Centers for Medicare & Medicaid Services
Skilled Nursing Facility (SNF) Prospective Payment System (PPS)
Resource Utilization Group-Version 4 (RUG-IV) National Provider Call
Moderator: Geanelle Griffith
June 23, 2010
1:30 p.m. ET

Welcome

Operator: Welcome to the Skilled Nursing Facility Prospective Payment System Resource Utilization Group, Version 4 conference call. All lines will remain in a listen only mode and cover question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

CMS greatly appreciates that many of you minimize the government's teleconferencing expense by listening to this call together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, please enter one. If there are between two and eight of you listening in, please enter the corresponding numbers between two and eight. If there are nine or more of you in the room, please enter nine.

Thank you for participating in today's call, I would now like to turn the conference over to Ms. Geanelle Griffith. Please go ahead.

Geanelle Griffith: Thank you Christy. Hello everyone and welcome to the Skilled Nursing Facility Prospective Payment System Resource Utilization Group-Version 4 National Provider Call. As stated before my name is Geanelle Griffith and I will serve as your moderator.

This call will review key aspects of the SNF PPS case mix system RUG-IV which will be put into place on an interim basis effective October 1, 2010. CMS subject matter experts will discuss coding procedures with emphasis on the appropriate Look-back Period to be used when coding the Minimum Data Set MDS 3.0 and how facility staff should separately report individual, concurrent, and group therapy for accurate payment. In addition, this call will

discuss how changes to the ADL coding requirements impact the assignment of MDS 3.0 records to a RUG-IV group.

Two additional provider calls will be held in August 2010 to explain the other payment issues including the transition from RUG-III to RUG-IV and the additional changes needed to install a hybrid RUG-III grouper mandated by statute.

Many of you took the time to submit your questions on the SNF PPS RUG-IV through the registration site. It is our hope that the formal presentation today will answer those questions that will only pertain to today's topic. If you haven't done so already, please take the time to download the PowerPoint presentation to follow along with the presenter. The PowerPoint presentation can be found on the SNF PPS web page on the CMS website.

With me here today is Sheila Lambowitz who serves as the Director of CCPG's Division of Institutional Post-Acute Care. I will now turn the call over to Ms. Lambowitz who will give some brief remarks as well as introduce today's presenter Ms. Ellen Berry.

Sheila Lambowitz: Thank you very much. Welcome everybody. I am really glad that you are able to join us for this call. We do have a lot to talk about in terms of the payment process that will go into effect in October. And I'll start with the question you're all just dying to ask. Why are we training you on RUG-IV when the law says that RUG-IV is supposed to be delayed?

Well, the law says that RUG-IV is supposed to be partially delayed. In effect, what the legislation did was create a hybrid system. One from column A, one from column B. Part of RUG-III and part of RUG-IV which is fine except our computer system, our groupers don't do one from column A one from column B. They are very linear. And they will either do RUG-III or RUG-IV. So we're in the position where we have to build a new grouper in order to process the MDS and then pay the claims according to the statute. And we are totally committed to doing that.

The problem is that our resources have all been focused on introducing the MDS 3.0 with the RUG-IV system and the MDS 3.0 is also legislated by statute to go in October. And what we were afraid of is that if we try to change gears and work on MDS 3.0 but try to change it to a hybrid RUG system that we would impact the success for implementation of the MDS 3.0.

So we decided that for safety's sake and also to be able to pay you something, we needed to come up with an interim plan.

So what we are doing is on a temporary basis starting October 1, all of your MDS 3.0 will be processed and we will calculate a RUG-IV group and we will make a temporary payment at the RUG-IV level. We will be building a hybrid RUG grouper so that we will be able to go back and reprocess the MDS if necessary and then reprocess claims to make sure that everybody will be paid at the proper rate.

But we wanted to make sure that we built this hybrid grouper correctly and paid accurately and didn't want to take a chance of basically using the technical term screwing it up. So, that's our plan for October. And you know, I think you need to understand what the RUG-IV system is going to do so that even if it's only a temporary system, you understand the information you get back to us when we assign a RUG group and of course RUG-IV will go into effect next year so consider this a practice session.

