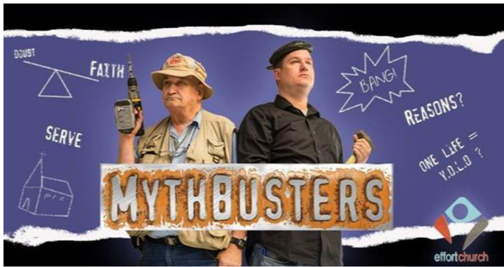
Are You Ready????



Part B Myths

- We have too many Part A residents
- We don't have enough staff
- The residents don't have Part B benefits
- They don't have co-insurance
- We don't understand the G-codes
- Part B development is all done by therapy

More Myths…..

- We don't get referrals from nursing
- Nursing doesn't document to support the skilled need
- Restorative nursing doesn't carry over
- We can't keep picking up the same residents over and over when they decline
- It's not ethical to pick them up
- Part B has to be limited to 3x/week

And Even More Myths….

- You're not allowed to do BID for Part B
- There isn't a big enough population of Part B residents in the facility to build a caseload
- We don't have time to screen
- We don't want to exceed the cap or the threshold
- MPPR doesn't make it financially worthwhile
- Dual Eligibles are too hard to get approved

- **Fact or Fiction?**
- **Truth or Myth?????**

Let the Mythbusting Begin……

- Part A Census Management
  - Utilize co-treatment as appropriate
  - Utilize group treatment as appropriate
  - Balance assistant to therapist ratio for treatment

  - All of the above enables your therapists to have more time to complete Part B screens and evaluations.

More Mythbusting

- Staffing issues
  - Manage the 8 Minute Rule and ensure that your staff understands it.
  - Maintain an appropriate assistant to therapist ratio.
  - Manage the 10 visit rule for Part B. Ensuring that your evaluating therapist is reviewing all Part B treatment will impact duration of treatment.

8 Minute Rule

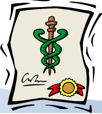
MINUTES TO UNITS CONVERSION

Minutes	Units
0 to 7	0
8 to 22	1*
23 to 37	2
38 to 52	3
53 to 67	4
68 to 82	5
83 to 97	6
98 to 112	7
113 to 122	8

***The FIRST unit MUST be 15 minutes in duration to count as a unit!!**

More Mythbusting

- Issues with Part B Benefits or Co-Insurance
  - Your business office should be able to tell you who in your facility who has Part B benefits.
  - For those who don't have Part B, help your families apply for it.
  - Many Part B co-insurance costs are covered by other commercial products or Ohio Medicaid.



More Mythbusting

- G-codes
  - Most rehab software products will prompt your evaluating therapists for every Part B eval that is completed for the required codes and modifiers.
  - This is also the case for the 10th visit updates.
  - Each area is well defined, as are all the modifiers.

More Mythbusting

- G-Codes
  - Take advantage of free products that summarize the codes in handy formats, such as:

    www.mediserve.com/cbor

  - For complete information about the G-codes and Modifiers, go to the CMS Website:

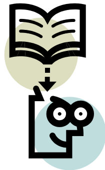
    www.cms.hhs.gov

More Mythbusting

- Part B program development:
  - Not JUST for rehab anymore!
  - Successful programs rely on everyone's eyes and ears.
  - Everyone in a facility can and should refer residents if they notice a change in function.

More Mythbusting

- The Referral Process
  - Education, Education, Education!!
    - All Staff In-services
    - Rehab Rounds
    - New Employee Orientation
    - Clinical/Nursing Meetings
    - Interdisciplinary Meetings
    - Care Conferences
    - Referral to Therapy Programs



Referral Programs

- A referral program enables and empowers everyone to work as a team to ensure the safety and well being of your residents.
- Your staff is the eyes and ears of the building.
- If you identify a change in a resident's level of function, make a referral to Physical, Occupational, or Speech Therapy.

More Mythbusting

- Nursing Documentation
  - There is no “Rule” as to how much documentation is required.
  - Any nurse can provide this documentation.
  - Have you reviewed information in the MDS reports for declines in various clinical areas (e.g. ROM)?

More Supporting Documentation

- It can come from anywhere!!
  - Activities
  - Dietary
  - Social Services
  - Nursing Assistants

More Mythbusting

- Our Frequent Flyers
  - Restorative Nursing Programs
    - We should meet with restorative monthly to review our residents’ clinical status.
    - Does the resident need to move from Restorative back to skilled therapy?
    - No one should be on restorative forever!

