Understanding the Nursing Home Billing Components

June 2015

Harmony Healthcare International, Inc.

HHI

- Compliance Program Development and Analysis
- PPS & Case Mix Onsite Chart Audits
- MMQ Audits
- Seminars
- Program Development
- Mock Survey
- Sample RAC Reviews
- 5 Star Rating Analysis

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“*We Care* About Care”
Understanding the Nursing Home Billing Components

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

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Disclosure: The planners and presenters of this education activity have no relationship with commercial entities or conflicts of interest to disclose.

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  - Business Development
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  - Specialties:
    - Healthcare Process Improvement, MDS3.0, Long-term Care
    - Electronic Medical Record Software, 3rd party healthcare reimbursement, contract negotiations, group presentations
  - MBA, Health Systems Administration
Nursing Home Payer Systems

SNF Reimbursement

- Medicare Part A
- Medicare C (Managed)
- Private/Self-Pay
- Other Commercial Insurance
- Medicaid

Medicare
Medicare Part A

- Federally Funded and Administered Health Insurance Program
- Eligibility:
  - Over 65, Permanently Disabled, ESRD
- Coverage for
  - Inpatient Hospital,
  - Skilled Nursing Facility
  - Certified Home Health Agencies
  - Hospice

Medicare Part B

- Same Criteria except optional
- Covers
  - Outpatient Services
  - DME

Medicare Part C

- Medicare Advantage Plans
  - Replaces traditional Medicare A
  - Private/Commercial Plans administer Medicare Part A benefits
  - Case Management Component control costs
  - Preferred Provider vs. Out of Network
    - Examples:
      - Today’s Options – United Health Care
      - Senior Blue- Blue Cross/Blue Shield
Medicare Part D
- Prescription Drug Coverage

Medicaid

Federal Health Insurance Program for people unable to pay for health care
- State and Federally funded
- State administered:
  - State Specific Regulations and Eligibility Requirements
Skilled Nursing Facility
Payer Applications

Payer Mix

Percentage of Nursing Facility Residents by Primary Payer Type, 2011

Source: U.S. Census, 2011

Medicare 14%
Medicaid 30%
Others 56%

1,365,300 Certified Residents

Medicare Part C – Medicare Advantage Plans

Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2014

Total Medicare Advantage Enrollment, 2014 – 15.7 Million

Part B 70%
Medicare Exchange 30%
HMO 14%

Source: U.S. Census, 2011

Medicare Part A – SNF Benefit

- 100 days of eligibility per Episode of Care
  - 20 days 100%
  - 80 days $152 co-pay (2014)
- Must meet specific federally mandated criteria
  - 3 Day Inpatient Qualifying Hospital Stay
  - Skilled Care: Nursing and/or Rehabilitation: OT/PT/ST
  - Daily Basis: Nursing 7 days, Rehab 5 days
  - Practical Matter: Must Require Inpatient SNF Care
- Must have a break of 60 days between each episode of care

Medicare Part A

- Per Diem/All inclusive Rates:
  - SNF Utilizes ‘MDS’ assessment tool to determine rate level or Resource Utilization Grouping (aka. RUG) required to care for patient
- Region Specific, Hierarchical Structure
  - Annual Adjustment to Rates Oct 1.
  - Case Mix adjusted based on resource utilization:
    - More Services/Higher Acuity= Higher rate
Medicare Part C
(aka Managed Medicare)
- Criteria similar to Medicare Part A
- May or may not need 3-day inpatient hospital stay
- Admission to SNF Requires Prior Approval
- Length of Stay - Case Managed by MCO
- Reimbursement Rate set based on individual contract between SNF and MCO
  - Levels: Based on intensity of service delivery
  - Resource Utilization (RUG) level based on MDS assessment

Other SNF Payers
- Private/Self-Pay
  - Average Daily Rate for Semi Private Room:
    - NYS: $340/day*
    - Central NY: $284**
  - Workman’s Comp- fee for service
  - Commercial Insurers- capitated or fee for service
  - Hospice- different systems depending on type of hospice agreement

Medicaid – New York
Per Day/Per Patient Rate Based on 4 “Buckets” of Expenses
- **Direct Costs:**
  - Clinical, Therapeutic, Supportive Care Expenses (i.e. Salaries of nursing staff) AND
  - Case Mix Score*
- **Indirect Costs:** Housekeeping, Laundry, Dietary, Adm., Utilities, Insurance
- **Capital Cost:** Interest and depreciation for approved capital expenses.
- **Non-comparable Costs:** Staff or services beyond the basic direct costs, such as salaried physicians, psychologists, nurse practitioners, swallowing disorder specialists, etc.
Calculating Medicare Part A and Medicaid Rates in the SNF:

