Steps to Success with MDS

SNF PPS and MDS 3.0: Breaking It Down

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Objectives

• Understand the basics of the SNF PPS
• Understand the different types of PPS assessments, combinations and schedules
• Understand how to approach and address complex MDS scenarios
Agenda

• SNF PPS Basics
• A Typical Question
• Breaking It Down
• Return To Scenario
• Conclusion
SNF PPS Basics – Understanding Terms

• Skilled nursing facility (SNF) refers to a Medicare-certified facility which provides short term post-hospital discharge care to Medicare beneficiaries.

• Nursing facility (NF) refers to long-term care facilities certified by the state survey agency (SSA) to provide services to Medicaid recipients.

• Most facilities are certified both as NFs and as SNFs.
• Medicare Part A provides an “extended care” benefit when a beneficiary is admitted to the SNF within a specified time period of being discharged from a medically necessary hospital stay in which the beneficiary was an inpatient for not less than 3 consecutive days before discharge from the hospital.

• Limited to a maximum of 100 days per benefit period. Patients must need and receive an SNF level of (skilled) care on a daily basis, and must be receiving services that, as a practical matter, can only be provided in an SNF on an inpatient basis.
• Makes a global per diem payment that includes all costs (routine, ancillary, and capital-related) of covered SNF services, except those for:
  – Operating approved educational activities and bad debts
  – “Excluded” services (i.e., those services which the law or regulations specify as separately billable under Part B by the outside supplier that furnishes them)
• Payment rate depends on resident classification into one of 66 Resource Utilization Groups (RUGs)
  – RUG classification and payment based on relative resource intensity that would typically be associated with each resident’s clinical condition
Within the 66 RUGs, there are 23 Rehabilitation, or Rehab, RUGs where the payment rate is driven primarily by the amount of therapy services delivered to the beneficiary

- Specifically, payment rate depends on the number of therapy minutes, number of therapy disciplines, and the number of days the resident received therapy services
- Over 90 percent of billed Part A days

Rehabilitation RUGs fall into one of five categories:

- Ultra-High – 720 minutes
- Very High – 500 minutes
- High – 325 minutes
- Medium – 150 minutes
- Low – 45 minutes
• The remaining 43 RUGs are non-therapy or nursing RUGs, where the payment rate is driven primarily by resident’s condition and characteristics.

• Nursing RUGs fall into one of six categories:
  – Extensive Services
  – Special Care High
  – Special Care Low
  – Clinically Complex
  – Behavioral Symptoms and Cognitive Performance
  – Reduced Physical Function
## SNF PPS Basics – OBRA vs. PPS

<table>
<thead>
<tr>
<th></th>
<th>OBRA</th>
<th>PPS</th>
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<tbody>
<tr>
<td><strong>Who</strong></td>
<td>All residents</td>
<td>All residents in a Medicare Part A-covered stay</td>
</tr>
<tr>
<td><strong>What</strong></td>
<td>MDS 3.0</td>
<td>MDS 3.0</td>
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<tr>
<td><strong>When</strong></td>
<td>Completed upon admission/discharge to/from a nursing home, quarterly, yearly, and when significant medical changes occur</td>
<td>Scheduled assessments at various intervals (5, 14, 30, 60, 90) and unscheduled assessments (mostly relating to changes in resident’s therapy program)</td>
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<tr>
<td><strong>Why</strong></td>
<td>Quality measurement, facility survey and certification requirements and care planning purposes</td>
<td>Payment rate determination</td>
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• The PPS scheduled and unscheduled assessments establish per diem payment rates for associated standard payment periods

• To verify that the Medicare bill accurately reflects the assessment information, two data items derived from the MDS assessment must be included on the Medicare claim:
  – Assessment Reference Date
  – Health Insurance Prospective Payment System (HIPPS) Code
• The first three positions of the HIPPS code contain the RUG-IV group code to be billed for Medicare reimbursement. The RUG-IV group is calculated from the MDS assessment clinical data.
  – For example: RUX, RUA, ES3, HE2, LE2, CE2, CE1, BB1
The last two positions of the HIPPS code represent the Assessment Indicator (AI), identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods and is based on the coding of Item A0310 on the MDS.

- The first digit of the AI code identifies scheduled PPS assessments that establish the RUG payment rate for the standard PPS scheduled payment periods.
- The second digit of the AI code identifies unscheduled assessments used for PPS.
• Example: The HIPPS code RUX10 represents that the resident fell into the RUG category Rehab Ultra with Extensive Services (RUX) which was classified on the 5-day PPS Assessment (1\textsuperscript{st} AI digit of “1”) which was not combined with any unscheduled assessment (2\textsuperscript{nd} AI digit of “2”)}
SNF PPS Basics – Billing SNF Services (cont.)

