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**

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

**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 an 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

<table>
<thead>
<tr>
<th>ADL Values: Bed Mobility, Toilet, Transfer</th>
<th>Level of Support</th>
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<tbody>
<tr>
<td>Performance</td>
<td>None/Setup</td>
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<tr>
<td>Independent/Supervision</td>
<td>0</td>
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<tr>
<td>Limited Assistance</td>
<td>1</td>
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<tr>
<td>Extensive Assistance</td>
<td>2</td>
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<tr>
<td>Total Dependence</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1 person</td>
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<tr>
<td></td>
<td>2 people</td>
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<table>
<thead>
<tr>
<th>ADL Values: Eating</th>
<th>Level of Support</th>
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</thead>
<tbody>
<tr>
<td>Performance</td>
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<tr>
<td>Independent/Supervision</td>
<td>0</td>
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<tr>
<td>Limited Assistance</td>
<td>0</td>
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<tr>
<td>Extensive Assistance</td>
<td>2</td>
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<tr>
<td>Total Dependence</td>
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</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
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Restoring Function, Renewing Life.
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)

<table>
<thead>
<tr>
<th>66 RUG-IV Groups</th>
<th>Facility Specific Total Rate, Wage Adjusted</th>
<th>66 RUG-IV Groups</th>
<th>Facility Specific Total Rate, Wage Adjusted</th>
<th>66 RUG-IV Groups</th>
<th>Facility Specific Total Rate, Wage Adjusted</th>
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<td>ES1</td>
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<td>$525.77</td>
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<td>RHX</td>
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<td>RHL</td>
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<td>RVA</td>
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<td>LD1</td>
<td>$384.55</td>
<td>PE2</td>
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<td>RHA</td>
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<td>RMC</td>
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<td>LB1</td>
<td>$325.09</td>
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<td>RMA</td>
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<td>PB2</td>
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<td>RLA</td>
<td>$265.94</td>
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<td>PA2</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>PA1</td>
<td>$213.61</td>
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</tbody>
</table>
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
• 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
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

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

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Projected</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADC</td>
<td>10</td>
<td>12.5</td>
<td>25%</td>
</tr>
<tr>
<td>ALOS</td>
<td>20</td>
<td>25</td>
<td>25%</td>
</tr>
</tbody>
</table>

- 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

- 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 COTOMRAs 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