Medicaid Case Mix Strategies

HARMONY UNIVERSITY
The Provider Unit of
Harmony Healthcare International, Inc. (HHI)

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Housekeeping

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- Contact Information for Questions

Objectives

- Identify requirements for scheduling
  OBRA MDS Assessment for Case Mix
- Identify Qualifiers for Case Mix
- Identify key elements of the
  interdisciplinary process for accurate
  Case Mix reimbursement
Medicaid Reimbursement

- Cost based/Flat Rate
  - CT, AL
- Non-MDS Acuity based
  - MA- MMQ
- MDS Case Mix
  - NY, NH, ME, VT, KS, MN, WI, WA...
  - MA July 2013?

Case Mix Theory

- 36 plus states currently use MDS based Case-Mix system
- Theory of value
  - Manage/control expenses
  - Correlates to acuity (partially) with reimbursement
  - Promote efficiency
  - Incentives higher acuity admissions
  - Pay Higher Rates for Higher Acuity

Rhode Island’s Plan

- Quarterly
- Budget Neutrality
- Transition from a facility specific cost based system to a price based model similar to Medicare PPS
- Payment methodology to be phased in over three years
  - Direct and Indirect Care
    - Year 1: 67% facility specific / 33% price based;
    - Year 2: 33% facility specific / 67% price based;
    - Year 3: 100% price based
Massachusetts’ Plan

- Quarterly
- Will have to meet the state's overall revenue neutrality requirement (i.e. it can’t cost more than the current MMQ tool on day one of implementation)
- Conversion from MMQ to MDS/RUG-IV 48 will need to be done simultaneous with the Medicaid nursing facility rate setting cycle, which is July 1st to June 30th each year
- Target date for implementing the new system will be July 1, 2013
- Preliminary decisions have been made

NY Update

- NY notes an increase in CMI from Jan 11 to Jan 12 of 6%, equating to $200 million.
- Delaying July 2012 payments to analyze the increases.
- Considering a cap of 5% for facilities with a significant increase in CMI. If a facility had an increase over 5%, they would receive the balance of payment beyond the 5% cap following an audit.
- Plan to manage may include private contractor audit of MDSs.
OBRA MDS Cycle

- MDS Assessments
  - Admission (comprehensive)
  - Quarterly
  - Annual (comprehensive)
  - Significant Change (SCSA) (comprehensive)

Assessment Reference Date (ARD)

- Drives due date
- "Observation" or "Look Back Period" is the time period over which the resident's condition or status is captured
- Common point in time for all questions
- Includes 11:59 p.m. on ARD
- Different look back periods for questions
  - Only those occurrences during the look back period will be captured

Assessment Reference Date (ARD)

- Schedule is set each quarter as a Master Schedule
  - 12 Week
  - 90 Days
  - 87 Days
- Flexibility is needed to select the best date that represents resources utilized by the resident
Assessment Reference Date (ARD)

- Coordination
- Communication
- Regulatory requirements
  - ARD
  - Interview
  - Completion
  - Transmission

OBRA Schedule

<table>
<thead>
<tr>
<th>MDS Type</th>
<th>ARD</th>
<th>Completion</th>
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<tr>
<td>Admission (Comprehensive)</td>
<td>Admission date + 13 days</td>
<td>14th calendar day of the resident’s admission (admission date + 13 days)</td>
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<tr>
<td>Annual (Comprehensive)</td>
<td>ARD of previous OBRA comprehensive assessment + 366 calendar days AND ARD of previous OBRA Quarterly assessment + 92 Days</td>
<td>ARD + 14 days</td>
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<tr>
<td>Significant Change in Status (SCSA) (Comprehensive)</td>
<td>ARD + 13 previous days</td>
<td>14th calendar day after determination that significant change in resident’s status occurred (determination date + 14 days)</td>
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<tr>
<td>Quarterly (non-comprehensive)</td>
<td>ARD of previous OBRA assessment of any type + 92 calendar days</td>
<td>ARD + 14 calendar days</td>
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</table>

Admission Assessment

A0310A=01

- Exhausted benefit, admit from home or no Medicare eligibility
- High resource utilization
- Potential rehab
- Potential IV Fluids
- Consider day to capture resources versus standard (e.g. day 7)
Frequency of Quarterlies

- The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type.
- Federal requirements dictate that, at a minimum, three Quarterly assessments be completed in each 12-month period.