Now, there is one other glitch kind of, well not really a glitch, but many of you have heard that there is legislation pending to repeal the delay of the RUG-IV system and proceed this October with the full RUG-IV system. The legislation has been supported by your provider association and you know, you may want to check with them for updates but right now, that legislation is still in process and it's moving through the system. It's included in bills in both the House and Senate. So we're waiting to see exactly what happens.

So that's kind of why we thought we really needed to start planning on RUG-IV now whether it becomes a permanent system this year or next year, at some point you're going to have to learn it and we will continue to make every effort to comply with the statutory requirements.

I wanted to mention one thing. If there are any swing bed providers on the call, this is probably the first time that you have had to do the parts of the MDS that required, that had quality measures, and questions on them and also had to do discharge assessments. I hope that you'll be able to look at the MDS 3.0 manual and make some sense of this but we are going to try to provide as much information as we can to make sure you can cope with the new requirements.

And finally, we have looked at the questions that you submitted and as much as we could, we tried to incorporate them in the presentation Ellen is going to give. Many of your questions are very helpful in helping us structure the next two calls so even if we don't address them today, we will certainly be addressing them in future training sessions. And with that, I'm going to turn it over to our presenter, Ellen Berry, who's going to go through the basics, you know, and the materials by the way if you haven't already gotten them are on the SNF PPS website so you can follow along.

Slides 2 through 27

Ellen Berry: Thanks, Sheila. Welcome everybody to our first of three audio conferences on SNF PPS and RUG-IV. Today, we will focus on the Look-back Period for certain items on MDS 3.0, the ADL index scoring, and rehab services. What we will not be doing is speaking directly on how to code the MDS. Most of the sections for Chapter Three have been updated and are posted on the website so for specific coding information, that is where you should look first and then contact your state RAI coordinator or you may submit questions to mds30comments@cms.hhs.gov.

First, we'll give a little bit background on RUG-IV. As many of you should know, we conducted a time study recently, called STRIVE (Staff Time and Resource Intensity Verification). Why did we do this? Well, RUG-III was based on time studies from the 1990s. Practice has changed, resident mix has changed as well as staff mix and we've seen a lot of technology advances in healthcare. What did we collect? We collected staff time as well as assessment data, the MDS 2.0, and the STRIVE addendum.

The study was conducted from spring of 2006 to summer of 2007 in 15 states. And what we found is practice has changed, technology advances have impacted the care provided to SNF residents, the resident mix and staff mix have changed. Therefore, we developed RUG-IV.

RUG-IV is very similar to RUG-III in that the data from the MDS is used to assign a person into a category based on services, treatments, and diagnoses. Just like RUG-III, assignment into a RUG does not mean that the person is receiving Skilled Nursing Facility level of care services. The provider must ensure that all the requirements for a SNF Part A stay are met such as the three-day qualifying hospital stay, the daily need for skilled services.

We maintained eight classification levels just as we have in RUG-III. However, they do vary a little bit different. We split the special care category into two levels – special care high and special care low – and then we combined the impaired cognition and behavioral problem categories into one group. There are 66 groups, the level of care presumption applied to the upper 52.

With RUG-IV and the MDS 3.0, we were able to add some conditions or services to some of the groups such as isolation for active infection and Parkinson's. We removed some qualifying conditions such as dehydration and suctioning. And then we moved some of the existing conditions or services within the hierarchy.

We extended the depression end split, whether a person has signs or symptoms of depression so that it also is the end split for special care categories. For greater detail on RUG-IV and the STRIVE project, please refer to our final rule from the last year as well as you can go to the SNF PPS website at http://www.cms.gov/snfpps and in the box on the left you can click on Time Study.

Our first topic is Look-back Period. Basically, this refers to services that are provided prior to admission/reentry into the SNF. In most instances services provided prior to the SNF stay are not used in the grouper for RUG-IV. Most

of these items are found in Section O. You will still be able to code those items if the person did receive those services in the hospital but that would be in column one, not column two. The grouper will look to column two in order to group someone into a category.

