Objectives

- Identify five common MDS 3.0 coding challenges
- Describe 5 item specific CMS coding updates
- Describe the Requirements for Medicare PPS scheduled and unscheduled assessments
- Explore payment implications of combining Medicare PPS scheduled and unscheduled assessments through a variety of case examples
- Identify three operational strategies for successful Medicare Revenue Cycle management
Introduction: Why are we here?

- Extensive training on MDS 3.0 provided by CMS and others throughout 2010
- MDS 3.0 implemented on October 1, 2010
  - Most facilities focused on Medicare transition
  - Once the dust settled…
    - Many questions have arisen as the assessment is used in the “real world”
    - CMS is providing clarification through help desk and Open Door Forum calls
- There is still plenty to learn!

Resident Interviews

Q: How do you handle the resident interview sections on the Discharge assessment if the resident is unexpectedly discharged?

A: Two step process

- Code the interview screening questions (C0100, D0100, F0300, J0200) based on whether or not the resident is able to be understood
- Fill in the interview responses with dashes (-)
Resident Interviews (cont.)

Q: How do you code the MDS if the resident refuses to participate in some or all of the interview?
A: Similar process to unplanned discharge
   ➢ Code the interview screening questions (C0100, D0100, F0300, J0200) based on whether or not the resident is able to be understood
   ➢ Fill in the question(s) the resident refuses to answer with dashes (-)

Resident Interviews (cont.)

Q: How do you schedule the resident interviews in relation to the ARD?
A: Depends on the type of interview
   ➢ PHQ-9© and Pain interviews: preferably on the day before or day of the ARD
   ➢ BIMS and Daily Preferences can be done any time during look-back period
      • If doing interviews together, make sure most stringent timing requirement is met
Section C: Cognitive Patterns

Q: During the BIMS interview the resident had no signs of delirium, however staff on other shifts state the resident displays inattention and disorganized thinking. How is C1300 coded?

A: Code the applicable items as “2”, behavior is present and fluctuates

➢ If any source disagrees about the presence of signs of delirium, the behavior is considered to be fluctuating
➢ Compare to baseline to determine if it is an acute change (C1600)

Section D: Mood

Q: How do you answer the question about poor appetite/overeating (D0200E/D0500E) for a resident with a feeding tube who is NPO?

A: Code a dash (-) if the resident had no nutrition by mouth during the lookback period for the interview.

➢ If the resident is only partially tube fed and is able to take PO feedings, this item may be applicable
c1  
this is different than the question was asking about? Yes?
cheryl, 2/24/2011
Section E: Behavior

Q: How do you code Rejection of Care (E0800) if the behavior continues after it was addressed?
A: This depends on whether the behavior was determined to be consistent with the resident’s goals

- If the behavior is consistent with goals, do not code E0800
- If the behavior is not consistent with goals and still persists, code E0800
  - Opportunity to review care plan and goals

Section G: Functional Status

Q: How do you code G0110I Toilet Use for residents with a catheter or ostomy?
A: Be sure you are assessing both methods of elimination

- Resident may require only limited assist with catheter but extensive assist transferring on/off toilet
- Emptying the catheter or ostomy bag does not count, but perineal/skin care does count
Section G: Functional Status (cont.)

Q: Can the ADL support provided by ambulance staff be included in coding G0110?
A: No, ambulance staff are not considered facility staff
   - If facility staff are involved in the activity (e.g. transfer from bed to stretcher) this would be counted

Section G: Functional Status (cont.)

Q: How do you code balance for surface-to-surface transfers (G0300E) for a resident who uses a mechanical lift?
A: Code “2” since the resident would be unable to stabilize without physical assistance
   - The code of “8” would not apply because the transfer occurred at least once during the 7-day lookback
Section H: Bladder and Bowel

- Q: How do you code continence for a resident with a leaking catheter/ostomy?
- A: Code “9”, not rated.
  - Continence in MDS 3.0 is based on number of continent voids/BMs
    - Not “wet” or “soiled” as in MDS 2.0
  - If the appliance was in place for the entire lookback, there would be no episodes of elimination to assess
  - If the appliance was in place for only part of the lookback, assess continence for the remaining time

Section K: Swallowing/Nutritional Status

- Q: Do you code swallowing disorders in K0100 for residents who are NPO and on a feeding tube?
- A: No. K0100 looks at current functional swallowing problems
  - If tube feeding was placed due to dysphagia and the resident is now NPO, then the symptoms of swallowing disorder would not be present
    - Different from MDS 2.0!
Section L: Oral/Dental Status