The MDS

- A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid.
MDS: Very Brief History

- Major Federal Nursing Home Reform OBRA’87
- 1990 Nursing Home Case Mix and Quality Demonstration Project
- 1991 The RAI Process and the Minimum Data Set (MDS) was implemented nationally
- Goal was to assist SNF’s in “preliminary screening to identify potential resident issues/conditions, strengths, and preferences” in an effort to develop an effective plan of care
- Provides federal regulators with data to track each nursing home resident’s cognitive, physical, clinical and psycho-social condition

MDS History

- SNF is required to complete MDS Assessments and transmit to CMS on all patients admitted to SNF per the federally mandated schedule, regardless of payer
- On Admission, Annually, (366 days) Quarterly (92 days), Significant Change
- Each May and October, CMS publishes changes, revisions and/or clarifications to the tool itself, sections or rules for completion as part of the ‘Final Rule’
- Multiple Revisions and additions over the last 20+ years. Currently over 30 pages of data must be collected and submitted per the federal submission guidelines on each patient in the SNF.

MDS Regulations Require

- A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
- Each completed assessment captures patient specific clinical and services data that occurred or was provided during a 7 or 14 day ‘look back’ time frame depending on the type of data
- All data included on MDS must be clearly supported through documentation in the medical record
MDS Section Item Sets

- A. Demographic
- B. Vision, Hearing, Communication
- C. Cognition
- D. Mood
- E. Behaviors
- F. Preferences
- G. Functional Status/ADL’s
- H. Bladder and Bowel Continence
- I. Active Diseases
- J. Health Conditions
- K. Nutrition Status
- L. Oral/Dental Condition
- M. Skin/Wounds: Pressure Ulcers
- N. Medications
- O. Special Treatment, Procedures and Programs
- P. Restraints
- Q. Participation and Goal Setting
- R. State Specific
- S. Nutrition Status
- T. Weight, artificial feeding
- U. Falls, Pain, Shortness of Breath
- V. Care Area Assessments
- W. Assessment Administration- attestations
- X. Correction Request
- Y. NY: Payer, Dental Care
- Z. Other

MDS

- CMS grouped certain disease/condition/clinical service related item sets together based on acuity, and amount of resource utilization required to provide care
- The groups are further categorized based on the amount of assistance required to assist the patient in completing their activities of daily living (ADL’s)
  - Specifically, move in bed, moving from surface to surface, eating and toilet use
- Algorithm within software produces a score derived from the conditions and resources required to provide care to the patient
- Known as Resource Utilization Group or “RUG” score

RUG-IV

- Refer to Handout
Example 1

Diagnosis: COPD (Section I)
Clinical Conditions (Section J):
- Shortness of Breath While lying flat

Mood State: (Section D) Assessment Score less than 10

HE1 Special Care High

Example 2

Diagnosis: Pneumonia (Section I)
Activities of Daily Living (Section G):
- Move In Bed, Ability to Move from Bed to Chair, Self Feed, Use toilet = 6

Mood State: (Section D) Assessment Score greater than 10

CC2 Clinical Complex

Example 3

Foot Infection with dressing (Section M)
Activities of Daily Living (Section G):
- Move In Bed, Ability to Move from Bed to Chair, Self Feed, Use toilet = 12

Mood State (Section D): less than 10

Non-Therapy RUG LD1 Special Care Low

Therapy RUG RVC Rehab Very High

Rehabilitation Services (Section D):
- OT: 180 min/5 days, PT 200 min/5 days
Example 4

Residents whose needs are primarily for activities for daily living and general supervision and not qualifying for other categories.

Activities of Daily Living (Section G)
- Move in Bed
- Ability to Move from Bed to Chair
- Ability to Self Feed
- Ability to toileting = 6

PC1 Reduced Physical Functioning

Impact of the MDS 3.0

MDS 3.0
- Medicare Reimbursement
- Publicly Reported Information QM/5 Star Rating
- NY Medicaid Reimbursement
- Survey
- Resident Care

Impact: Quality Measures, Survey and Resident Care
- Depending on the patient's condition, the scores can change from assessment to assessment throughout the time that the patient is in the SNF
- Software tracks the scores and items within the sets such as Cognition, Pain, Falls, Pressure Ulcers, Psychotropic Medications and ADL's to calculate the facilities Quality Measures
- http://www.medicare.gov/nursinghomecompare/search.html
- Gives facility leadership ability to identify and address changes in the patients condition
- Gives regulators the ability to identify potential areas of concern
Establishing the Medicare Rate

