Strategies and Best Practices for Managing RUG IV SNF Reimbursement

Objectives

- Provide information on the changes to PPS reimbursement under MDS 3.0/RUG IV for Medicare Part A residents in the SNF
- Provide information on the difference in per diem revenue under RUG IV compared to RUG III payment.
- Review basic concepts and provisions of RUG IV methodology
- Discuss strategies to ensure proper Part A SNF reimbursement for service delivery

Introduction

- Effective October 1, 2010, CMS implemented MDS 3.0 along with an updated RUG system referred to as RUGs IV
- Per CMS, the goal of MDS 3.0 and RUGs IV is to gather information that better assesses the patient and provides more accurate reimbursement based on the resources needed
Background

- Major Changes Impacting Reimbursement
  - The changes fall into 2 categories, those related to MDS 3.0 and those related to RUGs IV
    - MDS 3.0
      - Primarily focuses on redefining data collection with emphasis on “patient voice”
    - RUGs IV
      - Primarily focuses on redistributing the levels of reimbursement based on resource utilization

Update on Legislative Action

- Due to Healthcare Reform legislation RUG IV is delayed 1 year until October 2011.
- This legislation has not been repealed.
- On Oct 1 CMS did implement MDS 3.0 with RUG IV
- If legislation is not repealed CMS plans to implement Hybrid Grouper
  - Hybrid Grouper implementation slated for sometime in 2011 with RUG payments adjusted retroactively to Oct 1, 2010.
- CMS and nursing home industry is hopeful of legislative action. Mid-term election cycle playing a role.

MDS 3.0/RUG IV

General Overview
MDS 3.0
- Gives residents a stronger voice
- Increases clinical relevance
- Increases accuracy (validity and reliability)
- Increases clarity
- Substantially reduces time to complete

RUGs IV Case–mix
- Staff Time and Resource Intensity Verification Study (STRIVE)
  - Results used to develop MDS 3.0 and RUGs IV
  - Data is more current
  - Case–mix indices (CMIs) have been adjusted based on data collected.
    - Nursing CMIs increased by approximately 21 to 22%
    - Rehab CMIs decreased by approximately 41 to 42%
- Expands from 53 RUG groups under RUGs III to 66 RUG groups under RUGs IV

RUGs III
- 8 classifications with 53 groups
  - Rehabilitation Plus
  - Extensive Services
  - Rehabilitation
  - Extensive Services
  - Special Care
  - Clinically Complex
  - Impaired Cognition
  - Behavioral Symptoms
  - Reduced Physical Function

RUGs IV
- 8 classifications with 66 groups
  - Rehabilitation Plus
  - Extensive Services
  - Rehabilitation
  - Extensive Services
  - Special Care High
  - Special Care Low
  - Clinically Complex
  - Behavioral Symptoms
  - Cognitive Performance Problems
  - Reduced Physical Function

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Increases accuracy (validity and reliability)
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Changes to Hospital Look Backs

- Hospital Look Backs impacting reimbursement has been eliminated for most items.
  - Exception: IVF, TPN, Enteral Feedings

- All other services must now occur AFTER the patient was admitted to the center to impact reimbursement.

- Coding the service continues but must be differentiating between "While a Resident" or "While Not a Resident"

Hospital Look back Elimination

- Services that occur AFTER the patient was admitted to the SNF but in another setting can be coded on the MDS as occurring "While a Resident".

- This impacts the following services:
  - Extensive Services: Ventilator Care, Tracheostomy Care, Infection w/ Isolation
  - Special Care High: Respiratory Therapy
  - Special Care Low: Dialysis, Radiation
  - Clinically Complex: Oxygen, Transfusions, Chemotherapy, IV Meds

Extensive Services

Reduces the number of qualifiers from 5 to 3

<table>
<thead>
<tr>
<th>RUG III</th>
<th>RUG IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Meds</td>
<td>Ventilator Care</td>
</tr>
<tr>
<td>IV Fluids</td>
<td>Tracheostomy Care</td>
</tr>
<tr>
<td>Suctioning</td>
<td>Isolation for active infection</td>
</tr>
<tr>
<td>Tracheostomy Care</td>
<td></td>
</tr>
<tr>
<td>Ventilator Care</td>
<td></td>
</tr>
</tbody>
</table>
Impact