These services are such as IV medication, chemotherapy, and oxygen therapy. There are two treatments that based on MDS 3.0 coding, the provider is able to look back into the hospital stay to code those as long as they meet the definitions found for those items in Chapter Three and those are parenteral IV feeding and feeding tube, they both are located in Section K of the MDS 3.0.

On slide seven, we show some STRIVE results for pre and post services that are in RUG-III for extensive services. This is why we made the change of whether or not you could look back into the hospital stay for the services to categorize somebody into a RUG-IV group. What we found is that more staff resources are required to care for a person once they are in the SNF and they received the services in the SNF compared to when the resident only receives the treatment during the hospital stay.

The conclusion that we came to is that services furnished only during the prior hospital stay do not translate into greater staff resource after admission to the SNF. Therefore, in essence we have been overstating the resource needs for these residents who did not receive these treatments during the SNF stay.

ADL's coding requirements for RUG-IV. There are many similarities between RUG-IV and RUG-III when it comes to the ADL. The four late loss ADLs will continue to be used. Those are bed mobility, transfers, toilet use, and eating. We have an ADL score range. The ADL score is used as an end split for most categories, in fact all categories, except extensive services. Many categories have a minimum or maximum score requirement, extensive services, rehab plus extensive services, and special care high and low all have minimal scores whereas behavioral symptoms in cognitive performance has a maximum score. There are some conditions that still have a minimum score requirement such as MS, CP, Parkinson’s, and hemiplegia.

On slide 11, we show some of the differences between RUG-IV ADL score and the RUG-III ADL score. While both have a score range, we have changed the score range for RUG-IV from zero to 16. It was four to 18 in RUG-III. We have also standardized the index. In today's world, the RUG-III index varies between groups. For example, rehab very high L has an ADL index of seven to 15, whereas rehab high L has seven to 12, whereas rehab medium L has a seven to 14. With RUG-IV, we've made those so that if they were on a rehab very high L they will have a score of two to 10, same as rehab high L and rehab medium L throughout all of rehab.

A big difference is the eating score and how we calculate that. With RUG-IV we will be looking at both self-performance and the support provided in Section G for eating. We will no longer use the Section K items parenteral IV feeding or the tube feeding where in RUG-III we automatically applied the maximum eating score ADL. This change provides better categorization of residents receiving assistance in feeding. Residents who require one person physical assist or more needed comparable staff resources of those who are being fed by artificial means.

The new ADL scale is more sensitive and improves the ability to measure functional status more accurately and the larger range of an additional two points allows greater distinction and physical function.

On slide 12, we provide a snapshot of the ADL categories and how to score them based on self-performance and the support score. For more information you can refer to Chapter Six of the MDS 3.0 RAI manual.

Probably one of our hottest topics is rehabilitation. Rehab refers specifically to speech-language pathology services, occupational therapy, and physical therapy.

Slide 14 we show a snapshot of what skilled therapy is and the requirements that are to be met. These are not new requirements. Services must be ordered by a physician, or must be an active written treatment plan. The services must be at the level of complexity and sophistication that the judgment, knowledge,

and skill of a therapist are required. The services must meet accepted standards of medical practice and they must be reasonable and necessary.

Under Part B, there is a plan of care that must be certified. Skilled services must be provided by qualified personnel. As stated in 42 CFR Code of Federal Regulations 409.23, the clinicians who meet these criteria are physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and speech-language pathologists.

With MDS 3.0 we were able to look at how therapy is being delivered to each resident. The three different modes of therapy are individual, concurrent, and group. You must know the payer source for the resident in order to know how to code the minutes provided to that individual. There is a slight difference between Part A and Part B. We have included those in Section O of the MDS 3.0 RAI manual as well as in these slides.

