THE THERAPY AND MDS CONNECTION. MANAGING YOUR REIMBURSEMENT AND COMPLIANCE EFFECTIVELY

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Objectives

- Identify entitlement, eligibility, and applications of the benefit period
- Define Spell of Illness
- Understand skilled criteria in the SNF
- Daily Medicare Management
- Medicare Part B Program Management
- Strategies for Successful Management
Medicare Structure

What is Medicare?

- Medicare has 4 parts.
  - Hospital Insurance (Part A): can help pay for inpatient hospital care, inpatient SNF care and home health care
  - Medical Insurance (Part B): can help pay for medically necessary M.D. services, outpatient hospital services, and nursing home services. Can also help pay for home health care services and a number of other medical services and supplies not covered under Part A.
  - Part C: Managed Medicare Products
  - Part D: Prescription Drug Plan
Common Questions

- **What Services are covered under Part A?**
  - Routine Services (nursing services, room and board, laundry, housekeeping and personal care items)
  - Medical Supplies
  - Complex Medical Equipment
  - Rehabilitation Services (PT, OT, ST)
  - Respiratory Therapy
  - Nutritional Therapy
  - IV therapy
  - Pharmaceuticals
  - Oxygen
  - Diagnostic tests (lab, x-ray, etc.)
  - EKG

Physician Certification and Recertification

- The Cert/Recert must be completed as a condition of the Medicare Program. A new form is initiated when:
  - Resident is a new admission to the facility for Medicare coverage
  - Resident is readmitted to the facility and received Medicare coverage
  - Resident has had a change of condition within the 30 days of Medicare discharge and is returned to a certified bed for Medicare coverage
Physician Certification and Recertification

• The initial certification and all re-certifications must be signed and dated by the attending physician or a physician on the skilled nursing facility’s staff who has knowledge of the case. The date and signature cannot exceed the cert/re-cert date found to the left of the physician’s signature without written documentation for lateness. Under PPS Clinical Nurse Specialists and Nurse Practitioners can sign the form (PA’s cannot), unless employed by the facility.
• The certification can:
  ○ Identify that the resident meets the existing level of care definition
  ○ Simply state the resident’s assignment to one of the upper 52 RUG IV group (“not recommended”)

Physician Certification and Recertification

• Initial Certification:
  ○ The initial certification is completed on or prior to admission for Medicare coverage. The initial cert must clearly indicate that post-hospital extended care services are required and a description on the services to be provided.
• Recertification:
  ○ Each covers a 30 day period
  ○ Explain type of daily skilled care required
• Recommendation: When coverage ceases, document the reason on the cert/re-cert form
Physician Certification and Recertification

- Faxed copies are acceptable
- Can also mail a copy for signature
- Last resort: Medical Director can sign if he/she has knowledge of the case
- Maintain a copy in the medical record and one in the financial folder when coverage of services has ceased.

(Info available in Medicare Benefit Policy Chapter 8-Sect. 40)

Spell of Illness/Benefit Period

- A benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient, up to a certain specified max. amounts, may be paid for by the hospital insurance plan.
  - 90 days of hospital care (can be up to 150 if lifetime reserve days are used/60 lifetime reserve days)
  - 100 days of extended care services during the same benefit period
- There is no limit on the number of benefit periods available
Spell of Illness/Benefit Period

- Facility should track:
  - Residents in the 30 day window
    - For return of skilled needs
  - Residents for 60 consecutive days without skilled care
    - To monitor for eligibility of new benefit period
  - Residents whom remain at a skilled level of care after exhaustion of benefit days
    - For gap billing

Practical Matter Criteria

- Can the daily skilled care only be provided in the SNF as a practical matter
  - Considerations:
    - Outpatient services are not available in the area where the individual lives
    - Outpatient services are available, but transportation could cause excessive hardship or Treatment less effective than in the SNF
    - Consider the availability of a capable and willing caregiver
    - Use of alternate services would adversely affect the resident’s medical condition
Level of Care Criteria

- Services must:
  1. Be pursuant to a physician’s order
  2. Be reasonable and necessary
  3. Must be performed by or under the supervision of professional or technical personnel
  4. Require daily skilled services (Rehab 5 days = “daily”)

Skilled Criteria

- Skilled Rehabilitation Services (PT, OT, and ST) to be established by the therapists and the physician.
- Skilled Nursing Services to be established by the physician in conjunction with the SNF team.
Medical Appropriateness Exception

- An elapsed period of more than 30 days is permitted where patient’s condition make it inappropriate to begin an active course of treatment
- Must be predictable “at the time of the hospital discharge that he or she will require covered care within a predeterminable time period
- The fact that the resident enters the SNF for Non-covered or covered care does not negate coverage at a later date, as long as it was medically predictable

Daily Medicare Management
Daily Management

- Daily Focused meeting with PPS team
  - Nursing, Rehab, Business Office, Social Services, etc.
- Effective way to monitor reason for skilling on a daily basis and update any changes in condition and/or treatment
- Process leads to clean month end close and effective Medicare management

Preadmission

- Estimate RUG score and cost of treatment
  - Therapy cost
  - Consolidating billing charges
  - Pharmacy, lab, Radiology Expenses
- Ensure co-pay situation in place
- Back-up payer source
  - Can be skilled today but not tomorrow
Daily Management

- Establish reasons for skilling
  - Rehab
    - # of disciplines to be involved
    - Estimated time frame to meet goals
  - Nursing
    - Any treatments requiring daily skilled monitoring
      - Infections, Wound Treatment, Cardiac Issues, Behavior Monitoring and Medication Adjustment, etc.
  - Teaching Needs
    - Diabetic Teaching
    - Colostomy
    - Medication Regimen
    - Wound Care, etc.

Daily Management

- Discharge Plan
  - Estimated Length of Stay
    - This is just an estimation, may vary greatly from time of actual discharge
  - Final Discharge Destination
    - Home, ALF, Another SNF etc.
  - Discharge Barriers
    - Level of Function needed to reach D/C destination
    - Any Community Services
    - Medication/O2 management
    - Home management (e.g., stairs, ability to care for self at home, meal preparations)
Daily Management

• ICD-9 Codes
  o Reason for admission to hospital and continued need for skilled care in the SNF
  o Use V-codes when applicable
    • For Ortho aftercare
      o Use appropriate code to specify area to be treated
    • Remember we do not treatment the actual fracture we are treating the aftermath
  o Medical Codes
  o Therapy Codes

Daily Management

• ICD-9 Codes (cont.)
  o Make sure the codes support the services billed on the UB-04
    • If in a rehab category there should be therapy charges (only exception may be period pending an OMRA)
  o Readjust codes as needed
    • New onset of disease while in a Part A stay
      o Newly diagnosed pneumonia, code should be on correlating month’s UB-04
      o If issues resolved they should be deleted from the next month’s bill
Daily Management

- ICD-9 Codes (cont.)
  - Watch for benign codes
    - I.e., IDDM without complications (250.00) vs IDDM with renal manifestations (250.4 and follow with 5th digit when necessary) etc.
  - Updated ICD-9 codes should be communicated to the Business Office when they occur instead of waiting until the end of the month
    - This can be one of the biggest hold-ups at month end close
    - At least weekly
  - Track Diagnosis and ICD-9 codes on log
    - UB-04 only records the number codes

- ICD-10 Coming October 2014
  - Announced August 2012 that they would delay Oct 2013 roll-out for 1 year