- Below is an excerpt from the UB-04 form used for SNF billing purposes
- Box 44: HIPPS code associated with MDS assessment
- Box 45: Not used for SNF billing purposes
- Box 46: Number of days billed using associated HIPPS code
Each of the Medicare-required scheduled assessments has defined days for which the Assessment Reference Date (ARD) must be set – An ARD refers to the last day of the observation (or “look back”) period that the assessment covers for the resident

The Medicare-required standard assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments

Unscheduled assessments are completed in situations when due to a change in medical condition that would affect payment, a SNF provider must complete an assessment outside of the standard scheduled Medicare-required assessments
• Unscheduled PPS Assessments:
  – Start of Therapy (SOT) OMRA: Optional assessment used to classify a SNF Part A resident into a therapy RUG
  – Change of Therapy (COT) OMRA: Assessment required in cases where the resident’s therapy level changes to such an extent that he/she would classify into a different therapy category
  – End of Therapy (EOT) OMRA: Assessment required in cases where a resident’s therapy ends or in cases where the resident does not receive therapy services for three or more consecutive days
    • In cases where the resident’s therapy is planned to resume within 5 days of its ending, the facility may complete an EOT with Resumption OMRA
• There may be instances when more than one Medicare-required assessment is due in the same time period. To reduce provider burden, CMS allows the combining of assessments.

• When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements.

• It is also possible that a PPS Scheduled Assessment and a PPS Unscheduled Assessment may be combined or that two PPS Unscheduled assessments may be combined.

• When combining assessments, the more stringent requirements must be met.
SNF PPS Basics – Combining Assessments (cont.)

• Point of confusion: “If an unscheduled PPS assessment...is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required.”

• The “must” here refers to the fact that a scheduled assessment ARD in the window cannot be set for a day after the unscheduled assessment ARD
Example 1: Resident requires a 30-day assessment. The assessment is completed as a standalone assessment. What day(s) may be selected for the assessment ARD?
   – Answer: Any of Days 27–33

Example 2: Resident ends therapy on Day 26 of a Part A stay. The facility chooses to set the EOT OMRA ARD for Day 28 of the stay. This is within the 30-day assessment window. What day(s) may be selected for the 30-day assessment ARD?
   – Day 27: Standalone 30-day assessment (EOT OMRA still required)
   – Day 28: Combined 30-day/EOT OMRA
Example 3: Resident’s therapy changes to such an extent that a COT OMRA is required, with an ARD set for Day 29. This is within the 30-day assessment window. What day(s) may be selected for the assessment ARD?

Answer: Any of Days 27–28 (standalone 30-day assessment) or Day 29 (either standalone 30-day assessment or combined 30-day/COT OMRA)

Why is this different?

A COT OMRA is required 7 days from most recent assessment ARD. If 30-day assessment is set for on or before the COT OMRA ARD, the facility can effectively postpone or push back the COT OMRA due date.
• Assessment ARDs must be set for a day within the appropriate ARD window for that assessment. In cases where this is not done, a penalty is assessed.

• Early/Late Assessments: If an assessment ARD is set for earlier/later than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance.
• Missed Assessments: If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this error is discovered, this assessment is deemed missed.

• In the case of missed assessments, days which would have been paid by the missed assessment, had it been completed properly, are considered “provider-liable” and cannot be billed as part of the Medicare Part A stay.
“Knowledge without application is simply knowledge. Applying the knowledge to one’s life is wisdom—and that is the ultimate virtue.”

— Kasi Kaye Iliopoulos

Now that we have seen some of the basic rules, let’s examine how to apply these rules to a question we might receive on a typical day at the office.
A Typical Question

Facility admitted Receiving Therapy. 5 day completed the resident falls in a Rehab RUG. COT completed, resident falls out of Rehab. Therapy continues (they didn't realize the resident fell out of Rehab). COT assessments continue resident remains out of rehab. 30 day completed resident falls back into a rehab category. Meantime, Mother Nature plays havoc and therapy can't get to building so resident misses a session. Weekend follows missed session. Therapy picks back up on the Monday at same level; HOWEVER, because there are only 4 days of therapy, AND because Monday is being used as the ARD for an EOT R assessment, the resident does not fall into a Rehab RUG.

What should have been the progression of MDS assessments completed? And what should they do now?
Every scenario, no matter how complex and complicated it may seem, is nothing more than a combination of the simple rules you all understand.
Let’s consider a few less complex examples to illustrate this.