Significant Change In Status Assessment

**A0310A - 04**

- The ARD must be no later than 14th day after the determination is made that the criteria for a SCSA are met.
- The MDS completion date must be no later than 14th day after determination.

A “significant change” is a **decline or improvement** in a resident’s status that:
- Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not “self-limiting” (for declines only)
- Impacts more than one area of the resident’s health status
- Requires **interdisciplinary review** and/or revision of the care plan.
“Self-Limiting” Defined

- A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions.
- If the condition has not resolved within 2 weeks, staff should begin a SCSA.

Significant Change In Status Assessment

- When a resident’s status changes and it is not clear whether the criteria for a SCSA will be met, the nursing home may take up to 14 days to determine whether the criteria are met.
- After determining that the criteria for a SCSA are met, nursing homes should document the initial identification of a significant change in the resident’s status in the progress notes.

Significant Change In Status Assessment

- There is a determination that a significant change (either improvement or decline) in a resident’s condition from his/her baseline has occurred as indicated by:
  - Comparison of the resident’s current status to the most recent Comprehensive assessment AND
  - Comparison of the resident’s current status to the most recent Quarterly assessment (to avoid creeping)
  - The resident’s condition is not expected to return to baseline within two weeks (newly stated)
Significant Change In Status Assessment

- If there is only one change, staff may still decide that the resident would benefit from a SCSA
  - The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT
  - Decision as to whether or not the resident will benefit from a SCSA
  - Nursing homes must document a rationale, in the resident's medical record, for completing a SCSA that does not meet the criteria for completion

Significant Change Decline

- Decline in two or more of the following (this is not an exhaustive list):
  - Resident's decision-making changes
  - Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment
  - Resident's incontinence pattern changes or there was placement of an indwelling catheter (NEW for 3.0)

Significant Change - Decline

- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days)
- Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status; (NEW)
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before
Significant Change Decline

- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency PHQ-9
- Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (behavior)
- Overall deterioration of resident's condition

Significant Change Improvement

- Improvement in two or more of the following (this is not an exhaustive list):
  - Any improvement in ADL physical functioning area newly coded as Independent, Supervision, or Limited assistance since last assessment
  - Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases
  - Resident's decision-making changes for the better
  - Resident's incontinence pattern changes for the better
  - Overall improvement of resident's condition

SCSA

Residents with Terminal Conditions

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a SCSA assessment is required
- If a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) but remains a resident at the nursing home, a SCSA should be performed regardless of whether an assessment was recently conducted on the resident (NEW)
Snapshot

Most states have **snapshot date**. It is the date that assessments are “culled” from the state database to determine the Average CMI:

- Quarterly versus 6 months
  - NH, NY 6 month
  - Rhode Island, Massachusetts and Vermont quarterly
  - New Jersey is announced after date occurs

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Each state has a range for the allowable ARDs that will be in the snapshot:

- Most Recent OBRA assessment in last 92 Days coded as Medicaid
- Resident specific payment based on most recent MDS
- No Snapshot date and No average CMI
- Maine

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Midnight Census on the snapshot date will be the final determination

- Payor verified by the facility
- Data “culled” by the state MDS database
  - After correction period
  - After new Admission time frames
Which MDS?

- The most recent OBRA assessment coded as Medicaid
  - Some take most recent even if Medicare
  - Some have no general rule (ME)
  - Some utilize Medicare to factor in an offset factor in the rate
- Some states require Medicaid is coded as payor
  - Not on MDS 3.0. May require a Medicaid number in section A
  - State specific Section S coded as Medicaid

Which MDS?

- Discharge assessment and tracking records such as entry/reentry and death in facility do not generate a RUG classification but are required

Which MDS?

- Snapshot period may be extended for new Admissions in snapshot period without an Admission MDS in window
  - On census on snapshot date with Admission assessment with ARD after the set snapshot date
- States may have a the short-stay rate for all residents who stay less than 14 days
Which MDS?

