Top Ten Missed Opportunities In The SNF

Presented by:
Harmony Healthcare International, Inc. (HHI)

- PPS & Case Mix Onsite Chart Audits
- MMQ Audits
- Seminars
- Consulting
- Program Development
- Mock Survey
- Sample RAC Reviews
- JCAHO
- 5 Star Rating Analysis
Top Ten Missed Opportunities in the Skilled Nursing Facility

Presented by:
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Harmony Healthcare International, (HHI)

About Kris

Kris Mastrangelo, OTR/L, LNHA, MBA
Kris Mastrangelo, President and CEO, owns and operates Harmony Healthcare International, (HHI) an industry leader in Long Term Care consulting.

- 14,000 Medical records reviewed per year
- Core Business Patient Centered

Follow Me! @KrisMastrangelo

A Drive Down Reimbursement Memory Lane
Medicare

- Federal Health Insurance Program
- Title XVIII (Medicare)
- Into effect July 1, 1966
- Cost Based
- Ancillary Expense plus A & G
- Square footage
- Treated without minute criterion
- Patient outcomes
- LOCC
- RCL/Exceptions/Exemptions
- CDP: Certified Distinct Part

The Medicare Structure

- Guidelines directed by CMS
- Many different entities (ZPIC, RAC, OIG, DOJ)
- CMS allows the MAC to function in an Administrative capacity between healthcare providers and the government
- Kathleen Sebelius, Secretary (HHS) Health and Human Services, 2013

Cost Based to Prospective Payment

- 1988 MDS Care
- 1998 PPS
- Bankruptcy
- BIPA
- Therapy Transition
Federal Regulations

- Not always written clearly
- Not always written concisely
- Not always written definitively
- Do not always make logical sense
- Change on a regular basis!

Top Ten Missed Opportunities

1. Nurses Rule the World
2. Rehabilitation Departments
3. Skilled Therapy Documentation
4. ADL Coding
5. Clinically Anticipated Stay
6. MDS Accuracy
7. Respiratory Therapy
8. Depression
9. ARD Management
10. Scrutinize the Lower 14
Top Ten Missed Opportunities
Number One:

“Nurses Rule The World”

What is Skilled Care?

- Anchoring the Skill

Nurses Rule The World

Medicare Eligibility

Treated for a condition which was treated during a qualified stay…or… which arose while in a SNF for a treatment of condition for which the beneficiary previously was treated in a hospital

For Example:
Fractured hip develops pneumonia secondary to immobility

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Medicare Requirements

- The patient requires **Skilled Nursing Services or Skilled Rehabilitation Services** (i.e., services that must be performed by or under the supervision of professional or technical personnel) (See §214.1 – 214.3)

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Medicare Requirements

- The patient requires these skilled services on a **daily basis** (see §214.5)
  - Daily Nursing Notes
  - Treatment Sheets
Medicare Requirements

- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF (see §214.6)
- In other words, prove in your documentation why services need to be provided at a SNF level of care!

“Practical Matter” Criterion

1. Outpatient services are not available in the area where the individual lives
2. Outpatient services are available in the area where the individual lives, but transportation to the closest facility could cause an excessive physical hardship, be less economical, or less effective that placement in the skilled nursing facility

“Practical Matter” Criterion

3. The availability at home of a capable and willing caregiver should be considered, but the care can be furnished only in the skilled nursing facility if home care would be ineffective because there would be insufficient assistance at home for the patient/patient to reside there safely
“Practical Matter” Criterion

4. If the use of alternative services would adversely affect the patient/patient's medical condition, then as a practical matter the daily skilled service(s) can only be provided on an inpatient basis.

Medicare Requirements

- For example: Payment for a SNF level of care may not be made if documentation supports a patient's need as intermittent rather than a daily skilled service.
- Documentation in the patient's record must support the provision of a skilled level of care.

What is Skilled Care?

- Requires the skills of qualified technical or professional health personnel such as RN, LPN, PT, OT or SLP.
What is Skilled Care?

- Must be provided directly by or under the general supervision of a licensed nurse or skilled rehab personnel to assure the safety of the resident and to achieve the medically desired result.

- "General supervision" requires initial direction and periodic inspection of activity.

What is Skilled Care?

- Ordered by a Physician

What is Skilled Care?

- Services are needed and provided on a daily basis.
What is Skilled Care?

- The need for skilled care **must** be justified and documented in the medical record.
- Conditions may have prompted the initial hospitalization, but also include the conditions that arose during recovery in the SNF.

Why Nurses Rule the World

- Direct Skilled Nursing Services (Inherent Complexity)
- Management and Evaluation of a Care Plan
- Observation and Assessment
- Teaching and Training
- Skilled Rehabilitation

Skilled Services Categories: Inherent Complexity

**Inherent Complexity** – Direct skilled nursing services including:
- IV feeding
- IM or IV meds
- Tracheal or nasopharyngeal suctioning
- Tracheostomy care
- Ventilator support
- Daily care of extensive pressure ulcers or widespread skin disorders
Skilled Services Categories: Inherent Complexity

Inherent Complexity (Cont.)
- Tube feedings
- Respiratory therapy
- Unstable clinically with diabetes with injections
- Colostomy care, early post op care
- Irrigation, replacement or insertion of suprapubic catheters

Top Ten Missed Opportunities Number Two:

Rehabilitation Departments
“The Business within the Business”

Quote

“Remember, its not the questions you ask, but the questions you fail to ask, that shape your destiny.”