Daily Management

- RUGS-IV Management
  - Know your 66 RUGS (Resource Utilization Groups) Categories and reasons for residents to qualify into each
  - Do not use RUG score to determine whether resident is skilled or not
  - RUG score sets up a payment rate, it does not mean that a resident meets daily skilled requirements
    - Example: A resident falls into HE2 because of IV fluids that ended 7 days ago, but is currently clinically stable, may not require daily skilled care vs. another resident who was started on an antipsychotic 2 days ago may fall into a PD1 but requires daily monitoring for behaviors, medications and side effects management, frequent psych reviews, etc., this resident does meet the daily requirements
RUGS-IV Management

- FY 2012 Changes to Assessment Reference Date
  Windows to reduce duplication of minutes on subsequent assessments

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>ARD Range with Grace Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 day</td>
<td>Days 1-8 (no changes)</td>
</tr>
<tr>
<td>14 day</td>
<td>Days 13-18 (was 11-19)</td>
</tr>
<tr>
<td>30 day</td>
<td>Days 27-33 (was 21-34)</td>
</tr>
<tr>
<td>60 day</td>
<td>Days 57-63 (was 50-64)</td>
</tr>
<tr>
<td>90 day</td>
<td>Days 87-93 (was 80-94)</td>
</tr>
</tbody>
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RUGS-IV Management

- ARD Management (cont.)
  - Be cautious to not ignore medical treatments just because they classify into a rehab RUG score
    - Most pre-pay and post-pay reviews conducted by Fiscal Intermediaries/Medicare Administration Contractors are in Rehab categories, if the F.I./M.A.C. medical review department does not feel that the therapy treatment delivered was appropriate, then they will drop the score into the next qualifying category; it’s better to have a more appropriate clinical category than the default rate or similar.
RUGS-IV Management

- MDS Cycle
  - Discuss where they are in the MDS cycle daily
  - ARD
    - Status of completion (daily meeting is a good format to “remind” disciplines of need to complete)
  - Date of Transmission
    - Must be transmitted within 14 days of completion (some states require a shorter time frame)
    - MDS’ must be transmitted and accepted into the State/CMS database prior to billing
    - Some FI/MAC’s are now cross referencing the MDS repository when UB-04’s are submitted

- MDS Cycle
  - LOA’s
    - If resident is out for MLOA for <24 hours (and not admitted to the hospital) and not in the bed at midnight, that day cannot be billed for and the MDS cycle is readjusted by one day, you do not need to start a new MDS cycle
    - If out greater than 24 hours or <24 hours but admitted to the hospital then a new Medicare cycle must be started
    - An exception to this rule can be a “social leave”, a new cycle does not need to be started upon return, but the facility cannot bill for the days that “the head is not in the bed” at midnight (use caution in these situations as it may jeopardize Medicare coverage)
OMRA’s (Other Medicare Required Assessment)

- Now there is an End of Therapy OMRA and a Start of Therapy OMRA
- End of Therapy OMRA
  - Required only if the resident was in a Rehabilitation RUGS-IV Classification and will continue to need Part A SNF-level services
  - If last RUG score was in a clinical category an OMRA is not required
  - May be set day 1-3 after completion of all therapy. Payment changes on First Non-Therapy Day
- Start of Therapy OMRA
  - When a resident returns to Therapy 5-7 days/week
  - ARD is set 5-7 days after therapy starts

OMRA (cont.)

- Last day treatment was furnished is day zero
  - Not the day the discharge order was written
    - May vary due to refusals, MLOA’s, late order transcription
- Billing changes on the start or end date of the Therapy (unless it is into grace days, then you need to go back to the original date of the payment change over)
New OMRA’s

- End of Therapy Resumption (EOT-R)
  - To replace End of Therapy OMRA and Start of Therapy OMRA’s on residents that missed at least 3 consecutive days of therapy but resume services within 5 days
  - Require one MDS to be completed rather than two
  - Resumption must classify into the same RUG level
  - Will require new item set on the MDS
    - O0450A and O0450B resumption of therapy dates

New OMRA’s (2)

- Change in Therapy (COT) OMRA
  - Needed whenever there is a change in therapy level that would result in a change in RUG-IV level using RTM (Reimbursable Therapy Minutes) rather than just total minutes reported on the MDS.
  - Must monitor residents on a rolling 7 day cycle beginning the day after the previous assessment reference date
    - For example, if a 14 day MDS ARD is set on day 14, then the facility must monitor minutes delivered days 15 through 21. If a decrease in RTM’s is noted then the COT would be performed. Payment would change on day 15 to the new RUG-IV level. Then reassess on day 28.
  - ARD would be set on the 7th day resulting in payment change
New OMRA’s (3)

- Recent clarifications:
  - When a COT and regularly scheduled assessment are due at the same time the facility has the decision decide whether to combine or not.
    - For example, if the COT and 14 day assessment are due on day 14. The facility would be better off combining if the RUG category went up; and doing the 14 day as a “stand-alone” if the RUG category went down related to the 7 day retrospective payment that accompanies a Change of Therapy OMRA.

Daily Management

- Ensure all disciplines are aware of why the resident is in a Part A stay
  - Esp. the nurses on the unit so they understand what needs to be documented and monitored
Skilled Nursing Services

- IV medications, IV therapy, and IM injections
  - SQ Injections are not deemed skilled
- NG tube, G tube, J tube feedings
- Feedings account for 51% of daily calories or 26% of daily calories and 501cc
- Nasopharyngeal and tracheotomy aspiration

Skilled Nursing Services (cont.)

- Suprapubic catheters
  - Insertion, irrigation, and replacement of urinary catheters has been deleted
- Application on dressing involving prescription medications and aseptic techniques
- Pressure or stasis ulcers
  - 2 or more of any stage and treatment
  - Any Stage III or IV pressure ulcer and treatment
Daily Management

- Reasons to Skill
  - Management and Evaluation of a Care Plan
    - Are you establishing and/or monitoring the treatment regimen to meet the resident’s physical and emotional needs
    - Do needs require licensed staff to manage them
    - Are the total sum of unskilled services requiring skilled management
    - Are you providing the nursing process of observation, assessment, planning, implementation and evaluation
    - Risk of complicating factors, high probability of relapse
    - Is the resident’s condition stabilized

- Reasons to Skill
  - Observation and Assessment
    - Is there the likelihood of a change in the resident’s condition
    - Are skills of a licensed nurse required to monitor and evaluate the possible for a modification to treatment
    - Is there a need to initiate medical procedures (labs, radiology, blood gases, etc.)
    - Does the physician think there is a high likelihood of a change in condition
Daily Management

- Reasons to Skill
  - Observation and Assessment (cont.)
    - Is there a need to observe for therapeutic effects and/or adverse side effects of drug dosage adjustments or newly prescribed medications i.e. Coumadin, antibiotic therapy, new or adjusted steroid therapy, chemotherapy, pain medications, cardiac medications, psychotropic medications
    - Is the resident dehydrated, electrolyte imbalance
    - Are you performing daily assessment for: neurological, respiratory, cardiac, pain/sensation, gastro-intestinal, nutritional, circulatory, genito-urinary, musculoskeletal/mobility, skin

