In order to protect Medicare and Medicaid funds, CMS continues to increase scrutiny of nursing home billing claims. In response, facility staff are renewing their triple-check processes. So what is a “triple check”? Sometimes it is described as a process to compare the billing claim (UB-04) to the MDS and the medical record. It also can be described as three clinicians—billing office staff, MDS coordinator or nurse leader, and a therapist working together to review these documents for accuracy and consistency.

Call it the “triple, triple check” or the “3 x 3 check.” Either way, it is critical for facility staff to conduct these reviews to avoid inaccurate claims, which leads to denied or recouped payment. Even worse is the risk that your claim may be scrutinized by fraud and abuse auditors. Advances in technology are putting

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**The New Face of Triple Check**

Judi Kulus, NHA, RN, MAT, C-NE, RAC-MT

**In order to protect** Medicare and Medicaid funds, CMS continues to increase scrutiny of nursing home billing claims. In response, facility staff are renewing their triple-check processes. So what is a “triple check”? Sometimes it is described as a process to compare the billing claim (UB-04) to the MDS and the medical record. It also can be described as three clinicians—billing office staff, MDS coordinator or nurse leader, and a therapist working together to review these documents for accuracy and consistency.

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**Be on the lookout in three weeks for a new & improved LTC Leader!**

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**BIMS and Dementia Patients: Keys to Success**

Caralyn Davis, Staff Writer

**Conducting the Brief Interview for Mental Status**

(BIMS; MDS items C0200 – C0500) can be especially challenging for residents with dementia. CMS has provided coding instructions on pages C3 – C15 in Chapter 3 and in Appendix D of the *RAI User’s Manual* for the MDS 3.0. Here are some additional tips for interviewers:

**Watch the VIVE videos.**

CMS has developed a series of eight VIVE (Video for Interviewing Vulnerable Elders) videos to help staff conduct interviews. These videos “perfectly show the approaches to use with a difficult resident,” says Jennifer LaBay, RN, RAC-MT, director of clinical reimbursement and assessment for Health Concepts in Providence, RI.

**Do a meet and greet.**

“My first time meeting residents, I don't want to go in saying, ‘I'm going to ask these questions,’” says Shellie Spindle, LSW, social worker at Ennis (Texas) Care Center. “Instead, I like to get to know my residents—and let them get to know me—prior to doing the first assessment. That helps the interviews go more smoothly.”

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**The only way to make sense out of change is to plunge into it, move with it, and join the dance.**

—ALAN WATTS

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Continued on page 3
AANAC is proud to announce new professional development partnerships with Life Care Centers of America and Golden Living Centers. Our Professional Development Partner program gives these organizations the opportunity to provide membership, certification and education opportunities to their staff at discounted rates and these organizations now have the power of AANAC to ensure the highest quality of care possible for their residents.

Meet our new partners:
Since 1970, Life Care Centers of America has been providing unequaled nursing care and assisted living service. Our continuum of care campuses give our residents an individual care plan through various levels of care. But it’s our commitment to quality and professionalism that makes us second to none.

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Could your facility benefit by partnering with us?
Have your administrator check out the Professional Development Partner program at aanac.org/PDP
a new face on the need for triple check, as they allow data mining and enable contractors and third-party auditors to conduct remote billing claim reviews and cross-check them with the MDS system.

The federal government is seeking to ensure that the Medicare and Medicaid programs remain strong for current beneficiaries and future generations by detecting and reducing waste, fraud, and abuse in the billing and payment processes.

The growing list of audit entities with which facility staff may interface includes the Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs), Comprehensive Error Rate Testing (CERT), Recovery Audit Contractors (RACs), Medicaid Recovery Audit Contractors (RACs), and the Office of Inspector General (OIG), which includes the Office of Evaluation and Inspection (OEI) and the Office of Audit Service (OAS). The federal government is seeking to ensure that the Medicare and Medicaid programs remain strong for current beneficiaries and future generations by detecting and reducing waste, fraud, and abuse in the billing and payment processes.

The audit entities use sophisticated computer software that can screen for technical and other necessary claim information or filter for aberrant billing patterns. In order to select charts for review, auditors are homing in on some of these items:

• **RUG Utilization:** Above-average utilization of Ultra High and Very High Rehabilitation Resource Utilization Groups (RUGs). At the March CMS conference in St. Louis, CMS reported that the national average for Ultra-High Rehabilitation is 46.3% and for Very High Rehabilitation it is 27%.