Anthony Robbins
The Business Within the Business


Rehab Case Management Overview

- Operational Elements
- Standards of Operation
- Clinical Systems

Operational Elements

- Staffing
- Space
- Signage
- Equipment
- Marketing
Operational Elements
Staffing

- Registered Clinicians (OTR, RPT, SLP)
- Licensed Assistants (COTA, LPTA)
- Aides

Operational Elements
Staffing Mix

- Ideal Situation
- Availability
- Costs
- Individual

Operational Elements
FTE Calculation

- Part A Census
- Part B Pool
- Other Payors
Staffing/Caseload Calculation

Facility

- 120 bed facility
- 89% occupied
- 12 Medicare Part A's
- 15 privates
- 10 other

Staffing/Caseload Calculation

Part A

- (12 ADC) (75%) = 9 rehab patients

Staffing/Caseload Calculation

Part B

- Total Census 106.8 Minus:
  - 12 Medicare A's
  - 15 (private)
  - 10 (other)
  - = 69.8 Part B pool
  - (69.8) (.05) = 3.49 anticipated caseload
    (Conservative measure)
**Therapy Caseload**

- 9 Part A
- 3.49 Part B
- 12.49 Total Caseload

**FTE Calculation**

- Total 12.49 Residents
  - By 8 = 1.56 FTE OT = 62.45 hrs/week
  - By 8 = 1.56 FTE PT = 62.45 hrs/week
  - 10% PT = ST 1.56 = 6.25 hrs/week

**FTE Calculation**

- OT: 62.45 hrs/week
- PT: 62.45 hrs/week
- SLP: 62.25 hrs/week
- Total: 131.15 hrs/week
- = 3.28 FTE’s
Staffing Mix

- COTA: 40 hrs/week
- OTR: 22.25 hrs/week
- Total OT: 62.45 hours/week

Staffing

- Team Leader
- Aides

Operational Elements

- Space
- Signage
- Equipment
  - Capital
  - Supplies
- Marketing
- Policies & Procedures
Rehabilitation Supplies

- Splinting Material
- Theraputty
- ADL Equipment
  - Reachers
  - Sock aids
  - Elastic shoe laces
  - Long-handled sponges
- Speech Diagnostic Tools
- Hot and Cold Pack Covers
- Thera Band
- Wedges
- Sponges
- Cushions

Quality of Care

- State Surveys
- Under Utilization
- Fine
- Contractures
- Restraints
- Skin Breakdown

Policies & Procedures

- Evaluations
- Forms
- Programs
Standards of Operation

1. Productivity
2. Part B ppm
3. Part A Rehab Mix
4. Cost per hour
5. Margin
6. Revenue per hour

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Standards of Operation
Productivity: 75%

- 8 hours worked
- 6 hours billable
- 6/8 = 75%

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Standards of Operation
Productivity

- Consistent Standards
- Inclusive/Exclusive Aides
- Inclusive/Exclusive Team Leaders
Standards of Operation

- Tracking System
  - Automated
  - Manual
  - Explore Variances

Operational Strategies

- Rate Analysis
- 29% Med A Revenue Attributed to Rehab
- RUG Mix Analysis
- Clinically Appropriate Stay
- Separate Chain of Command

Clinical Systems

- Restorative Feeding
- Functional Maintenance
- Restorative Nursing
- Contracture Prevention
- Wound Care
- Restraint Reduction
- Positioning
Facility Integration Systems

- Integrated with Nursing
- User-Friendly Forms
- Established Protocol

Functional Maintenance Jimmo

- Establishment of Maintenance Program
- Skilled Care
  - Finger Foods
  - Splint Care
  - Care Giver Training
  - Adaptive Equipment

Restorative Nursing

- Medicare vs. Regulatory
- Restorative Aide
- Forms
- Integration / Training
Augmentative Evaluations
- Feeding
- Positioning
- Restraints
- Contractures
- Swallowing
- Cognitive/Perceptual
- Home Assessment

Contracture Prevention/Wound Care
- Screens Prior to Care Planning
- Change of Conditions
- Care Plans Attendance
- Rounds

Training
- Clinical
- Reimbursement
Denials Management

- Clinical Review
- Team Process
- RUG Intimacy

Strategic Overview

- Care
- Documentation
- Standards of OPS

Top Ten Missed Opportunities
Number Three:

Skilled Therapy Documentation
5 Tips To Improve Therapy Documentation

http://www.harmony-healthcare.com/blog/bid/97301/5-Tips-to-Improve-Therapy-Documentation

Rehabilitation Documentation

- Get back to basics!
  - Tell the patient’s story
  - State the Obvious
  - Why the skilled hands and brains of a therapist are needed?
  - Support with specific Physician orders

Incomplete Documentation

- Incomplete therapy documentation exposes the facility to financial loss in the case that medical records are reviewed by either the MAC or as a result of RAC audit.
Incomplete Documentation

Title XVIII of the Social Security Act; section 1862(a)(1)(A) states that coverage and payment will only be provided for those services that are considered to be reasonable and necessary (#1-7).

Missing therapy documentation limits the facility’s ability to make this justification.

Other possible reasons for denial of payment related to documentation are:
1. Failure to document a complete treatment plan as outlined in the required section of the evaluation.
2. Lack of documentation relating to the patient’s ability to demonstrate significant progress.

Beyond financial implications, incomplete documentation violates PT, OT and ST standards of practice.

Recommendation: Therapists should consider either “point of service” documentation or allot enough time during the day to complete all notes.
Incomplete Documentation

- All therapy original documentation be filed in medical record within 24 hours of completion.
- Content of documentation is critical in justifying Medical Necessity of provided services.

Components of Medical Necessity

1. Once a physician’s order for a therapy evaluation has been received, assess the resident to determine if therapy services are warranted. The services must be directly and specifically related to an active written treatment plan designed by a qualified therapist and approved by the referring physician.

2. Define the need for services that require the skills of a therapist and indicate why the services are needed now. A short-term intervention to establish and monitor a functional maintenance program may be considered a skilled service.
Components of Medical Necessity

3. Create a treatment plan and specify the amount, frequency and duration of treatment consistent with the nature, extent and severity of the illness or injury. Justify the specified intensity of treatment. The patient's medical needs must be considered and the therapy services must meet accepted standards of medical practice as specific and effective treatment for the patient's condition.

Components of Medical Necessity

4. Identify the recent change of condition required to warrant an evaluation.

5. Identify the most recent prior level of function (prior to the onset of the episode) and current level of function with objective measurements. Indicate the relationship between the current and prior level of function.

Components of Medical Necessity

6. Define the positive expectation or the patient's potential for improvement in function.

7. Set functional goals.

8. Assess whether the resident has made significant improvement (document in the progress notes).
Components of Medical Necessity

9. Evaluate whether other individuals providing care to the resident can see the patient’s progress or the impact of the therapy services. If differences or variations in documentation occur, (i.e., between therapy and nursing notes) explain the reason for the differences. Education with nursing staff on specific therapy techniques may be indicated, as well as the establishment of a functional maintenance program when appropriate.

