity Based Analysis for setting up standardized workdays and workload. For example, what does the typical CNA do during a shift?

	<u>Requires a Certification</u>	<u>Does Not Require A Certification</u>
Ambulate resident	X	
Bath resident	X	
Feed resident	X	
Dress resident	X	
Change resident	X	
Pass water		X
Lay out clothes	X	
Find clothes and put away		X
Take to dining room		X
Deliver trays		X
Set-up tray		X

Perform a restorative program	X	
Perform a rehab program	X	
Take to the bathroom		X
Answer call lights		X

In our studies, the CNA's are typically responsible for 50 to 60 tasks per shift for each resident. Of course, they do not get that workload done. Not even close. They tend to do the easier tasks first, and, if they have time left or are not pulled to cover the dining room or rounds they may get some PROM (Passive Range of Motion) done. Of the 50 to 60 tasks that the CNA's perceive that they are responsible for, only 25 require a certification to do. Clearly, over 50% of their day is wasted on busy work that someone else could do at less pay.

In my two facilities, when we took this busy work away and assigned it to hospitality aides, the work attitude improved immediately, as did retention and attendance. We also were able to get the restorative and rehab programs done that were not being done before. This resulted in more residents ambulating, with less bedsores and better appetites. And, the facility getting the five stars of quality from the surveyors. eventually the census began to rise due to the improved outcomes.

The studies we did embraced all job functions. I call this the "FOCUS on the Resident" program. When we did the nurse analysis, we found that of the 41 tasks that the nurse perceived she was responsible for, only 16 required a nurse license to do. A CNA or a Hospitality Aide could do the other 25. We found that the housekeepers were indicating a workload that was not meeting the expectations of management because they did what they could get done, not necessarily what needed to be done, for example, cleaning areas that were not high traffic and missing areas that needed more attention (resident areas). All functions had workloads that did not meet their job description, or management's perception of what was needed. A certain indication of a fouled up business model.

This revelation motivated a complete restructuring of the organization chart. We turned it upside down and put the resident at the top. We assigned different specialty units to Nurse Case Managers, utilizing our case management software, staffed the units with specialized case management teams, and did away with departmentalization. The Hospitality Services became the foundation for the non-clinical services to the resident and embraced housekeeping, laundry, dietary, and maintenance. Together with the Clinical Services, the Case Managers run their specialized units with their teams. The result is was improved morale, improved work conditions, improved attendance and improved retention of performing staff.

Alzheimer's Unit	Respiratory Unit	Rehab Unit	Extended Care Unit	Chronic Care Unit
Case Manager	Case Manager	Case Manager	Case Manager	Case Manager
Psycho/Soc Tech	High Tech Nurse	Rehab Nurse	Unit Nurse	Restorative Nr.
Behavior Tech	Pharmacology	Rehab Aide	Restorative Aide	Restorative Aide
Rec Leader	ADL Aide	Restorative Aide	ADL Aide	ADL Aide
Hospitality Aide	Hospitality aide	Hospitality Aide	Hospitality Aide	Hospitality Aide

The above functions relate to the services to be rendered and each function determines the job title, compensation level and performance measurements. For example, the Psycho/Social Tech is assigned a specific group of residents who have similar emotional problems based on their MDS triggers. Standardized Psycho/Social programs are formatted by the computer with

minutes of care to be conducted by the Tech in a class room setting for 30 minutes each day. The outcomes are measured by a Social Worker by comparing each participant's current classroom response in relation to their predetermined assessed needs and goals.

On the other hand, a Behavior Tech performs one on one interventions for a caseload of residents who have exhibited episodic behavior problems. The social worker, psychiatrist and/or psychologist assist in the prescribing of the medications, assessment of programmatic interventions with minutes of care attached and then evaluate progress towards individualized outcome goals. The ADL Aides function is focused on the residents who are fully dependent and do not have restorative potential.

Another example of specialization is the High Tech Nurse who specializes in post hospital cases that involve high tech equipment, medications and/or complex and extensive services. This position is a step up from the Pharmacology, Treatment and Unit Care Nurses.

Once the organization is functionalized, standardized and computerized in this manner, we can actually determine, based on the minutes of care attached to the triggered problems, how many full time equivalent staff (FTE's) we really need for each shift.

Of course, this seems like a dramatic leap of faith, yet, in the first facility I managed, we accomplished the transition to functionalization over a weekend during a 16" snowstorm. We had an early snowstorm that prevented half of the scheduled staff to get to the facility. We ran the operation better for three days with just half the staff. During that weekend, we changed the way we were organized and never looked back. This was the major catalyst to getting re-certified and the five stars of quality. So, it does not take forever to accomplish what we should do anyway...give your staff the opportunity to be successful based on the way the workload is assigned.

Since—turning around two trouble facilities using this technique, our company has been consulting with over 100 skilled facilities over the last ten years, attempting to get a commitment from the owners to set-up a "FOCUS on the Patient" program. It was not until PPS entered the picture that we started to get more interest in inventing a better wheel, so to speak. With the long term care industry lobbying for more money to spend on what is deemed to be staff shortages, we are helping facilities to reorganize, standardize and computerize for efficiency and cost effectiveness, thereby eliminating costly wasted time and effort.

Through this re-engineering of systems, realignment of workload and reorganization of workflow, the result is a reduction of FTE's, not an increase. Why is this so when every DON will tell you they are short staffed? It is because the staff they think they need do not show up as scheduled nor do they work productively the whole shift. If the staffing is based on workload and the staff can get their job done, they will show up as scheduled. And if the work is focused on the priorities, they will get the important tasks done.

If you don't believe this is important, just try balancing workload with worker's capacity and watch your bottom line grow. Think about it. What is the impact on our labor costs for replacing certain CNA's twice a year? What does it cost to try to get staff to show up for the night and weekend shifts? Once a value is put on the waste that is caused by an unstable workforce, performance bonuses can be used to share in the elimination of these wasteful costs. Then you end up paying fewer people more money for better performance and make more money the old fashioned way, by earning it with services.

Our calculations show that turnover costs \$125,000 per year in the typical 100 bed nursing facility. Absenteeism costs \$45,000 per year. That isn't the major cost, though. It is lost productivity and efficiency. This costs the 100 bed facility \$200,000 per year in ineffective outcomes, poor surveys and poor reputation in the medical community.

With restructuring and re-engineering comes a new organization chart, putting the resident at the top. More importantly, we build in a career ladder for the staff that starts at entry level and directs them into nursing, therapy, social work or administration.

Nursing	Therapy	Social Work	Administration
Hospitality Aide	ADL Aide	Activity Tech	Biller/Collector
ADL Aide	Restorative Aide	Behavior Tech	G/L Accountant
Restorative Aide	Rehab Aide	Psycho/Social leader	Chief Accountant
Rehab Aide	Therapy Aide	Social Service Aide	Cost Accountant
LPN – RN – BSN	Therapy Assistant	Social Worker	Controller
Gerontologist	Registered Therapist	Dir. Admissions	Chief Financial Officer
Case Manager	Rehab Director	Dir. Human Services	CFO/VP Finance
Director of Nursing	Administration	Administration	Administration

In the real world of health care today, remarkable stories are starting to emerge. In New York, where we implemented FOCUS two years ago, there was a reduction in full time equivalent clinical staff, increased wage rates from 4% to 23%, and a savings in cost of \$150,000 that went directly to the bottom line and improved outcomes. In Iowa, where the State is imposing RUG's as the basis for reimbursement, we are reorganizing facilities for the elimination of excess FTE's, improving pay scales and satisfying union and staff demands for more money. This is done, while improving profitability through improved restorative and rehab programs that optimize the revenue streams from Medicare and Medicaid.

In summary, we can ignore our social responsibility to the residents and to our staff and continue to ask our best customer for more money, but will that solve the problems that we have internally created by not organizing the work for the worker and the resident? It is not more money that will fix our image problems and our financial shortfall. It is improved management systems and methods, as it was in the automobile industry in the 1980's after the Japanese learned TQM from W. Edwards Deming, and captured market dominance from the United States for two decades.

Quotes from the facilities that have restructured their staff using these new methods:

Deb Schroeder, CEO, MBA, MHA of Bartels Lutheran Retirement Community states... "It is wonderful to be able to see staffing based on each resident's blueprint of care and know we are covering all the bases."