Example 1: I completed my 5-day assessment with an ARD of Day 8. Assuming nothing else happens, what days would this assessment control payment?
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Example 1: I completed my 5-day assessment with an ARD of Day 8. Assuming nothing else happens, what days would this assessment control payment?

Answer 1: The 5-day assessment would cover Days 1 – 14 of the SNF stay

- Pg. 2-49: Medicare-required 5-Day Scheduled Assessment
Example 2: I completed my 14-day assessment with an ARD of Day 15. Assuming nothing else happens, what days would this assessment control payment?

Example 2a: A Significant Change is Status Assessment (SCSA) is necessary for my resident. I intend to use an ARD of Day 15 and combine this assessment with my 14-day assessment. What day would this assessment begin controlling payment?
Answer 2: The 14-day assessment would control payment for Days 15–30

- Pg. 2-49: Medicare-required 14-Day Scheduled Assessment

Answer 2a: If a 14-day and an SCSA are combined with an ARD set for Day 15, then this assessment would control payment beginning on the first day of the scheduled assessment payment window (Day 15) and would use the Comprehensive Item Set

- Pg. 2-49: Medicare-required 14-Day Scheduled Assessment
- Pg. 2-58: Significant Change in Status Assessment
- Pg. 2-67: Medicare-required Scheduled Assessment and Significant Change in Status Assessment
Example 3: My 14-day assessment was completed with an ARD of Day 15 with a RUG of RVC. When would the COT Observation Period for this resident begin? When would it end?

Example 3a: On Day 22, I realized that a COT was necessary for my resident. I completed the COT with an ARD of Day 22 with a RUG of CE1.

What day would this assessment begin controlling payment?
Answer 3: With an ARD of Day 15, the COT observation period would begin on Day 16 and end on Day 22
• Pg. 2-54: Change of Therapy (COT) OMRA

Answer 3a: With an ARD of Day 22, a COT OMRA would begin controlling payment on Day 16, Day 1 of the COT observation period
• Pg. 2-54: Change of Therapy (COT) OMRA
Example 4: A resident, who was classified into a therapy RUG, misses three consecutive days of therapy, Days 29–31. I completed an EOT OMRA on this resident with an ARD of Day 31 and a RUG of CE1. What day would this assessment begin controlling payment?

Example 4a: I completed a 30-day assessment for my resident with an ARD of Day 29 and a RUG of RMC. Then, my resident misses three consecutive days of therapy, Days 29–31. I completed an EOT OMRA on this resident with an ARD of Day 31 and a RUG of CE1. Which assessment controls payment in this scenario?
Answer 4: An EOT OMRA establishes a new non-therapy RUG classification and Medicare payment rate beginning the day after the last day of therapy treatment regardless of day selected for ARD, in this case Day 29.

- Pg. 2-51: End of Therapy (EOT) OMRA

Answer 4a: An EOT OMRA establishes a new non-therapy RUG classification and Medicare payment rate beginning the day after the last day of therapy treatment regardless of day selected for ARD, in this case Day 29.

- Pg. 2-51: End of Therapy (EOT) OMRA
Example 5: I completed a 30-day assessment for my resident with an ARD of Day 29 and a RUG of RMC. Then, my resident misses three consecutive days of therapy, Days 29–31, but expects to resume therapy on Day 32. Which assessments control payment and on what days?
Answer 5: An EOT OMRA establishes a new non-therapy RUG classification and Medicare payment rate beginning the day after the last day of therapy treatment regardless of day selected for ARD, in this case Day 29. Therapy payment would resume on Day 32, using the therapy RUG classification from the 30-day assessment.

- Pg. 2-51: End of Therapy (EOT) OMRA

Note: In Examples 4–5, the facility may also opt to complete a combined 30d/EOT-R assessment, as opposed to doing two separate assessments. The payment implications would be the same, but reduce burden on the provider and complexity of the scenario.
• Begin by identifying all of the most relevant information
  – Reasons for late, missed, or unscheduled assessments not often relevant
• Think about components of the scenario based on the various MDS rules at play
  – If it helps, pull each relevant page out of the manual rather than continually flipping back and forth in a large binder
• Identify each rule/policy that is at play in the scenario
  – Make sure you understand how that rule/policy works in isolation before trying to consider it in combination with other rules/policies
• Proceed methodically through the scenario in the order of events
• It is important to understand the “hierarchy” within the SNF assessment and payment rules/policies, particularly in cases where assessments are combined.