Components of Medical Necessity

10. The supervising therapist should co-sign the notes of the assistant and provide supervision in accordance with the current state regulations.

Skilled Therapy Documentation

1. Evaluations
   - Tool for the government to ascertain whether or not the services are reasonable and necessary.
2. Functional Limitations

- Describe why the patient needs help.

It is imperative that therapists elaborate note writing to define the etiology for therapeutic interventions. Within this context, the therapist also needs to demonstrate why the daily skills, knowledge and judgment of a trained professional are required.

3. Safety:

- Safety issues are a top priority in health care. A safety problem exists when the patient is unable to handle himself in a manner that is physically and/or cognitively safe unless the therapist is involved.
- This may extend to all aspects of daily living as well as added secondary complications which may intensify the medical sequelae (such as skin breakdown).
4. Plans of Treatment:
   - The therapy plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached.
   - It is not adequate to estimate 1-2 months on an ongoing basis.

Aspects that must be addressed in the plan of treatment include:
- Type of Therapy Procedure
- Frequency of Visits
- Estimated Duration
- Diagnosis
- Functional Goals
- Rehabilitation Potential

5. Progress Notes
   - Weekly progress reports and treatment summaries need to address the following:
     - The patient's initial functional status
     - The patient's functional status and progress (or lack thereof) specific for the reporting period; including clinical findings (amount of physical and/or cognitive assistance needed, range of motion, muscle strength, unaffected limb measurements, etc.)
     - The patient's expected rehabilitation potential.
Skilled Therapy Documentation

Where a valid expectation of improvement exists, the services are covered even though the expectation may not be realized. Progress reports or status summaries must document a continued expectation that the patient’s condition will continue to improve significantly in a reasonable and generally predictable period of time. With the advent of the Jimmo Settlement, “the improvement” criterion has been elaborated and will be addressed in a future blog.

Source: Medicare Benefit Policy Manual, Documentation Requirements for Therapy Services – Section 220.3(Rev. 16), Issued: 12-21-12, Effective: 01-01-13, Implementation: 01-07-13

Top Ten Missed Opportunities
Number Four:

ADL Coding

Activities of Daily Living (ADLs)

Key Points

- The intent is to capture what the resident actually does, NOT what they could, would or should do
- Assistance needed varies from day to day, from shift to shift and even during a particular shift
- The reason that the assistance was required is irrelevant; it simply matters that it was needed.

Activities of Daily Living (ADLs)

Key Points

- Assistance must be provided by facility staff (that includes those that are employed by the facility as well as contract/agency staff)
- Do not include help provided by family members, ambulance staff, hospice staff, etc.

The Late Loss ADLs

- Bed Mobility
- Transfer
- Eating
- Toilet Use
ADL Scoring
PPS Impact

- Patient receiving **45 minutes** of therapy with **three days per week** (any combination of three disciplines) = **Rehab Low RUG**
- ADL Score = **11**
- RLB = **$363.35 per day**

ADL Scoring
PPS Impact

- Patient receiving **45 minutes** of therapy with **three days per week** (any combination of three disciplines) = **Rehab Low RUG**
- ADL Score = **10**
- RLA but.....
- **Index Maximizes to PC2 = $279.65**

ADL Scoring
PPS Impact

**Dollar Impact (per day) = $83.70**  
**Dollar impact (per 14 days) = $1,171.80**  
**x10 patients = $11,718.00**  
**x12 months = $140,616.00**

The patient is now in the **“lower 14” and highly prone to audit** by the FI/MAC!
How Is ADL Status Reported and Recorded in Your Facility?

- Let’s discuss the system in your facility to report/record ADL status
- Does it work well?
- Are you capturing the true picture of the resident?
- Why or why not?
- How can it be improved?

Top Ten Missed Opportunities Number Five:

Clinically Anticipated Stay

SNF Data

“Data, Data, Data, you cannot make bricks without clay”

- Sherlock Holmes

Clinically Anticipated Stay

- To navigate through these times of uncertainty, take a strong detailed look at the clinical data for beneficiaries discharged to home
- Collect data, drill it down and identifying clinical and financial opportunity is an approach that needs to be engrained in your organization

Clinically Anticipated Stay

- Tracking patient success and hospital readmission **post SNF discharge** is critical yet highly difficult to collect.
- Networks can indeed produce; however, results are limited due to patient and automation incompatibility.

Harmony Healthcare Discharge Destination Analysis 2011
Clinically Anticipated Stay

<table>
<thead>
<tr>
<th>Destination</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>55.6%</td>
</tr>
<tr>
<td>Hospital</td>
<td>20.2%</td>
</tr>
<tr>
<td>Death</td>
<td>4.7%</td>
</tr>
<tr>
<td>Other SNF</td>
<td>2.3%</td>
</tr>
<tr>
<td>In-House</td>
<td>16.9%</td>
</tr>
</tbody>
</table>

Clinically Appropriate Stay (Geometric Mean)

Sample Facility
FY2013

Harmony Healthcare International, Inc.
Individual Patient Record Database Criteria

- Meaningful Calculation of Length of Stay
  - Average LOS
  - Geometric Mean LOS
- Unified Description of Diagnoses Categories
- Uniformity of Diagnoses Terminology

Geometric Mean and Average Length of Stay Comparison

Geometric Mean and Average Length of Stay Algorithms

Average

$$ALOS = \frac{d_1 + d_2 + d_3 + \ldots + d_n}{n}$$

Geometric Mean

$$GMLOS = \sqrt[\sqrt{\ldots\sqrt{n}}]{d_1 \times d_2 \times d_3 \times \ldots \times d_n}$$

Geometric Mean Calculation Algorithm

$$GMLOS = e^{\left(\frac{\log d_1 + \log d_2 + \log d_3 + \ldots + \log d_n}{n}\right)} = e^{\left(\frac{\sum \log d_i}{n}\right)}$$

Note: In Excel Use the Function GEOMEAN
Sample Facility FY2013
Clinically Appropriate Stay (Geometric Mean)

- The following histogram depicts the 2013 Clinically Appropriate Stay in:
  - Days
  - Discharge Destination and
  - Diagnoses Category (HHI defined groups)
- This overview provides a broad based visual of multiple variables. The Orthopedic, Respiratory and Circulatory categories yield the highest CAS (GM), while In-House destination trends the highest overall CAS (GM).