More Mythbusting

- More about Frequent Flyers
  - If the resident has had a decline, we must screen to determine the need for an evaluation.
  - We should also screen based on the quarterly MDS schedule to ensure that all our residents are screened consistently.
  - Only a full evaluation can determine if skilled therapy may be required.
  - Even if they have had therapy in the past, we can pick them up again if we have determined there is medical necessity that requires a skilled level of care.

More Mythbusting

OBRA Guidelines:

As per OBRA and state survey guidelines, "The facility is to provide to each resident all the necessary care and services such that the resident can attain and maintain the highest practicable physical, mental, and psychological well-being." (OBRA, 1987; see also Federal Survey Tag F309)

More Mythbusting

- Ethics
  - It's unethical to NOT pick someone up for treatment if we have a documented decline in function that meets the CMS definition of medical necessity.
  - Our residents deserve to function at their highest practicable level for as long as possible.

Another one bites the dust

- It has NEVER been the case that Part B has to be limited to 3x/week.
- Part B frequency is driven solely by the clinical needs of our resident.
- That can be 5x/week or 6x/week based on the needs of the resident.

NO BID Treatment??

- **SEZ WHO???????**

- It can be BID, as clinically appropriate.

BID vs. Split

BID Treatment:

- The exact same services are provided twice in a day, usually in the AM and PM.
- Documentation must clearly indicate the exact same treatment was provided at 2 separate and distinct visits.
- The exact same interventions and CPT codes are provided for both visits.

BID vs. Split

Split Treatment:

- Extension of the QD treatment.
- Occurs when a treatment session begins, is interrupted for some reason, and continues at a later time.
- Services are not duplicated, as the subsequent session(s) is just an extension of the earlier session.
- The resident only receives one visit.

Frequency Rules

- Part B orders CANNOT be ranged. You must decide on a frequency and note that in your order.
- If you want to change the frequency, you must re-write your order.
- Likewise, if you want to do BID, it must be reflected in your order.

Skilled Status

- When Part B is delivered 5 or more times per week, it is considered a skilled level of care.
- While it does not occur frequently, it may impact your residents' 60 day break for their spell of illness period to qualify for Part A benefits.
- If you are concerned about this, always check with your business office.

More Mythbusting

- Potential Part B Census
  - A strong source of Part B is outpatient:
    - Instead of referring to home health, could some of these residents return for outpatient therapy?
    - Can you develop an outpatient market that goes beyond your own inpatient population?
    - What clinical specialty does your community need?

More Mythbusting

- Screening is a facility process
  - Rehab Rounds
  - Dining Room Screens
  - MDS Quality Measures Reports
  - MDS Quarterly Schedules
- A screen should only determine the need for an evaluation, not the need for treatment.

Screens

- Screens include a quick (10-15 min) review of the resident's chart in addition to observable and/or reported current functional status findings.

- A noted improvement or decline in any functional area would warrant an evaluation.
- No recommendations should be made from a screening other than the decision to evaluate or not to evaluate.

Physical Therapy Screens

- Recent Falls
- Pain
- Poor Balance
- Weakness
- Dizziness
- Improper Use Of Assistive Device
- Joint Contractures
- Muscular Rigidity
- Difficulty Standing
- Fear of Falling
- Inability To Climb Stairs
- Difficulty Sitting

Occupational Therapy Screens

- Pain
- Hand/Shoulder Joint Contractures
- Increased/Decreased Need for Assistance With ADLs
- Change in Activity Tolerance
- Poor Coordination
- Weakness
- Frequent Spills While Eating
- Neuromuscular Tremors
- Impaired Vision
- Inability to Hold Objects in Hand
- Inability to Lift Objects
- New or Changed Use of Physical Restraint
- Positioning Problems in Bed and/or Chair

Speech Therapy Screens

- Difficulty Swallowing
- Choking/Drooling/Weight Loss
- Shortness of Breath with Speech
- Impaired Speech
- Impaired Hearing
- Decreased Communication
- Poor Memory

The Screening Myth

" I don't know that resident."

" That resident is not appropriate for therapy services."

" There has been no change in functional status."

" They always lose the splints and stuff."

"He/She was just on caseload!!"

Sound familiar????

