Managing MDS 3.0
Part I: Principles of Coverage

Greenfield Rehabilitation Agency

Review of the Basics

- Qualifiers for Med A Coverage:
  - Technical:
    - Has Med A days available
    - 3 day qualifying hospital stay (3 midnights): Admitted on Sunday, DC Tuesday or admitted on Sunday and DC on Wednesday
    - Has been DC'd from SNF skilled Med A within 30 days
  - Clinical:
    - Services need to be daily based on medical necessity, could not be done as OP (discuss SLP skilling solely)
    - Services can only be provided in a SNF
    - Condition has to be related to the reason for hospitalization

Different Types of Medicare

- Medicare A (hospital insurance)
  - No additional cost to beneficiary
  - Pays for inpatient hospitalization, CAH, SNF non-custodial care, hospice and some home health care.
  - Paid for while they (or their spouse) was working

Medicare A Coverage of a SNF Stay

- Covers up to 100 days if meets skilled criteria
  - Days 1-20 covered in full
  - Days 21-100 require a daily co-payment (was $144.50 per day in 2012)
- Covers semi-private room, meals, nursing and rehab services, medications and medical supplies, ambulance transport, dietary counseling, lab tests and radiological tests

Different Types of Medicare

- Medicare B (Medical Insurance):
  - Monthly premium
  - Can get additional prescription drug coverage
  - Pays for doctor's services, outpatient hospital care, outpatient therapy services, etc. which are determined to be medically necessary.
  - In 2012 the premium for part B was $99.90 per month

Medicare Advantage Plans

- Medicare eligible folks have an option to enroll in replacement or advantage plans
  - Offer lower premiums
  - In exchange for management of their health services to control costs to offset the lower premiums
  - Many don't understand what they have given up in exchange for lower premiums

Medicare A Coverage of a SNF Stay

- Consolidated billing
  - SNF receives one lump payment to cover all these services based upon the RUG level obtained that reflects the intensity of the services provided
  - Awareness of this is important so to avoid ordering excessive tests or equipment that may not be necessary at the time

Benefit Period

- A new 100 day Medicare A benefit period begins when there is a 60 day break of non-skilled care in the facility or the patient went home and did not received daily skilled home health care.
  - Skilled services that "break" the 60 day period include: 5 day a week therapy services, tube feeding, trach care, home health under Med A

How is a Med A Stay Considered Skilled?

- Services must be ordered by a physician and under the supervision of professional personnel (therapists)
- Resident requires these services on a daily basis (five days a week is daily for therapy)
- Services can only be provided on an inpatient basis as a practical matter
- The services are reasonable and necessary for the treatment of the patient's illness or injury

What is a skilled service?

- *If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g.,…and ultrasound, shortwave, and microwave therapy treatments.*
- *The intermediary considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.*

RUG Levels

- Ultra High
  - 720 Minutes of therapy
  - At least 2 therapies
  - One discipline at least 5 calendar days
  - Other discipline at least 3 calendar days
- Very High
  - 500 Minutes of therapy
  - At least one therapy
  - One discipline at least 5 calendar days

RUG Levels

- Rehab High
  - 325 Minutes of therapy
  - At least one discipline at least 5 calendar days
- Rehab Medium
  - 150 Minutes of therapy
  - Any (or all) disciplines at least 5 days of any combination of the three disciplines
- Rehab Low
  - 45 Minutes of therapy
  - Any (or all) disciplines at least 3 days of any combination of the three disciplines

Discharges and Out to Hospital

- If a resident goes out to the hospital and is admitted, they must be discharged from therapy and a new evaluation performed when they come back.
- This differs from out for observation only, as a new evaluation would not need to be done. If they are gone over a "midnight" to the hospital, the day of that midnight needs to be "skipped" in the Medicare day count. This is done in Smart by selecting "skip day".
- Do not back any charges out of Smart. The facility discharge should be the day they leave the facility. The facility does not get paid for day of discharge, so when planned avoid treatment on that day.
- Possible discharge to hospice – communicate with facility

Basics About Therapy Service and Medicare A

- Services need to be ordered by a physician or other approved provider
- Therapy minutes counted can only be performed in the facility after admission
  - Cannot count minutes of therapy provided in hospital prior to discharge
  - Treatment can be provided inside or outside facility (home visits count)

Capturing Minutes of Therapy on the MDS

- To count as a day of frequency, at least 15 minutes of treatment must be administered
  - If they are refusing to come down because of illness, working even at least 15 minutes of bedtime allows us to ensure frequency is captured.
- Minutes provided can be counted on MDS even if they were administered less than 15 minutes for that day.
  - They still count towards the total minutes, but can't count towards frequency unless at least 15 minutes.