Jeremy Allen, Owner and CEO of Robynwood ALP, indicates... "I want the staff empowered to work and make decisions when I am not here, and know it will be the right thing to do. Activity Based methods allow me to do that."

Steve Warneke, CFO, CPA, CMA, also of Bartels ... "Most executives in health care do not understand the importance of Activity Based time standards linked to care plans when it comes to efficiency, productivity and quality. We must learn from manufacturing and the military that

structure and workflow are the most important facets of effective management and we are just now scratching the surface in long term care on computerizing the workload.”

Tim Lutner, CFO and Controller of Robynwood ... “The use of handheld and wireless computer technology to perform the assessment, documentation and costing of the care enables the nurses to become cost conscious without sacrificing quality. With the Caregiver Management System, we are more advanced than our long-term care competitors because we have the information real time. Who would have thought we could run a P/L statement by patient and have it agree with the general ledger and also be able to see who we were losing money on and correct it as we go along.”

“Restructure The Staff and They Will Stay”

MYTH #3

Common Misconceptions about Medicare for SNFs

The following misconceptions are misconceptions held by accountants about Medicare:

1. ***“Medicare is not the core of the nursing home (long term care) business.”*** Typically this is true because the facility does not know the rules and regulations governing coverage and misses a good 40-50% of the potential revenue. The accounting firms tend to operate on the guidelines promulgated by the fiscal Intermediaries and/or CMS (Center of Medicare/Medicaid Services), and on traditional accounting concepts, rather than on operational realities. Accountants are resource consultants on the financial impact of Medicare and not the economics of health care. The agenda of the accounting firms is to advise their clients on the flow of financial information into the cost reports, not on the ability of the operations to justify coverage and cash flow.
2. ***“It is better to be conservative in approaching Medicare coverage and cost than to be sorry and have to pay back retroactive denials.”*** The typical nursing home is receiving heavier care requirements because the hospitals are discharging patients sooner and with more medical problems. To be conservative on the revenue and billing side, and still have to meet the payroll and supply bills for heavy care, does not balance the budget. Therefore, it is necessary that every bit of revenue be captured and billed to the payer of choice. The payer of choice is the one that will pay the most, and the quickest and be in compliance with the patient’s insurance policies, of which Medicare is the principle policy for the elderly and disabled.
3. ***“Medicare bad debts are almost impossible to collect from Medicare.”*** The Medicare auditors are death on unsupported Medicare bad debts because Medicare is obligated to pay full value for coinsurance of \$101 per day for Part A and 20% of the charge for Part B. Therefore, they expect facilities to follow the rules to a “t”. It is therefore necessary that the provider establish credit policies and procedures for Medicare bad debts that follow the regulations, and then follow those policies when trying to collect the ever-increasing share that third parties pay. Now that the third party payers owe so much more of the bill, they are

starting to contest the validity of the skilled care billing to them. They are asking for medical records and denying the validity of the skilled care bill, even when Medicare pays their share. In the typical 100-bed facility, the coinsurance will run \$27,000 per month and the incidence of bad debts can go as high as \$5,000 to \$10,000 per month. If the third party does not pay and an effort to collect can be proven, the uncollected portion is to be paid by Medicare on the cost report. This also applies to Medicaid programs that do not pay coinsurance.

4. ***“Poor collection procedures for coinsurance, which is at least ½ of the Medicare part A bill, is the result of lazy bookkeepers and poor response time from the third payers.”*** All the third parties are slow pay and many are denying payment even when Medicare pays. To combat this reality, it is necessary to organize the Accounts Receivable record keeping into an open invoice system, which allows the bookkeepers to be efficient in reviewing and pursuing slow pay accounts. We recommend that the Medicare and Medicaid claims be logged and the logs also be utilized for posting: receipt vouchers, denials, aging, re-bills, credit balance reporting, refunds, admission severity of illness codes, and discharge destination codes. Then, any losses on coinsurance can be recovered from Medicare, as a bad debt, if the proper collection effort is made and documented. There is a lack of knowledge of what Medicare will pay for as a bad debt, which causes a loss of dollar for dollar reimbursement on the cost report. Typically, we find no written policies and procedures on Medicare bad debts, or if there are, they are not consistently followed.

Misconceptions held by therapists about Medicare:

1. ***“Denials are the score card for knowledge of the criteria of Medicare billing and documentation: if you don’t have many, you are doing a good job of managing coverage, and when therapy ends, Medicare coverage ends.”*** In fact, the lower the denial rate, the more likely the facility does not know how to skill a patient for Medicare Part A or B coverage. Under the entitlement provisions of the Social Security Appeals handbook, all qualifying stays are covered under Medicare, if their condition warrants: skilled care on a daily basis, by a licensed nurse or therapist, or, for an underlying medical condition for which they were hospitalized. A medical condition resulting from that hospitalization also applies. as long as it is reasonable and necessary, and can be treated in a skilled nursing facility.
2. ***“The utilization review should be conducted by the therapists, since Medicare ends when the therapy ends.”*** Utilization review is a concurrent function of the Medicare case manager position that the case management system sets up. Coverage is the main responsibility of the Medicare nurses, not the therapist. Many times the therapist is from an outside agency and has his own agenda, which is not necessarily in the best financial interest of the facility. They have an indemnification clause in the therapy agreement that requires that they refund the facility for any denials, so they will naturally want to have the final say on de-certification. It would be in the facility’s best interest to remove the indemnification and assume the responsibility as it will produce longer lengths of stay and more covered therapies.
3. ***“SNF therapy costs are shrinking because the availability of therapists is limited.”*** Since PPS, the therapy companies are not paying excessive amounts to sign therapists away from hospitals. Hospitals no longer provide Medicare therapies as a part of the DRG, since therapies are paid to SNF’s in the RUG’s formula. Hospitals often provide the service to the SNF under contractual arrangement and do the billing direct, without sharing the margin with

the facility. This means that the SNF provides the space and support free of charge. Under an arrangement deal, the facility should at least be paid rent and a percent of the margin. Otherwise, ancillary billings, which provides the facility with a 25% profit margin, all go to the therapy company.

Misconceptions held by nurses about Medicare:

1. "The nursing component under Medicare requires certain procedures to be covered, for example: tube feeding, insulin injections, stage three or four decubs requiring sterile dressings, lower extremity fractures requiring weight bearing orders, full blown strokes requiring one hour per day therapies". All of these procedural criteria were found to be illegal. Procedures such as tube feeding or insulin injections should not be used as the justification for Medicare coverage. It should be the patient's condition (i.e., nutritional deficit or blood sugar dysfunction). The break in a patient's spell of illness begins when the condition has been resolved.

100 day lengths of stay should be common, and additional benefit periods the norm, as the beneficiaries grow older and have more medical conditions that qualify them for hospitalization and long term care. Under the conditional definition, all admissions from the hospital with the three-day stay, or its equivalent (observation day), must be skilled, unless it is determined through assessment (MDS) and observation that the condition (s) for which they were treated in the hospital, has been resolved and no longer requires daily interventions. Typically, under the case management system, the nursing problems and interventions carry the case and the therapies are a supplementary service to further justify the skilled criteria for daily interventions. Under this interpretation, which is supported by numerous case law citations, either nursing OR therapy can keep a patient skilled.

2. **"If the patient is not receiving therapy five days a week and nursing seven days a week, the patient must be decertified."** This myth was promulgated by HCFA, until they were sued by AARP and decided they would allow the Intermediaries to look for a "reason to cover," not a "reason to deny." Therefore, therapy does not have to be happening five days per week if the patient is having a hard time tolerating that intensity, so long as nursing continues to be skilled on a daily basis. This will change the RUG's, category but will not terminate skilled coverage. For example, therapy could cover the patient for three days and nursing four days and still meet the seven day per week skilled criteria. The key words in the law and regulations as interpreted by case law are severity of illness, intensity of service and outcome (progress or deterioration of the patient's condition), which justify lengths of stay commensurate with the patients total condition, not just one therapy or nursing procedure.
3. **"Coverage decisions and interpretations should be made, by either asking the fiscal Intermediary or consultants who are following the CMS guidelines."** The right source should be the law and regulations. In each case, as with the law, you need to have a legal interpretation of the gray areas that exist with any government program and then follow those consistently, and appeal every denial on the basis of the documented level of care and skilled services planned and delivered. (Owners expect their administrators to contest all survey deficiencies that are not consistent with the law and that is what we teach our clients to do under the Medicare program.)