Screening Set-Up for Success

- Do your homework!
  - Bring referral sheets to your daily clinical meetings to discuss residents with the DON and Unit Managers to get more detailed information on the resident and their reason for potential therapy.
  - Have weekly meetings with your Restorative Nursing Coordinator and Nursing Assistants.
  - Check payer sources and last day under Medicare Part A with your business office.

More Mythbusting

- The Cap and Threshold
  - Don't let the cap and threshold become an excuse for denying care to any resident.
  - If denied, it can be appealed, assuming the documentation shows strong medical necessity and a skilled level of care.
  - We should never "manage to the threshold".

What is MPPR?

- **M**ultiple **P**rocedure **P**ayment **R**eduction
  - It has been in existence for many years for procedures performed in physician offices.
  - Applied to therapy in 2011
  - Applies ONLY to Medicare Part B
  - The current rate is 50%
  - This is applied to only one part of the CPT code:
    - Each CPT code reimbursement is calculated for 3 components (professional, medical, technical).
    - Only one component is subject to the 50% reduction.
      - If a CPT code is reimbursed at $30 ($10 for each component), the reimbursement will be $25 ($10 + $10 + $5, reduced).

MPPR Cont'd.

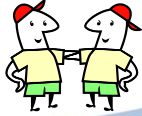
- **M**ultiple **P**rocedure **P**ayment **R**eduction
  - The <u>highest</u> paying CPT code performed for the day will be reimbursed at the full amount and every other one for the same day will be reduced.
  - The reduction is not discipline specific but applies to ALL codes performed on a given day, regardless of discipline.
  - Not all codes are subject to reduction.

More Mythbusting

- MPPR
  - The average reduction is roughly 15% of the CPT code.
  - 85% reimbursement is better than 0%!!
  - Make sure your team understands how the reductions are calculated.

The Mythbusting Continues

- Dual Eligibles
  - We must learn the prior approval process.
  - These will be treated like other Managed Care Part B payers and require pre-authorization prior to the start of care.
  - They are not subject to MPPR or the caps & threshold.



Importance of Medicare B

- Medicare Part B refers to therapy services provided to our residents to improve their quality of life.
- Our long term residents need our care and attention. They are subject to normal aging factors, illness and environmental issues that impair their life.
- Our services will help ensure that they live with the highest level of independence and quality of life.

Where can YOU start????

- Pick an approach
- Determine responsible parties
- Set Deadlines
- Commit to Your Outcomes
- Celebrate your successes

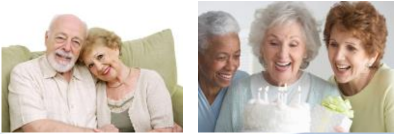
REPEAT!

Take the First Step

- What are you going to do?

The Last Word

- Part B programs enable our residents to continue to function at their highest practicable level.
- We owe it to them to provide whatever services are needed to accomplish this.



NOW……….

How are we going to get paid?

Common Denial Reasons

- The documentation must support clear, functional declines which require skilled therapy services to restore. The medical record should include the presenting condition or complaint, a significant change from the resident's usual physical or functional ability to warrant an evaluation and treatment, and an objective description of change in function.

Common Denial Reasons

- Therapy Services did not require the professional skills of a therapist to perform or supervise. Rehabilitative therapy occurs when the skills of a therapist are necessary to safely and effectively furnish a recognized therapy service and the goal is improvement of an impairment or functional limitation.
- The service must be such a level of complexity and sophistication or the condition of the resident shall be such that the services required, can only be safely and effectively performed by a qualified clinician or therapist supervising assistants.

Common Denial Reasons

- Therapy is not required to effect improvement or restoration of function where a resident suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the resident gradually resumes normal activity.

More Denial Reasons

- Documentation is repetitive in nature. Repetitious completion of activities once taught and monitored are non-covered.

Documentation

Reason for Referral of a Part B Resident

- This documentation should clearly demonstrate who made the referral, why rehab services were asked to screen/evaluate the resident, and what was the functional decline.

Documentation

Nursing and/or Physician documentation should support the need for therapy services.

- Examples of generic terminology or phrases to avoid:
  - » "PT secondary to hospitalization"
  - » "Guest has shown a decline"
  - » "M.D. referral"
  - » "Referral received from nursing"

Documentation

Reason for Referral

- Be sure to document who the referral source was, such as Nursing Assistant, Nursing, Dietary, Activities, Hospital admission, Family member, etc.
- Do not forget to tell what the functional decline the resident presents with from the illness or injury.
- Be as specific as possible.
- We have to prove to Medicare that there was a definite decline in function and why this occurred.