• **Length of Stay:** Above-average length of stay (LOS) for Medicare A beneficiaries. In its most recent report to Congress, MedPAC reported that the national average for LOS is 35 days.

• **Primary Diagnosis:** Diagnoses that do not support the reason for Medicare coverage. For example, a long-term care resident on the Memory Care Unit falls and breaks her hip. She comes back to the facility on Medicare A and receives physical therapy. The billing claim...
lists the primary diagnosis as Alzheimer’s rather than the after-care to hip fracture.

- **Ancillary Charges**: Claims that do not list the charges for services provided during the Medicare A stay, such as lab fees, medications, therapy services, or wound care supplies. For example, a resident is covered for enteral feeding, but the billing claim does not include feeding supplies provided.

- **Claim Edits**: Claims that don’t have the correct qualifying hospital stay dates or the correct admission and coverage days. The edits are able to cross-check the HIPPS code on the claim with the submitted and validated MDS assessments in the QIES ASAP system.

When a claim is selected for medical record review the medical reviewer will verify the following:

- The services were reasonable and necessary.
- Medicare services billed were ordered by a physician, provided as ordered, and documented as provided.
- Rehabilitation services were provided at the intensity deemed medically necessary. This is proven by clearly identified baseline status, clear and measurable goals, and progress toward the goals.
- All reimbursement related MDS items that generate the RUG level billed matches the supporting documentation in the medical record.
- Therapies were not continued past the resident’s prior level of functioning

continued on page 5
• Therapy services were not provided to individuals who were not reasonably capable of participation or of making and sustaining gains.

• Skilled nursing services criteria, observation and assessment, or teaching and training were provided by a licensed professional on a daily basis.

• Diagnosis stated on the bill is identified in the medical record and meets the criteria of being physician documented and active during the Medicare stay.

• Physician certifications and recertifications have legible signatures. Medicare requires that the services ordered and provided be authenticated by a legible identifier. Stamp signatures are not acceptable. A physician should not sign and let the facility staff enter the appropriate date.

Auditors have questioned documents where the dates clearly were not entered by the signatory.

• Notice of Medicare Non-Coverage (expedited review) and Advance Beneficiary Notice (SNFABN) or denials were issued properly.

Simple mistakes happen, and it is easy to overlook broken facility systems. Yet it is an essential part of a provider’s obligation as a contractor to be accurate and comply with program requirements. When facility staff become busy in their day-to-day work, auditing and taking time to verify information can be the first thing that gets overlooked.

Keeping the process simple will increase the likelihood that the checks will occur. To guide you in the audit process, utilize a sample audit tool in AANAC’s resources called the Medicare Audit form. Take time to audit a sampling of claims before they are sent for payment. Start with five percent, and if there are problems noted, then conduct a targeted, expanded audit until you can determine where the system breakdown is.

Triple checking the UB-04, MDS, and medical record by either multiple facility staff or an objective, outside auditor is critical for ensuring Medicare and Medicaid compliance. Don’t wait until the government auditor lets you know that you won’t get paid.

**Sources:**

MedPAC. (2011). “Relatively efficient SNFs maintained high Medicare margins” (Table 7-10). In Skilled Nursing Facility Report to Congress, chap. 7. Downloaded from: http://www.medpac.gov/chapters/Mar11_Cht07.pdf

Start early.
Interviews typically are more successful “before lunch or before patients have their therapy session,” says Pilar Consolo, BSW, director of the social services department at West Gables Health Care Center in Miami. “After therapy, patients tend to be more tired.” In the afternoon/evening, questions tend to make dementia patients “more anxious,” adds Spindle.

Try more than once.
Interviewers need to give dementia patients “enough chances to attempt the interview,” says LaBay. “Make the first attempt early enough in the day—or even in the assessment period—to give the staff time to go back and try again when it is a better time for the resident. Don’t just give it one shot and then give up.”

“If we can’t get a proper assessment in the morning, then we will try again in the afternoon,” explains Consolo. “We will try to interview at different times in the day to see which one they respond to better.”