Group Minutes

- Group is now defined as 4 residents, no less performing the same or similar activities
- Time spent in group is reported in Smart and on MDS as the full time in group
- Time will be "allocated" or reduced to only count as 25% for each resident
- Documentation must show group activities were individualized to each resident

Concurrent Minutes

- In this section of the MDS, the total amount of concurrent minutes should be recorded; however, only 50% of the minutes recorded will count towards the RUG level.
  - For example, occupational therapy can provide 178 minutes of concurrent therapy during the assessment period. 178 minutes is entered into section O0400B2, but calculating the RUG level, only 89 minutes count toward the RUG level.
- Smart and the MDS software calculates the RUG level for the facility will do the equation to only count 50% of the concurrent minutes, the provider should enter the total amount of concurrent minutes delivered.

Start and End Dates

- Therapy Start Date: Date the initial evaluation was conducted regardless if treatment was rendered or not.
- Therapy End Date: The last date the resident received skilled therapy treatment. Enter dashes if therapy ongoing.
  - If unavailable or refused, that would not count because the resident did not receive skilled treatment.

Minutes of Therapy Services

- Documentation spent on documentation or initial evaluation when there is no skilled care going on is not counted on the MDS.
  - Documentation done during a functional rest break or while educating patient on goals, progress or plan of care can be billed as long as another skilled service is going on.
  - If the resident is just "waiting", you can't bill that time.
  - All documentation must be done at point of service. There should be no downtime for doc as we are all functioning pretty much one on one.

Minutes of Therapy Service

- Therapist time spent on re-evaluations as part of the treatment process can be counted on the MDS
- Resident treatment time starts when he or she begins the first activity and ends when they finish with the apparatus or intervention/task and treatment is ended (for example a bathroom break without therapy assist or non-therapeutic rest).
- Family education when the resident is present is counted and must be documented in the resident's record. This is true for care conferences too.
  - Therapy should go first and do their piece. It is not necessary to stay the entire conference. The team can f/u with any questions that come up. If patient not present, not billable.

Minutes of Therapy Services

- Time required to adjust equipment or otherwise prepare for individual therapy of a particular resident is considered set up time and can be included in the count of therapy minutes delivered to the resident.
- Record actual minutes of therapy. Do not round to the nearest 5th minute. Therapy logs verify the provision of services with the plan of care and validate the MDS.
- Services provided at the request of the family when the therapist believes therapy is not medically reasonable and necessary cannot be counted on the MDS, even if performed by a therapist or assistant.

Minutes of Therapy Services

- If a therapist/assistant is transporting a resident to or from treatment and is engaging them in a discussion that uses the clinical decision making skills of a therapist, it is billable time
- If an aide transports, that time in transport does not count towards the MDS.

Modalities

- When providing therapy modalities, only skilled time can be counted towards the MDS.
- What is skilled time:
  - Time spent setting up the modality on the patient (positioning device or electrodes, positioning the resident)
  - Time spent educating the resident about the treatment
  - Time spent supervising the patient for their response to the treatment, checking in with them to see how they are responding, monitoring for performance or response to treatment
- If therapist is not supervising the resident and leaves the room to attend a care conference, the time cannot be counted as the resident is not receiving skilled care.

Co-Treatment Under Med A

- When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full.
- The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient.
- Use should be limited

Smart Tracking

- All residents who reside in your facility regardless if on therapy or not should be in your facility census for accurate Saturation reporting.
- Med As and HMOAs who are on nursing levels should be tracked in Smart as such to assist with accuracy in LOS reporting.
- Smart accuracy is extremely important regarding SSNs, MRNs, and payor source.
- All patients should be scheduled for treatment in Smart.

Smart Tracking

- All patients are expected to have scheduled times in Smart and this is expected to be communicated to the facility daily with a printed schedule from Smart.
- All ARDs should be planned in advance in Smart including COTs to ensure the planner logic is working and adjusting minutes for you.

OMRA

- SOT OMRA:
  - To be used when a resident is currently in a nursing category and is going to begin therapy services
    - For example, in the middle of a 30 day assessment at a nursing level and physician upgrades weight bearing so therapy can start again.
- Cannot be used to transition from one rehab category to another, only nursing to rehab
- ARD must be set 5-7 days after the start of therapy
- Day of the earliest evaluation is counted as Day 1 regardless if treatment is provided on that date
- Establishes a therapy RUG effective the date that therapy started

Medicare Short Stay Assessment

- Only can be used at the beginning of treatment
- Resident must be discharged from facility or Med A by day 8 in order to qualify to use this
  - Great for short term orthos and folks who are really sick and go back to the hospital
  - The basic premise is to capture an average of therapy provided over a short stay to capture the intensity of the services provided
- Captures when services are only provided for 1-4 days before ending

Medicare Short Stay Assessment

- Must meet the following **eight** conditions to be a Medicare Short Stay Assessment
  1. The assessment must be a SOT OMRA
  2. A 5-day or readmission/return assessment has been completed (can be done alone or combined with SOT OMRA)
  3. ARD must be on or before Day 8. ARD minus the start of Medicare stay date must be 7 days or less.
  4. The ARD of the SOT OMRA must be the last date of the Med A stay (last covered day).