4. **“Charting and assessment inconsistencies only hurt the facility in surveys.”** The most damaging impact of poor documentation is on the finances of the facility, which show up in a low average length of stay and low utilization of skilled and rehabilitation services. We recommend an average length of stay of 50 to 60 days for manageable case on Medicare Part A because of the functional deficits showing up on the MDS assessment. This results in more patients receiving 100 days of coverage and also qualifying for more coverage under Part B.

Misconceptions made by pharmacists, vendor supply and service companies and physicians about Medicare:

1. **“Many ancillary services should be billed direct by the vendor since the Medicare program will allow for the vendor to bill direct under Part B. This relieves the facility of having to bill it and collect it.”** Such a deal. It is not to the facility’s advantage to allow some one else to do the billing, which results in the vendor reaping all of the profits: tube feedings, medications, respiratory products, lab, x-ray. It is better that the vendor or the professional (e.g., attending physician, podiatrist, optometrist, dentist, audiologist, psychiatrist) share in the margin through the UB-92 billing for Medicare or the rental of space, so the facility has a source of income on all services provided in the facility. Otherwise, the facility is responsible for all of the quality issues and receives no resources for providing the delivery system.
2. **“Medicare Part B only pays for diagnostic and therapeutic services for patients who have had a decline in functioning and the DMERC’s (Durable Medical Equipment Regional Carrier) will only pay for surgical dressings and therapies.”** The coverage under Part B is being narrowed by interpretations made by the intermediaries under the CMS guidelines. Legally, this is promulgating regulations through the interpretative process and could be overturned in court. Now that decline in functioning is triggered by the MDS assessment form, more Part B coverage can be legitimately justified. Most of the Medicaid patients who have Part B coverage currently are in a state of decline and qualify for some therapy services to bring them to their maximum level of functioning. This is now required by the OBRA rules, so why not get paid for the services?

Misconceptions made by admissions directors about Medicare:

1. **“Medicare only pays if your mother improves. They don’t pay for more than about 10 days for therapy if an RN is overseeing the care around the clock every day.”** This is a direct quote made by an Admission Director that my wife Shari approached for admitting her mother to a skilled nursing facility. When we then pointed out that each of those statements were a misconception or myth, she became defensive and stated, “We know Medicare and don’t need you to tell us what to do.” My wife then approached the Administrator with a clarification of the real rules and regulations regarding entitlement. She was appreciative and indicated maybe they needed training on the finer points of Medicare. Ironically, she approached her boss at the home office and never called us back about such an education. My wife's mom stayed about 10 days but Shari had to be there every day to make sure the right diabetic diet was honored and that she got the right dose of insulin.

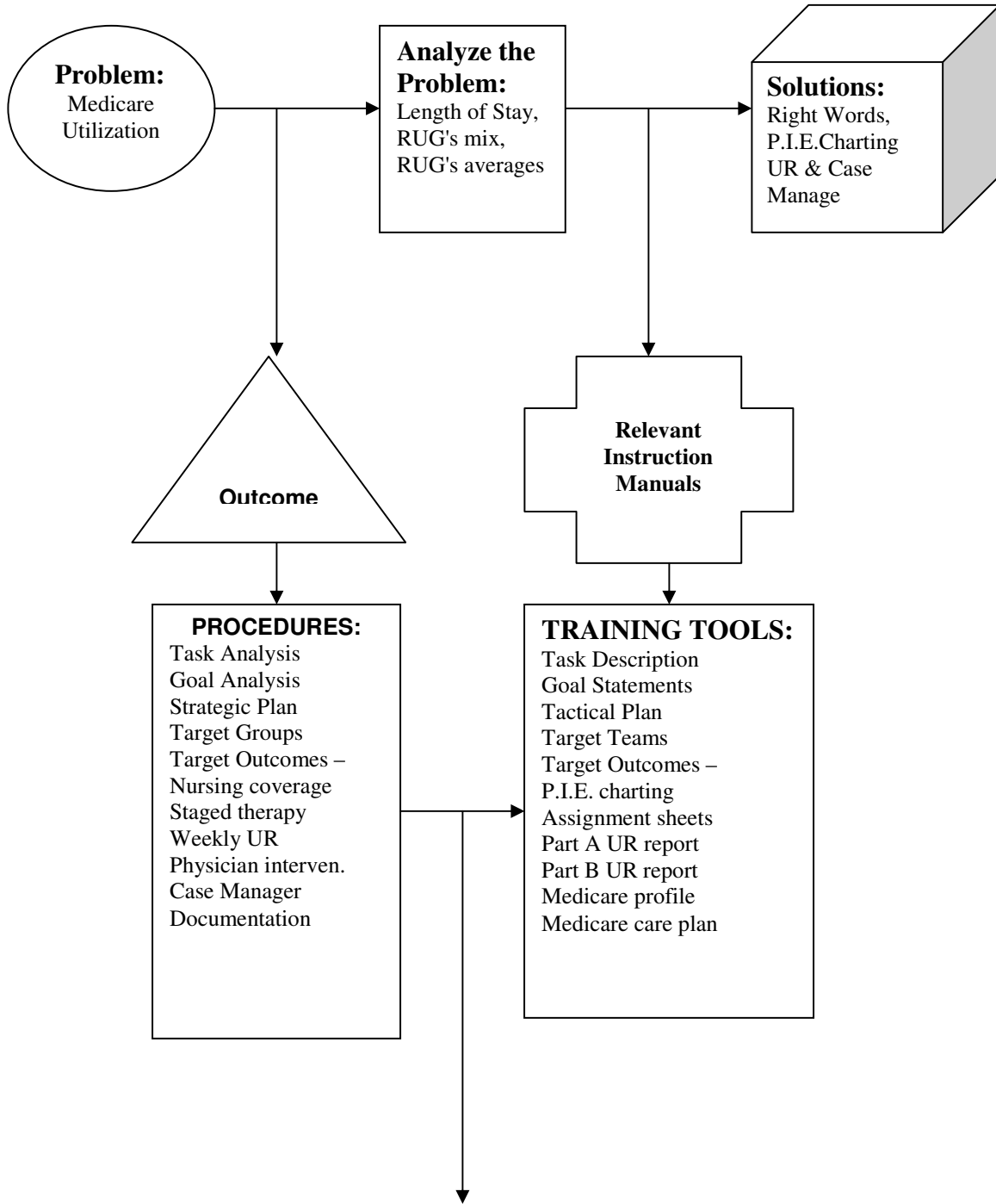
At the hospital that referred us to this SNF, the discharge planner made it very clear that my wife’s mother would not qualify for Medicare because she did not require skilled nursing

care. Shari pointed out that her blood sugars were erratic (from 300 to 500) and needed close supervision on her diet. Still, the discharge planner (a nurse) stated she had expertise in Medicare and she was confident that she would not get any benefits. After explaining to her our background, she began to listen to our reasoning for coverage. By the time we had Shari's mother admitted to the SNF, we had given away thousands of dollars of free advice that was considered to be revelations, not facts.

