

RehabCare

*Restoring Function, Renewing Life.*

# "The Business of Medicare"

## March 2012



# Objectives

- RUG IV and MDS 3.0
  - Briefly review the Assessment Schedule
  - Review Changes and Operational Impact
- Review Key Operational Statistics for evaluating and driving excellent Medicare Programming
- Identify strategies for Highly Effective Teams in best practice programs

# Common Terms

- MDS Minutes
  - The minutes of care delivered by rehab to the patient and reported on the MDS ***Report all of the minutes delivered***

- Rehab Minutes
  - The minutes that remain after individual, concurrent, and group minutes have been adjusted through the grouper. These minutes are used to calculate the RUG level

# Assessment Reference Date

- The ARD is the designated end-point of a common observation period
- The assessment window is designated for each PPS assessment which include “grace days”
- The ARD is chosen by input from the Medicare team to most effectively capture care provided in the look back period
- Final choice of the ARD must be made by the IDT to best capture the patient’s burden of care

# What is an ARD?

The ARD is intended to:

- Establish a common point in time for all staff participating in the assessment process to judge the patient
- Ensure everyone is evaluating the same assessment period
- Start the clock so that all assessment items refer to the patient's actual performance and health status during a set period in time

# ARD Selection

- The primary purpose of selecting the most appropriate ARD is to capture the greatest burden of care needed by the patient. This will result in proper reimbursement
- Adjusting delivery of service to achieve a RUG category for an assessment is not appropriate

# Important Considerations

- The ARD may be adjusted during the ARD window but not after the window has closed
- ARD selection must be completed by the last grace day of the assessment

# Communication

- Communication is essential for successful ARD selection
  - Communicate potential changes in ARD or care needs immediately
  - Communicate refusals of care the 1st day of refusing treatment
  - Discuss new treatments and changes of condition daily in each center
- Each team member should be communicating about the patients needs
- Each team member should understand their impact on the ARD selection and their impact on flexing an ARD

# ARD Influenced by

- ADL score
- Rehab minutes per day
- Chemo, Radiation, Oxygen, IV Medications, Active Diagnoses
- Skilled nursing treatments such as oxygen, wound care, tube feeding, etc.
- Restorative Nursing
- Last ARD – Timing of the Next MDS

# Completion of the RAI Process

- Medicare MDS Schedules must also meet or exceed OBRA requirements
- General Time Frames for completing MDSs
  - Admission MDS must be completed within 14 days of admission
  - CAAs, when required, must be completed within 14-days of admission
  - The care plan must be completed within 7 days after completing CAAs or by day 21 of admission
  - Transmission is required within 14 days of completing the MDS. (Transmission should be done daily or at a minimum of weekly or when more than 10 assessments completed.)

# Medicare Assessment Schedule

| Medicare MDS Assessment Type | Reason for Assessment (AA8b code) | Assessment Reference Date (Grace Days) | Number of Days Authorized for Coverage and Payment | Applicable Medicare Payment Days |
|---|---|---|---|---|
| 5 day | 1 | Days 1 – 5<br>Days 6-8 | 14 | 1 through 14 |
| 14 day | 7 | Days 11 –14**<br>Days 15-19 | 16 | 15 through 30 |
| 30 day | 2 | Days 21 – 29<br>Days 30-34 | 30 | 31 through 60 |
| 60 day | 3 | Days 50 – 59<br>Days 60-64 | 30 | 61 through 90 |
| 90 day | 4 | Days 80 – 89<br>Days 90-94 | 10 | 91 through 100 |

**CAAs must be performed with either the 5-day or the 14-day assessment.
If completing CAAs with the 14-day MDS, cannot use grace days.

# Important to know...

- Because the completion of the MDS generates the reimbursement level used for billing on the UB-04, the following must be completed **prior** to billing:
  - MDS must be completed including printing, signing, and dating
  - MDS must be transmitted and accepted by the CMS/QIES ASAP Database
  - The validation report must be printed and retained by the facility

# Hierarchy of RUGs

- Hierarchical – Classification of RUG levels: Lists the RUGs by Order of Classification
- Index Maximization – reviews the RUG Case Mix index. If a patient qualifies for one or more RUGs, it selects the RUG with the highest care needs

# Index Maximization

- Step One - Determine which groups the patient qualifies for
  - May qualify for more than one category
- Step Two - Determine which RUG has the highest weight (case mix index)
- The final RUG level is the highest case mix index

# MDS Scheduling Tools

- What tools do you have in place to help support the best decision?
  - How do you know your ADL score
  - How do you know which clinical qualifiers are present?
  - How do you track cognition and depression scales?
  - Are you discussing the 100-day tracker daily?