Medicare Short Stay Assessment

5. ARD of the SOT OMRA may not be more than three days after the start of therapy date.
   - It is not possible to have the ARD be 5-7 days after the start of therapy since therapy must have been able to be provided 1-4 days total.
6. Therapy started during the last 4 days of the Med A covered stay including weekends.
7. At least one discipline continued through the last day of Medicare A coverage.
   - In Section O, at least one discipline must have a dash-filled end of therapy date to indicate ongoing therapy or an end date of therapy services equal to the end of the Medicare A covered stay.
8. RUG assigned to the SOT OMRA must be a Rehab RUG

Medicare Short Stay Assessment RUG Qualifications

Average Daily Therapy Minutes	Rehab Category
144 or greater	Ultra High
100-143	Very High
65-99	High
30-64	Medium
15-29	Low

Factors Which Influence Facility Payment

- ADL Score (which is calculated by nursing) plays a huge role in facility reimbursement
  - 11-16 C (heaviest care)
  - 6-10 B
  - 0-5 A (walkie-talkie, independent)
- Let's look at how they score the ADLs areas which include: bed mobility, ambulation, transfers, dressing, eating, toileting, hygiene

Bridging the Language Gap Between Therapy and Nursing

Nursing Terms	Therapy Terms
Independent: no help or oversight at any time Coded = 0	**Independent:** no help or oversight at any time **_Therapy not needed to address any deficits related to this area._
Supervision: Oversight, encouragement, cueing three or more times Coded = 1	**Supervision:** Oversight, encouragement, cueing. **_Be careful using this to justify the skills of a therapist are needed and it could not be done by a member of the nursing staff._
Limited Assistance: resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance three or more times Coded = 2	**CGA (Contact Guard Assist):** Requires hand contact for safe and effective performance, tactile facilitation or for safety. Assistance is non-weight bearing in nature.
Extensive Assistance: Resident involved in activity, staff provided weight bearing support three or more times. Coded = 3	**Minimal Assist:** Resident can perform with 25% or less physical assistance. Activity can only be completed with set up. Help to sustain or initiate activity. **Moderate Assist:** Resident can perform with 50% or less physical assist. **Maximal Assist:** Resident can perform with 75% or less assistance.
Total Dependence: full staff performance every time during entire 7 day period. Coded = 4	**Dependent:** 100% assistance by one or more individuals.

Impact Upon Reimbursement

- RUA: $442.39
- RUB: $529.08
- RUC: $529.08
  - $86.69 difference from A to C. Over 14 days that comes to $1,213.66.
- RVA: $391.53
- RVB: $393.06
- RVC: $453.89
  - $62.36 difference per day A to C. Over 14 days that comes to $873.04.

RUG Grouper Effect

- The ADL score affects which RUG the facility chooses as some nursing levels will pay more.
- We put in Smart the RUG we qualified them for, not what the facility chose because it pays better.
- RUG rates differ from classification as urban to rural facility and per county area. See example chart.

Coming Up Thursday

- EOTs
- COTs
- When to combine and when to not combine assessments
- Email me questions and will answer on Thursday's call.

Greenfield Rehabilitation Agency
Continuing Education Survey

Title of Course: Managing MDS 3.0

Date of Presentation: Tuesday, April 17, 2012

Answer the following questions using the following scale:
5 – Strongly Agree
4 – Agree
3 – Neutral
2 – Disagree
1 – Strongly Disagree

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1. The material presented met the identified objectives for the topic.
   1 2 3 4 5

2. The course information was organized and presented clearly.
   1 2 3 4 5

3. The information was relevant to my practice as a therapist or assistant.
   1 2 3 4 5

4. Rate the course overall.
   1 2 3 4 5

Comments:

Name: _____ Discipline: _____

Primary Site: _____

Please fax to the GRAI office at 414-327-5411 and complete the posttest to receive your CEU certificate at the conclusion of the course.

