

June 2007

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# The Healthcare Bulletin

## DAVE2 Tip Sheet

The first DAVE2 educational Tip Sheet can now be accessed at <https://www.qtso.com/mdsdownload.html>. The Tip Sheet addresses MDS K5a, Nutritional Approaches, Parenteral/Intravenous feedings. CMS states that four to five more Tip sheets are to be posted in the future.

### Spell of Illness Quick Reference Chart

The CMS Spell of Illness Quick Reference Chart has been incorporated in the SNF On Line Manual System. This chart can be found in Pub 100-4, Chapter 6, Section 40.8.1.

### Updated Medical Review Process and Default Days

According to Transmittal 196, Change Request 5418, issued March 30, 2007, contractors will not pay facilities when there is no MDS in the state database, e.g., a missed assessment. Payment for default days will be made in only two circumstances: when the beneficiary expires or is discharged on or before day eight of the SNF admission or readmission and when there is a demand bill. For complete details see the transmittal at [www.cms.hhs.gov/manuals/downloads/clm104c05.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf), Medicare Claims Processing Manual, SNF Inpatient Part A billing, Chapter 6.

### Imaging and Laboratory Services in Nursing Homes

In the Office of Inspector General (OIG) 2007 Work Plan, the OIG states they will determine the extent and nature of any medically unnecessary or excessive billing for imaging and laboratory services provided to nursing home residents. Medicare pays more than \$200 million a year for imaging and laboratory services. The OIG will review a sample of services and examine utilization patterns in nursing facilities.

## Adjustment Bills

Providers have 120 days from the last covered day on the claim form to submit a timely adjustment claim. Adjustment claims may be necessary when the MDS coordinator has corrected an assessment and obtains a new RUG score or when the provider receives an invoice from an outside provider/vendor after a claim has already been submitted for the service period.

### Expedited Review Process Q&A

**Q.** What should a provider do if the patient refuses to sign the generic notice?

**A.** If the patient refuses to sign the generic notice, the provider must annotate the notice with the refusal and place the date of refusal in the final date blank. Additionally, the provider may choose to have the refusal witnessed, indicating the circumstances and persons involved. (*Source: Expedited Determination Process for Original Medicare Questions and Answers.*)

### Clarification of SNF No Payment Billing

CMS issued Transmittal 1252 dated May 25, 2007 that clarified No Pay billing instructions for SNFs billing a 210 bill type for non covered SNF stays. Previously, if a SNF billed a no pay bill, bill type 210, that overlapped a previously paid SNF Part B inpatient, bill type 22X, Medicare edits would not allow the claim to be processed. In order to bypass Medicare edits that do not allow SNF type of bill 210 to process when overlapping with previously paid 22X bill types, providers must include occurrence span code 74 with the 'statement covers period' of the 210 bill being submitted. Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 and room & board charges only. Other ancillary services are not required to be billed on these claims.

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