



In The News

Focus on facilitating more active lives for our clients keeps our work exciting.

Providing therapy services to the senior population has never been more exciting. Therapists have the opportunity to bring fresh ideas and intervention strategies to an increasingly vibrant and active population who know more, expect more and participate more. Our mission statement is “Enable our customers to provide the highest quality of life possible to their patients and residents”. That mission has moved us along a continuum that advances mobility training for seniors from ambulation at the household level to ambulation and balance for participation in strenuous leisure tasks. Activities of daily living have evolved from self care tasks to include safety behind the wheel of a car. The significance of these changes isn’t just that seniors are more active but speaks to this population’s increased knowledge and accountability regarding concepts of “healthy aging” and “productive living”. When we advance our knowledge base to incorporate therapeutic strategies to allow for these higher level activity expectations we are contributing to tasks that will allow our clients to stay healthy longer.

The Med PAC (Medicare Payment Advisory Committee) report from June of 2009 stated that Medicare fee for services (FFS) spending “is concen-

trated among a small number of beneficiaries.” Specifically, 1% of beneficiaries in 2006 utilized 16% of Medicare dollars. The next 4% of beneficiaries used 27% of total program dollars. The least costly half of Medicare beneficiaries used 3% of available monies.

Therapy services directed towards minimizing limitations and incorporating strategies that allow for a return to (or even an introduction to) an active lifestyle is what more and more seniors expect and what we must be able to deliver if we want to be part of the solution to the growing health care access and coverage quandary that exists today. Incorporating concepts of health maintenance and addressing issues of, and strategies for, safe exercise and activity post-discharge should be the routine.

Legacy has developed numerous clinical programs to assist our employees with incorporating concepts of healthy aging into the treatment regime. Our company’s mission can only be achieved by advancing each therapist’s abilities to automatically integrate post-discharge exercise and activity recommendations that will allow our clients to be the best they can be.

Sandy Hoskins, President

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Living Legacy — Our Mission, Vision and Values in Action

Excellence Award Winners Announced

Michelle Eagle, PTA is the June - September 2009 recipient of Legacy’s Award of Excellence. Linda Irwin, PTA is the winner of the October - December 2009 award. (cont’d page 4)

MDS, RUG-IV Take Effect October 1

Some of the most talked about changes on the Medicare landscape are the new version of the Minimum Data Set (MDS) and the associated RUG-IV classification system. After a delay last year, MDS 3.0 is set for implementation on October 1 of this year.

What follows is an overview of how the changes will affect therapy service delivery under the skilled nursing facility prospective payment system (SNF PPS). All of the changes are based on CMS's stated goal of more accurately reimbursing for services provided. The result is that only services actually provided while the patient is a resident of the SNF will be reimbursed.

"MDS 3.0 is...a unique assessment instrument... It is not a revision of the MDS 2.0."

--Thomas Dudley, CMS

Look Back Period -

The look back period will be modified for reimbursement purposes to include only services provided after a patient is admitted or re-admitted to a SNF. Services provided prior to admission can be coded, but will only be used for care planning purposes. The look back period remains seven days for most MDS 3.0 items.

Section T eliminated - In the current MDS, Section T is used to indicate the total therapy treatments and minutes a patient is *expected* to receive in the first fifteen days of his SNF stay. Without Section T "projected" therapy minutes will not affect a patient's RUG classification. Rather, only the actual minutes provided during an assessment period will contribute to the RUG classification.

To ensure that the intensity of therapy services is accurately captured and included in the RUG calculation, CMS has created a special assessment called the "start-of-therapy" OMRA. The start-of-therapy (SOT) OMRA will have an assessment reference date set five to seven days after the first day of therapy services. Payment adjustments will begin on the first day therapy services were delivered. Therefore, if the SOT OMRA is used, all days on which therapy is pro-

vided will be reimbursed at the appropriate Rehabilitation RUG rate.

SOT OMRA's may be combined with other required assessments such as the 14- or 30-day assessments.

A second therapy-related OMRA called the "end-of-therapy" (EOT) OMRA has also been added. The EOT OMRA is required when all therapy services have been discontinued but a patient still requires skilled nursing care. Current SNF PPS regulations require an OMRA within 8-10 days after the end of therapy. In MDS 3.0, the EOT OMRA must be completed 3-5 days after the end of therapy.

Concurrent Therapy - In the new MDS therapy minutes will be allocated by mode of therapy - individual, concurrent, or group.

Concurrent therapy is defined as one therapist or assistant treating multiple patients at the same time while the patients are performing different activities. Under current Part A regulations, there are no limits on the number of patients treated concurrently or on the number of concurrent treatment minutes a single patient may receive.

MDS 3.0 makes the following changes regarding concurrent therapy :

- No more than 2 patients may be treated at one time; both patients must be in the line of sight of the treating therapist or assistant.
- Minutes must be recorded in Section O of the MDS as concurrent treatment minutes. The total treatment time will be recorded. For example, in the case of concurrent therapy for 60 minutes, the entire 60 minutes will be reported for each patient. When the RUG calculations are made, only half of the time coded as concurrent (30 minutes) will be counted.