- Balanced Budget Act of 1997 changed Medicare SNF reimbursement from cost based to prospective payment
- Per diem - All Inclusive Rate
- Determined from MDS assessment RUG classification
- Rates adjusted for geographic variation in wages
- Annual Updates: Payment rates are increased each Oct. using a SNF market basket index
- Currently Utilizing MDS 3.0 RUG-IV ~ 66 groupers

Medicare and MDS

- Rate variable through stay depending on clinical condition and/or amount of therapy services
- Medicare/PPS assessment schedule dependent on length of SNF stay
- For 100-Day stay, at minimum 5 separate assessments
  - "5 Day" – Pays Days 1-14
  - "14 Day" – Pays Days 15-30
  - "30 Day" – Pays Days 31-60
  - "60 Day" – Pays Days 61-90
  - "90 Day" – Pays Days 91-100
- Other Medicare Required Assessments: Resets payments based on changes in therapy delivery intensity and schedule

MDS RUG = Medicare Rate
Impact of Rehabilitation
Harmony Healthcare International, Inc.

MDS RUG = Medicare Rate = Clinical Scores

Presumption of Coverage

Medicare Lower 14 RUG Classifications
Risk of Audit and Denial

Keys to Ensuring Accurate Medicare Reimbursement:

- MDS: Must understand MDS PPS rules/regulations to ensure accuracy in scheduling and completing MDS
  - 1000 points of information depicting 66 categories
  - ADL = 30% of Medicare Rate
  - Focused Role

- Rehab
  - Ensure delivery of efficient and clinically appropriate services with sufficient staffing
  - Daily communication with MDS to ensure accuracy in MDS schedule and with clinical staff and family to minimize disruption of therapy delivery

- Nursing: MDS must be reflective of Medical Record
  - Ensure daily nursing documentation reflects skilled level of care provided to patient
  - Ensure direct care staff accurately document assist for ADL's
MDS and NYS Medicaid CMI

Medicaid – New York
Per Day/Per Patient Rate Based on 4 “Buckets” of Expenses

- **Direct Costs:** Clinical, Therapeutic, Supportive Care Expenses (i.e. Salaries of nursing staff) AND
- **Case Mix Score**
- **Indirect Costs:** Housekeeping, Laundry, Dietary, Adm., Utilities, Insurance
- **Capital Cost:** Interest and depreciation for approved capital expenses
- **Non-comparable Costs:** Staff or services beyond the basic direct costs, such as salaried physicians, psychologists, nurse practitioners, swallowing disorder specialists, etc.

NYS Medicaid Case Mix Calculation

- **Case Mix** = Measure of Acuity and Resource Utilization
- Calculated bi-annually based on last Wednesday in January and July
- MDS 3.0 - 53 RUG III Model
  - Each RUG score is assigned a numerical score or Case Mix Index (CMI)
- CMIs for Medicaid MDSs are averaged for facility CMI score
- Most recent OBRA MDS completed in past 92 days used.
  - Utilize RUG Scores from federal MDS.
- Medicaid Only
  - Medicaid, Medicaid Pending, Medicaid Managed Care, Medicaid Hospice
### MDS RUG = Medicaid CMI Impact of Rehabilitation

<table>
<thead>
<tr>
<th>RUG</th>
<th>AOC</th>
<th>CMI</th>
<th>Qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2</td>
<td>0.70</td>
<td>0.65</td>
<td>1) Rehabilitation response, unable to ambulate 30 minutes</td>
</tr>
<tr>
<td>P3</td>
<td>0.70</td>
<td>0.65</td>
<td>2) Rehabilitation response to ambulation as limited (e.g., weakness, orthosis)</td>
</tr>
<tr>
<td>P4</td>
<td>0.70</td>
<td>0.65</td>
<td>3) Rehabilitation response to ambulation as limited (e.g., weakness, orthosis)</td>
</tr>
<tr>
<td>P5</td>
<td>0.70</td>
<td>0.65</td>
<td>4) Rehabilitation response to ambulation as limited (e.g., weakness, orthosis)</td>
</tr>
</tbody>
</table>

### MDS RUG = Medicaid Case Mix = Clinical Scores

<table>
<thead>
<tr>
<th>RUG</th>
<th>AOC</th>
<th>CMI</th>
<th>Qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>0.90</td>
<td>0.80</td>
<td>1) Hemorrhagic stroke</td>
</tr>
<tr>
<td>Q2</td>
<td>0.90</td>
<td>0.80</td>
<td>2) Traumatic brain injury (TBI)</td>
</tr>
<tr>
<td>Q3</td>
<td>0.90</td>
<td>0.80</td>
<td>3) Spinal cord injury (SCI)</td>
</tr>
<tr>
<td>Q4</td>
<td>0.90</td>
<td>0.80</td>
<td>4) Peripheral neuropathy</td>
</tr>
</tbody>
</table>