Individual therapy for both Part A and Part B is the treatment of one resident at a time. That resident is receiving the therapist or assistant's full attention. Treatment of a resident individually at incrementing times during the day is individual treatment. Minutes of individual treatment are added for the daily count.

Concurrent therapy. This is where Part A and Part B differ slightly. For Part A, as stated on our final rule last year, concurrent therapy is the treatment of two residents at the same time who are not performing the same or similar activities regardless of pair source. Both residents must be in line of sight of the treating therapist or assistant. Part B does not recognize concurrent therapy. Under Part B, treatment is either individual, that is, one on one or group (two or more individuals).

Group therapy. Under Part A was defined when SNF PPS went into place, it remains the same. The treatment of two to four residents at the same time regardless of payer source performing similar or the same activities to be supervised by a therapist or assistant and that clinician is not supervising any other individual. Part B the definition of group therapy is the treatment of two

or more residents at the same time regardless of payer source who may or may not be performing similar activities.

For coding therapy minutes on the MDS, you should code the actual minutes provided for each therapy mode. Set-up time is included for individual therapy cap time even when the therapy aide does the set-up, that time should be counted. As it is today, you are only to code the therapy minutes that have been provided since admission or readmission into the SNF which is following the evaluation of that resident. Because set-up time is included on the MDS, claims may not match the MDS exactly especially for a Part B claim.

As is today, there are certain instances where therapy minutes are not to be coded. The initial evaluation time, documentation time, services that are not medically necessary, a non-therapeutic rest period, non-skilled services as well as treatment that does not meet the therapy mode definition.

Two other items were added also to each of the therapy items in Section O. Those are the therapy start date and the therapy end date. These dates are important for other policies that we will cover in August in particular the short stay assessment. The therapy start date, this is the date that the most recent therapy regimen started.

The date may differ between the three disciplines since they may not all be providing therapy or they may start on different dates. It is the date that the initial therapy evaluation is conducted regardless if treatment was rendered or not.

The therapy end date is the date that the most recent therapy regimen ended. It is the last date the resident received skilled therapy treatment. Please note, we will go over this with the short stay policy on a future call. There may be dashes in that item for the short stay or even on a regular PPS scheduled assessment if the therapy is continuing.

On slide 22, there are some reminders to keep in place when you're coding the MDS. You want to report actual therapy minutes on the MDS. You do not

round. Do not apply any of the methodologies that we used for the RUG-IV grouper. The RUG-IV grouper will apply our rule where the concurrent therapy minutes are divided in half.

So if a resident received 100 minutes of physical therapy of concurrent, under concurrent, you enter 100, you do not enter 50. If you do that, you will actually possibly impact what RUG group that person is assigned to so make sure it's the actual minutes. Unlike with MDS 2.0, the therapist or the clinician completing the MDS for the therapy minutes, you do not have to apply the group cap for Part A, the 25 percent rule.

You will enter all the group minutes. The grouper will take that into account. That is something different so make sure that your staff is aware of that. Therapy definitions and limitations must be applied consistently whether or not the resident is in an assessment window. Residents non-therapeutic rest time is not counted. Therapy aide set-up time is counted for individual therapy.

Again, report actual minutes of skilled therapy services provided by qualified personnel. On slide 24, we provide a little sample test for RUG-IV which is not necessarily fair because you don't have the rates yet which you will have at the end of next month. By law, they will be out by July 30.

But those who have followed the STRIVE study may be able to figure these out but you have the answers anyway if you go to the following slides. Rank these conditions from high to low based on the resources generally needed to treat a SNF beneficiary. One, septicemia, two, ventilator-dependent, three, IV medications, four, comatose and five, surgical wound care. Now this is RUG-IV, not RUG-III. RUG-III, they will be classified differently.

On slide 25, we provide the minutes from the STRIVE data which is wage weighted to care for each of these types of residents. A resident who is ventilator-dependent required 405 minutes, at the most. Septicemia, 213, comatose, 197, surgical wound care, 146, an IV medication, 130.