- Q: How is a resident who is edentulous with properly fitting dentures in good condition coded in L0200?
- A: Code L0200B, No natural teeth or tooth fragments
  - Do not code L0200A because the dentures are not broken
  - This item assesses the state of the oral cavity, which is edentulous

Section M: Skin Conditions

- Q: Can a Norton/Braden completed within the last 90 days be coded in the Determination of Pressure Ulcer Risk (M0100B)?
- A: M0100 has a 7-day lookback
  - If the assessment was completed within the lookback, code it here
  - If not, consider coding M0100C, Clinical assessment
    - Other risk factors may be identified outside of formal assessment
Section M: Skin Conditions (cont.)

Q: How do you code an intact blister in M0300?
A: First determine if the blister is caused by pressure
   ➢ If pressure is the cause, examine the surrounding tissue
   ➢ If surrounding tissue is intact and normal in appearance code Stage 2
   ➢ If surrounding tissue shows changes in color/temperature, bogginess or firmness, this indicates suspected DTI

Section M: Skin Conditions (cont.)

Q: How do you code the most severe tissue type (M0700) for a Stage 1 or suspected deep tissue injury (DTI)?
A: M0700 looks at the tissue in the wound bed
   ➢ Stage 1 ulcers and suspected DTI have intact surface skin, thus no wound bed to assess
   ➢ Code M0700 with a dash (-)
Section M: Skin Conditions (cont.)

- Q: How do you code if two adjacent pressure ulcers merge into one between assessments?
  - A: Code it as one ulcer in M0300
    - Stage according to the deepest anatomical stage
    - The total number of ulcers (if no other ulcers have formed) will be fewer than the prior assessment
      - Although the number of ulcers has decreased, do not code as a healed ulcer in M0900
    - Code as a worsening ulcer in M0800 if the wound stage has worsened

Section M: Skin Conditions (cont.)

- Q: Can I code Ulcer Care (M1200E) for treatment to diabetic/venous/arterial ulcers?
  - A: No. M1200E refers only to care provided to pressure ulcers coded in M0300
    - M1200G (dressings) and or M1200E (ointments/medications) may be applicable
Section O: Special Treatments, Procedures, and Programs

- Q: Can a resident on precautions for c.diff be coded in M0100M, Isolation or Quarantine?
  - A: It depends on the room
    - Yes: if the resident is alone in a private room
    - No: if the resident is placed in a room with another resident with the same infection (i.e. cohorting)
      - Further clarification needed: if the resident can move freely about the facility

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Section O: Special Treatments, Procedures, and Programs (cont.)

- Q: What is the therapy end date if the resident received treatment on Monday, cannot tolerate therapy on Tuesday-Thursday, and the order to discontinue is written on Friday?
  - A: Monday. The therapy end date is the last day that the therapy was actually received by the resident
    - Regardless of whether it was anticipated to continue as of that date

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End of Therapy OMRA

- Q: If three or more days of therapy in a row are missed but the resident has not been discharged from therapy, is an EOT OMRA required?
- A: Yes, if the facility provides therapy 7 days a week
  - Includes therapeutic holds and emergencies (e.g. severe weather)
  - When therapy resumes, a new evaluation is required
  - Optional SOT OMRA may be completed

Modification of Assessments

- The rules for modification/inactivation of assessments will change as of April 1, 2011
  - Modification for Type of Assessment (A0310) and target date (Entry date A1600, Discharge date A2000, ARD A2300) will no longer be allowed
  - If any of these fields need to be changed, an inactivation is required
Resident Interview Process

- Is your facility’s process working?
  - Who is doing the interviews
  - How are the interviews arranged
  - Are residents and staff comfortable with the interviews?
- If the resident interview cannot be completed, how is the staff assessment done?
  - Interview staff instead of the resident
  - Direct care staff should be familiar with the questions

Interdisciplinary Input: Use your Team!