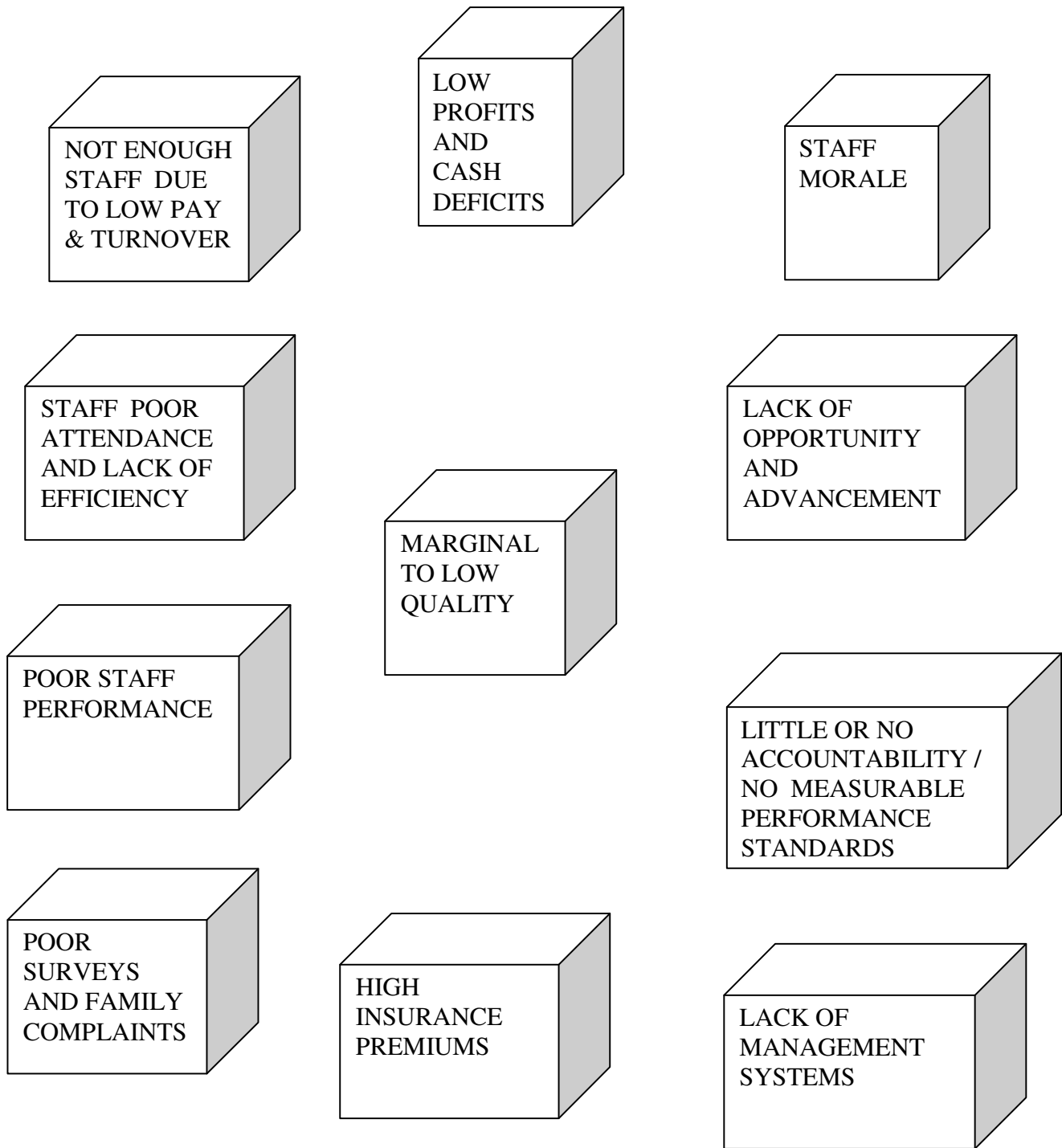
2. **“Medicaid patients are allowed to waive their Medicare benefits so they can return to their old bed.”** Under Medicare/Medicaid reimbursement regulations, the Medicaid patient does not have the right to waive their benefits unless their family can pay privately. Medicaid had the right to recover the funds if they determined that the patient qualified for Medicare and did not get the coverage. To prevent this from happening, we teach the admissions staff how to communicate the room transfer regulations in a way that allows the family and patient to understand that it is in their best interest to have Medicare pay for all services, including therapies and medications after a qualifying hospitalization.
3. **“Patients that have received benefits for tube feeding, IV’s, insulin injections, and decubs are not being allowed another spell of illness if they use up their first 100 days.”** The regulations allow the facility to break the spell of illness if the patient is transferred from the Medicare unit and experiences decline in level of care. The level of care must be less than the skilled level paid for by Medicare. The documentation must prove this. Therefore, I recommend that the initial coverage not be based on a procedure, i.e., (tube feeding). Coverage should be based on; the total condition of the patient upon returning from the hospital, and the documentation utilizing a level of care charting system that is used to document the reduction in the level of services. *(It is my experience that the level does in fact decline because there are fewer nurses with less rehabilitation and monitoring going on in the non-certified units.)*
4. **“A lack of knowledge of the Medicare admitting and utilization review procedures, which causes misinterpretation of coverage criteria, is the fault of the physicians and hospital discharge planners because of the misinformation given the families upon discharge from the hospital and transfer to a nursing homes.”** In reality, the facility must provide information and education to the physicians and discharge planners regarding the Medicare rules in long term care because they are dramatically different than in the doctor's office, and in the hospital. The discharge diagnosis from the hospital does not have to be the admitting diagnosis for the SNF. In fact it is rare that the; hospital and the nursing facility will be treating the exact same disease codes. Therefore, it is necessary for the SNF to work up a coverage profile for each admission and justify the coverage utilizing the MDS triggers and the medical diagnosis tied into treatment programs carried out by licensed personnel. This will maximize the coverage days and ancillary care.
5. **“It is not worth appealing all denials because it is too time consuming and you don't win anyway.”** If denied claims are not being aggressively appealed and taken to a hearing to protect the beneficiaries' entitlement rights under Medicare part A and Part B, the opportunity to optimize the Medicare resources is lost. (The typical provider thinks that no denials are good. I believe just the opposite; it indicates a lack of knowledge of coverage and a fear of the unknown.) With the proper documentation system in place, all denials should be appealed and most will be overturned by the Intermediary or Social Security Administration's Administrative Law Judge (ALJ).