Don’t rush.
Overburdened IDT members are often in a hurry, notes Spindle. “However, you’ve got to have time to sit down and visit with dementia patients,” she says. “You can’t be rushed with the interview. You need to make them feel comfortable and at ease with you.”

Interviewers also need to be sure to give residents the appropriate time to respond as indicated in the RAI Manual, says LaBay. For example, the instructions for C0300 (temporal orientation) allow residents “up to 30 seconds for each answer.” That may seem like a long time to be sitting waiting for residents to answer, “but it may take them that long to process the question to give you an answer,” she says.

Go off the grid.
“Interviewers need to set the interviews as appointments and let the other team members know, ‘I’m going to be doing patient interviews from this time to that time. So don’t interrupt me unless it’s a dire emergency,’” suggests LaBay. “The interviewer shouldn’t be distracted by a ringing or vibrating cell phone, a beeping pager, an overhead page, or a walkie-talkie. It’s hard enough to get an alert and oriented person to participate. If you add in the dementia on top of it, the resident’s not going to do the interview with you if you’re too distracted to pay attention.”

Reassure nervous residents.
“Residents with dementia are nervous about being asked questions and not having the right answer,” says Spindle. “A lot of them ask, ‘Did I pass? Did I fail?’” For example, the questions in C0300 are often difficult for dementia patients because knowing the year, month, and day is not important to them or their days all run together, she says. “They often feel like a failure when they don’t know these answers, so it’s important to reassure them that whatever answer they give is OK—that it isn’t a pass or fail interview.”

Keep it quiet.
“Environmental surroundings are important to consider with the dementia patient,” says Sarah Riggin, RN, C-NE, RAC-MT, an MDS nurse consultant with Forth Smith, AR-based Nursing Consultants. “Distractions from other residents, televisions, or even the scenery outside the window may cause for a poor environmental setting.”
BIMS, continued from page 6

response. Try to go to a quieter place, with fewer distractions, and a place that is not intimidating or distracting to the resident.”

Often, bringing the patient to the social work or nursing office will help because the patient is away from stimulations, points out Consolo.

**Make residents comfortable.**

Dementia patients need to be in an environment they feel comfortable in, says Spindle. While some patients can be interviewed in an office to limit distractions, others may need to be interviewed in their rooms, with the interviewer doing whatever he or she can to mitigate outside distractions.

However, keeping the resident comfortable may mean occasionally conducting interviews in some unusual places. “For example, I have one patient who is very calm in the hallway,” says Spindle. “That seems a little odd due

*continued on page 8*

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**New Antipsychotic Quality Measures Posted on Nursing Home Compare**

CMS and the National Partnership to Improve Dementia Care in Nursing Homes are working to reduce the use of antipsychotic medication for residents in nursing homes. Raising public awareness about the use of these medications shines a spotlight that facilities can’t ignore. The two new Quality Measures (QM) posted on Nursing Home Compare identifies the level of antipsychotic medication use for both long- and short-stay residents. The MDS items used to draw the QM data are section No410A, antipsychotic use and the excluded diagnoses in section I. Each of the two measures excludes three diagnoses from the calculation. They are Schizophrenia, Tourette’s syndrome and Huntington’s disease. In addition, it shows how each facility compares to other facilities in their state and on a national level. The posted national level is 23.9% for long-stay residents and 3% for short-stay residents. CMS states their goal is a 15% reduction in the overall national rate which would mean a national prevalence of 20.3%. That doesn’t mean that less than 20.3% is acceptable for an individual facility.

CMS states their goal is a 15% reduction in the overall national rate which would mean a national prevalence of 20.3%. That doesn’t mean that less than 20.3% is acceptable for an individual facility. Toward the end of 2012, CMS may adjust the national target downward and establish a new 2013 goal. CMS encourages facilities to work with their physicians, pharmacy, and interdisciplinary team to continue to reduce and discontinue use of these medications.

The details and specifications can be found [here](#).

For the latest information on how you can to maintain or improve your psychotropic use quality measures check out “Interventions that Matter: Antipsychotic Use in Dementia Care,” presented by nationally known expert, Dana Saffel, President and CEO of PharmaCare Strategies Inc.

AANAC members pay only $99 for on demand access. Click here to purchase the Webinar and help your team minimize the use of these potentially dangerous drugs in your facility and meet the challenge of the new CMS initiative today!
to the lack of privacy, but she gets very anxious if we go anywhere else to do the interview.”