- The MDS requires a complete picture of the resident 24x7 throughout the lookback period
- How does your facility collect this information?
  - No one person can cover it all
  - Direct care staff should know what to watch for, e.g.
    - Changes in mental status
    - Swallowing problems
    - Behavior
  - Keep all staff in the MDS schedule loop
Collecting the Information

- How does your facility collect the information for the MDS?
- Typical documentation includes
  - ADL flow sheets
  - Wound assessment sheets
  - MAR/TAR
  - Pain assessment
- Is anything falling through the cracks?
  - More documentation vs. communication with staff

Never Stop Learning

- Staff competencies can include MDS guidelines
  - ADL coding, wound assessment, skilled documentation etc.
- CMS will continue to update coding rules
  - Make sure you have the most recent revision of the MDS 3.0 Manual
Overview of the RUG-IV Grouper

- Changes based on
  - MDS 3.0 data set
  - STRIVE study results (Staff Time and Resource Intensity Verification Project)

- Structural Changes to the RUG hierarchy
  - Modification results in 8 major classification categories and 66 payment groups
    - Sub groupings based on therapy, ADL, depression and restorative nursing
    - Merger of Behavior and Cognition
    - Split of Special Care
  - Payment group inclusion criteria are changing

A Shift In Values: How Therapy Time is Counted

- In MDS 2.0 concurrent therapy was captured in the same manner as individual therapy; both had similar “value” in RUG-III

- MDS 3.0 and RUG-IV change how therapy time is counted
  - STRIVE showed that the industry shifted from one-on-one or individual therapy to concurrent therapy

- In RUG-IV, concurrent therapy time is not counted as individual therapy time for each of the residents treated concurrently
  - Concurrent therapy minutes are divided in half by the RUG grouper
Changes To The Look Back Periods

- MDS 3.0 Special Treatments, Procedures and Programs (O0100) employs same 14 day look back
  - Medicare Part A only considers those services provided while a resident in SNF

- MDS 3.0 all items have a 7 day look back period unless otherwise noted

- Key items with changed look back periods
  - Pain (shortened to 5 days)
  - Mood (PHQ-9© shortened to 14 days)
  - Bowel and Bladder (shortened to 7 days)
  - Diagnoses (Only “active” in the last 7 days)

Location of Service Provision Impacts

Extensive Service Qualifiers

- RUG-IV reimbursement for Extensive Services (Section O) will include only services provided after admission (or readmission) to the SNF

- Special treatments and programs provided in the past 14 days outside the SNF will be collected and used in Case-Mix States for Medicaid
Rehabilitation RUG Categories

- Rehabilitation Plus Extensive Services/Rehabilitation
  - Extensive Services criteria no longer captured prior to admission
  - Rehabilitation criteria-no change
- New assessments to capture therapy
  - Medicare short stay assessment
  - OMRA Start of Therapy
- Calculation of therapy minutes is separated
  - Individual
  - Concurrent (one-half)
  - Group (25% limitation)

Adjustments to the ADL Score

- Same four late loss ADLs: bed mobility, transfer, eating, and toilet use
- Each individual component ADL Index score ranges from 0 to 4
- Overall ADL Score will range from 0-16
- Each component ADL is scored by using both the Self-Performance and Support Provided
  - Eating support code is now added
    - Parenteral/IV and Feeding Tube no longer apply to ADL score
### Calculating the Total ADL Score

**STEP # 1**

To calculate the ADL score use the following chart for bed mobility (G0110A), transfer (G0110B), and toilet use (G0110I). **Enter the ADL score for each item.**

<table>
<thead>
<tr>
<th>Self-Performance</th>
<th>Support</th>
<th>ADL Score</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1 =</td>
<td>Column 2 =</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-0, 1, 7, or 8</td>
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<td>G0110A =</td>
</tr>
<tr>
<td>2</td>
<td>any number</td>
<td>1</td>
<td>G0110B =</td>
</tr>
<tr>
<td>3</td>
<td>-0, 1, or 2</td>
<td>2</td>
<td>G0110H =</td>
</tr>
<tr>
<td>4</td>
<td>-0, 1, or 2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3 or 4</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

- New code of “7” used to describe ADL that does not occur 3 times or more
- Code of “8” no longer adds points to the ADL score
  - Weighted the same as “0” or “1” for bed mobility, transfers and toilet use

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### Calculating the Total ADL Score (cont.)

**STEP # 2**

To calculate the ADL score for eating (G0110H), use the following chart. Enter ADL score.