EXHIBIT A

ANALYSIS OF MEDICARE PROBLEM

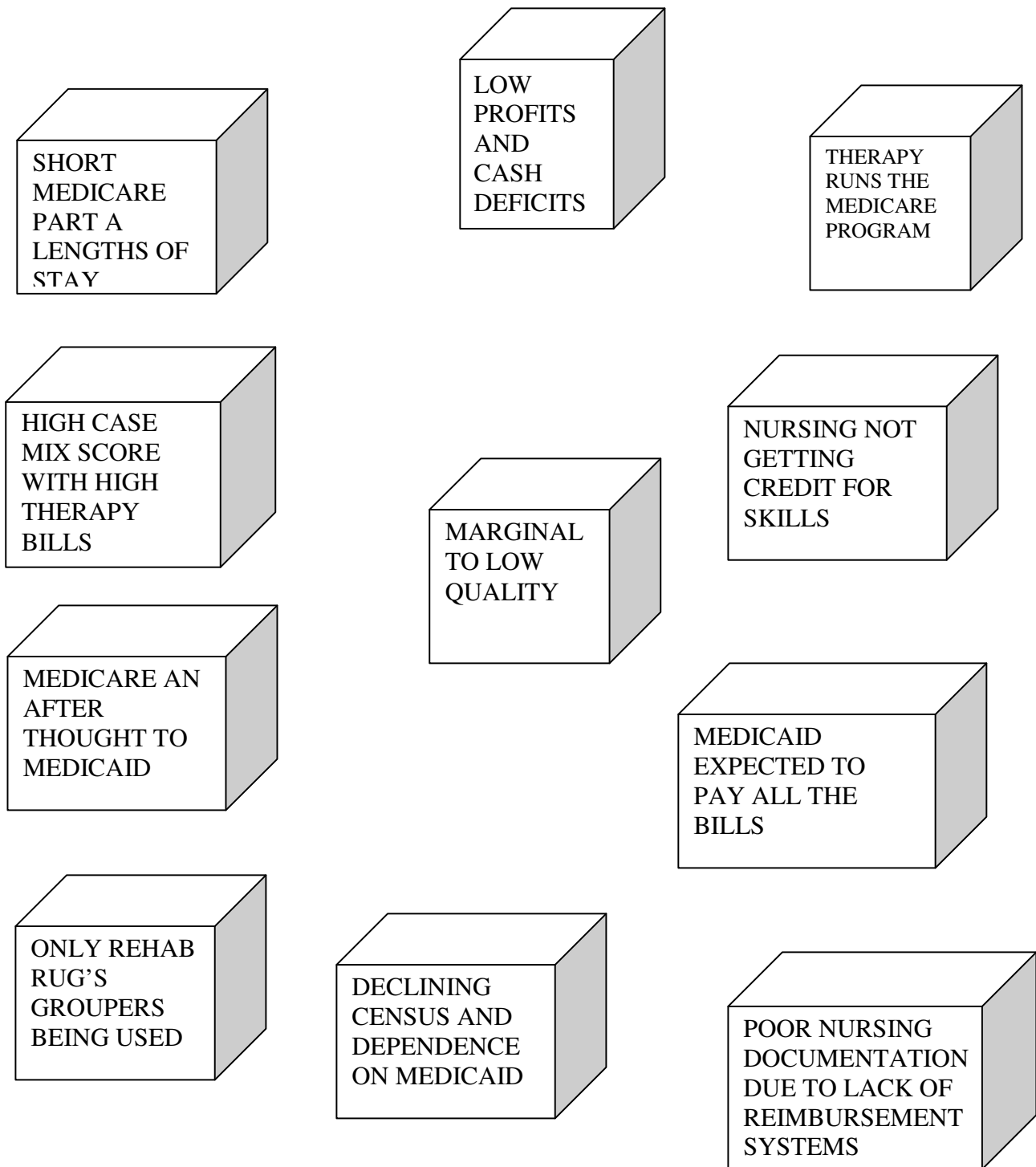


CONNECT SYMPTOMS TO STAFFING PROBLEMS TO RESULTS



Draw arrows to link the symptom, problem and result. To get the results you want, you must treat the problems, not the symptoms!

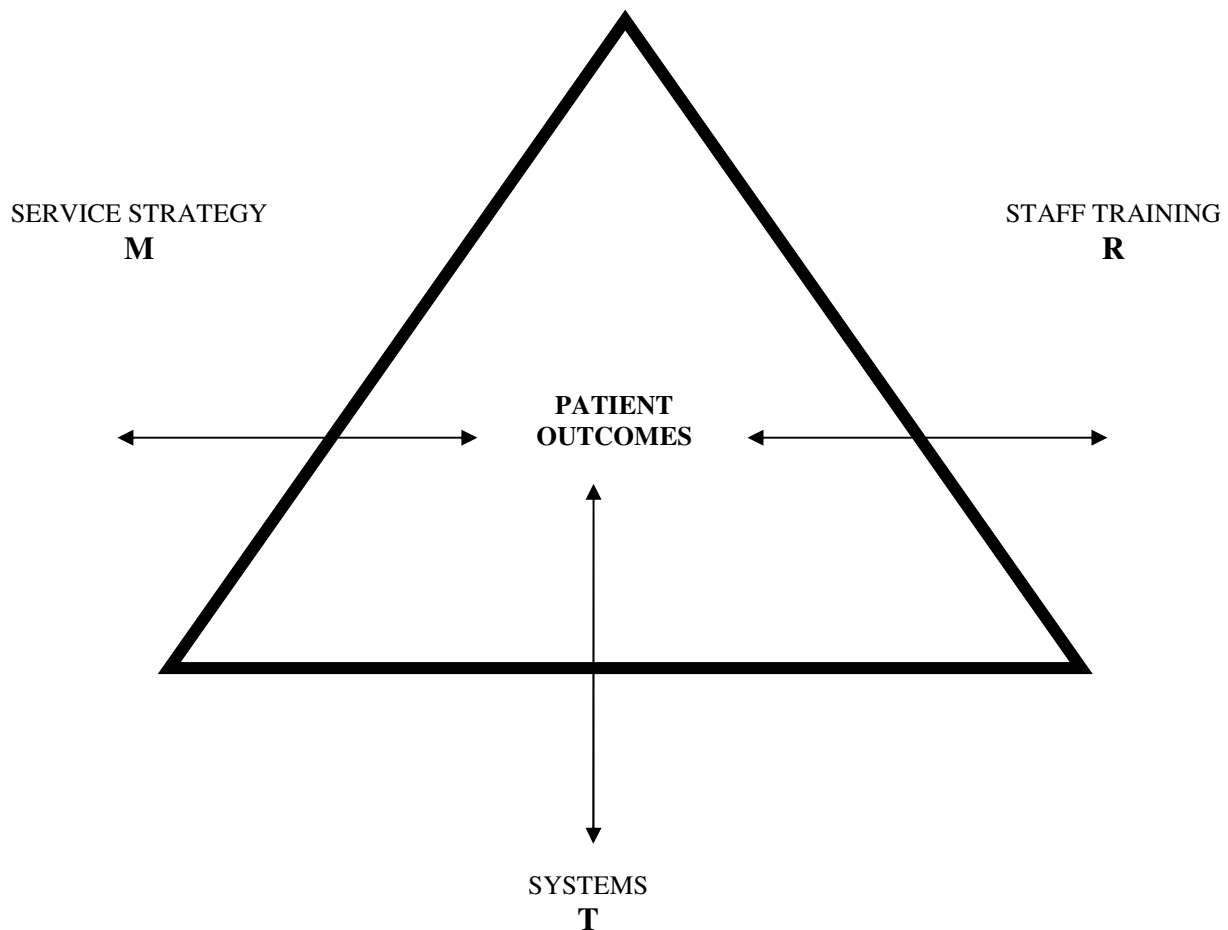
CONNECT SYMPTOMS TO MEDICARE PROBLEMS TO RESULTS



Draw arrows to link the symptom, problem and result. To get the results you want, you must treat the problems, not the symptoms!

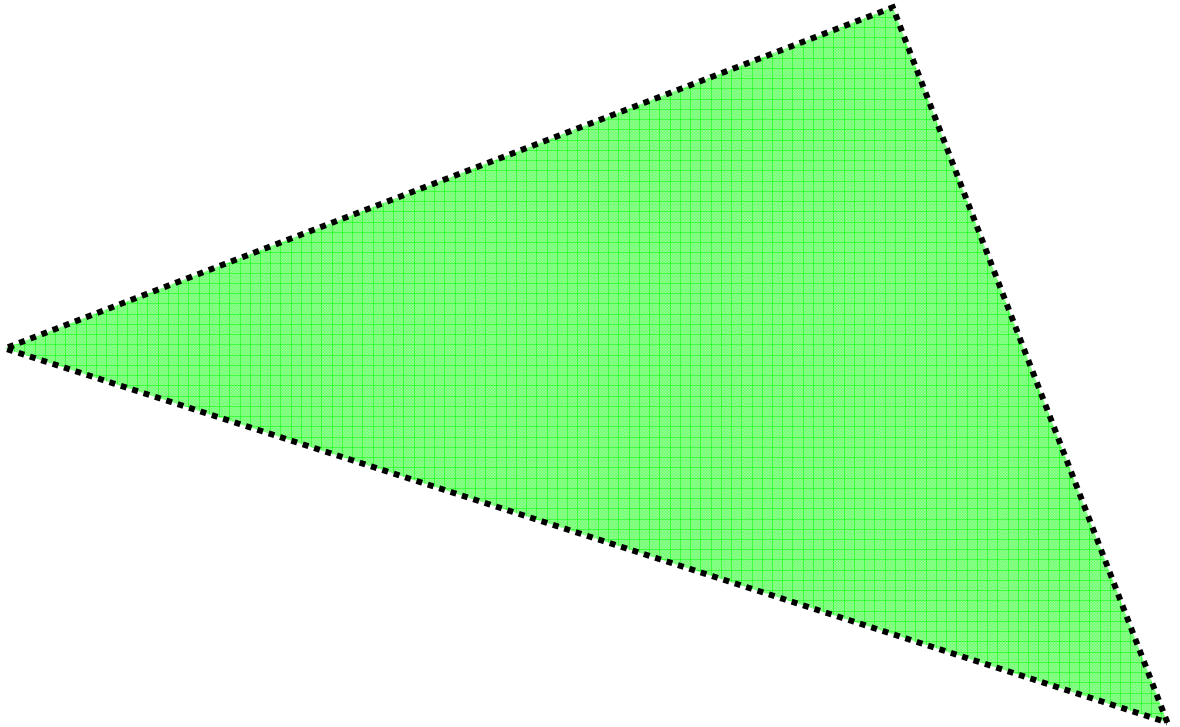
MANAGED RE\$OURCES TECHNOLOGY

- 1) Develop a Strategic Plan for serving your community's special wellness and health care needs.
- 2) Align the workload for efficiency and productivity by standardizing the work for ease of training and performance.
- 3) Implement systems to aide workers in performance and proof of a quality work product.