### MDS RUG = Medicaid CMI Impact of Lower 18

<table>
<thead>
<tr>
<th>RUG</th>
<th>AOC</th>
<th>CMI</th>
<th>Qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1</td>
<td>0.90</td>
<td>0.80</td>
<td>1) Clinically significant depression</td>
</tr>
<tr>
<td>L2</td>
<td>0.90</td>
<td>0.80</td>
<td>2) Severe pain</td>
</tr>
<tr>
<td>L3</td>
<td>0.90</td>
<td>0.80</td>
<td>3) Cognitive impairment</td>
</tr>
<tr>
<td>L4</td>
<td>0.90</td>
<td>0.80</td>
<td>4) Physical inactivity</td>
</tr>
</tbody>
</table>

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CMI – “Add-On’s”

- Dementia Diagnosis with
  - Impaired Cognition (IA, IB Scores)
  - Behavioral (BA, BB Scores)
  - Reduced Physical Functioning with ADL 10 or less
- Qualifies for additional $8.00 per day
- Body Mass Index (BMI) is greater than 35 (PHL §2808 2-b(b)(xi))
  - BMI greater than 35
  - Calculated per MDS
  - Qualifies for additional $17.00 per day
- Traumatic Brain Injury
  - Qualifies for additional $35.41 per day

Keys to Ensuring Accurate Medicaid Reimbursement

- **MDS Coordinator**: Understand Scheduling rules/regulations and schedule MDS to accurately reflect clinical conditions
  - Strong communication with clinical team
- **Rehab**: Ensure Rehab Team understands SNF regulations and provides appropriate services
  - Highest practical level of function
  - Jimmo Settlement
  - Communicates with MDS
- **Nursing**: MDS must be reflective of Medical Record
  - Strong communication with MDS on resident changes/issues
  - Ensure daily nursing documentation reflects skilled level of care provided to patient
  - Ensure direct care staff accurately document assist for ADL’s

MDS and SNF Current Environment
Current Environment

- MDS
  - Highly vulnerable to error
  - Much State and Federal Focus
  - OMIG Work Plan
    - "Improper Payment"
    - Over Coding
    - Medical Record Documentation not supportive of MDS

NYS OMIG: Medicaid CMI

- NYS DOH and OMIG began auditing New York State facilities whose CMI changed by more than five percent between the January 2011 to January 2012 roster submissions in 2013
- 2014 and 2015 OMIG Work Plan: Minimum Data Set: OMIG will review Minimum Data Set submissions from nursing facilities. During State Fiscal Year 2014-2015, OMIG will collaborate with DOH to initiate reviews of data submissions OMIG Audits continued with 2013 MDS submissions.
- High risk areas such as ADL’s, Therapy Logs

OIG – Federal 2015 Work Plan

- Medicare Part A billing by skilled nursing facilities:
  - Prior OIG work found that SNFs increasingly billed for the highest level of therapy even though beneficiary characteristics remained largely unchanged. OIG also found that SNFs billed one-quarter of all 2009 claims in error; this erroneous billing resulted in $1.5 billion in inappropriate Medicare payments
- Questionable billing patterns for Part B services during nursing home stays
PEPPER

- Program for Evaluating Payment Patterns Electronic Report (PEPPER)
- MDS Medicare PPS Assessment Data
- Initial SNF release August 31, 2013
- Hospital PEPPER reports released 2005
- Annual

Target Areas

- Therapy RUGs with High ADLs
- Nontherapy RUGs with High ADLs
- Change of Therapy Assessment
- Ultra High RUGs
- Therapy RUGs
- 90+ Day Episodes of Care

Risks and Opportunities

- SNFs whose target percents are at or above the 80th percentile (i.e., in the top 20 percent) are considered at risk for improper Medicare payments with areas at risk for overcoding
- SNFs whose target percents are at or below the 20th percentile (i.e., in the bottom 20 percent) are considered at risk for improper Medicare payments with areas at risk for undercoding
Take Away

- Critical Role of MDS in Medicare, Medicaid Reimbursement as well as Quality Measure and Survey
- MDS complex, highly specialized, highly susceptible to error
- Successful facilities invest in MDS support and education

Bibliography

- Genworth Cost of Care 2014 Survey
- Oscar Data 2011
- NYS DOH January 2014 SNF Medicaid Rates
- **NYS DOH**
  - [https://www.health.ny.gov/facilities/nursing/estimated_average_rates.htm](https://www.health.ny.gov/facilities/nursing/estimated_average_rates.htm)

Questions/Answers

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