Daily Management

- Reasons to Skill
  - Teaching and Training Activities
    - Self-Administration of:
      - Injectable Medications
      - Complex Range of Medications
      - G-tube Feedings
      - New Diabetic (Medications, dietary changes, foot care)
    - Self Catheterization
    - Skin/Wound Treatments
    - Prosthesis Care, Care of Splints, braces, orthotics
    - Maintenance of Central Lines, Suprapubic tubes
    - New colostomy or ileostomy care
Skilled Rehab

1. Must be directly and specifically related to an active written treatment designed by the M.D. after any needed consultation with a qualified therapist
   - Signature must be obtained prior to billing Medicare
2. Must be of level of complexity that requires the judgment, knowledge and skills of a qualified therapist
3. Assessment based on patients restoration potential in a “reasonable and generally predictable” period of time
4. Services are necessary for establishment of a safe and effective maintenance program

Daily Management

- Reasons to Skill
  - Rehabilitation Needs
    - At least 5 days per week
    - Watch for Dialysis patients, rehab must be at least 5 separate days a week
    - Caution: Watch for residents falling into RM category who do not receive therapy 5 separate days a week
    - Tracking of Distinct Calendar Days added to MDS October 2013
  - Therapy must be delivered for at least 15 minutes a day to code on the MDS (this does not need to be all at once)
Daily Management

- Reasons to Skill
  - Rehabilitation Needs:
    - Count only therapy delivered in the facility or with the facilities therapists (i.e. home eval/treatment)
    - Count only actual treatment time- Reimbursable Therapy Minutes
    - Group therapy cannot exceed 25% of the time in the 7-day observation period
    - Number of Disciplines Involved
    - Monitor minutes delivered on a daily basis as a team when they are in the assessment date range
    - Appropriate amount of disciplines and minutes for the assigned RUG score
  - Be sure the therapy department is aware of any planned LOA's (medical or social) to adjust treatment times accordingly
  - Monitor refusals for any reason (medical, emotional, etc.)
  - Monitor for change in RUG levels for COT
  - Again, Monitor ARD’s closely in this time frame
  - Discuss any D/C planning needed for therapy (continued treatment at home, any medical equipment needed such as wheelchair walker)
  - Status of Discharge Barriers
Daily Management

- Restorative Nursing
  - Rehab Low with therapy involvement
    - Therapy 3 days a week for at least 15 minutes a visit and restorative 6 times a week in qualifying areas for at least 15 minutes in each (they do not need to be 15 consecutive minutes)
    - This makes more sense for the LTC resident in that the actual transition plan will be over to nursing
    - Know if your F.I./M.A.C. allows for restorative as a stand alone skill
      - Probably no more than 2 weeks
      - Must have 6x/week in 2 areas at least 15 minutes each, licensed progress notes (can be written by R.A. and countersigned by nurse), and care plan
      - Must have goals for continued improvement
      - Recommend an MD order is in place

Documentation Guidelines

The key to success is appropriate/accurate documentation
Daily Management

- **ADL Score**
  - One of the most inaccurate areas in the DAVe audits
    - Facilities tend to under code this area
  - Remember to include care delivered around the clock
    - Many residents require increased levels of care at night
  - Monitor ADL care given by all disciplines
    - In therapy, activities, esp. with the Nursing Assistants on all shifts
  - Code for actual care delivered not what you think the resident is capable of doing

Daily Management

- ADL Score (0-16)
  - **B**ed Mobility (0-4 Points)
  - **E**ating (0-4 Points)
  - **T**oilet Use (0-4 Points)
  - **T**ransfers (0-4 Points)
    - One incorrect coding of an ADL category from limited to extensive assist or number of assist required can cost over $120/day
Ancillary Management

- DME/Dressing Supplies/Oxygen
  - Are we using the most cost effective appropriate treatment for the resident
  - Know what cost entail on a daily basis
  - Monitor Supplies/adaptive equipment ordered
    - Be sure any special equipment for the resident is labeled
      - Custom W/C’s, W/C cushions, Dressing and O2 supplies, IV/Tube feeding supplies

Ancillary Management

- Pharmacy Cost
  - Know the medication regimen prior to admit
  - Is there a less expensive equal alternative?
  - Discuss any changes in medication treatment
    - Especially IV therapy, Epogen, Neupogen type medications
  - Monitor your pharmacy bills to ensure the charges are correct
    - Correct medication for patients and price
  - Watch for house stock medications being ordered as resident specific from the pharmacy
  - Use your pharmacist’s recommendations
Ancillary Management

- Lab/X-Ray/Radiology Charges
  - Review upcoming procedures
  - Watch for unnecessary procedures and repeat procedures
    - Know what was performed in the hospital and have available for Primary Physician
    - Repeat stable tests (can frequency be decreased)
  - Monitor invoices at the end of the month to ensure accurate prices and that test were actually performed on the stated resident’s in a part A stay
  - Are Medicare consolidating billing exclusions performed in an outpatient hospital rather than at the MD’s office

Ancillary Management

- Excludes services when performed in outpatient hospital setting:
  - Cardiac Catheterization
  - CT Scans
  - MRI/MRA
  - Radiation Therapy
  - Angiography
  - Venous Procedures
  - Lymphatic Procedures
  - Ambulatory Surgery involving the use of an Operating Room
  - Certain Chemotherapy Drugs and Administration Services
  - Dialysis and ambulance transport
  - Physician Professional Services
  - Certain Emergency Room Services
  ***Reviewing PET Scans for possible exclusion
Ancillary Management

- **Physician Outpatient Visits**
  - Watch for Outpatient Procedures and Visits
    - Physicians can bill separately for the professional component
    - Bill us directly for the technical component
      - Example: Resident goes for MD appt and blood work is drawn, we pay for actual blood work, but the physician can bill for interpretation on the labs
    - Do you and the physician have an authorization form in place to perform tests on a Part A resident
    - Is the physician willing to perform certain tests in an outpatient hospital setting
    - What tests can be done at the facility prior to the resident’s visit to the physician’s office (i.e. labs, portable x-ray)

- **Physician Outpatient Visits**
  - Do you have a Provider Agreement in Place
    - CMS requires that an “arrangement” contract be in place with any outside supplier (Medlearn Matters article from May ’04)
    - The absence of a written agreement with the supplier risks not being paid for services
    - The facility may also be liable for failing to inform the outside entity that the resident is in a Part A stay causing the provider to incorrectly bill Part B
    - CMS has no standard form for this but is working on it
Ancillary Management

- Use the **SNF Consolidated Billing Annual FI/MAC Update File** (formerly the SNF Help File) on the CMS website to help find what the facility is liable for or whether the physician or service provider can bill separately.
- Reimburse at the Medicare Allowable Rate with the correlating HCPCS code, also available on the CMS website, not the actual amount charged with mark-up (which can be over 1000%).
  - CMS actually only pays 80% of this rate.
- The provider should know ahead of time on your intention to pay at the Medicare Allowable Rate to avoid any confusion after the services have already been rendered (include with Provider Agreement or Continuity Form).