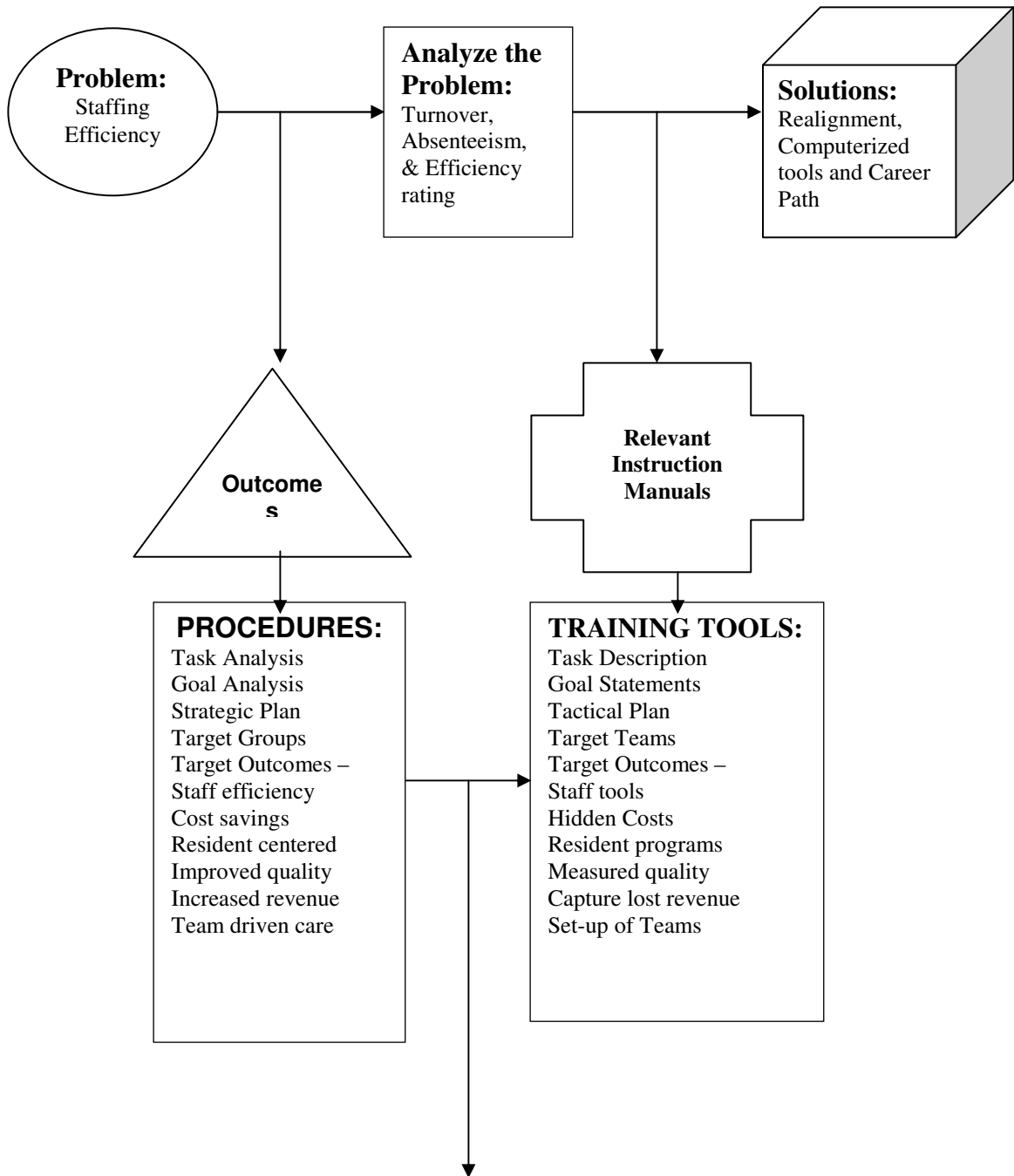


“Where Outcome Means Income”