**Use visual props.**

“Often we don’t get an immediate response from verbal communication alone,” says Consolo. “So we use a lot of props to grab patients’ attention.” For example, for C0200 (repetition of three words), rather than just saying the words or saying the words while displaying cue cards printed with the words “sock,” “blue,” and “bed,” West Gables’ social workers use laminated pictures of a sock, the color blue, and a bed. “We’ve blown up the pictures to 8 by 10 inches so the patients can see them more clearly,” she notes.

**Invest in external amplifiers.**

These assistive devices are very helpful with dementia patients, says LaBay. “Sometimes staff think that dementia patients are more demented than they really are, and the external amplifiers help bridge the communication gap.”

**Redirect/refocus the resident.**

“Keeping the resident on task is more difficult when dealing with dementia,” says Riggin. “Asking the question, then allowing for a response sometimes causes the resident to veer off into an entirely different topic. Bringing them back by redirection and re-asking the question often is all it takes to get the resident to respond.”

**Get the IDT talking.**

At many facilities, social workers do some interviews (e.g., the BIMS), and nurses, including the MDS coordinator, conduct some interviews (e.g., pain). “It’s important for the team to talk to each other so they know if some interviews are being completed,” says Consolo. “When that happens, we both go to the patient to find out what works best.”

Providers may find that they need to switch up which staff members conduct some interviews, points out Riggin. “Some dementia residents do better with certain staff members, even a male interviewer vs. a female one.”

**Ask nurse aides to participate.**

Sometimes residents who won’t even talk to family members “are like an open book when the CNA is in the room speaking to them,” notes Consolo. “Especially for long-term care patients, the CNA is the one face they see day in, day out. So if we can’t get anything out of a patient during the interview process, we bring in the CNA to get the ball rolling.”

**Script the BIMS for large non-English-speaking populations.**

The patients at West Gables predominantly speak Spanish. To counteract confusion due to differences in dialect, “we sat down and typed out the BIMS interview script using the most basic Spanish we could,” says Consolo. “That way, when the social workers do the interview in Spanish, they all use the same verbiage, and we can achieve more consistent results.”

**Start fresh every time.**

“The staff has to look at each interview of a resident as a new assessment,” stresses Spindle. “If the resident with dementia was not able to answer the questions on the first assessment, that does not mean they will not be able to on, for example, the second or third assessment. You never know when you will catch that resident at a moment of clarity. And that moment of clarity can give you a new look at that resident and meet a need you had not thought of before. It is so important to try interviewing the resident every time and not go directly to the staff.”
Antipsychotic Quality Measures

Is it true, on the new QMs, that CMS has changed the criteria and anyone without Tourette's, Huntington, and schizophrenia diagnosis will trigger for antipsychotic without a diagnosis?

Yes, this is correct. The Long-Stay QM that will be used to track progress of the CMS National Partnership to Improve Dementia Care in Nursing Homes has only 3 exclusions. The numerator is anyone with an antipsychotic on the target assessment and the denominator is everyone with a target assessment, except those with exclusions, and there are only 3 exclusions. This is different from the one in the CASPAR system, at least for now. There is also a Short-Stay measure of antipsychotic use—it is an incidence measure—and it, too, has only the 3 exclusions.

You can download the specs at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/AntipsychoticMedicationQM.pdf

Rena R. Shephard, MHA, RN, RAC-MT, C-NE
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Assessment Not Used for Payment

One of my residents was ill and on medical hold for therapy, resulting in only four treatment sessions and a decline in RUG level on her COT date. Her COT observation date coincides with her 30-Day assessment for day 29.

Since the days coincide and her rate would decrease, I wouldn’t need to do the COT, just a 30-Day, and my rate would change on day 31. On my next COT observation date, or day 36, the rate would go up, so I would do a COT.

My question is: In this scenario, the 30-Day assessment wouldn’t be used for billing, since the COT on day 36 would pay from day 31, so do I have to do the COT for day 29?

No, you don’t have to complete the COT. In this situation, there is no gap where an assessment that is “used for payment” is not available to bill on. The “used for payment” policy applies only if the resident is discharged from Part A before the beginning of the payment window for the respective assessment.