- With changes to Hospital Look Backs and Extensive Services under RUG IV there will be a substantial reduction in Rehab + Extensive Service categories (REx)
- RUG III average REx was 44%
- Expected RUG IV average REx is <10%

Nursing RUG Categories

Special Care is divided into two categories

- Special Care High (ADL score 2 or higher):
  - Respiratory Therapy x 7 days
  - Parenteral/IV fluids
  - Comatose w/ dependent ADLs
  - COPD w/ shortness of breath while laying flat
  - Fever with Pneumonia, Wt Loss, Vomiting or Tube Feed.
  - Septicemia,
  - Diabetics w/ daily injections & MD order changes,
  - Quadraplegia with ADL score of 5 or higher

- Special Care Low (ADL score of 2 or higher):
  - Cerebral Palsy
  - Multiple Sclerosis
  - Parkinson’s Disease
  - Respiratory Failure with O2 Therapy
  - Feeding Tube
  - Skin Ulcers
  - Foot infections or wounds with dressing
  - Radiation while a resident
  - Dialysis while a resident

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  - Foot infections or wounds with dressing
  - Radiation while a resident
  - Dialysis while a resident
**Nursing RUG Categories**

Clinically Complex (ADL score of 2 or higher)
- Pneumonia
- IV Medications
- Hemiplegia with ADL score of 5 or more
- Surgical Wounds or Open Lesion with Tx
- Burns
- Chemotherapy
- O2
- Transfusions

Impaired Cognition & Behavior categories are combined.

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**ADL Coding**

The premise for ADL index scoring is the same but the sensitivity of the scale to physical limitation is greater.

There are an increase number of ADL end-splits
- Special Care High/Low = 4
- Clinically Complex & Reduced Physical Function = 5

More endsplit letters for RUG categories
- A B C D E

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**ADL Coding**

Consider the following:
- The ADL score impacts a portion of the RUG rate
- The difference between an RUA and an RUB is approximately $120/day

- The difference between a Clinically Complex patient with an ADL Score of 1 and an ADL score of 2 is approximately $37/day.

- Overall impact of ADL coding is approximately $15 - $25 financial impact to average Medicare rate.
Depression Indicators

- Coding depression indicators is essential to being compensated for the care we are already providing, along with accurate assessment of our patients’ needs.

- The estimated increased reimbursement assigned to Depression ranges from:
  - Special Care High: $60 – $74ppd
  - Special Care Low: $48 – $65ppd
  - Clinically Complex: $20 – $26ppd

Depression Indicators

- Now includes Special Care High and Special Care Low RUG categories (in addition to Clinically Complex)
  - Depression has been expanded to 13 RUG groups (increased from five under RUG III).
  - Overall impact of Depression coding is approximately $5–$10* financial impact to average Medicare rate.

  *with 90% Rehab days, 10% Nursing

Rehab Services

- Under RUGs III, a therapy projection occurred on a 5 day MDS when a patient is projected into a Rehab High, Medium or Low category based on an estimated level of rehab minutes/days a patient can achieve by day 15 of the SNF stay.

- As of October 14th, the therapy projection has been eliminated

- Short Stay provisions have replaced projection
Rehab Services

No changes in requirements for therapy minutes or days to achieve Rehab RUG categories.

Rehab Services

Types of Therapy
- All Rehab minutes coded according to type:
  - Individual
  - Group
  - Concurrent

- The RAI Manual defines each type of therapy.

- The definition for each type must be met in order to code the minutes on the MDS for Medicare Part A billing purposes.

Rehab Services

Therapy Minutes Allocated toward RUG score as follows:
- Individual – 100% (no change)
- Concurrent – 50% (new)
- Group – maximum of 25% of allowable minutes (no change)

CMS can now track the types of therapy being delivered.
OMRA's

Other Medicare Required Assessments
- OMRA's are completed when therapy is initiated and when therapy ends.
  - Start of therapy OMRA
  - End of therapy OMRA

- Can be completed in combination with another MDS or as a stand alone assessment.