Ancillary Management

- **Transportation**
  - Monitor how your resident gets to outpatient destinations.
  - Is an ambulance necessary vs. chair.
  - Does the facility have a transport vehicle.
  - Know what is covered for ambulance transport.
    - ER Trips, Dialysis, Outpatient visits for consolidated billing exclusions: cardiac cath, MRI/MRA, CT scans, radiation therapy, etc.)
## DAILY MEETING

- Keep the meetings brief and to the point
  - Divert unnecessary non-team related conversations
- Expect team members to come prepared with the information they are expected to provide
- Wait until weekly meeting to elaborate if needed (i.e. ICD-9 code changes, future discharge plans)
- Have log updated and available for the month end close process

## Ongoing Management

- Continue to monitor residents in their **30 day window** for any presence of returned skilled needs
  - Number of days available after the part A stay
  - Return to Part A without a hospital stay
- Monitor for **60 day break in skilled needs** to see when the resident is eligible for a new benefit period/spell of illness
Daily Management

- Monitor the status of “non-coverage letters”, SNF ABN forms
  - Generic Notice (CMS Form 10123)
    - Beneficiary has 48 hours to request an expedited appeal
  - Detailed Notice (CMS Form 10124)
    - Will be requested by QIO if appeal requested by beneficiary
  - Keep MDS cycle going if QIO review or demand bill is requested or CMA review is anticipated
- SNF ABN form is available on CMS website (Form # CMS-10055) www.cms.hhs.gov/medicare/bni for Part A
  - CMS is still working on final draft (will probably be different from current form available on the website)
  - The intention is to replace all of the other forms (determination for continued stay, determination upon admission, etc.)

Month End Close

- Reconciliation with Business Office, MDS Coordinator, and Therapy Department
  - Verify:
    - Certification/Recertification are updated (including therapy certs)
      - SNF care must be certified upon admit, within the first 14 days and then every 30 days thereafter
    - Have MDS’ been transmitted and accepted into the state data base
    - MDS Info on UB-04: ARD’s, RUGS-IV Classification, days in each category, correct HIPPS codes
    - Therapy Charges (Do they support the RUG score?)
    - Ancillary Charges (Are they appropriate?, Were they delivered?)
ANY QUESTIONS?

THE MEDICAID CASE MIX PROCESS
Objectives

Participants will gain:

• Understanding of the Medicaid Case Mix Process
• Knowledge to implement an effective weekly meeting involving the interdisciplinary team
• Understanding of the importance of the relationship between the clinical team and the therapy department
• The skills to implement an effective Part B program
• The ability to withstand audit scrutiny
• Overview of the potential changes to the process

Overview

Most states have or are planning to move to the RUG-IV system

• Directly driven from MDS data
• 48 Group model seems to be what most states are implementing
• It uses all of the clinical/non-therapy categories
• Use one therapy category “RA” which is the equivalent of “RM” with 5 ADL index breakdowns “A-E” as is used in many of the clinical categories
• There are also many factors that vary state to state that tie into the rate. I.e. cost report information, capital cost components
Weekly IDT review

Recommended team members

- Nursing leaders
- MDS
- Therapy
- Activities
- Social Services

Daily review at clinical report for any potential significant changes in status and changes in treatment

Weekly Case Mix/Medicaid Review

Review of the long term care residents that are coming due for an MDS assessment in the next 30 days

Review previous RUG score

Monitor for the potential need for Part B therapy

- Recommend quarterly Therapy screens are conducted during this 30 day window

RUG utilization review

- Review to see what clinical indicators are present and the time frames in which they are delivered
RUG Score Projections

- Clinical Indicators
- ADL Status
  - Do you have a mechanism to review daily changes in ADL status?
  - Most electronic systems have an ADL index report
- End Splits
- Restorative Program
- Behavioral Indicators

Estimated Case Mix Index (CMI)

Review Process

Ensure the team understands the elements of the RUG system

Diagnosis capture
- For example, if a resident has a diagnosis of CVA is there the presence of hemiplegia
  - Often find that this is documented in therapy notes but there is no supporting physician diagnosis

ADL’s

Restorative nursing

Respiratory Therapy

Behavior monitoring and documentation
Restorative Nursing

Restorative nursing program

- Must have 2 programs consisting of at least 15 minutes per day per program
- Must have measurable objectives and interventions documented in the care plan
- Must have periodic evaluation by a licensed nurse and be documented in the medical record
- Nursing assistants must be trained in techniques that promote resident involvement
- Does not include groups with more than four members

Respiratory Therapy

- Appropriate capture of Respiratory Therapy
  - Must total 15 minutes per day and be captured 7 days
  - Remember “assessment” time captured must be completed by an RN
- Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.
Common Challenges

- Watch for increased frequency of MDS’
- Missed significant changes in status assessments
- Inaccurate coding of MDS’
- Lack of supporting documentation
- Lack of team coordination
- RUG confusion
  - More likely when using RUG-III system for Medicaid as RUG-IV is used for Medicare PPS
- Watch for dips in CMI during the “off-cycle”

Case Mix Rate

Currently NY case mix consists of multiple components

- Direct costs
- Indirect costs
- Non-comparable costs
- Capital expenditures
Case Mix Index

53 RUG III Levels (current system used)

- Rehabilitation
- Extensive Services
- Special Care
- Clinically Complex
- Impaired Cognition
- Behavior Only
- Physical Function Reduced

There are currently 2 picture window dates—Last Wednesday of January and July

Case Mix Assessment Schedule

I recommend to keep the CMI process going everyday all year as most states review every 3 months

Only OBRA assessments—Annual, Quarterlies, Significant Changes and Significant Corrections of Prior Assessments

Additional assessments
- Significant Change in Status
- OBRA assessment after a change in payer source
- Hospice assessments when on or off of service

Assessments must be completed within 92 days of previous assessment
**Strategies for Success**

- Run an effective meeting
- Screening process
- Having a strong and well run Part B therapy program
- Communication between nursing and rehabilitation
- Knowledge of definitions
- Maintaining compliance with MDS process
- Accurate MDS coding
- Back up systems in place- support for MDS department, “Assistant Therapy Director”

**Managed Medicaid Model**

- NY potentially looking at conversion from 2014-2017
- Involves Managed Care Organizations managing the process

**Pro’s and Cons’ to the system**
- Multiple different entities in the process
- A/R timing generally triples to quadruple
- Increased denials
- May help overall reimbursement as the rate is generally resident specific
- Can potentially save the overall Medicaid system money
QUESTIONS

“How to Maximize Your Part B Therapy Program”

Presented By:
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Course Objectives

- Discuss what an effective and efficient Part B therapy program should look like
- Integrate the clinical and fiscal outcomes of the therapy department with the goals of the facility
- Describe proven strategies to best meet your resident population’s needs
- Improve clinical control of care programs and delivery that will survive audit scrutiny

Medicare Part B Eligibility and Enrollment

- Individuals residing in the United States who become entitled to premium-free Part A are automatically enrolled in Part B
- A person age 65 or older who is not entitled to premium-free Part A must:
  - United States resident and either a citizen, or an alien who has been lawfully admitted for permanent residence with 5 years continuous residence at time of filing
  - Individuals who are not eligible for automatic enrollment, or who previously refused Part B, or who terminated their Part B enrollment, may enroll (or re-enroll) only during prescribed enrollment periods
    - 4 Enrollment Periods: EIP, GIP, SEP (2 Versions)
Medicare Part B Eligibility and Enrollment

Termination of Enrollment

- By voluntary request
- Failure to pay premiums
- For individual under 65 (disabled and ESRD) – because their Part A entitlement ended
- Death of the beneficiary

Medicare Part B Outpatient Therapy Benefit

- Outpatient occupational therapy, physical therapy and speech-language pathology services are a covered Medicare benefit as outlined in Title XVIII of the Social Security Act
- Outpatient therapy services may also be provided incident to the services of a physician or non-physician practitioner
- Services may be provided on an ambulatory outpatient basis as well as to inpatients and homebound individuals who do not have Part A benefits, who do not qualify for Part A services, or who have exhausted Part A benefits
Medicare Part B Outpatient Therapy Benefit (cont)