- Medicaid
- Medicaid Hospice
- Managed Medicaid - SCO (Senior care option)
- Non-Skilled

Section S

- State specific
- Not in RAI manual
- Additional add on for certain criteria
  - Vermont: Behavior (request)
  - NY Dementia and BMI
  - Maine and NY: TBI

State Auditors

- States differ in how their case mix is audited by Medicaid
  - “Case Mix Police”
  - MA Sampling (not confirmed). Expect intense audit
  - NH None-Survey only
  - WA has regular visiting state Quality Assurance nurses that review MDSs
  - ME 10% review. ID error rate falls below
  - Nevada-Score based (strict)
Average CMI

- States generate a rate of Medicaid reimbursement that include the average CMI. The rate may include other factors:
  - Inflation
  - Facility costs
  - Clinical/Quality Add-ons
  - Pay for Performance

Average CMI

- Some states weigh each facility’s CMI to other facility’s:
  - Share a pool of money
  - If your facility does well than another facility may lose many
  - New Hampshire

CMI

- Each RUG is assigned a Case Mix Index (CMI) value
- Resources Utilized
- Based on 1.0 as an average acuity
- Values may change after each snapshot
- Reflect the actual state average
RUG Grouper

- Each state has a specific RUG grouper that determines the RUG
  - RUG-III 53 Extensive (NY)
  - RUG-III 34 (NH, Maine)
  - RUG-IV 48 (MA, RI, Vermont)

Hierarchical Versus Index Maximizing

Hierarchical Classification

- Used in some payment systems, in staffing analysis and in many research projects
- You start at the top and work down through the RUG-III model
- When you find the first of the 53 individual RUG-III groups for which the resident qualifies, then assign that group as the RUG-III classification and you are finished

Index Maximizing Classification

- Used in Medicare PPS and most Medicaid payment systems
- Designated Case Mix Indices (CMI) for each RUG group
- The first step: determine all of the RUG group for which the resident qualifies
- Then choose the RUG group that has the highest case mix index
- Simply choosing the group with the highest index
Hierarchical Versus Index Maximizing

While illustrating the hierarchical classification model, it can be adapted for index maximizing

* Evaluate all classification groups
* Ignoring instructions to skip groups and noting each group for which the resident qualifies
* Record the CMI for each of these groups
* Select the group with the highest CMI

CMI

The hierarchy of rates is different for each state grouper

- NH RUG-III; SSC is higher than RAC
- NY RUG-III CC2 SSC
- RI/MA LB1 CB2

Federal State RUG-IV

48 CMI

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Federal State RUG-III
34 (NH) CMI

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Default

- If an MDS is not transmitted the default RUG will apply.
  - PA1
  - BB1
- States may have a penalty for an assessment that is completed and or submitted later than the due date

RUG Add Ons

- May have their own additional criteria requirements
- Maine Extensive Services Traumatic Brain Injury (section I)= SE. End split is based on ADL. SE3 15-18, SE2 10-14 SE1 7-9
- Aphasia=Clinically Complex
- May be similar to Federal/Medicare but different
- Very High Rehabilitation: 450 minutes or more of therapy per week

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Common Rug Grouper Elements

- One Level of Rehab
  - Criteria for Rehab low → Rehab Ultra all have the same CMI. Category is Rehab with end splits for ADL.
  - MA, RI, NH, Maine, NV, WI
- Nursing Only
  - Rehab RUGs excluded

Common Rug Grouper Elements

- Extensive Rehab
  - NY included
  - Not included NH, ME, MA, RI
- Section S of MDS is state Specific and may impact case mix
  - NY Dementia
  - Each State has their own Section S requirements not found in the RAI manual

RUG Grouper

Know the specific clinical requirements for the state specific grouper!!
Late Loss ADLs

There are eleven ADLs that are listed on the Minimum Data Set or MDS. They are bed mobility, transfers, walk in room, walk in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene & bathing.

Late Loss ADLs

Four of these are considered “late loss ADLs” meaning that people retain their functional ability in these four areas the longest. The four late loss ADLs are bed mobility, transfers, eating and toilet use.
Late Loss ADLs

- A resident may lose the ability to dress himself or walk, but may still have the ability to turn in bed, get out of a chair, feed himself and/or assist with using the toilet.