Start of Therapy OMRA

SOT OMRA – OPTIONAL
- Can be done any time therapy is initiated.
- Completed 5–7 days after therapy initiated
- The new Rehab RUG payment will begin on the day therapy is started and will continue until either therapy ends or the next scheduled assessment period begins, which ever occurs first.

Impact
- Ability to capture additional days of reimbursement at the Rehab rate when care is initiated between payment periods.

End OF Therapy OMRA

EOT OMRA
- Required when therapy treatment end and Part A stay continues
- Completed 1–3 days from the last day of therapy.
- Non-Rehab RUG payment will begin on the first non-therapy day.

Impact
- RUG rate changes to nursing category after therapy discharges
- Change in reimbursement occurs sooner than under RUGs III – loss of "OMRA days".
Short Stay Provision

- The Short Stay provision provides an alternative rehab RUG payment for patients that receive less than 5 days of rehab and are in the center for 8 days or less
- The Short Stay provision is a replacement for therapy projections.
- There are 8 criteria that MUST be met for a patient to qualify

Short Stay Provision

**Short Stay Criteria includes**
- The assessment must be a Start of Therapy OMRA
- A PPS 5 day or return/readmission has been completed.
- ARD of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare stay.
- The ARD of the Start of Therapy OMRA must be the last day of the Part A Medicare stay (A2400C).
- The ARD of the of the Start of Therapy OMRA may not be more than 3 days after the start of therapy.
- Rehab therapy started during the last 4 days of the Medicare Part A covered stay.
- At least one therapy continued through the last day of the Medicare Part A stay.
- The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group

Short Stay Provisions

If all conditions met:

*Average is the Total Therapy Minutes divided by the number of days from the start of therapy through the assessment reference date*

<table>
<thead>
<tr>
<th>Daily therapy minutes (average)</th>
<th>RUGs IV category</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-29</td>
<td>Rehabilitation Low</td>
</tr>
<tr>
<td>30-64</td>
<td>Rehabilitation Medium</td>
</tr>
<tr>
<td>65-99</td>
<td>Rehabilitation High</td>
</tr>
<tr>
<td>100-143</td>
<td>Rehabilitation Very High</td>
</tr>
<tr>
<td>144 or greater</td>
<td>Rehabilitation Ultra High</td>
</tr>
</tbody>
</table>
Short Stay Provisions

If a patient meets Short Stay criteria
• All days from the therapy start date up to the discharge date will be reimbursed at the Rehab RUG
• If therapy **did not** start on day 1, then the Nursing RUG will be used for all days prior to the start of therapy date, followed by the Therapy RUG used for the days rehab services were delivered.

Analyzing the Financial Impact: RUG III to RUG IV

Background

8 Major RUG categories
• Rehab + Extensive (REx)
• Rehab
• Extensive Services
• Special Care High
• Special Care Low
• Clinically Complex
• Behavior and Cognition
• Reduced Physical Functioning

66 RUG categories
Background

Impact

- The per diem rate for each category under RUG IV is higher than the same or similar category under RUG III.
- The rules and qualifications for RUG categories are more restrictive compared to RUG III – but daily payments are higher.
- RUGs IV is budget neutral.
- Appropriate reimbursement for SNF care will be dependant on our ability to execute on the rule changes.

IMPORTANT

The following examples will provide a basic understanding of the financial impact comparing RUG III to RUG IV payment rates.

Examples assume full RUG IV payment schedules recently published in the Federal Register.

RUG payment calculations would be different if hybrid grouper payments are used.

These examples do not include the potential impact of operational strategies implemented by the provider as a result of RUGs IV.