That is different than what we have in RUG-III where IV medication was up near ventilator dependent. On slide 26, we provide estimated, I emphasize estimated, RUG rates for RUG-IV. And as you can see there, we give a comparison of the RUG-III rate to the RUG-IV. There has been industry concern that with the application of the concurrent therapy that they would see a decrease in payment.

In reality, payments are going up. We have high B under RUG-III, that's $349, under RUG-IV, it would be $434. Ventilator does increase significantly. IV medication remains about the same. If the person was in a SE2 level today they would receive $276 a day versus RUG-IV in CB2 clinically complex B2, $278.

And that's our conclusion for the presentation.

Question and Answer Session

Geanelle Griffith: Thank you, Ellen. Christy, we will now open the call for questions but before we begin the question and answer session, I'd like to remind everyone that this call is being recorded and transcribed. So please state your name and the organization in which you represent. In an effort to get as many questions asked and answered as possible, we ask that you limit your number of questions to just one. Christy, you may now open the lines for questions.

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity.

Please note your line will remain open during the time you're asking your question so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Tanya Stewart. Your line is open.

Tanya Stewart: Yes, I'm with Regional Nursing and Rehab. And the question is can we count minutes for therapy if they participate in the care plan?

Sheila Lambowitz: I'm sorry, are you asking if you can count minutes if the therapist participates in care planning?

Tanya Stewart: Yes.

Sheila Lambowitz: I'm sorry… Is the resident involved? What…

Tanya Stewart: Yes, the resident and family members are involved.

Sheila Lambowitz: Yes, but I don't think during the care planning process… the question would be is the therapist actually performing a therapy modality as part of care planning. I suspect not. And in that case, the care planning would be considered under the – under a documentation type of responsibility and that is not counted as a therapy minute.

Tanya Stewart: OK, thank you.

Sheila Lambowitz: Next question.

Operator: Your next question comes from the line of Donna Davis. Your line is open.

Donna Davis: Yes, I'm with the United Regional Medical Center Nursing Home. And I'm wondering if there will be a copy of the question and answer session available to print at a later time.

Geanelle Griffith: Yes, at least two weeks after the call. There will be a transcript and MP3 audio file posted to the SNF PPS web page.

Donna Davis: Thank you.

Sheila Lambowitz: So that means you don't have to frantically write all of these down. Next question.

Operator: Your next question comes from the line of Margaret. Your line is open.

Cindy: Yes, actually, this is Cindy. I'm from Frankford, Michigan. My question is with the doors for Medicaid. How is this going to impact the 3.0 going to impact the doors because we pulled out information right from 2.0.

Sheila Lambowitz: OK. In your state, do they call the Medicaid payment system doors? Is that what you are referring to?

Cindy: Yes, it's the qualification for Medicaid to pay for stay in nursing home.

Sheila Lambowitz: OK. I think one you probably should talk to your state representative first and they can give you the detailed information but just so that everybody will know, we've been working as closely as we can with all of the state Medicaid agencies to make sure that they are going to have access to the MDS 3.0 data and that they can also convert it for use in whatever payment system they are currently using whether that's a version of RUG-III or any other kind of system. So we are working with the states and the states are working with their vendors to make sure we get this right. Yes, do you have a follow up?

Cindy: No. Thank you.

Sheila Lambowitz: Thanks. Next question please.

Operator: Your next question comes from the line of Annette Stuvly. Your line is open.

Joy Lichica: My name is Joeylyn Lichica, I was just asking a question about the student or can I supervise the student and both of us count our minutes with therapy?

Ellen Berry: Yes. In Section O of Chapter Three, we do provide specifics on students and when it’s considered individual versus concurrent versus group so you'll need to refer to Section O. And when you say I, I don't know if you’re a therapist or an assistant. So, a therapist could supervise a therapy student or a therapy assistant student. An assistant can supervise just an assistant student. They could not supervise the therapy student.

Shelia Lambowitz: And those are probably more licensure requirements than they are CMS requirements but we’ve worked, we’ve checked with the therapy associations to make sure that was correct. I hope that helps. Next question.

