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Simple and Easy: Winning in PDPM Payment and Regulatory Strategies

Untangle Your MDS 3.0 Data Processes

3 Steps to Quality Services and Accurate Payment

Stepped up oversight by governmental agencies is deepening the focus on MDS database accuracy. Primary drivers behind the increased level of scrutiny on facilities include:

- The regulatory structure of federal and state programs (Medicare and Medicaid) requiring strict policies, processes, and documentation for submitted claims and coverage decisions

- Three survey tags on MDS assessment requirements: F-Tags 636, 641 and 642

- Investigations into what facilities are being paid and the integrity of the substantiating data

- New analytics like CMS and GAO reports

In this era of heightened regulatory requirements, data on the MDS 3.0 is king, and vigilance on behalf of facilities is essential to ensure operational and fiscal success.

Enhancing Database Accuracy

Facilities need to be able to demonstrate that they are meeting all of the guidelines and regulatory parameters. This means understanding the requirements for how data is created, how it is entered on the MDS 3.0, and how it creates payment.

There are simple approaches managers can use to establish a regular evaluation and reinforce accurate, consistent data collection, reporting and facility database content.

1. Ensure Staff Competency: It is essential that each team member be competent with the new definitions and data formulation for each section or item on the MDS 3.0 – October 2019 update. Specifically, Tag 641 in the current regulatory process states: "Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment." Make sure the admissions department, nursing, and operations leadership all have copies of and review Ch 8 of the Medicare Benefit Policy Manual as well as Chapter 6 of the RAI Manual on eligibility criteria so the MDS accurately reflects the resident's status during the assessment reference period. And incorporate training in your orientation and onboarding of new staff.

2. Evaluate Your Data Formulation Process: How is the data formulated? Where does it come from? Who handles it? Operational leadership should review the data formulation and documentation process since the structure of interdisciplinary documentation must meet reproducibility standards. This step should include:

   - Focus on the first 7 days of the stay for documentation of care, observations and interview activity.

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- Reference the structure of the definitions, timing and content of assessments in the RAI Manual – October 2019 updates. Revise your policies when the RAI Manual changes.

- Document responsibility for data coding, timing of data collection and accuracy certification.

- Ensure staff coding into the MDS database are given directions for the data items and a copy of the attestation statements. Each section of the MDS should have a person identified who is responsible for coding.

3. Document: Several actions in the data formulation process require interdisciplinary documentation to substantiate MDS coding when specific payment- and quality-related audits are conducted. For example, requests and additional information at the time of a dmission must be documented. And for the assessment, facilities will need appropriate documentation behind the necessity of services as well as physician certification. An accuracy certification and attestation statement signed by everyone who puts data on the MDS 3.0 is also required to avoid an F-Tag 642 citation. To ensure compliance, pay attention to the timelines and location for documentation as well as any required formats.

The Role of Audits

Audits are essential to ensure your process results in accurate data since all areas of payment are affected by the quality of the assessment. To benchmark your approach, your staff can conduct internal audits of Medicare Part A claims for overall data accuracy or you can hire a consultant to review and document the data accuracy and reproducibility.

During audits, several key areas of diagnostic coding should be assessed:

- Primary Diagnosis Payment Categories (PT, OT, Speech)

- Secondary Diagnosis Payment Categories (Nursing)

- I-8000 Diagnosis Codes (NTA)

In addition, you should ensure where the diagnosis is documented and whether it is authorized in the record.

Your risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding. For example, if the provider codes that the resident's primary diagnosis is a major joint replacement, then the reviewer should be able to verify that the resident received a major joint replacement.

Conclusion: MDS Data Writes Medicare Part A Checks

Over 200 items on the MDS can influence a facility's Part A Medicare payment. It is critical that all staff adapt their habits of documentation and reporting to gather the new data required. To ensure proper processes, oversight and constant communication by mangers is essential.