Sample Facility FY2013
Histogram: Days, Destination, Diagnoses Category

Sample Facility FY2013
Destination Distribution

<table>
<thead>
<tr>
<th>% Patients</th>
<th>CAS</th>
<th>% Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>73% Home</td>
<td>11.9 days</td>
<td>71% Home</td>
</tr>
<tr>
<td>12% Hospital</td>
<td>6.6 days</td>
<td>8% Hospital</td>
</tr>
<tr>
<td>10% In-House</td>
<td>21.7 days</td>
<td>19% In-House</td>
</tr>
<tr>
<td>2% Death</td>
<td>4.1 days</td>
<td>1% Death</td>
</tr>
<tr>
<td>1% Other</td>
<td>19.1 days</td>
<td>2% Other</td>
</tr>
</tbody>
</table>

Total Composite CAS | 11.6 days
Sample Facility FY2013 Destination Distribution

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days:</td>
<td>5,164</td>
</tr>
<tr>
<td>Total Patients:</td>
<td>354</td>
</tr>
<tr>
<td>Total Composite CAS:</td>
<td>11.6</td>
</tr>
<tr>
<td>National CAS:</td>
<td>18.3</td>
</tr>
<tr>
<td>State CAS:</td>
<td>16.6</td>
</tr>
</tbody>
</table>

Sample Facility FY2013 Diagnoses Category CAS (GM)

- **Top 3 categories:**
  - Orthopedic
  - Respiratory
  - Circulatory

- **Orthopedic:**
  - 12.1 days representing:
    - 40% patients (144 patients)
    - 42.9% days (2,148 days)

Sample Facility FY2013 Diagnoses Category CAS (GM)

- **Respiratory:**
  - 10.7 days representing:
    - 14.7% patients (53 patients)
    - 13.3% days (665 days)

- **Circulatory:**
  - 17.4 days representing:
    - 6.1% patients (22 patients)
    - 10.6% days (529 days)
Top 6 Diagnoses by Patient Days

1. Total Knee Replacement:
   - 10.4% days (536 days)
   - 9.7 days CAS (GM)
   - 14.4% patients (51 patients)

2. Pneumonia:
   - 8.2% days (423 days)
   - 11.2 days CAS (GM)
   - 8.5% patients (30 patients)

3. ORIF Hip:
   - 8% days (413 days)
   - 23.1 days CAS (GM)
   - 4.5% patients (16 patients)

4. Total Hip Replacement:
   - 6.6% days (343 days)
   - 10.1 days CAS (GM)
   - 7.1% patients (25 patients)

5. CVA:
   - 6.6% days (343 days)
   - 18.2 days CAS (GM)
   - 3.4% patients (12 patients)

6. CHF:
   - 4.1% days (214 days)
   - 11 days CAS (GM)
   - 4.5% patients (16 patients)
Sample Facility FY2013
Diagnoses by Patient Days

Top 3 categories: Orthopedic, Respiratory, Circulatory

Orthopedic:
- 12.2 days representing:
  - 47.3% patients (121 patients)
  - 48.7% days (1,744 days)

Respiratory:
- 11.1 days representing:
  - 11.3% patients (29 patients)
  - 10.2% days (364 days)

Circulatory:
- 18.5 days representing:
  - 4.7% patients (12 patients)
  - 6.5% days (234 days)
Sample Facility FY2013
Home
CAS (GM) by Category, % Patients and % Days

Top 3 categories:
- Orthopedic
- Circulatory
- Respiratory

Orthopedic:
- 24.6 days representing:
  - 25.7% patients (9 patients)
  - 27.6% days (253 days)

Circulatory:
- 41 days representing:
  - 14.3% patients (5 patients)
  - 26.7% days (245 days)

Respiratory:
- 17 days representing:
  - 17.1% patients (6 patients)
  - 12.5% days (115 days)
Sample Facility FY2013
In-House
CAS (GM) by Category, % Patients and % Days

Top 3 categories:
- Respiratory
- Orthopedic
- Cardiac

Respiratory:
- 9.7 days representing:
  - 27.9% patients (12 patients)
  - 36.5% days (129 days)

Orthopedic:
- 6.2 days representing:
  - 27.9% patients (12 patients)
  - 28.6% days (101 days)

Cardiac:
- 5.2 days representing:
  - 18.6% patients (8 patients)
  - 15% days (53 days)
Hospital destination CAS (GM) is **6.6 days** below the National Average. Hospital destination represents **12%** of discharge destinations and **8%** of days. This indicates on average patients are returning to the acute care by day 6 of their care placing them in the window for readmission penalties.

**Top 3 categories:**
- Respiratory
- Circulatory
- Orthopedic

**Respiratory:**
- 5.3 days representing:
  - 50% patients (4 patients)
  - 71.1% days (32 days)
Sample Facility FY2013
Death
CAS (GM) by Category, % Patients and % Days

- **Circulatory:**
  - 2.4 days representing:
    - 25% patients (2 patients)
    - 11.1% days (5 days)

- **Orthopedic:**
  - 4 days representing:
    - 12.5% patients (1 patient)
    - 8.9% days (4 days)

Sample Facility FY2013
Death
CAS (GM) by Category, % Patients and % Days

Top 3 categories:
- Orthopedic
- Respiratory
- Cardiac

**Orthopedic:**
- 46 days representing:
  - 20% patients (1 patient)
  - 40.7% days (46 days)
Sample Facility FY2013
Other SNF
CAS (GM) by Category, % Patients and % Days

- Respiratory:
  - 11.2 days representing:
    - 40% patients (2 patients)
    - 22.1% days (25 days)
- Cardiac:
  - 19 days representing:
    - 20% patients (1 patient)
    - 16.8% days (19 days)

Clinically Anticipated Stay

Harmony’s (HHI) data depicts that rehospitalization of 4,027 patients during the SNF stay results in the highest rate of hospital return days 8-14 while the most frequent diagnosis (and reason for return) is pneumonia:
- It makes you wonder about respiratory therapy doesn’t it?
Jimmo v. Sebelius

The Jimmo v. Sebelius case challenged Medicare’s use of an "Improvement Standard" to make coverage determinations.