- Covered services: PT, OT and SLP evaluations and treatments.
  - Must be medically necessary for the diagnosis and treatment of impairments, functional limitations, disabilities, or changes in physical function and health status provided:
    - A plan for furnishing services was established by a clinician
    - The beneficiary was under the care of a physician
    - The plan is certified/recertified for an applicable payment period and periodically reviewed by a physician or non-physician practitioner

Medicare Part B Outpatient Therapy Benefit (cont)

- The Therapy Plan of Care (evaluation) must contain at a minimum:
  - Diagnosis(es) – Medical and Treatment
  - Long-term treatment goals
  - Type of therapy (OT, PT, or SLP)
  - Amount of therapy (number of times in a day)
    - Once a day versus BID treatment
  - Frequency (number of times in a week)
  - Duration (time to long-term goals in weeks or treatment sessions)
  - Dated physician or NPP signature will meet the certification requirement.
Medical Necessity

- The services must be of a level of complexity and sophistication that requires specific knowledge, skill, judgment, and services can only be performed by a licensed therapist or assistant
- The patient is expected to improve materially in a reasonable and generally predictable amount of time
- The services are necessary to safely and effectively establish a maintenance program
- Interventions must be consistent with accepted standards of medical practice and be specific for the condition of the patient
- The intensity, frequency, and duration of treatment are reasonable and appropriate for the individual patient

Skills of a Therapist

- Evidenced in documentation by emphasizing the subjective reports and objective descriptions of changes necessitating the skills of the therapist/assistant
- Best practice recommendation is to document therapist skill by indicating/describing all physical/tactile, cognitive/verbal, and visual cues provided during therapy intervention
Medicare Part B Outpatient Therapy Cap

- Balance Budget Act of 1997 enacted financial limits (caps) on outpatient OT separately and outpatient PT and SLP combined
- The caps limited the annual amount of outpatient therapy services a beneficiary could receive regardless of condition or need
- Applied to all outpatient settings except outpatient hospital

Medicare Part B Outpatient Therapy Cap (cont)

- Deficit Reduction Act of 2005 enacted exceptions to the cap
- Several Acts since then have extended and clarified the caps exception process (see next slide).
- For 2014, the therapy caps are $1,920 for OT and $1,920 for PT and SLP combined. An increase of $20 from 2013 caps.
- Providers submit claims with a KX modifier to indicate an exception to the cap was provided and appropriate
Medicare Part B Outpatient Therapy Cap (cont)

- Law directs CMS to continue to allow exceptions to therapy caps for medically necessary services provided through March 31, 2014.
- Part B claims between $1920 and $3700 are eligible for the automatic exception process.
  - KX modifier for claims
    - Qualifies for the cap exception
    - Services are reasonable and necessary services that require the skills of a therapist
    - Are justified by appropriate documentation in the medical record
- Currently there is no advance approval required.

Medicare Part B Outpatient Therapy Cap (4)

- Alternatives to the therapy caps are being explored including the requirement of additional or modified reporting to provide functional outcome data and new coding and bundled per-session payments
- CMS Developing Outpatient Therapy Payment Alternatives (DOTPA) Project
  - RTI contracted by CMS to gather data upon Admission and Discharge from therapy services for Medicare Part B residents for 6 month time frame
  - Participating facilities are exempt from MAC/RAC audits during the data collection time frame
Medicare Part B Physician Fee Screen

- The Part B fee screen for each procedure is comprised of three Relative Value Unit (RVU) components:
  - Work component
  - Practice expense component
  - Malpractice component
- The three components are valued, then added together and multiplied by a constant Conversion Factor in order to obtain a Full Rate
- Some procedures are time based and others are serviced based (and may only be billed once per day per discipline)

Multiple Procedure Payment Reduction

- Physician Payment and Therapy Relief Act of 2010 codified the modification of the multiple payment procedure reduction (MPPR) by applying a reduction to the practice expense (PE) component for the second and subsequent billed SNF outpatient therapy services
  - 50% reduction for Skilled Nursing Facilities effective April 1st, 2013
  - 20% for office-based therapy services
  - CMS expects that MPPR will decrease therapy payment by 15%
- The PE component identifies the expected cost for preparing a patient for a procedure and is intended to reimburse providers for such costs
Multiple Procedure Payment Reduction (2)

- CMS believes that since the PE component is part of every therapy procedure, providers are being overpaid for prep time when more than one procedure is performed in a day for a patient.
- MPPR applies to OT, PT, and SLP services when performed on the same day for the same patient and reflects that the PE component has been reduced for multiple procedures and multiple units.
- The reduction applies to HCPCS codes contained on the list of “always therapy” services on the Medicare Physician Fee Screen.

Correct Coding Initiative - Modifier 59

- CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims.
- The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported.
- The NCCI contains two tables of edits:
  - The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.
Correct Coding Initiative - Modifier 59 (2)

- **Definition** - The “-59” modifier is used to indicate a distinct procedural service. The clinician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure, different site, or separate injury (or area of injury in extensive injuries).

Correct Coding Initiative - Modifier 59 (3)

- **Rationale** - Multiple services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, a modifier was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service.
- Crosses all three therapy disciplines
- Is applied when you have component CPT codes being billed at the same time as a comprehensive CPT code
Correct Coding Initiative - Modifier 59 (4)

**Example**

92507 (Treatment of speech, language, voice, communication and/or auditory processing) is a comprehensive code expected to encompass oral motor therapeutic exercise, self-care management training, cognitive skills training, etc. Therefore, when 97110 (therapeutic exercise), 97532 (Cognitive skills development), or 97535 (Self care management training) are billed under Physical and/or Occupational Therapy – a modifier-59 needs to be applied to the component codes with supporting documentation of service (even though the resident received services from all three therapy disciplines).

Functional Maintenance Programs

- The specialized skill, knowledge and judgment of a therapist may be required, and services are covered, to design or establish a maintenance program, assure patient safety, train the patient, family members, caregiver, and/or unskilled personnel and make infrequent but periodic reevaluations of the program
- May be concurrent with rehabilitative treatment
- May evaluate and establish a maintenance program without rehabilitation therapy being indicated
Functional Maintenance Programs (2)

- When the intent of therapy is not necessarily rehabilitative, but to develop a maintenance program to delay or minimize functional deterioration, instructing patients and/or caregivers is expected to require 2-4 visits with supporting documentation being necessary to justify more visits
  - Patient/Caregiver Training
  - Environmental Modification

Billing of Timed Code Treatment Minutes

- To determine the total allowable units, based on the total Timed Code Treatment minutes:

<table>
<thead>
<tr>
<th>Units</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8-22 mins</td>
</tr>
<tr>
<td>2</td>
<td>23-37 mins</td>
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<tr>
<td>3</td>
<td>38-52 mins</td>
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<tr>
<td>4</td>
<td>53-67 mins</td>
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<tr>
<td>5</td>
<td>68-82 mins</td>
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<tr>
<td>6</td>
<td>83-97 mins</td>
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<tr>
<td>7</td>
<td>98-112 mins</td>
</tr>
<tr>
<td>8</td>
<td>113-127 mins</td>
</tr>
</tbody>
</table>