BETT

- Bed mobility (G0110A)
- Eating (G0110H)
- Transfer (G0110B)
- Toilet use (G0110I)

Points to Remember About Self-Performance

- Code resident’s performance, not capacity
- Code resident’s performance not facility policy
ADL Self Performance

- Code the resident's performance over entire shift, not including set-up
  - 0. Independent: No staff assistance or supervision
  - 1. Supervision: Encouragement or cueing provided by the staff

ADL Self Performance

- 2. Limited Assistance: The resident received physical help in guided maneuvering of limbs or other non weight-bearing assistance
- 3. Extensive Assistance: The resident performed part of the activity and received assistance of the following types:
  - Weight-bearing support or
  - Full staff assistance in the task/or portion of the task, during part but not all shift

ADL Self Performance

- Rules of 3
  - Weight-bearing support 3 or more times
  - Extensive Assist
  - Non weight-bearing support 3 or more times code Limited Assist
Self Performance

4. Total Dependence: Full staff assistance of the entire activity each time it occurs. There was no participation by the resident.

8. Activity Did Not Occur
- The activity did not occur or family and/or non-facility staff provided care
- Examples:
  - The resident was on bed rest so transfer did not occur
  - The resident is non-ambulatory

7. Occurred 1 or 2 times

ADL Support

ADL Support Provided: Code for the most support provided over the entire shift
- No Support
- Set up help only
- One person physical assist
- Two or more provided physical assist
- Activity itself did not occur during entire shift

RUG-IV ADL-Step 1

Calculate for Bed Mobility, Transfer and Toilet Use

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RUG-IV ADL-Step 2

Calculate for Eating

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RUG-III ADL-Step 1

Calculate for Bed Mobility, Transfer and Toilet Use

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RUG-III ADL-Step 2

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Bed Mobility

- How resident moves to and from:
  - Lying position
  - Turns side to side
  - Positions body while in bed

Eating

- How the resident eats and drinks (regardless of skill). Includes intake of nourishment by other means, such as:
  - Tube feeding
  - Total parenteral nutrition

Transfer

- How the resident moves between surfaces to/from:
  - bed
  - chair
  - wheelchair
  - standing position (exclude to/from bath and toilet)
Toilet Use

- How the resident:
  - Uses the toilet room (or commode, bedpan, urinal)
  - Transfers on/off toilet
  - Cleanses
  - Changes pads
  - Manages ostomy, manages catheter
  - Adjusts clothes

Documentation Tips

- Code care also observed/reported as provided by other individuals who are on the staff (or contract staff) of the facility
- If the care is provided by family or other non-facility staff for the entire shift, use the code of “8”

Documentation Tips

- Flow Sheet/Trackers reflect the care received by the patient
- It is a must that documentation accurately reflects the true amount of staff time resources required for the care of the patients on the unit
Documentation Tips

- Behaviors, agitation or inability to follow commands which require staff to “touch” or “make physical contact” with the patient is a physical assist in the identified task.
- Determine if assistance was provided with any ADL tasks such as physical assist or tactile cues with transfers, bed mobility, eating or toileting.

Documentation Tips

- An example includes lifting the resident’s hand to place at the edge of the bed in order to rise for transfer or lifting the resident’s foot off the wheelchair pedal in order to transfer.
- Both are examples of Extensive Assistance.

Documentation Tips

- Does the resident require any hands on assistance to start a task due to difficulty with attention, task segmentation or inability to follow verbal cues?
- An example includes lifting the resident’s hand with a cup in it towards the mouth in order to initiate the task of drinking.
- This is an example of Extensive Assist even if the patient completes the meal independently after getting started.
Documentation Tips

- Break each ADL activity into sub-tasks when considering final coding for the shift.

Documentation Tips

- An agitated or aggressive patient may require 2 staff members to provide care for the overall safety of patient and staff.
- A patient may “sundown” and require more hands on assist later in the evening.

Documentation Tips

- Rehabilitation patients may have pain or increased fatigue following therapy programs and thus require more help.
- A patient may be quite capable of performing a task but due to depression or anxiety may lack motivation or become fearful of participating.
**RUG IV ADL Nursing**

- E (15-16)
- D (11-14)
- C (6-10)
- B (2-5)
- A (0-1)

---

**RUG III ADL Nursing**

- Varies by Category (see Handout):
- Example Special Care

<table>
<thead>
<tr>
<th>RUG-III ADL Score</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 – 18</td>
<td>SSC</td>
</tr>
<tr>
<td>15 – 16</td>
<td>SSB</td>
</tr>
<tr>
<td>7 - 14</td>
<td>SSA</td>
</tr>
</tbody>
</table>

