

Risk Free Medicare

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

Centers for Medicare & Medicaid Services (CMS) pays or Caregiver Management Systems, Inc.) pays. If Medicare is so risking why would we agree to pay if Medicare does not. Our policy is to teach providers how to document the skilled care, bill for it and fight for payment. Why? Because Medicare entitlement law and regulations are the platform for billing, not the Fiscal Intermediary policies or interpretive guidelines.

After you learn the legal application of Part A benefits, you will be properly billing and documenting Medicare for Restorative Services. By utilizing Part A benefits triggered by the Caregiver Management System, the patients have an opportunity to return to the community based programs, and you will have the resources to make Medicare your primary pay source.

How can this be when no else seems to know this? Here are the facts:

- 1) Fox v. Bowen and Transmittal 262 give you the authority to justify two to three times the amount of Part A benefits.
- 2) Of the maximum of 100 days per spell of illness, you should be averaging 40 days for the patients who are going home, and 60 to 70 days for those staying in your facility on some other payment source.
- 3) 100 day stays are to be coordinated with Medicaid after deferring private spend down as long as possible.

Why haven't you been educated on this?

- Therapy companies take advantage of the Prospective Payment System (PPS) by using their minutes of care to dominate the Minimum Data Set (MDS) version of Medicare coverage. MDS consists of only 18 problems and there are many more problem triggers than just the minimum.
- Nurse consultants operate only on what they hear from the Fiscal Intermediaries at coding or billing seminars. Their policies are guidelines, not rules and regulations.
- Accounting firms have opted out of the equation unless they hire nurses or therapists, because PPS is operations driven, not accounting driven.
- Medicare experts who graduate from the Fiscal Intermediaries have the conventional guideline knowledge, though not the practical regulatory knowledge.
- CMS is interpreting Medicare in their own way to keep costs down and force the providers to do their homework and deliver better restorative services. It is not their responsibility to teach providers how to bill them more.

- State surveyors are not schooled in Federal Medicare reimbursement rules, nor are they knowledgeable about the rules for payer of last resort, Medicaid.

How do I know this?

- Over 40 years experience in hospital, nursing home, home health and physician reimbursement.
- Performed audits of claims and cost reports for agencies of the State and Federal governments, Blue Cross, and Aetna.
- Involved with Medicare since its inception. Assisted in setting up the Medicare Division of Blue Cross in 1966 and wrote the initial white papers on HCFA's (Health Care and Financing Administration – now CMS) Prospective Payment System (PPS) in Long Term Care in the 1970's, which began the process of developing MDS and RUGs approaches to pricing services for long term care.
- Had inside information when Fox v Bowen was sent to the Fiscal Intermediary.
- Wrote three books on activity-based cost accounting for long-term care and more than 100 published articles on health care reimbursement and cost systems topics.

* **Caregiver Management Systems** - Caregiver Management Systems, Inc. has implemented activity based cost accounting and activity based management computer systems in long term care facilities. Caregiver Management Systems, Inc. is acknowledged as the only Prospective Payment System (PPS) Resource Utilization Expert in the country. Caregiver's copyrighted Care Plan Library has over 3,000 Blueprints of Care for PPS Reimbursement. The Caregiver business solution provides an accurate and cost effective way to insure proper documentation and staff accountability, leading to efficient patient centric care.

Caregiver Management Systems, Inc. is a management consulting firm specializing in long-term care. Caregiver Management Systems has implemented the Caregiver model in 117 nursing homes since 1991, and increased their Medicare resources by \$110 million, of which \$40 million went to the bottom line.

* **Fox v. Bowen** – In the landmark case of Fox v. Bowen (Federal District Court Case Fox v Bowen 656 F. Supp.1236 (D. Conn. 1986), the Government's interpretative guidelines on paying for treatment over outcomes were overturned. A Connecticut Federal judge determined that CMS (Centers for Medicare and Medicaid Services) had violated Medicare beneficiaries' entitled constitutional rights to skilled nursing services and ordered CMS to revise the Skilled Nursing Manual to clarify the requirements for coverage under Medicare Part A. The court ordered CMS to reopen 14,000 cases and pay for the skilled care. The court also

ordered them to look for a “reason to pay” instead of a “reason not to pay.” The court's purpose was to ensure that claims are approved when the requirements are met. The Government's fiscal intermediaries are still violating the decision. Agencies deny honest claims for Medicare benefits and the patients are forced into spending down their personal assets and going on the welfare program funded by Medicaid. As a result of non-adherence to Fox v. Bowen, Medicaid, the last resort, is going bankrupt on a service that legally is to be paid by Medicare Part A.

* **Transmittal 262** – As a result of Fox vs. Bowen (Federal District Court Case Fox v Bowen 656 F. Supp.1236 (D. Conn. 1986), CMS took action in 1987 by issuing a Medicare regulation called Transmittal 262. However, CMS never sent this information to the providers. It was only sent to the fiscal intermediaries, who offered no education or training on the transmittal or the court-ordered process. Under Transmittal 262, a patient cannot be denied coverage based on “Rules of Thumb,” such as: lack of restoration potential, ability to walk a certain number of feet, degree of stability, and general inferences about patients with similar diagnosis or general data related to utilization. Transmittal 262 can double or triple a patient's Medicare Part A days and redistribute RUGs days more profitably throughout the 53 groups.