Prospective Payment System - RUG IV

Urban Federal Per Diem Rate

Wage Index: 0.9226 Effective 10/01/2011

County: Appleton/Calumet/Outagamie

RUG III Category	Labor Related	Non-labor Related	Nursing Component	Therapy Component	Therapy Non-Case Mix Component	Non-Case Mix Component	Total Rate
RUX	$506.32	$230.76	$406.06	$214.22		$77.61	$697.89
RUL	495.28	225.73	390.84	214.22		77.61	682.68
RVX	450.67	205.39	396.93	146.64		77.61	621.18
RVL	404.33	184.27	333.06	146.64		77.61	557.30
RHX	408.30	186.09	387.80	97.37		77.61	562.79
RHL	364.17	165.97	326.97	97.37		77.61	501.95
RMX	374.54	170.70	375.64	63.00		77.61	516.25
RML	343.65	156.62	333.06	63.00		77.61	473.67
RLX	328.94	149.91	343.70	32.08		77.61	453.39
RUC	383.85	174.94	237.25	214.22		77.61	529.08
RUB	383.85	174.94	237.25	214.22		77.61	529.08
RUA	320.95	146.28	150.56	214.22		77.61	442.39
RVC	329.30	150.08	229.64	146.64		77.61	453.89
RVB	285.17	129.96	168.81	146.64		77.61	393.06
RVA	284.06	129.46	167.29	146.64		77.61	391.53
RHC	286.94	130.77	220.52	97.37		77.61	395.50
RHB	258.25	117.70	180.98	97.37		77.61	355.96
RHA	227.35	103.62	138.39	97.37		77.61	313.37
RMC	252.07	114.88	206.83	63.00		77.61	347.44
RMB	236.63	107.84	185.54	63.00		77.61	326.15
RMA	194.70	88.73	127.75	63.00		77.61	268.36
RLB	245.08	111.70	228.12	32.08		77.61	337.81
RLA	157.92	71.97	107.98	32.08		77.61	217.67
ES3	462.26	210.67	544.45		$15.09	77.61	637.15
ES2	361.85	164.92	406.06		15.09	77.61	498.76
ES1	323.23	147.32	352.83		15.09	77.61	445.53
HE2	312.20	142.29	337.62		15.09	77.61	430.33
HE1	259.24	118.15	264.62		15.09	77.61	357.32
HD2	292.34	133.23	310.24		15.09	77.61	402.94
HD1	243.79	111.11	243.33		15.09	77.61	336.03
HC2	275.79	125.69	287.43		15.09	77.61	380.13
HC1	230.55	105.08	225.08		15.09	77.61	317.79
HB2	272.48	124.18	282.87		15.09	77.61	375.57
HB1	228.35	104.07	222.04		15.09	77.61	314.75
LE2	283.52	129.21	298.08		15.09	77.61	390.79
LE1	237.17	108.09	234.20		15.09	77.61	326.90
LD2	272.48	124.18	282.87		15.09	77.61	375.57
LD1	228.35	104.07	222.04		15.09	77.61	314.75
LC2	239.38	109.10	237.25		15.09	77.61	329.95
LC1	201.87	92.00	185.54		15.09	77.61	278.25
LB2	227.24	103.57	220.52		15.09	77.61	313.22
LB1	193.04	87.98	173.37		15.09	77.61	266.08
CE2	252.62	115.13	255.49		15.09	77.61	348.20
CE1	232.76	106.08	228.12		15.09	77.61	320.82
CD2	239.38	109.10	237.25		15.09	77.61	329.95
CD1	219.52	100.05	209.87		15.09	77.61	302.58
CC2	209.59	95.52	196.18		15.09	77.61	288.89
CC1	194.14	88.48	174.89		15.09	77.61	267.59
CB2	194.14	88.48	174.89		15.09	77.61	267.59
CB1	179.80	81.94	155.12		15.09	77.61	247.82
CA2	164.35	74.91	133.83		15.09	77.61	226.54
CA1	153.32	69.87	118.62		15.09	77.61	211.32
BB2	174.28	79.43	147.52		15.09	77.61	240.22
BB1	166.56	75.91	136.87		15.09	77.61	229.58
BA2	144.49	65.85	106.45		15.09	77.61	199.16
BA1	137.87	62.84	97.33		15.09	77.61	190.04
PE2	232.76	106.08	228.12		15.09	77.61	320.82
PE1	221.73	101.05	212.91		15.09	77.61	305.62
PD2	219.52	100.05	209.87		15.09	77.61	302.58
PD1	208.48	95.02	194.66		15.09	77.61	287.36
PC2	188.62	85.97	167.29		15.09	77.61	259.99
PC1	179.80	81.94	155.12		15.09	77.61	247.82
PB2	159.94	72.89	127.75		15.09	77.61	220.45
PB1	153.32	69.87	118.62		15.09	77.61	211.32
PA2	132.36	60.32	89.73		15.09	77.61	182.44
PA1	126.83	57.81	82.12		15.09	77.61	174.82
Total							