Financial Impact – Nursing RUG

Stage 4 wound, Depression Indicators and ADL score of 15-16

<table>
<thead>
<tr>
<th>MDS 2.0/ RUG III</th>
<th>MDS 3.0/ RUG IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUG = SSC</td>
<td>RUG = LE2</td>
</tr>
<tr>
<td>271.58 per day</td>
<td>405.53 per day</td>
</tr>
<tr>
<td>X 30 days</td>
<td>X 30 days</td>
</tr>
<tr>
<td>= $8147.40</td>
<td>= $12,165.90</td>
</tr>
</tbody>
</table>
Financial Impact – Nursing RUG

Diabetic with daily injections and 2 order changes, Depression Indicators and ADL score of 15-16

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</tr>
</thead>
<tbody>
<tr>
<td>RUG = CC2</td>
<td>RUG = HE2</td>
</tr>
<tr>
<td>270.03 per day</td>
<td>446.56 per day</td>
</tr>
<tr>
<td>X 30 days</td>
<td>X 30 days</td>
</tr>
<tr>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td>$8100.09</td>
<td>$13,396.80</td>
</tr>
</tbody>
</table>

Financial Impact – Therapy RUG

Rehab 5 x per week 330 minutes, ADL score of 11-16

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<th>MDS 2.0/ RUG III</th>
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<tbody>
<tr>
<td>RUG = RHC</td>
<td>RUG = RHC</td>
</tr>
<tr>
<td>364.54 per day</td>
<td>487.76 per day</td>
</tr>
<tr>
<td>X 30 days</td>
<td>X 30 days</td>
</tr>
<tr>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td>$10,936.20</td>
<td>$14,632.80</td>
</tr>
</tbody>
</table>

Major Change: Extensive Services and Look back Elimination

What is the financial impact of losing the look back period and the changes to Extensive Services?
Financial Impact

Mr. Jones received IV Medication 2 days before being admitted to the center. Once arriving to the center Mr. Jones required total assistance of 2 people for all late loss ADLs and will be skilled for a stage 4 wound, and has received 5 days and 500 minutes of PT/OT in the look back period.

**MDS 2.0/ RUG III**
RUG = RVX
467.62 per day
X 14 days
= $6546.68

**MDS 3.0/ RUG IV**
RUG = RVC
$51.51 per day
X 14 days
= $7721.14

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Major Changes: Rehab

What is the financial impact of allocating 50% of concurrent therapy minutes?

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Financial Impact
Concurrent Therapy

The 30 day MDS is being completed. During the look back period Mr. Jones received a total of 730 minutes of which 300 were provided concurrently. A total of 580 minutes are counted on the MDS. Mr. Jones ADL index score is 15.

**MDS 2.0/ RUG III**
RUG = RUC
$28.59 per day
X 30 days
= $15,857.70

**MDS 3.0/ RUG IV**
RUG = RVC
$51.51 per day
X 30 days
= $16,545.30
What is the financial impact of losing up to 9 OMRA days after therapy has discharged?

Financial Impact
End of Therapy OMRA
Mr. Brown met all his therapy goals and was discharged from therapy services after his last treatment on day 40. The 30-day assessment was in Ultra High. Mr. Brown continues to require daily skilled nursing wound care for a stage 3 wound and he also being managed and evaluated for treatment of depression.

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<td>405.53 per day</td>
</tr>
<tr>
<td>X 9 days</td>
<td>X 9 days</td>
</tr>
<tr>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td>$4,757.31</td>
<td>$3,649.77</td>
</tr>
</tbody>
</table>

Revenue Changes from RUGs III to RUGs IV
- Pro-forma based on comparison of Federal Rates FY 2010 (RUG III) and FY 2011 (RUG IV)
- Fixed Rehab RUG Mix
- Impact of Concurrent
  - Mitigate 100%
  - Mitigate 50%
  - Mitigate 0%
- Assumptions
  - Crosswalk from RUGs III to IV for ADL endspits and Extensive Service.
**RUG IV IMPLICATIONS**

- Vents, Trachs and Active Infection (with rehab) have highest reimbursement rates
- Proportion of Rehab + Extensive categories will be lower
- Part A revenue will be there – if new rules are properly executed (OMRA’s, Short Stay etc)
- Potential for lower Rehab utilization – impact of concurrent therapy
- Potential for more emphasis on Nursing qualifiers

**FUTURE CONSIDERATIONS**

- Medicare rate adjustments should budget neutrality be exceeded
- Re-hospitalizations
  - ACO’s - Accountable Care Organizations
  - Bundled payments
- Pay for Performance

Thank you for your attention. Questions/Discussion