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**ADL Defining RUG Qualifier**

- **RUG IV**
  - MS, CP, Quadriplegia, Hemiparesis and Parkinson’s Disease must have ADL score greater than or = 5 ADL score greater than or = 5
  - Coma All ADL must be Dependent or did not occur (4→8)
  - Extensive ADL greater than 2
ADL Defining RUG Qualifier

- RUG III
  - ADL score of 7 or more Extensive and Special Care
  - Coma All ADL must be Dependent or did not occur (4–8)

Extensive Category RUG IV

- Nursing Only:
  - Tracheostomy care
  - Ventilator/respirator
  - Isolation for active infectious disease while a resident

Extensive RUG IV

- O0100M: Isolation or quarantine for active infectious disease does not include standard body/liquid precautions
  - Code only when the resident requires strict isolation or quarantine alone in a separate room because of active infection; (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease in an attempt to prevent spread of illness
Isolation or Quarantine

- Case by case
- Physician order
- Track and document isolation on treatment sheets

Extensive RUG III

- Extensive Services qualification based on ADL Sum >7 and one of the following services:
  - IV feeding in last 7 days
  - IV medications in last 14 days
  - Suctioning in last 14 days
  - Tracheostomy care in last 14 days
  - Ventilator/respirator in last 14 days
- Added to Rehab in NY

RUG III: Extensive Services Count

- RUG III SE Count:
  - Parenteral IV – K5A = 1
  - IV Medication – P1ac = 1
  - Special Care = 1
  - Clinically Complex = 1
  - Impaired Cognition = 1
RUG III: Extensive Services Count

<table>
<thead>
<tr>
<th>Extensive Count</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 or 5</td>
<td>SE3</td>
</tr>
<tr>
<td>2 or 3</td>
<td>SE2</td>
</tr>
<tr>
<td>0 or 1</td>
<td>SE1</td>
</tr>
</tbody>
</table>

Rehabilitation-Single Level

- 150 Minutes and 5 days or more (15 min per day minimum) in any combination of Speech, Occupational or Physical Therapy in last 7 days
- OR
- 45 Minutes and 3 days or more (15 min per day minimum) in any combination of Speech, Occupational or Physical Therapy in last 7 days AND at least 2 nursing rehabilitation services (See nursing rehabilitation qualification)

Rehabilitation-Single Level

<table>
<thead>
<tr>
<th>Rehab</th>
<th>RUG IV</th>
<th>RUG III</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAE</td>
<td>15-16</td>
<td>N/A</td>
</tr>
<tr>
<td>RAD</td>
<td>11-14</td>
<td>17-18</td>
</tr>
<tr>
<td>RAC</td>
<td>6-10</td>
<td>14-16</td>
</tr>
<tr>
<td>RAB</td>
<td>2.5</td>
<td>10-13</td>
</tr>
<tr>
<td>RAA</td>
<td>0-1</td>
<td>4-9</td>
</tr>
</tbody>
</table>
Leveled Rehab:

**High Intensity Criteria** (either (1) or (2) below may qualify):
- 325 minutes or more (total) of therapy per week AND At least 1 discipline for at least 5 days

**Medium Intensity Criteria** (either (1) or (2) below may qualify):
- 150 minutes or more (total) of therapy per week AND at least 5 days of any combination of the 3 disciplines

Category 2: Rehabilitation Low

**Low Intensity Criteria** (either (1) or (2) below may qualify):
- 45 minutes or more (total) of therapy per week AND At least 3 days of any combination of the 3 disciplines AND 2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days
Rehab Case Management

- Know if Rehab will impact!
- Key concepts include:
  - 5 times per a week for Part B
  - Rehab Low with Restorative
  - Quarterly screening 3 weeks prior to quarterly MDS
  - Communication to MDS to schedule MDS when therapy evaluations occur. May be an early quarterly or Significant change