Documentation

Prior Level of Function (Long Term Care Resident)

- Clearly state the resident's functional status prior to the onset of the illness, accident, surgery, hospitalization, etc.
- Is the resident on a restorative program, do they get OOB, how long OOB, primary mode of transportation in the facility, does he/she go to the DR for meals, attend activities, do they utilize any positioning devices, etc.?
- Be specific on the amount of assistance they need from caregivers and what they can do on their own.
- What equipment do they own or utilize?

Documentation

- Prior Level of Function justifies the skilled intervention/medical necessity because it establishes the baseline level of function and validates the decline or improvement from this baseline.
- Be specific and detailed.
- We have to paint the picture and tell the story!

Documentation

- Medical Necessity (Skilled Intervention)
  - "The skills of a therapist are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation." (CMS 100-02, 220.2)
  - "The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the resident's condition."
  - Observations, assessment, treatment techniques, training to teach the resident how to manage his/her treatment regimen.

Skilled Intervention

- Skilled intervention includes observations, evaluation, and treatment techniques that can ONLY be provided by a licensed professional.
- Unskilled services are routine exercises, ambulation, endurance activities, routine practice of self-care skills, hot packs, sign language, daily feeding programs.

Documentation

Skilled Therapy Daily Documentation

- Provides proof that a resident received skilled services, thus satisfying Medicare's "Daily Basis" requirements for skilled rehab intervention.
- This protects you from denials of individual treatments by Medicare reviewers.
- Medicare pays for the services of the therapist, not what the resident is doing.

Documentation

Daily rehabilitation documentation must meet the following criteria:

1. Identify which skilled interventions were provided.
2. Indicate the level of complexity of the condition that warrants the services of a licensed therapist/therapy assistant.
3. Describe the skill provided by the therapist and the resident's response to that skilled intervention.
4. Correspond to the deficits being addressed in the short term goals.

Documentation

What we do is highly sophisticated and technical in nature. 90% of the time, our documentation does not show it.

We need to use our therapeutic terminology to describe what we are doing.

Challenge your clinicians! We need to take credit for what we are doing and justify to Medicare that it took the skills of the therapist to complete the treatment and not a non-skilled professional.

Next Up…Restorative Myths

- Restorative is an extension of therapy services.
- The restorative program has to match the exact referral from the therapist.
- Anyone can do the restorative documentation as long as it is cosigned by an RN.

More Restorative Myths

- Having everyone on restorative will drastically improve your case mix.
- Restorative programs are unnecessary and do not benefit the residents.
- We can't do restorative programs because we do not have dedicated Restorative Nursing Assistants.

Restorative and Case Mix

PE1 = 1.6983	PE2 = 1.7400
PD1 = 1.5509	PD2 = 1.5821
PC1 = 1.3925	PC2 = 1.4489
PB1 = 1.0892	PB2 = 1.1054
PA1 = 1.0000	PA2 = 1.0503

Restorative and Case Mix

BA1 = 1.0259	BA2 = 1.2090
BB1 = 1.4116	BB2 = 1.4861
IA1 = 1.1481	IA2 = 1.2366
IB1 = 1.4600	IB2 = 1.5112

Restorative and Case Mix

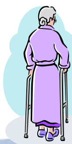
- Even with EVERY resident on restorative nursing programs, the impact on overall case mix is insignificant.
- Usually resulting in a change of less than .04 overall.

Advantages of a Restorative Nursing Program

- Enhances the sense of satisfaction and relationship between the resident and his/her caregiver.
- Decreases risk of complications. Residents who can function more independently are less likely to suffer from skin breakdown, urinary incontinence, contractures, falls, etc.

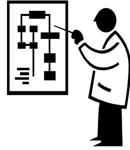
Advantages of a Restorative Nursing Program

- Uses resources more effectively.
- Provides a positive reputation for your facility.
- Maintains, improves, or prevents decline in the resident's ability to function and to perform self care activities as independently as possible.



Restorative Process Flow

To facilitate a successful restorative program, develop a clear structure that focuses on continuum of care.



Recommendations for a Restorative Program

You should implement a form to enable communication between restorative and therapy.

