MDS Alert

Medicare Payment: Estimate Therapy Minutes Without Penalizing Residents,Your Ledger - Or Rousing DAVE

8 steps to crossing Section T off your worry list.

Is your facility pulling rehab RUGs out from under residents'feet and the facility's bottom line by under projecting therapy minutes in Section T?

Worse: Does your facility consistently estimate therapy minutes in Section T that have a mysterious way of never materializing completely? In the age of DAVE audits, that's one RUG pattern you definitely don't want to develop. Yet erring on the side of caution to tiptoe around fraud and abuse fears won't help your residents achieve optimal outcomes, which can lead to survey issues.

The trick is to estimate therapy minutes based on a resident's actual needs and rehab potential. It sounds simple, but facilities still falter. Experts suggest the following steps to keep your therapy estimates on target and your facility off DAVE's radar screen (DAVE stands for Data Assessment VErification, the government's new auditing program to ensure MDS data integrity. (See the related story on DAVE.)

1. Understand the reason for Section T and use it accordingly. "The purpose of Section T is to protect both the resident and the facility at the time of the admission or 5-day MDS," says **Gail Neustadt, NHA, SLP**, a rehab therapy consultant with **Flagship Rehabilitation Services** in Martinsburg, PA.

Say a resident is admitted and is projected to RUG into "very high" but ends up getting only two hours of treatment over a 15-day period, so the MDS staff records only 120 minutes in Section P, Neustadt postulates. That person will at least go into the high rehab category based on that 5-day MDS.

Remember: Estimated minutes won't RUG a resident into very high or ultra high rehab.

2. Know the in's and out's of completing Section T. "You can only estimate minutes in Section T on the 5-day MDS or on a readmission MDS," says **Marilyn Mines, RN**, a consultant with **FR&R Healthcare Consulting** in Deerfield, IL. (To review the coding directions for estimating therapy days and minutes in Section T, see p. 65.). In addition, don't record the estimated minutes in Section T until therapy has completed its evaluation, Neustadt advises. **Tip:** "Have all three disciplines do the evaluation (if there appears to be a need for all three) on the same day," she counsels.

Watch out for this practice:
One might reason that if you set the assessment reference date (ARD) on day one or very early, you don't have to record projected minutes because the RAI manual says a therapy evaluation has to be done and the therapy scheduled before estimating minutes, observes **Cheryl Field, MSN, RN, CRRN.** "And some providers have felt that they could ethically do this in order to maximize the RUG (get an SE3), but DAVE has identified this as an area of concern," cautions Field, who is director of clinical and reimbursement services with **LTCQ Inc.** in Lexington, MA.

On the other hand, don't put all your eggs in a rehab RUG. "Make sure to always capture and code clinical services during the look-back period, including hospital services such as IVfluids, IVmedications, transfusions, etc.," says **Jan Zacny, RN**, a consultant with **BKD Inc.** in Springfield, MO. "That's important even if the patient is receiving skilled rehab services in the SNF," she says, "because if the claim gets audited and the FI denies the rehab therapy, the claim would at least be adjusted to a clinical RUG group -- if the facility has the supporting documentation."

3. Develop an admission assessment system that identifies therapy candidates before they come in the door. "The facility's admission people can use a RUG-driven tool (a checklist with boxes, preferably) when they talk to the hospital

discharge planner to get an idea up front of whether the resident is going to RUG into a rehab or nursing category," Neustadt advises. "When done properly, the resident [who is a candidate for therapy] comes in with therapy orders" from the physician, which gets the ball rolling quickly.

Hint: Some of the best candidates for rehab include those with orthopedic problems related to osteoarthritis and rheumatoid arthritis, such as hip fractures or knee replacement with both mobility and activities of daily living needs, advises Neustadt. Also top on the list: Residents with cerebral vascular accident who have residual aphasia, mobility disorders and activities of daily living needs.

What type of patients will probably not be able to receive estimated therapy minutes? "Someone with IV antibiotics or a medically complex condition where therapy is really going to be more of a risk to the patient in terms of actually providing the minutes," says **Eric Keiper,** director of rehabilitation services for **Morrow County Hospital**, in Mt. Glead, OH.

"That person will probably need time to recover in a clinical RUG, although we might still do therapy in our SNF during that time at a low level," Keiper tells **Eli**.

4. Consider using a standardized therapy evaluation and monitoring protocol. "If the facility's evaluation of the resident is guided by standard policies and procedures and clinical protocols/tools performed at specified times ... it should be on safe ground in projecting therapy minutes on the MDS," says **Beth Klitch**, principal of **Survey Solutions Inc.** in Columbus, OH.

5. Keep the resident and family in the loop. Klitch knows of facilities where DAVE auditors zeroed in on projected minutes in Section T that weren't provided. "And when the auditors questioned family members as to whether the facility staff had told them that their loved ones would be getting therapy, they were clueless," Klitch warns. Even worse, the residents in question weren't typical rehab patients for whom rehab therapy would normally be the first line of treatment.

Lesson learned: During the care planning process, talk to the resident and family about their goals and plans for care -- and document that you did, suggests Mines. Include a question on the admission form that asks the resident/family: "What has your doctor or other healthcare providers told you about the reason you are here?"

6. Watch out for practices that make it look like the facility had no intention or capability of delivering estimated therapy minutes.For example, auditors may question a pattern where the facility predicts a high rehab RUG in Section T, but the therapists don't even start seeing the resident until the fourth day of the SNF stay. "If the facility has staffing limitations, it should not over project therapy minutes that it knows its existing staff can't deliver," warns **Arnie Cisneros**, a physical therapist in Saginaw, MI.

7. Document why estimated therapy minutes don't materialize in specific instances. "For example, document if the resident got sick or refused to participate in therapy," advises **Pauline Watts, PT**, cofounder of **Encompass Education Inc.**, a rehabilitation education and consulting firm in Palm Harbor, FL.

Example: Klitch recalls one instance where the facility projected a high number of therapy minutes for a resident who appeared to be a solid rehab candidate. But once the therapy started, the woman appeared too dizzy and ill to participate. The SNF staff found out that the woman was seriously anemic, which no one had anticipated. And the resident's blood count didn't come up after a blood transfusion at first, so therapy ended up being delayed nine or 10 days. "Documentation of that type of incident should indicate that the condition was unforeseen," Klitch notes.

8. Don't be bullied by the fiscal intermediary. "While the facilities need to provide resident rather than financially focused care, facilities should not allow themselves to be bullied by the fiscal intermediary," Neustadt emphasizes. So, if all your "T's are crossed" when doing Section T -- following the steps above -- don't be afraid to challenge a claim denial.