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Understanding Medicare MDS 3.0 for the Rehabilitation Professional: ICD-10, G Codes, Goal Writing and Ethics for Subacute Rehabilitation and Skilled Nursing Home Facilities

Caroline Joy Co

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On October 1, 2015 the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). Also, the Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA; Section 3005(g)) published at http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf states that “The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on resident function during the course of therapy services in order to better understand resident condition and outcomes.” This reporting and collection system requires claims for therapy services to include non-payable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary’s functional status at the outset of the therapy episode of care, at specified points during treatment, and at the time of discharge. These G-codes and related modifiers are required on specified claims for outpatient therapy services–not just those over the therapy caps. This book can help occupational therapists, physical therapists, and speech therapists understand Medicare standards for subacute care programs that aim to be compliant with Medicare MDS 3.0 standards and state regulations. Documenting and billing strategies are also discussed in this book. This book has been updated to discuss the new MDS assessment schedule, distinct days of therapy, co-treatment, the allocation of group therapy minutes, the revised student supervision provisions, the EOT (End of Therapy) OMRA (Other Medicare Required Assessment) and new resumption items, and the new PPS assessment-COT (Change of Therapy) OMRA. Appropriate billing and documentation should be present in the medical record. Medicare is increasingly reviewing therapy claims to ensure that the therapy provided did require the skills of a therapist. This book discusses establishing medical necessity, refusing to care for a resident, restraints, safety, creating incident reports, supervising assistive personnel, and resident privacy. Coding and billing for subacute and long-term care settings are also covered in this book, along with denial and appeal management, regulatory guidelines for insurers, and improving cash flow with denial management strategies. Proper coding and documentation ensures that facilities will keep their money upon a post-payment medical record audit. The information provided here in no way represents a guarantee of payment. Benefits for all claims will be based on the resident’s eligibility, provisions of the law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and its requirements.

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