The lawsuit was brought on behalf of:
- Six individuals representing a Nationwide class of Medicare beneficiaries
- National organizations representing people with chronic conditions

Individual Plaintiffs: Glenda Jimmo

Paul O. Boisvert for New York Times
Individual Plaintiffs

- Lead plaintiff, **Glenda Jimmo**, is a 76-year-old Medicare beneficiary from Bristol, Vermont
- Blind since birth and has had her right leg amputated due to complications from diabetes
- Requires a wheelchair, and receives multiple home health care visits per week for various treatments for her complex condition
- Medicare denied coverage for these services, saying that she was unlikely to improve

Individual Plaintiffs: **Rosalie J. Berkowitz**

*New York Times October 22, 2012*

- [Image of Rosalie J. Berkowitz]

Individual Plaintiffs

- **Rosalie J. Berkowitz** is an 81-year-old Medicare beneficiary from Stamford, Connecticut
- Multiple Sclerosis
- Medicare denied coverage for home health visits and physical therapy on the grounds that her condition was not improving
- Her family said she would have to go into a nursing home if Medicare did not cover the services
National Organizations
- National Multiple Sclerosis Society
- Parkinson’s Action Network
- Paralyzed Veterans of America
- Alzheimer’s Association
- United Cerebral Palsy
- National Committee to Preserve Social Security and Medicare, an advocacy group

Improvement Standard
The settlement addresses Medicare terminating or denying coverage to beneficiaries who are not improving for Medicare Part A and Part B

Improvement Standard
- Plaintiffs alleged the “Improvement Standard”:
  - Is "a covert rule of thumb" that is not supported by the Medicare statute or regulations
  - Operates as an additional condition of eligibility which effectively denies beneficiaries coverage of certain skilled services
Improvement Standard

- According to the Complaint, Medicare has:
  - Failed to make assessments regarding a beneficiary's "unique condition and individual needs"
  - Does not rely on the Medicare statute, regulations and manuals, but relies on "more restrictive internal guidelines, policies, and Local Coverage Determinations ("LCDs")"

CMS Settlement

- Attorneys from the Center for Medicare Advocacy, Vermont Legal Aid and the Centers for Medicare & Medicaid Services (CMS) have agreed to settle the "Improvement Standard" case, Jimmo v. Sebelius
- A proposed settlement agreement was filed in Federal District Court on October 16, 2012
- The Settlement was approved on January 24, 2013

Jimmo v. Sebelius

- The judgment indicates that as long as a patient requires skills of a therapist or a nurse, a patient would meet the skilled coverage criteria despite not making functional gains
- Documentation must support the need for skilled therapy intervention
Practical Application

- What does this mean for the SNF?
- How do you proceed?
- What can I do tomorrow to implement change in my facility?

Embrace the OBRA ’87 regulations which require facilities to provide services to meet “the highest practicable physical, medical and psychological well-being”

Top Ten Missed Opportunities
Number Six:

MDS Accuracy
MDS Accuracy

“Don’t Sweep Bad [MDS 3.0] Coding Under the RUGs”

http://www.harmony-healthcare.com/blog/bid/97993/Don-t-Sweep-Bad-MDS-3-0-Coding-Under-the-RUGs

---

MDS Accuracy

- Most MDS 3.0 Sections are vulnerable to error
- Accurate reimbursement through the MDS 3.0 process
- Multiple recent MDS 3.0 Coding instruction updates

---

PEPPER
Program for Evaluating Payment Patterns Electronic Report
PEPPER

- Compares SNFs to other SNFs nationally
- 2013 Report was received via mail on or about August 30, 2013
- Envelope with red print on the outside containing your facility specific PEPPER
- Perceived as Junk mail

Outliers and the Evolution of PEPPER

- CMS sees high Medicare expenses as suggestive of over coding
- CMS asserts 20% highest expenses are questionable
- CMS identifies expenses above the 80th percentile as outliers
- CMS asserts that the Bottom 20% of outliers are under coding
- The bottom 20th percentile as outliers could be perceived as evidence of poor Quality of Care

PEPPER Data

- Compare Targets Report
- Target Area Reports
- SNF Top RUGs Reports
- Jurisdiction-wide Top RUGs Reports
Where is My PEPPER?

- From TMF Health Quality Institute
- PEPPERResources.org from the PEPPER HELP Desk
- http://pepperresources.org/HelpContactUs.aspx

Skilled Nursing Facility Distribution Schedule

- TMF will distribute PEPPER according to the schedule and methods below.
  - Annually, on or about May 5 through May 12, 2014
  - SNFs/swingbeds that are part of a short-term acute care hospital
  - Electronically via QualityNet secure file exchange

- Free-standing SNFs and SNFs that are part of another type of hospital
  - Available electronically to the SNF’s CEO, president or administrator via secure portal on PEPPERresources.org

Note: SNFs that are part of a critical access hospital will not receive PEPPER.
PEPPER

- Targeted areas were derived from two recent Office of Inspector General (OIG) Reports:
  - “Inappropriate Payments to skilled Nursing Facilities Cost Medicare than a Billion Dollars in 2009” (November 2012)
  - “Questionable Billing by Skilled Nursing Facilities” (December 2010)

Claims Data

- The SNF PEPPER provides SNFs with their jurisdiction, state and national percentile values for each target area with reportable data for the most recent three fiscal years
- When the target (numerator) count is less than 11 for a target area for a time period, statistics are not displayed

Target Areas

- Therapy RUGs with High ADLs
- Non-therapy RUGs with High ADLs
- Change of Therapy Assessment
- Ultra High RUGs
- Therapy RUGs
- 90+ Day Episodes of Care
Compare Targets Report

- Each SNF PEPPER summarizes claims data statistics (obtained from paid SNF Medicare UB-04 claims) for SNF episodes of care that end in the most recent three federal fiscal years (the federal fiscal year spans October 1 through September 30).
- A SNF is compared to other SNFs in three comparison groups:
  - Nation
  - Medicare Administrative Contractor (MAC) jurisdiction and
  - MAC state.
- These comparisons enable a SNF to determine if its results differ from other SNFs and if it is at risk for improper Medicare payments (i.e., is an “outlier”).