Ronald A. Orth, RN, NHA, CPC, RAC-MT
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Effective Communication

I am a 3 – 11 charge nurse. The DON had all of the nurses on our shift come to her office, where she told us she received complaints about our attitude and she expects us to straighten out. I am very offended by this. I take pride in the fact that I treat people with respect. I want to talk to her about it, but I don’t want to make the situation worse. How do I start?

How a nurse leader communicates directly influences the success of what he or she is trying to accomplish. Building relationships with staff members is critical to the ability to motivate, but in this case by pulling everyone together and telling them to “straighten out,” your DON immediately raised the defenses of those being addressed. Studies have shown that job satisfaction and staff retention are directly linked to the relationship that employees have with their immediate supervisor. If your DON had specific knowledge of one or two individuals who were identified as having an attitude problem, she should have met with them individually to address the concern in private. Now she has placed a communication barrier between herself and her nurses. You can help to recover this situation by asking to speak with her privately. When you are alone, ask if there is something specific that involves your performance and tell her that you want to know so that you can make it right. If she provides you with an example, ask her to assist you in identifying corrective actions. Be careful to listen and not become defensive. Speak the way you want to be spoken to. If there are no specifics regarding your performance, ask how you can assist her in improving the team’s performance on the 3 – 11 shift. As you talk with her in this manner, you will demonstrate to her how best to address a future problem. Check back with her after several days and periodically to see how she thinks things are going. Your respectful interactions with her may help her to adopt a leadership style that increases her effectiveness.

Betty Frandsen, RN, NHA, MHA, C-NE
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## AANAC 2012
### UPCOMING WORKSHOPS

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The workshop schedule is subject to change and is updated regularly. To see a full AANAC Training Partner workshop schedule, visit aanac.org/workshops
SAVE THE DATE

SAN ANTONIO

APRIL 29 – MAY 3, 2013
Advanced Directory Search

Find the advice you need or just make a new friend.

When a new member joins AANAC, they are automatically entered into the AANAConnect member directory. If you’re looking for a specific person, you can easily locate them by mousing over “Directory” and then clicking “Find a Member.” You’ll have the option of searching the directory by first or last name, email address or company name.

But, sometimes you might be interested in finding somebody whose information you don’t have. That’s when we recommend using the “Advanced Search” option. Not only will you have the same options as the general search, but you’ll find hundreds of other options to search on. Here’s a partial list of some that might be helpful:

- **Areas of Expertise:** Do you need help with a very specific skill set? Use the “Areas of Expertise” option to look for members of AANAConnect who have identified themselves as skilled in areas like billing, coding, Medicare, team-building, or RUGs, just to name a few.

- **Specialty Programs:** Is your facility looking into adding a new specialty program? Do you have a resident with specific needs that your facility needs to address? Use the “Specialty Programs” search function to find a member who can explain how their own program works, or even how it was implemented in their own facility. You’ll find options for Alzheimer’s and/or Dementia, Wound Care, Swing Beds, and much more.

- **Likeness:** Maybe you just want to find a few people out there who are “like you.” By using the “Likeness” search function, you can customize your search to return only those community participants who have similar qualities as you. From organization size to skills and certifications, you could find your new best friend and professional sidekick.

This is just a small sample of the many different options you have when searching through the directory. We invite you play around and see how many new connections you can discover using this method of searching. Don’t forget that having a photo can really help you start a conversation, as people are more trusting of those with a personable profile.

So go ahead, start searching the directory for some friendly faces and maybe even your new best friend, right here on AANACConnect.

continued on page 13

Active Discussions This Week on AANACConnect:

**LTC Network:**

**Thread Subject:** Dr. Note
**Posted by:** Victoria Watson

Dr. refuses to put note in progress notes to state seen res. on such & such a date. Was told at MDS conference that could not use daily log during PPS meetings etc... to say Dr. seen res. They said it has to be documented in progress notes. He wants it in black and white why he needs to do this. Am unable to find what I need. Any ideas?

So on new admit I have to code 0 for did Dr. see res in last 7 days even though I know he did and all because he won’t just put a little note in his progress notes. It takes 1 – 2 weeks for dictation to get back & posted in chart.