# MDS 3.0 Changes: Extensive Services

- Elimination of look back
- Extensive services limited to:
  - Tracheostomy care
  - Ventilator/Respirator
  - Isolation for active infectious disease while a resident

# MDS 3.0 Changes: ADLs

- ADL Scoring remains important aspect related to calculating burden of care (reimbursement). Weighted value increases under RUG IV
- As in RUG III,bed mobility, transfer, eating, and toilet use are the four ADL scores that determine end split. Scoring is (now) standardized across the 4 measures
- *The way ADLs are numbered changes with RUG-IV:*
  - Total number of ADL points possible is increased to 17 points (RUG-III is 15 points)
  - RUG-IV scale for counting ADLs are 0 to 16 (RUG-III uses 4 to 18)
  - ADL component scores range from 0 to 4 for each of the four areas. Under RUG-III, 3 areas were scored 1 to 5 and eating was scored 1 to 3 (see table next page)

# MDS 3.0 Changes: ADLs

continued

| ADL Values: Bed Mobility, Toilet, Transfer | | | |
|---|---|---|---|
| | Level of Support | | |
| Performance | None/ Setup | 1 person | 2 people |
| Independent/ Supervision | 0 | | |
| Limited Assistance | 1 | | |
| Extensive Assistance | 2 | | 4 |
| Total Dependence | 3 | | |

| ADL Values: Eating | | | |
|---|---|---|---|
| | Level of Support | | |
| Performance | None/ Setup | 1 person | 2 people |
| Independent/ Supervision | 0 | 2 | |
| Limited Assistance | | | |
| Extensive Assistance | 2 | 3 | |
| Total Dependence | | 4 | |

# MDS 3.0 Changes: Therapy

- CMS has used changes in MDS 3.0 that affect payment for therapy including the following:
  - Concurrent therapy: minutes are divided/allocated among patients instead of counting as 1:1
  - On MDS 3.0, therapy minutes will be coded in these types:
    - Individual therapy
    - Concurrent therapy consisting of no more than 2 patients regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant
    - Group therapy rules are not changed. For MDS 3.0 coding it consists of 2 to 4 patients who are performing similar activities, and are supervised by a therapist (or assistant) who is not supervising any other individuals. The 25 percent cap continues to apply.
- Section T deleted, (in MDS 2.0 estimated therapy is entered in Section T)
- OMRA: Shortened, added an optional abbreviated start-of-therapy assessment

# RUG-IV Rates (Boston-Quincy)

| 66 RUG-IV Groups | Facility Specific Total Rate, Wage Adjusted |
|---|---|
| RUX | $852.67 |
| RUL | $834.09 |
| RVX | $758.94 |
| RVL | $680.90 |
| RHX | $687.61 |
| RHL | $613.28 |
| RMX | $630.75 |
| RML | $578.73 |
| RLX | $553.94 |
| RUC | $646.42 |
| RUB | $646.42 |
| RUA | $540.51 |
| RVC | $554.55 |
| RVB | $480.22 |
| RVA | $478.37 |
| RHC | $483.22 |
| RHB | $434.91 |
| RHA | $382.88 |
| RMC | $424.50 |
| RMB | $398.49 |
| RMA | $327.89 |
| RLB | $412.73 |
| RLA | $265.94 |

| 66 RUG-IV Groups | Facility Specific Total Rate, Wage Adjusted |
|---|---|
| ES3 | $778.46 |
| ES2 | $609.37 |
| ES1 | $544.34 |
| HE2 | $525.77 |
| HE1 | $436.57 |
| HD2 | $492.31 |
| HD1 | $410.56 |
| HC2 | $464.44 |
| HC1 | $388.26 |
| HB2 | $458.87 |
| HB1 | $384.55 |
| LE2 | $477.45 |
| LE1 | $399.41 |
| LD2 | $458.87 |
| LD1 | $384.55 |
| LC2 | $403.13 |
| LC1 | $339.95 |
| LB2 | $382.69 |
| LB1 | $325.09 |

| 66 RUG-IV Groups | Facility Specific Total Rate, Wage Adjusted |
|---|---|
| CE2 | $425.42 |
| CE1 | $391.98 |
| CD2 | $403.13 |
| CD1 | $369.69 |
| CC2 | $352.96 |
| CC1 | $326.94 |
| CB2 | $326.94 |
| CB1 | $302.79 |
| CA2 | $276.77 |
| CA1 | $258.20 |
| BB2 | $293.50 |
| BB1 | $280.49 |
| BA2 | $243.33 |
| BA1 | $232.19 |
| PE2 | $391.98 |
| PE1 | $373.40 |
| PD2 | $369.69 |
| PD1 | $351.10 |
| PC2 | $317.66 |
| PC1 | $302.79 |
| PB2 | $269.34 |
| PB1 | $258.20 |
| PA2 | $222.89 |
| PA1 | $213.61 |