• When determining the appropriate item set, hierarchy generally runs from least to most comprehensive item set, following the most stringent or basic requirements.
• When determining the appropriate item set, hierarchy generally runs from least to most comprehensive item set, following the most stringent or basic requirements

• Example: A provider intends to combine a 30-day assessment with COT-OMRA, but is unsure of which item set to use for the combined assessment. Which item set would be used in this scenario?

• Answer: 30-day assessment item set
• For payment rules, hierarchy generally runs in the opposite direction, with the “triggered” assessment controlling payment.

• Generally speaking, unscheduled assessments would “trump” payment from scheduled assessments, taking over the payment per the unscheduled assessment rules.
Generally speaking, unscheduled assessments would “trump” payment from scheduled assessments, taking over the payment per the unscheduled assessment rules.

Example: A 30-day assessment is completed for a resident, which classifies the resident into RUB. A COT-OMRA is completed for this resident one week later that classifies the resident into RVB. Which assessment controls payment?

Answer: The COT-OMRA trumps the payment rate set by the 30-day assessment.
Return to Scenario

Facility admitted Receiving Therapy. 5 day completed the resident falls in a Rehab RUG. COT completed, resident falls out of Rehab. Therapy continues (they didn't realize the resident fell out of Rehab). COT assessments continue resident remains out of rehab. 30 day completed resident falls back into a rehab category. Meantime, Mother Nature plays havoc and therapy can't get to building so resident misses a session. Weekend follows missed session. Therapy picks back up on the Monday at same level; HOWEVER, because there are only 4 days of therapy AND because Monday is being used as the ARD for an EOT-R assessment, the resident does not fall into a Rehab RUG.

What should have been the progression of MDS assessments completed? And what should they do now?
Return to Scenario –

Breaking Down Question (cont.)

- Resident in rehab RUG on 5-day
- COT completed with resident falling out of rehab
- COT observations mistakenly continue
- 30-day reclassifies resident into rehab
- Resident misses three consecutive days of therapy
- Therapy resumes at prior level
- EOT-R does not produce a rehab RUG
- Question: What should have been the progression of MDS assessments completed? And what should they do now?
Return to Scenario –
Breaking Down Question (cont.)

What policies/rules were used here?

• Chapter 2, Section 2.9, Page 2-49
  – ARD and payment rules for 5d and 14d assessments
• Chapter 2, Section 2.9, Pages 2-51 – 2-54
  – ARD and payment rules for EOT-R
• Chapter 2, Section 2.9, Pages 2-54 – 2-58
  – ARD and payment rules for COT OMRA
• Chapter 2, Section 2.9, Page 2-58
  – ARD and payment rules for SCSA combined with scheduled assessment
• Chapter 2, Section 2.11, Page 2-64
  – Combined assessment policy
Missing Information

• What was the ARD of the 5-day?
• What was the ARD of the 14-day?
• Was the 14-day combined with the COT that dropped the person from rehab?
• If not, when did that COT occur?
• Were any other COT assessments (not checks, but actual assessment completion) done prior to the 30-day assessment?
Missing Information – With Responses

• What was the ARD of the 5-day?
  – Day 8 – RVC10

• What was the ARD of the 14-day?
  – Day 15 – RVC21

• Was the 14-day combined with the COT that dropped the person from rehab?
  – No, but was combined with an SCSA (the plot thickens...)

• If not, when did that COT occur?
  – Day 22 – CE10D
Missing Information – With Responses (cont.)

• Were any other COT assessments (not checks, but actual assessment completion) done prior to the 30-day assessment?
  – No, but the 30-day was combined with a COT OMRA
  – ARD = Day 29, HIPPS = RMC3D
Putting it together

- 5d ARD was day 8 (24 Jan) and = RVC
- The 14d/SCSA ARD was day 15 (31 Jan) and = RVC
- Therefore, a COT review was due on day 22 (7 Feb)
  - This COT = CE1, so the resident drops out of rehab, effective 1 Feb
- The 30d ARD set for day 29 (21 Feb) and = RMC
- This is supposed to be billed starting day 31 (23 Feb)
- However, the provider completes an EOT with ARD of Day 31 (23 Feb), with a resumption of therapy date of 2/24, and = CE1
Response

• 5d controls payment on Days 1–14 at RVC
  – Example 1
• 14d/SCSA controls payment on Day 15 at RVC
  – Examples 2 and 2a
• COT controls payment on Days 16–28 at CE1
  – Examples 3 and 3a
• EOT-R controls payment from Day 29 forward
  – Examples 4 and 4a
• 30d not used for payment, but does establish therapy classification for resident
  – Example 5
Summary

• Scenario type questions can be very complex and involve interactions among various MDS rules
• Think of Legos®: Break it down
• If you are unsure, ask for help!