Target Area Reports

- PEPPE Target Area Reports display a variety of statistics for each target area summarized over three years.
- Each report includes:
  - Target area graph
  - Target area data table
  - Comparative data
  - Interpretive guidance
  - Suggested interventions

HHI Analysis

<table>
<thead>
<tr>
<th>Percentile Ranking</th>
<th>Target Area</th>
<th>Target Count</th>
<th>Percent</th>
<th>National</th>
<th>State</th>
<th>Medicare (Medicare)</th>
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<td>Therapy High ARI Days</td>
<td>2,799</td>
<td>51.4%</td>
<td>60.3</td>
<td>50.1</td>
<td>50.7</td>
<td></td>
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<tr>
<td>Non-Therapy High ARI Days</td>
<td>526</td>
<td>26.7%</td>
<td>39.2</td>
<td>40.0</td>
<td>46.3</td>
<td></td>
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<tr>
<td>Change of Therapy Assessments</td>
<td>66</td>
<td>6.9%</td>
<td>31.8</td>
<td>60.0</td>
<td>34.0</td>
<td></td>
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<tr>
<td>Ultra High ICU Days</td>
<td>3,097</td>
<td>59.4%</td>
<td>44.4</td>
<td>49.3</td>
<td>77.2</td>
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<tr>
<td>90+ Day Episodes of Care</td>
<td>19</td>
<td>9.0%</td>
<td>25.9</td>
<td>22.0</td>
<td>26.9</td>
<td></td>
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Are You Ready for the SNF PEPPER?

Why is Data Collection and Analysis a MUST?

Are You Ready for the SNF PEPPER?

Compliance, Compliance Compliance!
Are You Ready for the SNF PEPPER?

- Per CMS
  - The Office of Inspector General encourages SNFs to **develop and implement a compliance program** to protect their operations from **fraud and abuse**
  - Beginning in 2013, SNFs are required to have a compliance program
  - As part of a compliance program, a SNF should conduct **regular audits** to ensure services provided are necessary and that charges for Medicare services are correctly documented and billed
  - The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide the SNF's auditing and monitoring activities

Compliance Program

- Per Federal and State laws and Federal healthcare program requirements
- A system of policies and procedures
- Monitoring and Auditing tools
- Communication and reporting methods
- Enforcement
- Leadership

Compliance Is Mandatory

- Medicare/Medicaid Condition of Participation
- March 23, 2013
- Patient Protection and Affordable Care Act
Compliance and Ethics Program

OIG Supplemental Guidance:
“Compliance programs help nursing facilities fulfill their legal duty to provide quality care; to refrain from submitting false or inaccurate claims or cost information to the Federal health care programs; and to avoid engaging in other illegal practices”

Be As Informed As Possible

OIG Guidance


MDS 3.0 Accuracy

MDS Coding Accuracy Is a Key Element in Maintaining Compliance
Impact of the MDS 3.0

- Medicare Reimbursement
- Publicly Reported Information
- In Some States, Medicaid Reimbursement
- Resident Care
- Survey

MDS 3.0: Who has the information needed to accurately complete it???

In Other Words... Everyone Who Knows The Resident

RUG-IV

- Accurate coding of the MDS 3.0 assessment is critical to ensure appropriate care planning and an accurate RUG-IV classification
- All coded MDS 3.0 assessment items should be fully supported by documentation in the clinical record
RUG-IV

- Resource Utilization Groups
- Each MDS qualifies for multiple RUG classifications, and the software automatically chooses the highest reimbursement rate
- Rehabilitation Intensity, Diagnoses, Nursing Services, and ADLs all contribute
- Documentation must support all coding on the MDS 3.0 assessment

RUG-IV Impacts

- Presumption of Coverage Criteria remains
- Applies to upper 52 groups as encompassed by the following categories:
  - Rehabilitation Plus Extensive Services
  - Rehabilitation
  - Extensive Services
  - Special Care High
  - Special Care Low
  - Clinically Complex

RUG-IV Impacts

- Daily oversight of skilled nursing needs and identification of clinical indicators is critical!
- Per CMS:
  - Know the RUG classifications
  - Know your rates
Totality

While it is true that dialysis is one of the discrete indicators for assignment to a RUG within the Special Care Low category—a category to which the level of care presumption applies for a short period of time at the start of a SNF stay—it is the totality of items and services included within a given RUG, not any one specific coded service, that actually serves to justify the presumption.

Top Ten Missed Opportunities Number Seven:

Respiratory Therapy

Respiratory Therapy

Skilled Nursing Documentation, Provide Evidence of Respiratory Therapy

http://www.harmony-healthcare.com/blog/bid/97994/Skilled-Nursing-Documentation-Provide-Evidence-of-Respiratory-Therapy
Definition

The RAI Manual defines Respiratory Therapy as:

Services that are provided by a qualified professional (respiratory therapists, respiratory nurse)

Definition

The RAI Manual states that:

Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function

Definition

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 Therapy

- Respiratory Therapy by definition includes:
  - Coughing and Deep Breathing Exercises
  - Incentive Spirometry
  - Assessment of lung sounds as well as the delivery of nebulizer therapy

- The patient admitted with an active pulmonary issue is appropriate to receive these skilled assessments on a daily basis

Respiratory Therapy

- To qualify for the Special Care High RUG, Respiratory Therapy must be delivered 7 days with at least 15 minutes per day within the look back period.
- Documentation of the time spent with the patient while delivering this service is mandated.