RUG III Leveled Rehab ADLs Splits

<table>
<thead>
<tr>
<th>REHAB RUG-III</th>
<th>RUG-III</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL Score</td>
<td>Class</td>
</tr>
<tr>
<td>15 – 18</td>
<td>R_C</td>
</tr>
<tr>
<td>8 – 14</td>
<td>R_B</td>
</tr>
<tr>
<td>4 – 7</td>
<td>R_A</td>
</tr>
<tr>
<td>REHAB RUG-III</td>
<td>RUG-III</td>
</tr>
<tr>
<td>Extensive</td>
<td>Class</td>
</tr>
<tr>
<td>16-18</td>
<td>R_X</td>
</tr>
<tr>
<td>7 -15</td>
<td>R_L</td>
</tr>
</tbody>
</table>

RUG III: Physician Visit/Order

- RUG III Only
- Number of days in last 14, Physician Visit/order changes:
  - Visits >=1 day and changes =>4 days OR
  - Visits >=2 days and changes =>2 day
- Significant impact on case mix
- Close monitoring
- ARD Management
Depressive Indicators

- **Depression End Splits**: Signs and symptoms of depression are used as a third-level split for the Special Care and Clinically Complex categories
  - D0300 PHQ-9 Total Severity Score is greater than or equal to 10 but not 99
  - or
  - D0600 PHQ-9 Total Severity Score is greater than or equal to 10

Depressive Indicators

- **PHQ-9 Interview**:
  - Accurate completion per RAI requirements in optimal environment
  - Staff Assessment when criteria met

K0500: Nutritional Approaches

- **Parenteral/IV Feeding RUG III/IV**
  - K0500 (Nutritional Approaches) includes any and all nutrition and hydration received by the nursing home resident in the last 7 days, *either at the nursing home, at a hospital as an outpatient or as an inpatient*, provided they were administered for *nutrition or hydration*
Section I: Accurate Diagnosis Coding

- Coma, MS, CP; Hemiparesis, Quadriplegia (III/IV)
- Septicemia, Pneumonia (III/IV)
- (III/IV)
- Parkinson's (IV)
- COPD and shortness of breath while lying flat (IV)
- Dehydration (III)
- Internal Bleed (III)
  - Hematuria

Diabetes

- Diabetes with and 7 days injections:
  - RUG IV: 7 days insulin injection AND Insulin order changes last 7 days on 2 or more days
  - RUG III: 7 days any injection AND any physician order changes on 2 or more days in last 14 days

Fever

- RUG III/IV: Fever (2.4 degrees above baseline) and:
  - Pneumonia
  - Tube feed
  - Vomiting
  - Weight loss
  - Fever and Dehydration (RUG III only)
Respiratory Treatment

Definition:
“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 Treatment

“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.”

Respiratory Treatment

“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.”
Skin

- RUG III/IV with 2 or more skin treatments:
  1. 2 or more venous/arterial ulcers; or
  2. 1 Stage II pressure ulcer and 1 venous/arterial ulcer
  3. 2 or more Stage II pressure ulcers; or
  4. 1 or more Stage III or Stage IV pressure ulcers
  5. Unstageable Ulcer due to eschar
- 2 Stage IIs (RUG III only)

Skin

- RUG III/IV:
  1. Burns
  2. Surgical wound
  3. Open lesion
  4. Foot infection/wounds
  5. Diabetic foot ulcer
  6. Open lesion on foot

Skilled Procedures

- While a Resident RUG IV
  1. In House, ED Visits, Outpatient
- Either While or While not a Resident for RUG III
  1. Provided at acute upon return from Acute
  2. In House, ED Visits, Outpatient
Skilled Procedures

- Following Special Procedures:
  - Radiation therapy, Chemotherapy or dialysis (III/IV)
  - Tube feeding (III/IV)
  - Oxygen therapy (III/IV)
  - Respiratory failure and oxygen therapy (IV)
  - Transfusions (III/IV)
  - IV medication (III/IV)

Behavior-Cognition

- Behavioral Systems and Cognitive Performance Category
  - Behavior and cognitive combined for RUG IV; Separate RUG III
  - ADL Score 5 or less for RUG IV
  - ADL Score of 10 or Less RUG III
  - This is a high functioning resident
  - A BIMS score of less than or equal to 9 will meet the criteria for cognitive impairment

Behavior

- E0100A Hallucinations
- E0100B Delusions
- E0200A Physical behavioral symptoms directed toward others (2 or 3)
- E0200B Verbal behavioral symptoms directed toward others (2 or 3)
- E0200C Other behavioral symptoms not directed toward others (2 or 3)
- E0800 Rejection of care (2 or 3)
- E0900 Wandering (2 or 3)
Reduced Physical