<table>
<thead>
<tr>
<th>Self-Performance</th>
<th>Support</th>
<th>ADL Score</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1 (G0110H) =</td>
<td>Column 2 =</td>
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<td></td>
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<tr>
<td>-0, 1, 2, 7, or 8</td>
<td>-0, 1, or 8</td>
<td>0</td>
<td>G0110H =</td>
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<td>-0, 1, 2, 7, or 8</td>
<td>2 or 3</td>
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<tr>
<td>3</td>
<td>2 or 3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2 or 3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

- RUG-IV modified the ADL component score for eating
  - When limited assistance or weight bearing support occurs with eating, this adds 2 points to the ADL score
  - Does not use Parenteral/IV feeding or feeding tube items

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RUG-IV Category Level ADL Splits: Rehab

<table>
<thead>
<tr>
<th>RUG Category</th>
<th>Rehab Level</th>
<th>ADL 0-1</th>
<th>ADL 2-5</th>
<th>ADL 6-10</th>
<th>ADL 11-14</th>
<th>ADL 15-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab + Extensive</td>
<td>Ultra High</td>
<td>RUL</td>
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<td>RUX</td>
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<tr>
<td></td>
<td>Very High</td>
<td>RVL</td>
<td></td>
<td></td>
<td>RVX</td>
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<td>High</td>
<td>RHL</td>
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<td>RMX</td>
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<td>Low</td>
<td></td>
<td></td>
<td></td>
<td>RLX</td>
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</tr>
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<td>Rehab</td>
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<td>RUA</td>
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<td>Very High</td>
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<td>Medium</td>
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<td>RMA</td>
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<tr>
<td></td>
<td>Low</td>
<td></td>
<td></td>
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<td></td>
<td>RLA</td>
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RUG-IV Category Level ADL Splits: Non-Rehab

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<th>RUG Category</th>
<th>Rehab Level</th>
<th>ADL 0-1</th>
<th>ADL 2-5</th>
<th>ADL 6-10</th>
<th>ADL 11-14</th>
<th>ADL 15-16</th>
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</thead>
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<td>Extensive Services</td>
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<td>HB</td>
<td>HC</td>
<td>HD</td>
<td>HE</td>
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<tr>
<td>Special Low</td>
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<td>LC</td>
<td>LD</td>
<td>LE</td>
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<td>Clinically Complex</td>
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<td>CA</td>
<td>CB</td>
<td>CC</td>
<td>CD</td>
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<td></td>
<td>BA</td>
<td>BB</td>
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<td>Cognitive Reduced</td>
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<td>PB</td>
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<td>Physical Function</td>
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</tr>
</tbody>
</table>

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RUG-IV: ADL Changes in MDS 3.0

Effect:
- Change in calculation of ADL scores and thresholds

Impact:
- More difficult to classify patients into “B”, “C”, and “X” RUG categories

Opportunities/Options:
- Educate direct care staff to fully capture resident ADL performance and support

Extensive Services

- **ADL score =>2**
- **Retained: ventilator and tracheostomy care**
  - Requires intensive staff resources
  - Ventilator/respirator care, and tracheostomy care qualify only when they are administered post-admission to the SNF
- **Added:**
  - Post-admission infection/isolation
- **Dropped:**
  - Suctioning
  - Parenteral/IV feeding (moves to Special Care High)
  - IV medications (moves to Clinically Complex)
Special Care High

- **ADL score =>2**
- **Residents with complex care or significant medical conditions including**
  - Coma and completely ADL dependent
  - Quadriplegia + ADL =>5, respiratory therapy for 7 days
  - Fever with pneumonia, or vomiting, or weight loss
- **Added:**
  - Parenteral/IV feedings (formerly Extensive Services)
  - Septicemia, (formerly Clinically Complex)
  - Diabetes with injections and order changes (formerly Clinically Complex)
  - Comatose qualifier (formerly Clinically Complex)
  - COPD + SOB when lying flat
- **Dropped:**
  - Fever + dehydration/tube feeding with food/fluid requirements

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Special Care Low

- **ADL score =>2**
- **Residents with complex care or significant medical conditions including**
  - Multiple sclerosis, cerebral palsy +ADL =>5
  - Ulcers (Two or more stage II or one or more stage III or IV PU) with treatments
  - Tube feeding with requirements
  - Radiation*
- **Added:**
  - Parkinson’s disease with ADL =>5
  - Respiratory failure and oxygen therapy*
  - Two or more arterial/venous skin ulcers, or one Stage II PU and one venous/arterial ulcer with treatments
  - Foot infection/diabetic foot ulcer/other open lesion of foot with treatment
  - Dialysis treatment*
- **Dropped:**
  - Surgical wounds or open lesions with treatments (moves to Clinically Complex)
  - Aphasia requirement (for tube feeding) * while a resident