Examples

- The facility may use a specialized flow sheet or record the time spent with the patient on the MAR or TAR as identified below:
  - MAR Examples:
    - DuoNeb 1 unit does via handheld nebulizer q.i.d.
    - Record total minutes spent with patient delivering Respiratory Therapy
Mar Example

<table>
<thead>
<tr>
<th></th>
<th>8/10/12</th>
<th>8/11/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 am</td>
<td>JS</td>
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</tr>
<tr>
<td>12 pm</td>
<td>JS</td>
<td>SF</td>
</tr>
<tr>
<td>4 pm</td>
<td>RO</td>
<td>KM</td>
</tr>
<tr>
<td>8 pm</td>
<td>RO</td>
<td>KM</td>
</tr>
</tbody>
</table>

Record total minutes spent with patient delivering Respiratory Therapy

<table>
<thead>
<tr>
<th></th>
<th>8 am</th>
<th>15</th>
<th>20</th>
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<tbody>
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<td>12 pm</td>
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<tr>
<td>4 pm</td>
<td>15</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>8 pm</td>
<td>22</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

TAR

TAR Examples:

<table>
<thead>
<tr>
<th></th>
<th>8/10/12</th>
<th>8/11/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-9 am</td>
<td>JS</td>
<td>SF</td>
</tr>
<tr>
<td>9-11 am</td>
<td>JS</td>
<td>SF</td>
</tr>
<tr>
<td>10 am</td>
<td>RO</td>
<td>KM</td>
</tr>
<tr>
<td>4 pm</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

Respiratory Therapy

- Clinical documentation should support the capture of the respiratory therapy minutes within the medical record
- Harmony recommends the use of respiratory flow sheets or adapting the information within the treatment sheets
- Supportive documentation within the nurse’s narrative notes to evidence the need for observation and assessment for probable exacerbation of a respiratory illness is necessary
Requirements

- 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.

Top Ten Missed Opportunities

Number Eight:

Depression

Identification of Mood Disorders:
MDS 3.0 Section D

http://www.harmony-healthcare.com/blog/bid/97995/Identification-of-Mood-Disorders-MDS-3-0-Section-D
A Key Point from the RAI Manual

- the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder
- Assessors do not make or assign a diagnosis in Section D, they simply record the presence or absence of specific clinical mood indicators

D0200: Mood Interview (PHQ-9)

- Record the resident’s responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood
- Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician

D0300: Total Severity Score

- PHQ-9 Total Severity Score can be used to track changes in severity over time.
- Total Severity Score can be interpreted as follows:
  1-4: Minimal depression
  5-9: Mild depression
  10-14: Moderate depression
  15-19: Moderately severe depression
  20-27: Severe depression (20-30 for PHQ-9Ov)
Practice/Policy Implications and Potential Staff Education Needs

- Provider notification of PHQ-9 changes
- Investigation of actual mood issue and root causes
- PHQ-9 is a single point in time interview
- PHQ-9OV should include information from all shifts and disciplines
- The primary CNA should not be the only source of information – let’s talk about why!
- Follow up plan for D02001 = 1

Mood

- The signs/symptoms of mood distress are identifiable and treatable
- Assessment and MDS coding of this section does not assign a diagnosis of depression or other mood disorder
- Facility staff should be on the lookout for indicators of mood distress and act promptly to report and address them

Staff Assessment of Resident Mood (PHQ-9-OV)

Key Points:
- Staff from all shifts who know the resident best should be interviewed
- Staff should report symptoms even if the staff believes the symptom to be unrelated to depression
- Symptom presence and frequency (over the last 14 days) should be reported
Top Ten Missed Opportunities

Number Nine:

ARD Management

Clinical Components of ARD Management


ARD Management

- Team Member Effort
- Graphic Spreadsheet
  - Limitations of automation
- Handwritten
- Frequency
- Tracking of PPS and other payor sources
  - Medicare Advantage transition to Part A, must begin again with a 5 day assessment
ARD Management

Clinical Meeting components of ARD Selection

- **Rehab:** Targeted RUG level, last therapy treatment dates, SOT, COT and EOT ARD dates
- **Pre-Admission:** Skin and IV hydration (Nursing)
- **ADL:** Falls and overall declines that may indicate an increase in ADL assist (Nursing/Rehab RUG)

ARD Management

Clinical components of ARD Selection

- **Emergency Room:** Potential capture of IV hydration (ADL/Nursing RUG)
- **MD Orders:** Potential to capture new nursing qualifier
- **Respiratory:** Treatment and Shortness of Breath
- **MDS Proactive Management of ARD**
- **Nursing Qualifiers:** Skin, IV Medication/Hydration, Oxygen, etc.

Medicare PPS Assessments

- **Scheduled Assessments**
  - Set at regular intervals during the Medicare stay
- **Unscheduled Assessments**
  - Driven by clinical events that may occur during the Medicare stay
SNF PPS MDS Regularly Scheduled

<table>
<thead>
<tr>
<th>MDS Assessment/Type</th>
<th>Assessment Reference Date</th>
<th>Grace Days</th>
<th>No. of Days Coverage</th>
<th>Applicable Days</th>
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</thead>
<tbody>
<tr>
<td>5 Day /Return</td>
<td>1-5</td>
<td>6-8</td>
<td>14</td>
<td>1-14</td>
</tr>
<tr>
<td>14 Day</td>
<td>13-14</td>
<td>15-18</td>
<td>16</td>
<td>15-30</td>
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<tr>
<td>30 Day</td>
<td>27-29</td>
<td>30-33</td>
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<td>31-60</td>
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<td>60 Day</td>
<td>57-59</td>
<td>60-63</td>
<td>30</td>
<td>61-90</td>
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<tr>
<td>90 Day</td>
<td>87-89</td>
<td>90-93</td>
<td>10</td>
<td>91-100</td>
</tr>
</tbody>
</table>

PPS and OBRA MDS may be combined if ARD and completion date meet both requirements.

How Is Mood Status Reported and Recorded in Your Facility?

- Let's discuss **the system** in your facility to report/record **mood status**
- Does it **work well**?
- Are you capturing **the true picture** of the resident?
- Why or why not?
- How can it be **improved**?