- The form needs to be completed prior to the last day of skilled therapy.
- The form should not be completed in therapeutic terminology. It must be completed in language that Nursing Assistants will understand.
- The form is a recommendation for restorative and **NOT** the actual program. Your Restorative Coordinator should take the referral and develop the formal Restorative Program based on many different factors.

Recommendations for a Restorative Program

- These forms should be reviewed at your clinical meeting and discussed with the Restorative Coordinator.
- You should train the Restorative Coordinator and Nursing Assistants in the interventions recommended with return demonstration.
- Staff on each shift should be educated on the interventions for each resident.
- Be creative with your referrals in terms of the different programs that are available.
- Be sure the interventions are realistic, clear, and integrated in their daily care when appropriate.

Types of Programs

- Range of Motion
- Splints and Braces
- Positioning and Bed Mobility
- Transfers
- Ambulation
- Activities of Daily Living
- Eating and Assisted Dining
- Prosthetic Management
- Bowel and Bladder
- Communication

Implementation of Programs

- When a referral is received, your Restorative Coordinator should assess the resident and determine what programs would be appropriate.
- The initial note is completed and should include the resident's strengths and deficits, indicate equipment and staff assistance required, identify risk factors associated with possible functional decline, and describe the resident's goals for maintaining or improving functional abilities.
- Your Restorative Coordinator should develop the restorative plan of care.
- Nursing Assistants should be educated on how to complete the program. Documentation should be initiated.

Documentation

Each program has specific requirements for documentation.

1. Daily documentation is required for verification that the program was executed.
2. In order to code the Restorative Program on the MDS, the total time in the documentation must equal at least 15 minutes per day.
3. The Restorative Programs can be provided up to 7 days a week.
4. Episodic documentation to explain why the resident did not participate is required.

Documentation

At periodic intervals, the Restorative Coordinator must evaluate the restorative program and document the following:

- Resident's progress toward the goal and/or decline in function.
- Revise the program or continue program as written.
- Refer the resident to a different level of program.
- Discharge the resident from the restorative program.
- Refer to therapy due to a significant functional decline or improvement.

RAI Manual

- Clarifications
  - Must have at least 15 minutes a day of an activity to count, time must be documented in blocks of 15 minutes or more.
  - The 15 minutes of time in a day may be totaled across 24 hours, however 15 minute increments cannot be obtained by combining two activities.

RAI Manual

- Clarifications
  - Active or passive movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative program.
  - For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures.

RAI Manual

- Clarifications
  - Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff.
  - These grooming programs would need to be individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Ohio

- Assessment must establish a baseline.
- An RN shall conduct and document a nursing assessment; analyze the assessment data; develop, maintain, or modify the nursing component of the plan of care; and reassess the resident's status, nursing component of the plan of care, and make changes in nursing interventions.

Ohio

- The resident's plan of care should include specific interventions and approaches, establish measurable restorative goals that include frequency and duration, and are related to the resident's deficit.
- A restorative program may be implemented as an adjunct program to therapy but not duplicating the exact program in therapy.
- When a resident is discharged from the therapist's care and picked up by restorative, the RN may incorporate the recommendations of the therapist into the plan of care for the restorative program. The RN should review these recommendations, make an assessment, and develop the restorative program.

Ohio

- Service delivery must document specific activity, frequency (number of days), duration (number of minutes), and service provider.
- Groups with 1- 4 residents per supervising helper or caregiver must be clearly identified as group sessions, the number of residents in the group and the amount of time spent in each session documented, and the duration minutes divided between group participants.
- Services must be delivered for at least 15 minutes per day (although they do not have to occur in a continuous block of time) in order to code this item on the MDS 3.0.

Ohio

- The practice of the RN merely co-signing notes written by a LPN, STNA, or the therapist's evaluation is not an acceptable standard of practice.
- Co-signing any type of documentation is no longer acceptible by the Ohio Department of Job and Family Services (ODJFS) effective July 1, 2004.

A Final Word on Restorative

- Restorative programs alone do NOT improve your case mix!
- Strong restorative documentation can be a driver for Part B referrals.
- These referrals WILL significantly improve your case mix.

In Conclusion

- Therapy and Restorative are programs that are designed to enhance the quality of life for our residents.
- It can also generate revenue to support our facilities.

JUST DO IT!!!