IDT cooperation is critical not only for the successful completion of the MDS, but also to ensure that a resident receives the best care possible. See what our experts have to say about this particular situation and share your own advice by clicking on the thread subject above.

**MDS Connection:**

**Thread Subject:** Interviews
**Posted by:** Lori Smith

Anyone having problems getting their interviews done before the ARD, and need to put dashes? Any suggestions, advice?

It’s always nice to have a few tricks up your sleeve to help manage an increasing workload and various interviews. See how some of our community members eliminate the stress and stay on top of their game in this particular thread subject. Take away a new tactic or share your own advice by clicking on the subject above.
**What You Need to Know**

Check out these latest updates from the “Need to Know” section of the AANAC homepage and find the information you need to get the job done right.

- Culture Change Webinar Sept. 5—Moving In Day: Person Directed Approach
- Aug. 7 Special Open Door Forum: Manual Medical Review of Part B Therapy Claims
- 2012 SNF Consolidated Billing HCPCS Code File Correction Re: J9033

**Coding Tip**

If an interviewable resident decides not to participate in the BIMs, PHQ-9, Pain and Customary Preferences interviews, does your medical record have the necessary information to code the MDS related staff assessment? If not, interview staff on all shifts and document their information to support the MDS coding.

*Judi Kulus, NHA, RN, MAT, RAC-MT, C-NE  (jkulus@aanac.org)*

**Treatment of Members Policy**

AANAC has posted the Treatment of Members Policy on the website. If you need to access it, please click here.

**Get Answers Now**

When you need answers fast, the best place to start is AANACConnect. We have thousands of member questions that have already been answered by our experts who moderate the communities 24/7. Just type your topic into the search box to see the discussions, tools and peer-submitted resources that may be just what you’re looking for.
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**Q + A, continued from page 9**

**Covering for Call-ins**

Does anyone have a plan in place that works effectively for coverage for call-ins? This was a rough weekend and something needs to change. Do you have people on-call? Mandatory overtime? What do you do at your facility that works? Thank you.

We started having the nurses (or CNAs) all take a day of call on the weekends. It made it so that every 2 – 3 months each nurse took one day of call. We paid the on-call $1 per hour if they weren’t called in, or regular wages if they were. Whoever was working tried to fill the spot before calling the on-call person. This works well because the staff don’t want to call their co-workers on their weekend off. Of course if two shifts are short, an additional person has to help. If someone calls in on a weekend, they have to work their next weekend off. This has cut down on call-ins on weekends. We also use a system that sends out an alert to all staff phones when a shift needs coverage. This has eliminated all the individual phone calls and saved a lot of time. Hope this helps.

*Marilyn Stufflebean, RN*

**Start of Therapy**

**Scenario:** Our resident was admitted for 6 weeks or more IV vancomycin, post total knee hardware infection and extraction. (She has no one who can do IVs at home, Home Health will only come in for 2 weeks, she has no transportation to get to an Infusion clinic TID and they are closed on weekends.)

- She was admitted on 7/13 with an ARD for 5 day/admit = 7/20. Rug level was Ultra High.
- Both PT/OT discharged her on 7/20.
- EOT ARD = 7/23 to reset for nursing rug for IVs.
- On 7/24 she went to her MD and he wants more therapy.
- PT feels they can pick her back up at a Medium Rug. No OT.

I am thinking I can do a SOT combined with a 14-day on 7/30 using the last grace day. I have read and re-read the manual and I hope this is what I understand? Thanks in advance for ANY input!

If 7/24, the day she went to the MD is also the date of the PT evaluation, yes. The SOT has to be 5 – 7 days from the evaluation date. In this case, you can and should combine a SOT with a scheduled PPS assessment when it meets both of the criteria.

*Judy Wilhide Brandt, RN, C-NE, RAC-MT (judy.wilhide@judywilhide.com)*

**Generic Notices**

In the past I was taught that if a resident is short-term rehab and is being discharged home with home therapy that a generic and notification letter does not have to be done. But if they are being discharged and not going to receive therapy at home then you should do one. Now I am hearing that no matter what, I have to do the notification letters that Medicare A will end on this day. Which way is it?

Yes, you must give the Generic Notice; home health therapy does not matter.

*Ronald A. Orth, RN, NHA, CPC, RAC-MT (raorth@clinicalreimbursement.com)*
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