- Each code provided for 15 minutes should be billed 1 unit and then the remaining minutes should be totaled to determine if and which additional code should be billed
Billing of Timed Code Treatment Minutes (2)

**Example 1**
30 minutes: PT Evaluation (97001)
25 minutes: Therapeutic Exercise (97110)
18 minutes: Gait Training (97116)

**Correct Billing is:**
1 unit of 97001 (PT Evaluation is untimed)
1 unit of 97110 (15 minute block, 10 minutes remaining)
1 unit of 97116 (15 minute block, 3 minutes remaining)
1 additional unit of 97110 should be billed as it has the highest remaining minutes of the two timed codes

Billing of Timed Code Treatment Minutes (3)

**Example 2**
32 minutes: Self-care Management (97535)
7 minutes: Therapeutic Activity (97530)

**Correct Billing is:**
2 units of 97535 (2 15 minute blocks, 2 minutes remaining)
1 unit of 97530 (0 15 minute blocks, 7 minutes remaining)
The 1 unit of 97530 is billed, despite not having a 15 minute block, because it has the highest remaining minutes where the total of 39 minutes provides for 3 timed units to be billed
Billing of Timed Code Treatment Minutes (4)

Example 3
7 minutes: Neuromuscular Reeducation (97112)
7 minutes: Therapeutic Activity (97530)
7 minutes: Manual Therapy (97140)

**Correct Billing is:**
The clinician shall select which CPT code to bill since each service was performed for the same amount of time and only 1 unit is allowed.

97112 - $30.20, 97530 - $31.49, 97140 - $27.22

I recommend selecting the highest reimbursing CPT code!!

Part B Program Development

What Can Facilities Do Right Now?
- Complete screen requests timely and with customer service
- Observe main dining room during a meal
- Observe/Co-lead an activity session
- Review Restorative Programs
- Implement and maintain splint/brace/prosthetic log
- Implement and maintain thickened liquid/alt. diet log
- Encourage Outpatient Therapy where appropriate
Therapy Screens

- **Screening** is a preliminary process of gathering and integrating information to determine the need for further examination or intervention.
- Based on a problem-focused, systematic collection and analysis of data to identify individuals in need of physical, occupational, or speech therapy intervention or other health care services.
- A screen is a process involving patient observation, chart review, and discussion with nursing staff.
- The purpose of a screen is to determine if an initial evaluation by a Physical, Occupational, or Speech Therapist is indicated.
- Many states permit a physical/occupational therapy assistant to perform a screen; however, some take the position against (Mass).

Therapy Screens (2)

- Facilities should establish a process in which screen requests for therapy services are formally presented to the therapy department when a decline of function is noted.
- All facility departments and caregivers (including family members) should be educated on the screen referral process.
- Once received the therapy department should respond to the screen request as timely as possible (encourage to be same day or at the latest within 24 hours).
Therapy Screens (3)

Physical Therapy:
- Change in Functional Abilities
  - Bed Mobility
  - Transfers
  - Ambulation
  - Wheelchair Mobility
- Change in Posture/Positioning
  - Positioning in bed, chair, wheelchair
  - Postural Changes and Body Control
  - Contractures
  - Continued effectiveness of current orthotics/prosthetics

Therapy Screens (4)

Physical Therapy (continued):
- Change in Balance/Safety
  - Falls
  - Balance Difficulties sitting or standing
  - Restraint Reduction
  - Coordination and Functional Reach
  - Environmental Safety
- Change in Physical Function
  - Strength
  - Endurance
  - Range of Motion
### Therapy Screens (5)

**Physical Therapy (continued):**

- **Physiologic Changes**
  - Pain Management
  - Skin Integrity/Wound Management
  - Bowel/Bladder Management
  - Cardio-pulmonary system
  - Diabetes/Edema/Vascular system
  - Vertigo/Dizziness

### Therapy Screens (6)

**Occupational Therapy:**

- **Change in Function**
  - Self-care Management
  - Difficulty Feeding
  - Bed Mobility, Wheelchair Mobility, and Transfers
  - Decreased participation in Activities and Leisure Interests

- **Change in Posture/Positioning**
  - Positioning in bed/chair/wheelchair
  - Postural Changes and Body Control
  - Restraint Reduction
  - Contracture Management
### Therapy Screens (7)

**Occupational Therapy (continued):**

- Change in Coordination
  - Fine Motor Skills
  - Gross Motor Skills
  - Sensation
- Change in Physical Function
  - Strength
  - Activity Tolerance
  - Range of Motion
- Change in Visual/Perception
  - Visual Skills and Safety Hazard Recognition

### Therapy Screens (8)

**Occupational Therapy (continued):**

- Physiologic Changes
  - Pain Management
  - Skin Integrity
  - Bowel and Bladder Management
  - Edema/Vascular system
- Cognition and Behaviors
  - Changes in Mental Status and Function (attention and concentration)
  - Behavior Management
  - Environmental Modification
  - Difficulty in memory/problem solving/decision making/sequencing
Therapy Screens (9)

Speech Language Pathology:
- Change in Eating/Swallowing
  - Difficulty Chewing and Swallowing
  - Muscle Weakness (Oral Motor)
  - Difficulty taking medicine
  - Oral Discomfort
  - Aspiration (Entry of food/liquid into the airway below vocal folds)
- Change in Nutrition
  - Weight Loss
  - Diet Changes
  - Tube Feed Reduction

Therapy Screens (10)

Speech Language Pathology (continued):
- Communication
  - Difficulty making needs known
  - Difficulty understanding
  - Problems with word finding, articulation, audibility
  - Difficulty hearing
- Cognition
  - Deficits in memory, problem solving, decision-making, sequencing, attention, concentration, etc.
  - Behavior Management
Therapy Screens (11)

Respond with Exceptional Customer Service

- If the therapy referral was appropriate and led to an evaluation, thank the referral source and promise to keep he/she posted on the course of therapy and continue to encourage additional referrals
- If the therapy referral did not lead to an evaluation, thank the referral source, educate on the conditions that would have constituted a course of therapy, and assure that the resident’s condition will continue to be monitored for potential therapy intervention

Dining Room – Meal Observation

- Occupational Therapists and Speech Language Pathologists are encouraged to observe resident dining hours for:
  - Challenges with self-feeding due to limited strength, endurance, range of motion, coordination, perception, cognition, etc.
  - Signs and symptoms of swallowing problems (aspiration) such as watery eyes, runny nose, cough, holding food in mouth, leakage of food from mouth, complaints of discomfort with diet, etc.
- Therapists utilize a course of therapeutic exercise, therapeutic activity, self-care management including adaptive equipment, swallowing treatment, and cognitive retraining as needed to improve function and safety
Activities – Observation and Co-leading

- Occupational and Physical Therapists should observe and at times co-lead activity sessions in order to:
  - Ensure that activities are graded to match residents’ physical and cognitive abilities and note changes from baseline performance
    - If the selected activity has been presented at too low a level for a resident, often you will find the resident becoming restless, exhibit disruptive behaviors, or even trying to exit the activity session
    - If the selected activity has been presented at too high a level for a resident, often you will find the resident becoming restless, confused, or even asleep during the session
  - Become aware of residents who may be having increased room isolation