ARD Management

START OF THERAPY (SOT) OMRA
Start of Therapy (SOT) OMRA

- **Optional** assessment
- Completed **only** to classify a resident into a Rehabilitation Plus Extensive Services or Rehabilitation group
- ARD must be set on days 5-7 after the start of therapy
- Medicare **payment rate** begins on the day therapy started

ARD Management

**But Wait……..**

STOP

**Proposed Rule FY2014 Therapy Distinct Days ruling**

ARD Management

END OF THERAPY (EOT) OMRA
End of Therapy (EOT) OMRA

- **Required** when the resident was classified in a Rehab RUG-IV and continues to need Medicare Part A SNF-level services after the discontinuation of all therapies
- ARD must be set on day 1, 2, or 3 after the last treatment day
- Establishes a new non-therapy RUG classification and Medicare payment rate which begins the day after the last day of therapy treatment

**ARD Management**

**CHANGE OF THERAPY (COT) OMRA**

- Complete when the intensity of therapy changes; includes the total reimbursable therapy minutes (RTM), and other therapy qualifiers
- Number of therapy days and disciplines providing therapy, changes to such a degree that the beneficiary would classify into a different RUG-IV category for which the resident is currently being billed
- Applies to the 7-day COT observation period following the ARD of the most recent assessment used for Medicare payment
Change of Therapy (COT) OMRA

- Payment begins on Day 1 of the COT observation period and continues for the remainder of the current payment period
- Unless the payment is modified by a subsequent COT OMRA or other (scheduled or unscheduled) PPS assessment.

ARD Management

EARLY, LATE, OR MISSED PPS ASSESSMENTS

Early PPS Assessment

- **Scheduled Assessment:** If an assessment is performed earlier than the schedule indicates the provider will be paid at **default rate** the number of days the assessment was out of compliance
Early PPS Assessment

Example:
- A Medicare-required 14-Day assessment with an ARD of day 12
- One day early
- Paid at the default rate for the first day of the payment period that begins on day 15

Late PPS Assessment

Failing to set the ARD
- Failure to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must still complete a late assessment
- The ARD can be no later than the day the error was identified
Late PPS Assessment

- Billing the Default Rate
  - The ARD on the late assessment is set prior to the end of the period during which the late assessment would have controlled payment, and no intervening assessments have occurred,
  - SNF must bill the default rate for the number of days that the assessment is out of compliance, including the ARD

Late PPS Assessment

- The SNF will bill all covered days during which the late assessment would have controlled payment at the default rate regardless of the HIPPS code calculated from the late assessment

Missed PPS Assessment

- Failing to Set an ARD
  - Failure to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window; resident was already discharged from Medicare Part A when the error is discovered
  - The provider cannot complete an assessment and the days cannot be billed to Medicare A
Late PPS Assessment

- All Covered Days Billed at Default
  - The ARD of the late assessment is set after the end of the period during which the late assessment would have controlled payment, or
  - An intervening assessment has occurred, the provider must still complete the assessment
  - The ARD can be no earlier than the day the error was identified

Missed PPS Assessment

- Saving Grace
  - In some cases, an existing OBRA assessment in the QIES ASAP system may be used to bill for some Part A days when specific circumstances are met
  - A stand-alone discharge assessment may not be used in this case

Missed PPS Assessment

- Discharged Patients
  - An unscheduled assessment is required (i.e. COT, EOT), but not completed timely
  - The assessment is missed and cannot be completed
  - All days are provider liable
Top Ten Missed Opportunities
Number Ten:

Scrutinize The Lower 14


Lower What???

- Behavioral Symptoms and Cognitive Performance
- BB1 & BB2
- BA1 & BA2
- ADL Score 5 or less qualifies for this category
Behavioral Symptoms and Cognitive Performance

**Behavior:** Determine whether the resident presents with one of the following behavioral symptoms:
- Hallucinations
- Delusions
- Physical behavioral symptoms directed toward others (2 or 3)
- Verbal behavioral symptoms directed toward others (2 or 3)

---

Behavioral Symptoms and Cognitive Performance

**Behavior**
- Other behavioral symptoms not directed toward others (2 or 3)
- Rejection of care (2 or 3)
- Wandering (2 or 3)

---

Lower What?

**Reduced Physical Function**
- Category applies if no other category requirements are met

**Restorative nursing**
- PE1 & PE2
- PD1 & PD2
- PC1 & PC2
- PB1 & PB2
- PA1 & PA2
Lower 14 RUG Classification

- Administrative presumption of coverage **DOES NOT** exist for a beneficiary who is correctly assigned into one of the lower 14 RUG groups on the initial 5-day assessment
- Documentation must support that these beneficiaries meet the level of care requirements

---

Medicare Program Integrity Manual

**Level of Care Criteria Not Met**

- If the beneficiary does not meet the SNF coverage criteria as defined in Section 6.1.3B, the contractor shall deny the claim in full

  - Medicare Program Integrity Manual Chapter 6 - Intermediary MR Guidelines for Specific Services

---

Medicare Contractor Guidance

- “Do not gauge your success with billing according to Medicare guidelines by a low denial rate/high pay rate because one hundred percent claims review is not possible, although random claim review selection can uncover billing errors, an expansion of SNF claims review is expected.”
Medicare Contractor Guidance

“SNFs can prepare and be ready for this additional scrutiny by teaching staff about the impact that completing thorough and accurate documentation has on your line of business. A second recommendation includes utilizing risk managers......to ensure claims are compliant with Medicare guidelines inclusive of accurate and adequate supporting documentation.”

Lower 14 RUG Classification

Patient days that fall into the "lower 14" RUG categories are at a risk of a Medicare Audit

This sparks an interesting discussion about Medicare eligibility and the facility’s responsibility to provide an entitled service

Lower 14 RUG Classification

Medicare eligibility is not determined by what RUG group the assessment generates

If a patient meets eligibility criteria, he/she is to remain "skilled" until that treatment regimen is essentially stabilized and the patient no longer demonstrates a need for daily skilled services
Lower 14 RUG Classification

- Skilled eligibility must be clearly documented to avoid denial of payment under audit.
- Perform in-house audit of medical records for "lower 14" RUG scores

Lower 14 RUG Classification

- The patients' skilled needs should be clearly outlined and communicated to the staff to ensure that supportive documentation is present in the medical record on a daily basis

Top Ten Missed Opportunities

1. Nurses Rule the World
2. Rehabilitation Departments
3. Skilled Therapy Documentation
4. ADL Coding
5. Clinically Anticipated Stay
6. MDS Accuracy
7. Respiratory Therapy
8. Depression
9. ARD Management
10. Scrutinize the Lower 14
Questions/Answers

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