Operator: Your next question comes from the line Joanne Didmer. Your line is open.

Stacey Chugan: Yes. I'm Stacey Chugan from Helen Hayes Hospital up in New York. We were just wondering, we have onsite prosthetists and orthostists in our facility who often see the patients for fabricating, braces, casting, modifying them, educating them on how to use them. And Medicare pays for those services so we were wondering if those minutes might count as treatment minutes. I know you specified PT, OT, and speech. But I was just wondering if possibly those minutes could count also.

Sheila Lambowitz: No, they cannot.

Stacey Chugan: OK. Thank you.

Sheila Lambowitz: OK. I will say, it is an interesting concept in I think it is fairly unusual to have that type of service provided by facility staff. So we will keep this in mind that we develop additional initiatives too – it's just it was not something we looked at in the STRIVE project.

Geanelle Griffith: OK. Next question.

Operator: Your next question comes from the line of Pat Bacon. Your line is open.

Pat Bacon: Hi. This is Pat Bacon, I'm calling from Alta Bates Summit in Oakland, California. My question is concerning the IV medication RUG-III to RUG-IV interpretation. We are seeing much more complex medication deliveries for the patients in our Skilled Nursing Facility, they are multiple antibiotics, multiple medications and this doesn't seem to be reflecting that increase in higher acuity.

Sheila Lambowitz: Yes. This is Sheila. Ellen and I were nodding at each other, so I'll take this one but it would be the same answer. You're right, in that the RUG methodology looks at IV in terms of the staff resources it takes to administer the IV and does not address the cost of the IV medications that are being administered. That's something that we are looking at in terms of developing

some additional adjustments to increase payment for non-therapy ancillaries and even possibly to look at outlier provisions that would assist facilities that have unusually high cost patients.

So we're aware of the problem. And RUG-IV does not in itself totally solve that. But we've talked a little bit about how much higher the rates are for some of the medical conditions when you look at when you compare the RUG III to the RUG-IV rates and since the amount we pay for non-therapy ancillaries including and especially drugs falls under that nursing component. We are increasing our payments for non-therapy ancillaries significantly under RUG-IV it's just that when you have very high cost antibiotics, we still have more work to do.

Pat Bacon: OK. Thank you.

Sheila Lambowitz: Next question.

Operator: Your next question comes from the line of Sheryl O'Conner. Your line is open.

Mark Steven: Hi this Mark Steven from Well Stop Holding Subacute Rehab. Have three questions, the first one regarding qualifying conditions. We've been going through some I don't know if you call it issues but premorbid conditions, for instance, pneumonia. Is that a qualifier or not for subacute rehab?

Sheila Lambowitz: You're speaking to SNF level of care services?

Mark Steven: Yes exactly. And now, I understand the three-day qualifying stay naturally and for instance we've been told pneumonia now is a self resolving condition. And thus does not qualify for subacute rehab and subsequently RUG.

Sheila Lambowitz: I think you're looking at two different issues. First whether the person requires SNF level of care services. And those requirements are specified in the 42 CFR 409 which are, you know, daily requirement, a skilled need, practical matter, three-day qualifying stay, for a condition that was treated during the hospital stay or during the SNF stay.

And then whether or not that person is assigned into a RUG group. You know we can't sit here and say yes that condition applies because it does depend on the individual and everybody does present differently with different types of diseases and treatments. So if you have an individual case that you need to be opined upon, you should contact your Medicare Contractor, your AB/ MAC to determine whether or not that person is appropriate for your SNF or not.

Mark Steven: Understand. And second question. The therapy dates now on the RUG-IV goes from most recent to last, whether they have different discipline or not. What is the intent of it versus what we used to do or are doing?

Sheila Lambowitz: I'm sorry. Can you speak a little louder for one thing; we are having a lot difficulty hearing you.

Mark Steven: Yes. The therapy dates that are going to be listed from most recent to last, what is the intent of this? Why are we changing?