Restorative Programs

- Designed to follow therapy interventions and maintain resident progress/independence/quality of life
- Reduce the risk of secondary complications, illness and infection associated with functional decline
- Meetings should occur routinely between the restorative and therapy department to:
  - Ensure programs are being carried out as instructed and resident progress towards goals is being tracked
  - Barriers to progress or unanticipated gains are reported to therapy for potential therapy intervention or modification of the program
  - Communication and competency remain effective
Splint/Brace/Prosthetic Log

- Physical and Occupational Therapy should have a master log of all residents with active treatment programs for orthotics (splints), braces, and prosthetics
- Log should be routinely reviewed to ensure:
  - Devices are in active use and are being appropriately applied per an established schedule
  - Skin integrity and color are intact (no abnormal redness or skin deterioration)
  - Range of motion is being performed along with the skin checks pre and post splint application
- Lost devices, inconsistent application, and failure to monitor skin/joint integrity are easy citations for surveys

Alternate Diet/Thickened Liquid Log

- Occupational and Speech Therapy should have a master log of all residents on an altered diet, thickened liquids, and/or who have been issued adaptive equipment to assist with self-feeding
- Log should be routinely reviewed to ensure:
  - Diet and liquid status is being followed and tolerated as established and consistent with physician orders
  - Adaptive equipment remains present and is utilized appropriately and residents are supported at appropriate level of care
  - Resident positioning is conducive to support eating and feeding at highest level of independence at least restrictive diet
Community Outpatient Therapy

- Determine if facility is conducive to providing community-based outpatient therapy services
- Although no formal regulations are in place, check with the State Department of Health for procedural expectations such as:
  - Clinic entrance and waiting area sufficiency
  - Conflict with SNF resident rooms and common areas
  - Access to emergency medical services
  - Retention of medical records
  - Access to treatment area and equipment
- Start by offering continuation services to Part A discharges

Part B Program Development

What Can Facilities Do With a Little Planning?

- Obtain Quarterly Screen List
- Review Quality Measure Report (6 mth)
- Review ADL Documentation
- Attend key clinical meetings:
  - Falls/Restraint Reduction
  - Weight Loss/Skin Integrity
  - Quality Assurance
- Conduct staff inservices:
  - Rehab Indicators and referral process
  - Gen. Orientation: Smart Mechanics/Safe Patient Handling Techniques/ADLs/Swallowing, etc.
Quarterly Screen Process

- Obtain a list of residents each month from the MDS Department whose quarterly/annual MDS Assessment is required to be completed
- Complete a Therapy Screen of the residents on the list at least 2 weeks in advance of the Quarterly Assessment Reference Window
  - This will ensure that patients in need of and receiving therapy services will be captured and reflected on the MDS
  - Rehab RUG scores often will carry a Medicaid case mix score that will capture over a Nursing RUG score
  - Familiarize yourself with State Medicaid RUG scores as States may utilize a different RUG System and Case Mix than Medicare

ADL Documentation

- Whether electronic or manual all facilities document on resident performance and how much staff support was needed to complete Activities of Daily Living
- If an electronic system is utilized, reports can be generated which will compare a resident’s performance and support levels from one period of time to another in order to note functional declines, stabilization, or improvement
- A therapy screen should be completed whenever a functional decline or improvement is noted to determine if further therapy intervention is necessary
Key Clinical Meetings

- Facilities traditionally hold key clinical meetings to discuss the following areas which may require therapy intervention:
  - Falls – recent falls with or without injury
    - Should have both a Fall Prevention and Fall Intervention Program
    - Should use standardized testing to provide objective data to support program recommendations:
      - Timed Up and Go (TUG)
      - Tinetti Gait, Balance, Combined
      - Functional Reach
      - Berg
      - M-GARS

Key Clinical Meetings (cont)

<table>
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<tr>
<th>Area of Review</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Test (y/n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of fall in the last 6 months.</td>
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<tr>
<td>Medical diagnoses that may contribute to falls.</td>
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<tr>
<td>Possible risk hypotension or orthostatic hypotension.</td>
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<tr>
<td>Documented osteoporosis. (Increased risk of injury with fall.)</td>
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<tr>
<td>Medications that may contribute to falls.</td>
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<tr>
<td>Incontinence.</td>
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<tr>
<td>Visual deficits.</td>
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<tr>
<td>Physical condition or impairment that may contribute to falls.</td>
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<tr>
<td>Cognitive impairment or behavior issues affecting safety awareness.</td>
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<tr>
<td>Physical environment concerns.</td>
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<tr>
<td>Strength deficits that may contribute to falls.</td>
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<tr>
<td>ROM deficits that may contribute to falls.</td>
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<tr>
<td>Balance deficits that may contribute to falls.</td>
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<tr>
<td>Special tests indicate mobility, balance, gait, or cognitive deficits that may contribute to falls. (Ex. Berg, M-GARS, Tinetti, Functional Reach, TUG, etc.)</td>
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</tr>
</tbody>
</table>
Key Clinical Meetings (cont)

- **Restraint Review**
  - Determine devices utilized in the facility and make an official least restrictive to most restrictive list
  - Look for opportunities to reduce the restraint or to lessen the amount of time the resident is restrained
  - Assess posture, trunk and limb control, endurance, cognition, behaviors/tendencies, etc.

- **Skin Review**
  - Pressure areas in need of relief through positioning and equipment intervention
  - Wound care
  - Skin breakdown due to contractures, edema, moisture, sheering, etc.
  - Nutrition

Key Clinical Meetings (cont)

- **Weight Loss – Unplanned significant weight loss or gain**
  - Swallowing relation – Modified Barium Swallow Study
  - Oral Motor (mouth muscular) weakness
  - Poor dentition
  - Pathology
  - Nutrition
  - Increased activity or inactivity
  - Cognitive changes
  - Behavioral changes
  - Functional decline
**Inservices**

- Introduction to OT, PT, and SLP Personnel/Services
- Rehab Indicators and Referral Process
- Smart Mechanics/Safe Patient Handling
- Swallowing and Diet Modification
- Adaptive Equipment for Activities of Daily Living
- Dementia Capable Care and Environmental Modification
- Success Stories

**Referral Program Indicators**

- Holding food or meds in mouth
- Choking, coughing, watery eyes or runny nose with food or drink
- Decreased food intake, or recent weight loss
- Decreased participation in activities
- Change in ability to understand or be understood
- Recent falls
- Change in walking or getting in/out of bed or chair
- Decreased strength
- Sliding/Leaning in chair
- Change in ability to dress, toilet, groom, or feed self
- Arms, hands, legs, become stiff or tight
Part B Program Development

What Can Facilities Do With a Team Effort?
- Referral Recognition Plan
- Implement a Walk-to-Dine Program
- Implement Rehab Dining Program
- Implement Seating and Positioning Program
- Implement Dementia Therapy Program
- Implement Modalities Program
- Implement Incontinence Management Program
- Encourage Professional Development and Training

Referral Recognition Program

- Objective is to encourage referrals outside the therapy department
- Define your recognition program
- Promote through inservice with emphasis on where and how recognized referrals for the month will be displayed
- Make a “Big Deal” about it!
- Can configure for individual, department, unit recognition and run monthly/annual/both
Walk-to-Dine Program

- Establish Committee
- Determine Procedure
- Identify Candidates
- Identify Tracking Method
- Make it FUN!
- Track Referrals/Educational Opportunities
Rehab Dining Program

- Primarily Speech Therapy referred/monitored for eating and Occupational Therapy referred/monitored for feeding
- Determine Candidates
- Train Staff
- Observe Program
- Recognize Transition and/or Referral Opportunities
- Dietary Partnership is Critical