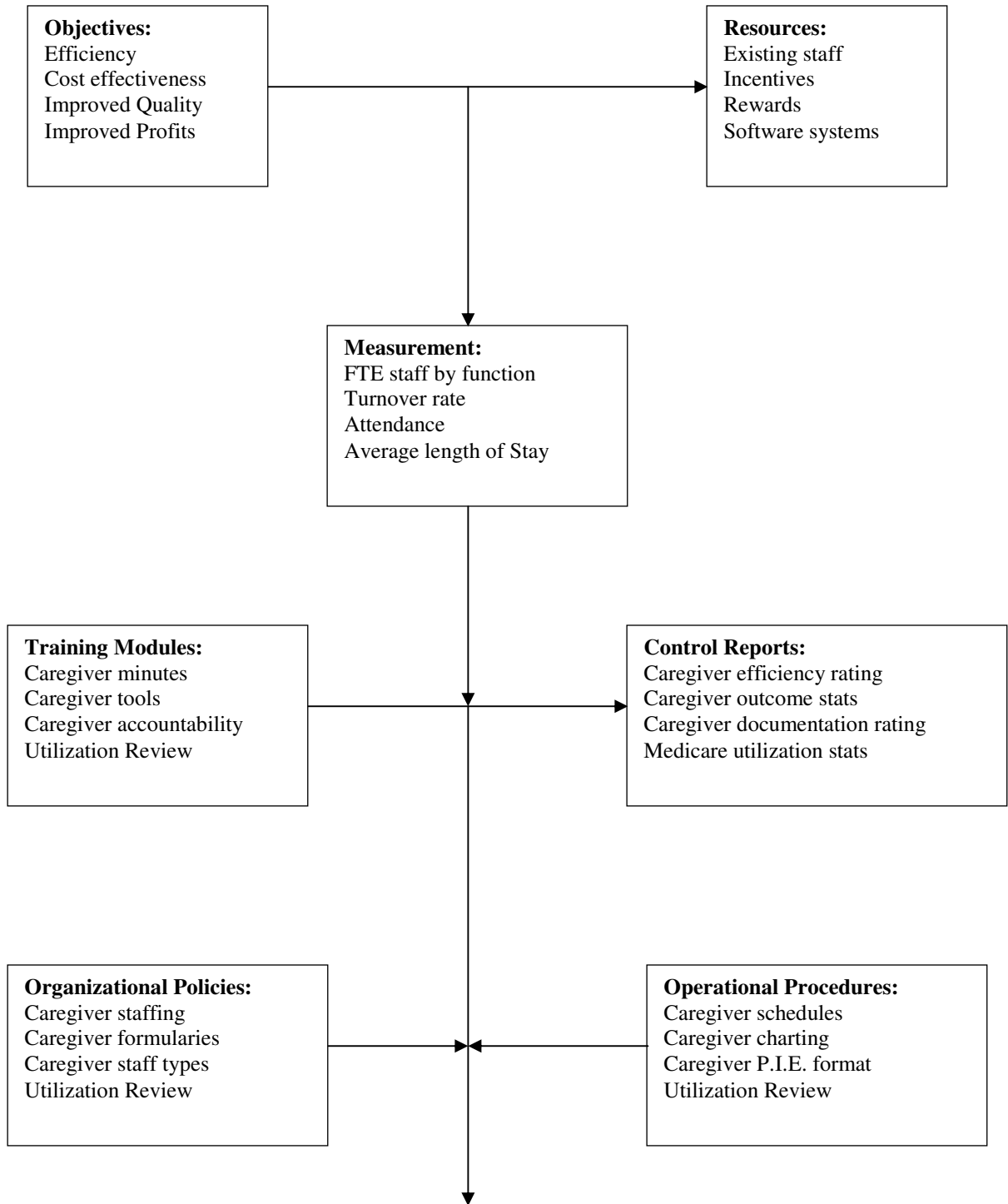
*ANALYSIS,
DESIGN AND IMPLEMENTATION OF **MRT***



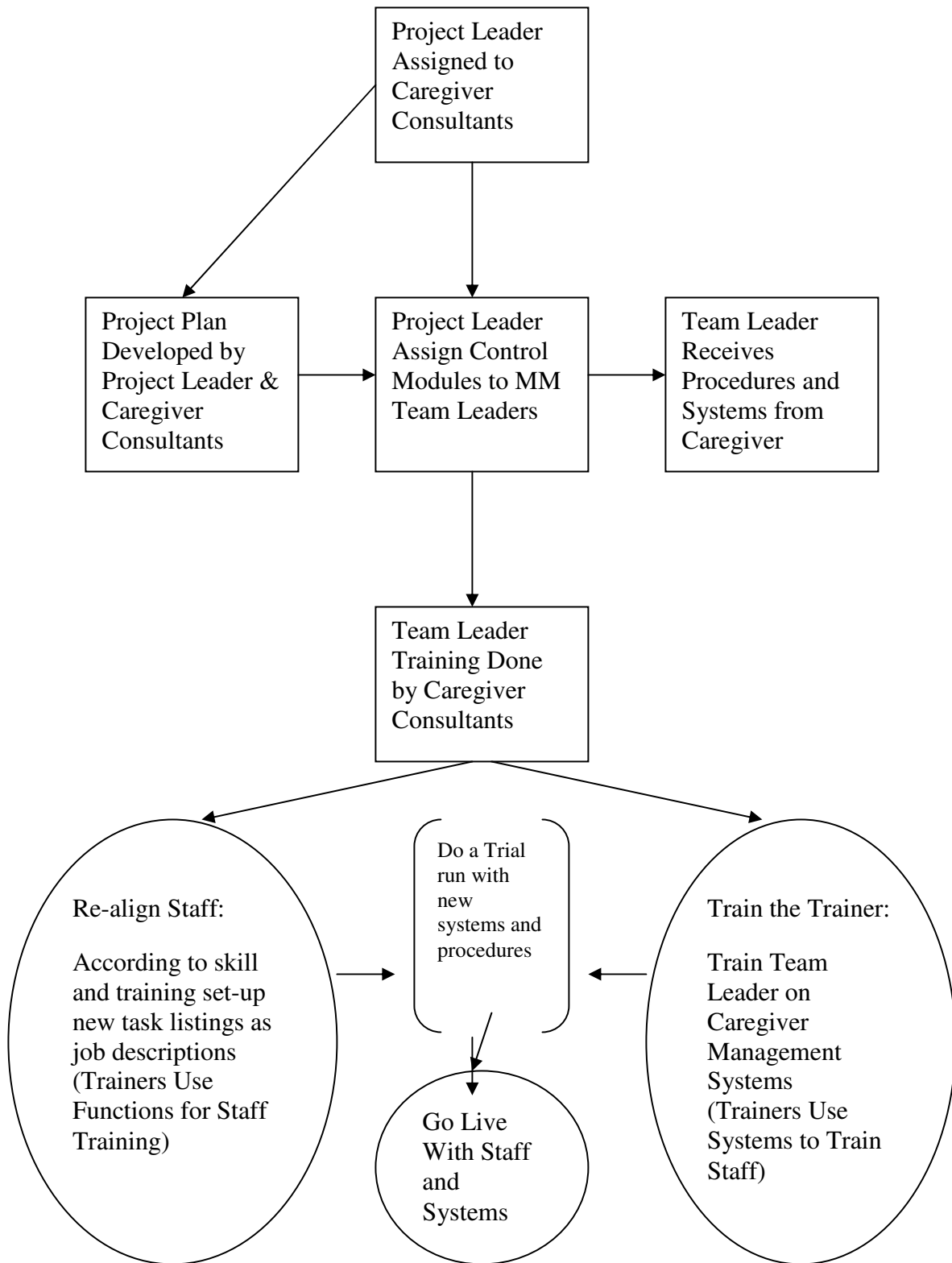
ANALYSIS OF PROBLEM



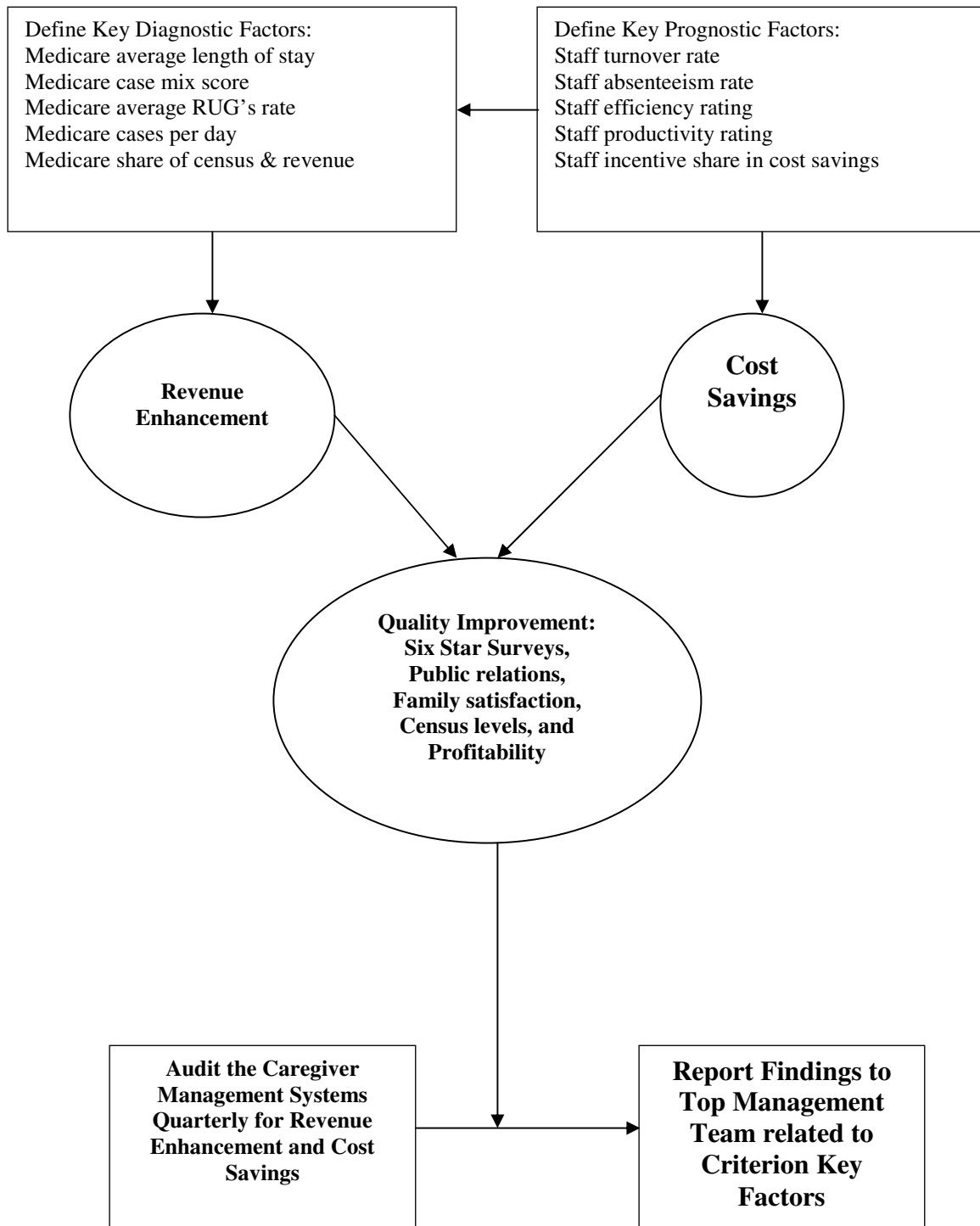
DESIGN OF INSTRUCTION



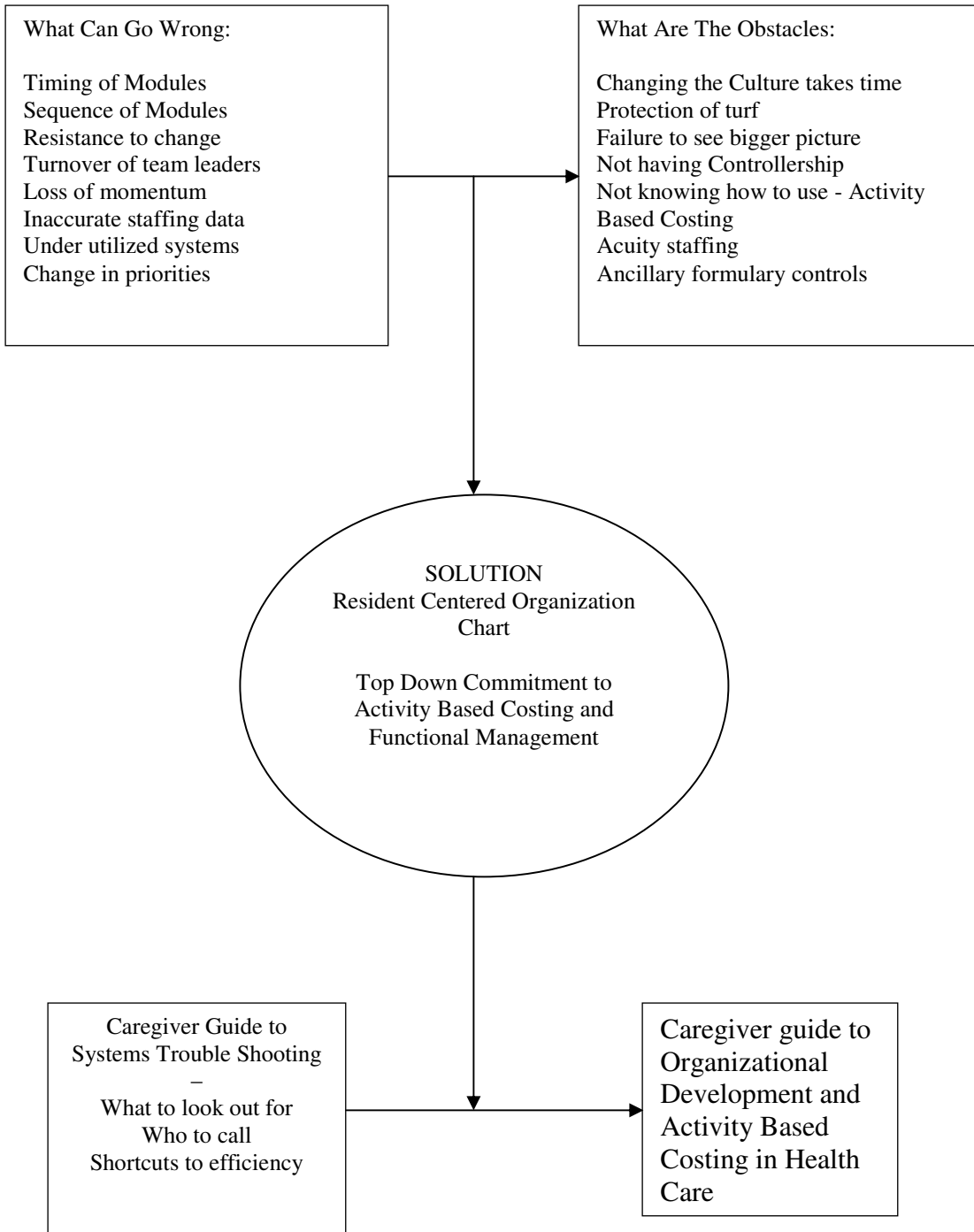
IMPLEMENTATION OF MRT SYSTEMS AND PROCEDURES



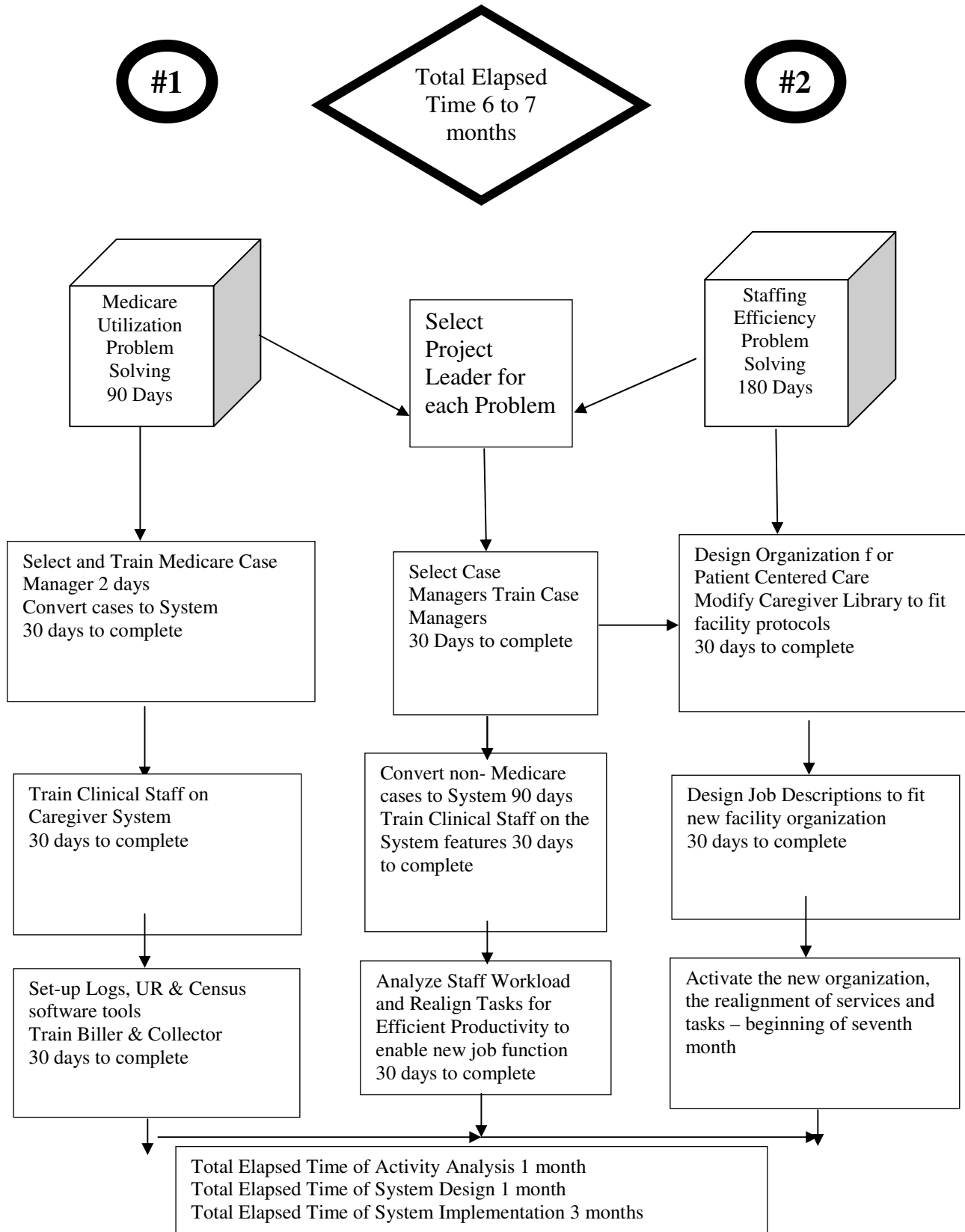
CRITERION TESTS



MONITOR AND REVISE



TIMELINE FOR IMPLEMENTATION



* **Minimum Data Set (MDS)**—U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes, based on 18 problem triggers.

* **Prospective Payment System (PPS)** – A method of reimbursement enacted by Medicare for paying skilled nursing facilities, based on standard problem categories. PPS replaces the retrospective cost reporting method originally used as a method of settling up with skilled nursing facilities on their actual annual costs versus the estimated payment they received during the year.

* **Resource Utilization Groups (RUGs)** – A payment system in nursing homes that determines what Medicare is willing to pay. Under the Prospective Payment System (PPS), each beneficiary is designated to one of 53 RUGs categories. Skilled nursing facilities must be adept at using all 53 Resource Utilization Groups (RUG) categories for Medicare reimbursement. Each RUG includes patients with similar service needs that are expected to require similar amounts of resources. The per diem payment rate for each RUG is calculated as the sum of four components for: 1) routine services (e.g., room and board, linens, and administrative services); 2) nursing services; 3) therapy services; and (4) ancillary services for pharmaceuticals, medical supplies, lab tests, radiology, durable medical equipment and related medical costs attributable to the skilled nursing stay.