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Cheryl.Field@PointRight.com  781-457-5900
March 2011  www.PointRight.com
Clinically Complex

- Residents receiving complex clinical care who do not meet the minimum ADL requirement for Extensive Services or Special Care
  - Pneumonia
  - Hemiplegia/hemiparesis and ADL >=5;
  - Chemotherapy*
  - Oxygen*
  - Burns
  - Transfusions*

- Added:
  - IV medications* (formerly Extensive Services)
  - Surgical wounds or open lesions with treatments (formerly Special Care)

- Dropped:
  - Dehydration
  - Physician order changes

* while a resident

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Behavioral Symptoms and Cognitive Performance

- Behavioral Symptoms and Cognitive Performance

- Residents display cognitive impairment in decision-making, recall, and short-term memory
  - Score above the threshold amount on the MDS 3.0 with respect to the brief interview for mental status
  - OR
  - Display one of the following: hallucinations, delusions, physical, verbal or other behavioral problems directed towards others, rejection of care, or wandering
  - May not exceed a maximum ADL cut-off of 5
  - Restorative nursing end split

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Last But Not Least

Reduced Physical Function

- Residents whose needs focus on ADLs and general supervision
  - Impaired Cognition or Behaviors and ADL >5 get downgraded to this grouper
- All residents are sorted into subgroups by ADL level
- Restorative nursing end split

Scheduled PPS Assessment Types

<table>
<thead>
<tr>
<th>PPS Assessment</th>
<th>ARD</th>
<th>Grace Days</th>
<th>Payment Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Day Readmission/Return</td>
<td>Days 1-5</td>
<td>Days 6-8</td>
<td>Days 1-14</td>
</tr>
<tr>
<td>14-Day</td>
<td>Days 11-14</td>
<td>Days 15-19</td>
<td>Days 15-30</td>
</tr>
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<td>30-Day</td>
<td>Days 21-29</td>
<td>Days 30-34</td>
<td>Days 31-60</td>
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<td>60-Day</td>
<td>Days 50-59</td>
<td>Days 60-64</td>
<td>Days 61-90</td>
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<tr>
<td>90-Day</td>
<td>Days 80-89</td>
<td>Days 90-94</td>
<td>Days 91-100</td>
</tr>
</tbody>
</table>
PPS Assessments

- Scheduled PPS assessments (A0310B)
  - Predetermined ARD and grace days
  - One scheduled assessment may not replace another scheduled assessment
  - Must be completed in order
  - Same predetermined payment days, which may be impacted by an unscheduled assessment

Unscheduled PPS Assessment Types

- Other Medicare Required Assessments (OMRA)
  - Used to re-set RUG payment rate when therapy is started or discontinued
  - New in MDS 3.0: Two distinct types of OMRA assessments
    - End of Therapy OMRA
    - Start of Therapy OMRA
      - Start and End of Therapy OMRA
PPS Unscheduled Assessments (cont.)

End of Therapy (EOT) OMRA (A0310C=2)
- Resident receiving OT, PT, and/or SLP and was classified in a Rehab Plus Extensive Services or Rehab RUG
- All therapies have been discontinued and the resident continues to receive skilled services
- Set ARD 1 to 3 days after all therapies discontinued
  - First non-therapy day is the first day that therapy would have been provided
    - If a facility does not provide therapy on weekends, that day would be Monday
- Sets new RUG effective on the first non-therapy day

PPS Unscheduled Assessments (cont.)

Start of Therapy (SOT) OMRA (A0310C=1)
- Optional assessment
- Resident who had been classified in a non-Rehab RUG starts therapy
- Re-sets RUG to Rehabilitation Plus Extensive Services or Rehabilitation group
- Set ARD 5 to 7 days after start of therapy
  - First therapy day is day 1
- Sets new RUG effective on the first therapy day
PPS Unscheduled Assessments (cont.)