Seating and Positioning Program

- Come up with a catchy name: Peety’s Positioning Clinic
- Identify Candidates
- Determine Positioning Device Needs
- Take before and after pictures as appropriate
- Promote Results and Awareness in Community through Vendor Relationships
Dementia Therapy Program

- Additional Training Recommended
- Assess Physical and Cognitive Abilities
- Modify Environment to lend to greatest self-performance success
- Match to performance being documented by Caregivers
- If it matches, establish HABILITATIVE maintenance program
- If a mis-match, establish REHABILITATIVE program, then maintenance program

Modalities Program

- Accelerated Care Plus (ACP) or Alternative Equipment Purchase or Leasing
- Offers continuing education courses and credits all related to the use of modalities in long-term care (Incontinence Programs)
- 20% caseload utilization is approximate return on investment
- Structure relationship with Rep to maximize product benefit
- Track Outcomes
Continuing Ed. and Professional Development

- Diversify treatment team skill set
- Promote Professional Development by setting goals for individuals and the team
- Offer to provide education at a level the target audience can understand
- Make it relevant and be able to provide cost/benefit for approval
- Organization should purchase materials, not individuals

ANY QUESTIONS?
Challenges

- Inappropriate coding on the MDS cost many facilities
  - ADL’s
  - Missing Diagnosis that qualify into certain RUG categories
- Lack of Understanding of Skilled Criteria for Nursing Observation and Assessment
- Lack of documentation on behaviors
- Poor communication amongst departments

Challenges

- Turn Over in Staff
  - What is the cause?
  - Are people crossed trained?
- Increased Time Constraints
- Compliance with MDS completion
  - Are all staff doing their parts?
  - Timeliness of assessments
  - Integrity of coding
  - Late transmissions-only 14 days to transmit
Challenges

- Additional Assessment Types
  - Discharge assessments
  - Start and End of Therapy Assessments
  - Change of Therapy OMRA Educational Needs
  - Does your staff fully understand the process
  - Does everyone know their part in the process
- MDS drives the survey process
  - Errors on the MDS can also equate to survey tags
  - The shift to the QIS survey makes process less subjective

Strategies for Success

- Education
  - Keep your MDS Coordinators and Therapy Directors educated
  - Ensure MDS department is keeping the rest of the staff educated
  - Sign up for the CMS SNF Open Door Forum
    - Call happens every 6th Thursday
    - Information is provided on these calls that is not provided elsewhere
  - Sign up for the CMS SNF List Serve
  - Ensure there are back up
    - For changes
    - Time off
    - Times of increased volume
Strategies for Success

- **Communicate**
  - Daily meetings with the PPS team
  - Listen to what staff are saying
  - Focus on assessments completion daily

- **Redefine the role of the MDS Coordinators**
  - This has become a specialty
  - Is the correct person in the job
  - Are they doing duties that could or should be assigned elsewhere

- **Therapy Department**
  - Daily monitoring of minutes, refusals, treatment tolerance, upcoming appointments

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**Strategies for Success**

- **Respond with a “Sense of Urgency”**
  - Staff the therapy department to be able to dedicate resources as indicated for evaluation and treatment seven days per week.
  - Employ a computerized software product to assist in the planning, scheduling, sustaining and optimal capture of RUG levels.
  - Implement concise daily and more in depth weekly meetings to discuss category tracking, clinical updates, and ensure that potential barriers to the plan of care are quickly identified and action planned as an interdisciplinary team.
  - Develop and implement a functional therapy patient schedule. Greater importance must be placed on assisting the flow of patients to and from the therapy department (as well as between departments in many cases). This may require:
    - Dedicating transportation aides
    - Having unit personnel review the schedule nightly for appointment conflicts
    - Having clinical nursing review the schedule nightly for clinical service conflicts (i.e.: medication management, wound care, bowel and bladder programs, etc.)
Strategies for Success

• Don’t settle for being less efficient
  o Implement a forecasting utilization/staffing tool based on optimal service utilization to ensure that the therapy department has adequate resources to meet the needs of Medicare Part A patients without having to limit services to other beneficiaries.
  o Employ “real-time” management reports to help analyze:
    ▪ Therapy minute threshold over-delivery (greater than 5-7 percent)
    ▪ Therapy minute threshold critical under-delivery (within 5-7 percent of higher reimbursement category)
    ▪ Fiscal impact and minute differential of Change of Therapy (COT) OMRAs
    ▪ Reimbursable productivity by department, by discipline, and by therapist
    ▪ Cost per reimbursable minute
  o Implement and educate therapists on point-of-service documentation strategies.
  o Flex therapy department staffing hours to minimize scheduling conflicts and ensure maximal opportunity to provide services to residents who may be either out for appointment or are experiencing medical complications or setbacks.

Strategies for Success

• Stay the course
  o Develop and implement strategies to ensure optimal, outcome supported lengths of stay.
    ▪ Employ a computerized software product to assist in the tracking of average length of stay by diagnosis, discharge destination, and referral source (if possible).
    ▪ Implement an outcome measure instrument (preferably computerized) and determine performance benchmarks.
    ▪ Educate therapists and nurses with discharge consideration points to review prior to recommending service termination
    ▪ Ensure that adequate restorative nursing resources are available to assist the transition to Rehab Low as clinically indicated for residents transitioning from therapy services to either skilled nursing care or long-term care.
Strategies for Success

• Don’t let therapy remain an island
  o Facility administration should routinely observe the therapy department to:
    ▪ Provide feedback and support
    ▪ Evaluate use or scarcity of department resources
    ▪ Obtain feedback from clinicians on what their perceived needs may be
  o Encourage greater visibility throughout the facility:
    ▪ Dining room observation
    ▪ Activities observation and co-leading
    ▪ Walk-to-dine program sponsorship
    ▪ Dementia therapy programming
  o Attend to results:
    ▪ Month end service reconciliation for accuracy and skilling criteria adherence
    ▪ Quarterly utilization of service report with dedicated goal-action plan
    ▪ Identify success stories
    ▪ Recognize positive gains and benchmark achievement

Strategies for Success

• Look for inefficiencies within the MDS Department
  o Are assessments being completed that don’t need to be
    ▪ Frequently find admission assessments being completed upon readmission
    ▪ Do not perform PPS MDS to early in the ARD window
    ▪ Assess whether MDS Coordinators are in unnecessary meetings
      ▪ i.e., care plan meetings when unit managers are present
    ▪ Assess resident interview ability to deem whether Resident vs. Staff assessment is performed.
Strategies for Success

- Skilled Nursing Services
  - Ensure that staff are aware of non-therapy skilled services
    - Chapter 8 of the Medicare Benefit Policy Manual

- RUG-IV Management
  - Ensure staff understand and all elements of the RUG-IV system to ensure that you are getting paid for the services delivered

- ADL management
  - Monitor ADL’s closely for accuracy and daily ADL index
  - Ensure all staff understand the elements of ADL documentation and the impact on quality and reimbursement
  - Transition to electronic documentation if feasible

Strategies for Success

- Team process
  - All members need to understand their roles
  - What and when needs to be completed

- Accountability
  - All staff need to be held to the same standards
  - Everyone needs to understand the importance of the process

- Meeting Success
  - Must be focused and well run

- Encourage your staff
  - A little Thanks goes a long a way
QUESTIONS

THANK YOU

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