- No other criteria met

Restorative End Split

- Reduced Physical/Behavioral /Cognitive
- End Split is restorative nursing 6 days in 2 areas

Restorative End Split

- Count the number of the following restorative services provided for 15 or more minutes a day for 6 or more of the last 7 days:
  - H0200C, H0500** Urinary toileting program and/or bowel toileting program
  - O0500A,B** Passive and/or active ROM
  - O0500C Splint or brace assistance
  - O0500D,F** Bed mobility and/or walking training
Restorative End Split

- Restorative (Cont.)
  - O0500E Transfer training
  - O0500G Dressing and/or grooming training
  - O0500H Eating and/or swallowing training
  - O0500I Amputation/prostheses care
  - O0500J Communication training

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Restorative End Split

- **Maintaining** independence in activities of daily living and mobility is critically important to most people
  - Functional decline can lead to depression, withdrawal, social

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Restorative End Split

- Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
Restorative End Split

- Restorative needs, but is not a candidate for formalized rehabilitation
- Upon discharge from therapy
- In conjunction with formalized rehabilitation therapy
  - Restorative (therapy 3 Days 15 minutes and Restorative Nursing 6 Days in 2 Areas)
  - Meets Rehab RUG criteria

Restorative Nursing Program Defined

- The following criteria for restorative care must be met:
  - **Measurable objective and interventions** must be documented in the care plan and in the medical record
  - Evidence of periodic evaluation by the licensed nurse must be present in the medical record

Restorative Nursing Program Defined

- RN/LPN Supervision
  - State specific
  - Minimum 30 Days
  - Does not include groups with more than four residents per supervision helper or caregiver
  - Evidence of Restorative Nursing Aid training
ARD Management
- Review schedule and select best ARD
  - Interviews needed so may have lost opportunity if unable to schedule interviews
  - Assessments may be completed early but NEVER late
    - Potential State Deficiency even with 1 late ARD
- Flexibility in ARDs
- Communication between discipline to meet all RAI requirements

ARD Management
- Exhausted benefit while on rehab
  - New admit and on rehab through day 100 Medicare
  - Schedule Quarterly assessment with ARD day after Medicare ends to capture rehab
  - Rehab needs to coordinate ARD and minutes
  - Easier to combine with 90 day PPS but will not be in Case Mix

Admissions
- Schedule Medicaid Admission MDS ARD based on Acuity:
  - ARD, completion and CAAs by day 14
    - Coordination of care-Respiratory Treatment 7 days, Rehab
  - RUG qualifiers
    - NH while not a resident
    - MN While a resident
    - MA?
    - IVF not addressed with addition of 2 columns
Clinical Changes

- Communication with Direct Care Staff:
  - ED visits or hospitalization less than 3 days. May also be exhausted benefit.
  - Skin
  - Respiratory changes
  - ADL decline (CNA/LNA)
  - Falls
  - Acute illness
  - Orders and visits (RUG-III NH,NY)

Clinical Changes

- Acute conditions such as vomiting, respiratory changes, increased pain, changes in behaviors, falls or any other unusual occurrences
- Fevers should be monitored closely especially after a vomiting episode. Any acute condition should be monitored every shift with an entry in the nursing notes for 24 hrs or per facility policy

Case Mix Documentation

- Documentation for the long term care residents is not usually performed on a daily or even weekly basis
- When an acute condition arises it is important for the nursing staff to track and document
- Increase documentation of current status during ARD window
Medicaid Hospice

- Initiation or graduation from Hospice requires Significant change with ARD 14 days after initiation or termination
- Opportunity to capture decline medically
- Opportunity for rehab if improved and Hospice terminated

Summary

- Develop clinical policy and procedure to document RUG qualifiers
- Communicate (Clinical Changes, ARDs…)
- Coordinate (Rehab, Admissions and Social Services…)
- Document
- Prepare for audit

Questions/Answers

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Harmony Healthcare International

Have you Considered a Customized Complimentary HARMONY(HHI) MEDICARE PROGRAM EVALUATION
or CASE MIX ANALYSIS for your Facility?
Perhaps your facility has potential for additional revenue
Benchmark your facility against key indicators and national norms
Email us at for more information
RUGS@harmony-healthcare.com
Analysis is cost & obligation free