- Start and End of Therapy OMRA (A0310C=3)
  - Must meet both ARD criteria:
    - 5 to 7 days after start of therapy
    - 1 to 3 days after all therapies d/c
  - Sets Rehabilitation Plus Extensive Services or Rehabilitation RUG from first therapy day through last therapy day
  - Sets non-Rehab RUG from first non-therapy day through end of payment period

MDS 3.0: Capturing Therapy

- Counting “projected therapy” (section T) is eliminated; therapy minutes must be actually provided to contribute to RUG-IV group assignment
  - Either “do it” from the start and capture Rehab RUG on the 5 day; or
  - Wait and then complete a Start of Therapy OMRA once 5 days of therapy have been provided

- What happens when you can’t get 5 days of therapy in because of a short stay?
  - The Medicare Short Stay Assessment
    - This is a way of getting credit for providing rehab and missing the 5 day requirement due to a discharge
Medicare Short Stay Assessment
Eight Qualifying Criteria

1. The MDS must be a Start of Therapy OMRA
2. The ARD (SOT OMRA) must be the last day of the Medicare Part A stay (A2400C)
3. The ARD must be on or before the 8th day of the Part A stay (7 day LOS or less)
4. Completed alone or combined with any OBRA MDS or PPS 5-day or readmission/return MDS
5. Rehabilitation therapy (SLP, OT, or PT) started during the last 4 days
6. At least one therapy continued through the last day of the Part A stay

Medicare Short Stay Assessment
Eight Qualifying Criteria (cont.)

7. The ARD (A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Item O0400A5, O0400B5, or O0400C5, whichever is earliest).
8. The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Z0100A). If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.
Medicare Short Stay Minutes Table

<table>
<thead>
<tr>
<th>RUG Category</th>
<th>Average Therapy Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultra High</td>
<td>144 minutes or more</td>
</tr>
<tr>
<td>Very High</td>
<td>100 - 143 minutes</td>
</tr>
<tr>
<td>High</td>
<td>65 - 99 minutes</td>
</tr>
<tr>
<td>Medium</td>
<td>30 - 64 minutes</td>
</tr>
<tr>
<td>Low</td>
<td>15 - 29 minutes</td>
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</tbody>
</table>

FAQ “Why Did I get the AAA rate on my Medicare Short Stay Assessment?”

- All 8 criteria were met
- CMS returned AAA RUG
- Why?
- Answers:
  - Non-Rehab RUG
  - Average number of minutes provided were less than RL
  - Nursing Case Mix index may be higher than RL
PPS Unscheduled Assessments (cont.)

- Significant Change in Status Assessment (SCSA) or Significant Correction to Prior Full Assessment (SCPA)
- When not combined with a PPS assessment, sets new RUG effective on ARD
  - When combined with a PPS assessment and grace days are not used, sets new RUG effective on ARD
  - When combined with a PPS assessment and grace days are used, sets new RUG effective on first day of payment period of the PPS assessment

Combining OBRA and PPS Assessments

- OBRA and PPS assessments may be combined if the ARD windows coincide
  - e.g., Admission/5 day, Quarterly/90 day, OMRA/Quarterly
- The most stringent requirements for MDS completion, ARD, and item set requirements must be met
  - e.g., Admission/14 day must be completed by day 14, Quarterly/90 day must have ARD within 92 days of Admission ARD
  - If a PPS assessment is combined with an Admission, Annual, SCSA, or SCPA, the comprehensive item set is used (full MDS with CAA)
### Understanding Index Maximization

#### Rehab

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
<th>0-5</th>
<th>6-10</th>
<th>11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUC</td>
<td>Ultra High Intensity</td>
<td>58</td>
<td>57</td>
<td>58</td>
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<tr>
<td>RUB</td>
<td>Ultra High Intensity</td>
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<tr>
<td>RUA</td>
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<td>RVG</td>
<td>Very High Intensity</td>
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<tr>
<td>RYD</td>
<td>Very High Intensity</td>
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<td>49</td>
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<tr>
<td>RHC</td>
<td>High Intensity</td>
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<td>53</td>
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<tr>
<td>RHA</td>
<td>High Intensity</td>
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#### Extensive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
<th>0-5</th>
<th>6-10</th>
<th>11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES3</td>
<td>Tracheostomy &amp; Ventilator/respirator</td>
<td>58</td>
<td>58</td>
<td>58</td>
</tr>
<tr>
<td>ES2</td>
<td>Tracheostomy or Ventilator/respirator</td>
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<td>53</td>
<td>53</td>
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<tr>
<td>ES1</td>
<td>Isolation for active infectious disease</td>
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</table>

#### Special Care High

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
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<th>6-10</th>
<th>11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>HE2</td>
<td>Depressed</td>
<td>46</td>
<td>46</td>
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