# Most Important Revenue Drivers?

- Skilled ADC
  - Admissions
  - Discharges
- Medicare Rate
  - Extensive Services
  - Nursing ADL Index
  - Rehab Days/Minutes

# MCA Utilization: Daily Rate

- Components of Medicare A Rate
  - Nursing: extensive services (limited opportunity under RUG IV)
  - Nursing: activities of daily living
  - Rehab – rate of utilization (days & minutes)

# Financial Impact of ADL's

- ADL $ Difference
  - RUA to RUB = $106
  - RVB to RVC = $74
- If MCA ADC is 30 = average of 912 Medicare RUG days/month
- Assume 100 (11%) Rehab RUG days/SNF with ADL opportunity:
  - 100 days x $90 = $9k
  - Annualized = $108k

# Financial Impact of Therapy Case Management

- RUG Level $ Difference
  - RVB to RUB = $173
  - RHA to RVA = $94
- If MCA ADC is 30, then you have avg. of 912 Medicare RUG days/month
- Assume 100 (11%) Rehab RUG days/SNF with RUG level opportunity:
  - 100 days x $134 = $13k
  - Annualized = $160k

# Medicare A Revenue - ADC

- What is the Revenue Value of 1 MCA ADC?
  - Formula = ADC x Rate x days/period
  - Assume $540 PPD
  - 1 ADC x $540 ppd x 365 days/year = **$197K**

- How many (additional) admissions are required to increase MCA ADC by 1?
  - Formula = 365 days per year / ALOS
    - Example 1: 365/20 = 18.3
    - Example 2: 365/30 = 12.2
    - Example 3: 365/35 = 10.4

# Medicare A Revenue - ADC

continued

Average Daily Census

- Admissions – Rehab Involvement
  - Marketing
    - Great Stories
    - Tour Ready
  - Quality Care – communication
    - Clinical Excellence
    - Optimal Recovery
- Discharges – who is the gatekeeper?
  - Plan of Care includes discharge plan. Needs to be interdisciplinary

# Impact of ALOS on ADC

Average Length of Stay - The Math

- 10 admissions x 20 day ALOS each = 200 census days
- 10 admissions x 25 day ALOS each = 250 census days

| | Current | Projected | % Increase |
|---|---|---|---|
| ADC | 10 | 12.5 | 25% |
| ALOS | 20 | 25 | 25% |

- Each ADC increase (@ $540 ppd)= approx. $197 K of revenue annually. The approx. impact of the above example (Increase ADC by 2.5) = $493K annually

# Medicare A ALOS

Average Length of Stay - Pitfalls

- ADC Set point (Glass Ceiling)
  - Admissions
  - Bed Availability
  - Staffing – RNs and Therapy
- Communicating with the clinicians about the efficacy of managing ALOS

# Primary Cause of MDS Errors

- Poor payer source verification on admission
- Inaccurate ARD Selection
  - Failure to use the ARD Scheduling Tool
  - Missed or Skipped PPS Meeting
  - Poor communication around missed sessions
  - Changes in Rehab after the PPS Meeting
  - Not looking at discharges and pending changes in rehab when scheduling
- Unplanned discharges

# Successful Programs

- Daily
  - PPS Meeting (ARD Scheduler)
  - Work from Patient Schedules for all care
  - Discuss missed sessions (have a plan)
  - Review ADLs for accuracy at bedside
- Weekly
  - Conduct an effective Case Management Meeting and review Medicare/MCO/Part B
  - Review the MDS Alert Report
  - Review CM Key Metrics Weekly (Monday)

# Successful Programs

continued

- Have an active plan to prevent unplanned discharges
  - Unplanned Hospitalization
  - Dissatisfied patients
- Provide ongoing ADL education
- Have an active plan to manage missed sessions at the time they are missed
- Have scheduled weekend coverage for rehab
- Use the ARD Scheduler daily and check the patient status at the end of the day
- Use the PLOF assessment to drive DC planning
- Understand the COT OMRAs are not a bad thing, titration of rehab is normal
- Never discharge a patient to avoid the next assessment. DC is based on the patient's goals