Resources

To learn more about MDS 3.0 and RUG IV visit the CMS web site at the link below.

www.cms.hhs.gov/NursingHomeQualInits

Once there, choose "MDS 3.0 for Nursing Homes and Swing Beds" from the menu on the left side of the page.

Recovery Audit Program

In October 2008, CMS announced that the recovery audit demonstration project designed to “identify improper payments” would become permanent. There are now four recovery audit contractors (RACs) charged with conducting the search for overpayments or underpayments to Medicare providers.

Each RAC (see list, bottom of page) is required to list the issues targeted for review. The issue list is updated on a monthly basis on the RACs’ web sites.

Which Claims? All paid Medicare claims, whether Part A or Part B, are subject to audit within certain limits. Claims as old as three years may be audited, but claims paid earlier than October 1, 2007 are off limits. The total number of claims that can be audited during any 45-day period is also limited.

Targeted Reviews A review of the recovery audit demonstration data provides some clues about where the RACs are looking for improper payments. For example, issues for hospital providers have focused on improper coding and incorrect assignment of DRGs because these areas were major factors in overpayments identified in the demonstration project.

For SNFs, reviews will likely target medical necessity. The demonstration project data show that 40% of SNF overpayments were related to failure to meet Medicare coverage criteria for skilled therapy.

How to Be Prepared The prospect of undergoing a claims audit can be daunting. But there are some actions providers can take to prepare for the possibility. To turn an old sports adage around, in claims review preparation, offense is the best defense.

Legacy’s documentation training and review protocols focus on the same areas the RAC reviewers will: correct ICD-9 coding; documented evidence of the need for skilled therapy services (medical necessity); the use of clinically objective data to justify continued services.

SNF providers can use these same parameters in reviews of their current medical records. In addition, chart reviews and ongoing training should focus on making sure that staff understand Medicare coverage criteria. There are four very specific criteria listed in the Medicare Benefit Policy Manual, Chapter 8, Section 30. Internal chart reviews should reveal that documentation exists to show that each of those four coverage guidelines is met.

Dealing With Denials Even the best efforts of everyone involved probably will not eliminate RAC determinations of overpayment. That means dealing with the appeals process. The RAC demonstration project has some encouraging data on that score. Of the Part A appeals pursued, 43% had decisions favorable to the provider. For Part B appeals, the number was 47%. Legacy’s historical rate of favorable decisions on appeal is even higher than that. While no one welcomes the time and effort involved in the appeals process, there is ample evidence that the pursuit is worth it.

The coverage and documentation guidelines the RACs are focusing on are not new. However, the level of scrutiny is. We will continue to monitor the RAC web sites regularly to identify their focus issues and notify our staff and customers as appropriate. Likewise, our level of commitment to quality service delivery and documentation remains high so that we enter the era of RAC audits prepared.

Recovery Audit Contractors

Region A (Northeast) - Diversified Collections Services

Region B (IN, IL, OH, MI, MN, KY, WI) - CGI Technologies

Region C (CO, TX, FL, NC, SC, VA, AR, OK, GA, LA, MS, AL, TN, WV) - Connolly, Inc.

Region D (MO, KS, NE, IA and the West) - HealthDataInsights

To access CMS Manuals, go to www.cms.hhs.gov. On the home page choose Manuals from the Top 10 Links on the right hand side of the page. The Benefit Policy Manual is IOM 100-02.

Living Legacy — Our Mission, Vision and Values in Action

Michelle Eagle, Linda Irwin - Recipients of “Rehab Director Award of Excellence”

Michelle has been a Legacy employee for 9 years and currently serves as the Rehab Director at three NC facilities – Magnolia Gardens, Mt. Vista, and Veranda. Michelle’s can-do attitude and performance reflect the heart of Legacy’s values, mission, and vision. In nominating Michelle for the award, Area Rehab Manager, Vanesa Garces stated – among other things – as follows: “Michelle is dedicated, committed, and loyal to Legacy. In addition to meeting performance expectations, she has a great energy about her that brings a smile to those around her.”

Linda has been the Rehab Director at Woodland Terrace for two years. In nominating Linda, Melissa Hanson, RVP described her as “the epitome of what Legacy strives for”. The rehab team offers several clinical programs - pulmonary therapy, continence management, memory care, Safety in Motion (Legacy’s fall risk reduction program) - with excellent reported outcomes and positive resident

response. As Hanson stated, “Customer service is key to Linda and it shows.” Linda runs several groups to support wellness in her community.

As winners of the RD Award of Excellence, Michelle and Linda have received an elegant recognition plaque, a \$100 Visa® card, and Legacy sundries.

We are fortunate to count Michelle and Linda as members of the Legacy team. Appreciation also goes out to their exceptional rehab staff for supporting these two Rehab Directors and for helping to make Legacy an industry role model.

CLINICAL LADDER INTRODUCED

To support our focus on excellence in clinical service delivery, Legacy has created a new role, the Clinical Program Lead. For details, contact your ARM or Area Rehab Clinical Specialist.