Ellen Berry: Well, the therapy start and end dates are new to be coded on the MDS. We use those dates for the short stay policy as well as the Start of Therapy OMRA and the End of Therapy OMRA.

So those are needed so that we can provide you, the grouper provide you with the appropriate RUG assignment so you can bill us appropriately. And we'll be going over those policies in August. And Chapter Two and Chapter Six of the RAI manual will address those areas.

Sheila Lambowitz: I wanted to add, just one more thing that one of the healthcare reform initiatives really requires us to get a better understanding of services and outcomes not only in one particular setting but across settings. And to do that we need to have more precise information about the services that are provided to individual beneficiaries.

And so, that's one of the reasons you see some of the changes in the requirements and that we definitely want to know more about the course of therapy. So there are a variety of purposes. Does that help?

Mark Steven: Yes, it does. Thank you.

Sheila Lambowitz: OK, good.

Operator: Your next question comes from the line of Evelyn McKay. Your line is open.

Evelyn McKay: Hi. I have two questions. One addresses the concurrent therapies. Currently there's a CPT code for group therapy, but there is not one for concurrent therapies. So how do we capture those? Do we add our own categories? Because there is a CPT code for group but not for concurrent.

Ellen Berry: Well CPT codes were used for Part B billing, not for Part A and…

Evelyn McKay: I'm sorry. Yes we understand that but we use them across the board because we tried to align it within Med B minutes. So if anybody looks back and sees what kinds of treatment we're providing they can see exactly what categories we're using under the therapy.

And I heard some time ago that they were trying to line A and B.

Sheila Lambowitz: I don't think we have an answer for that yet but we are starting to work with our claims processing people and our coding people to make sure that we do have the appropriate codes to support the RUG-IV. So, we'll have to put that on a list for a future call and we'll try to get you more information.

Evelyn McKay: Thank you and I have a follow up on the Look-back Period and the use of grace days. Now that Section T is gone for predictors and those which would affect the rehab medium and rehab high, are there any thoughts of having the use of grace periods for the most part to get a clearer picture of the person and the seven day Look-back Period?

Ellen Berry: Well grace days have always been allowed and they will continue to be allowed. So, for the five days you can have an ARD on day one through day eight and that will continue. We did try to lessen the wording for grace days in the RAI manual.

So I would suspect – and this is just speculation – that some facilities may use grace days more frequently with RUG-IV than they would have with RUG-

III. Now do keep in mind that we do have the Start of Therapy OMRA, and again we'll go over that in two months, in August.

But there is information in the manual now on the Start of Therapy OMRA, as well as the End of Therapy OMRA, in that if a person is outside the window and therapy has started, you will be able to complete a very short assessment to group that person into a RUG category.

Evelyn McKay: Oh, that sounds great.

Ellen Berry: OK.

Evelyn McKay: Thank you very much.

Ellen Berry: You're welcome.

Sheila Lambowitz: And we're going to be discussing that in more detail in August.

Evelyn McKay: OK. Thank you.

Sheila Lambowitz: Sure.

Operator: Your next question comes from the line of Chris Evans. Your line is open.

Chris Evans: Yes. I am from Sims Pension from Pittsburgh, Pennsylvania. My question is regarding rehab billing under Part B. As far as the rehab aide setting up, we are not allowed to bill that time under Part B. Is that correct?

Ellen Berry: That is correct.

Chris Evans: Only Part A?

Ellen Berry: Well, it's not billing under Part A. It's whether or not you can code it on the MDS. As for your Part B, you could code it on your MDS. However – that's why I made the statement that your claim may not match your MDS minutes.

Chris Evans: OK – and a second quick question, under care planning, if a resident attends a care plan with the therapist present, and they're talking about discharge

planning to the home, safe ADL equipment that's needed, safety issues within the home, could those minutes not be billed under ADL?

Sheila Lambowitz: No they couldn't be billed under ADL, the discussion of space practices. This is similar to a question we got before and what we'll try to do is do a kind of a question-and-answer and get back to you in more detail.

But I understand what you're saying. It's just these things don't necessarily fit into the current structure of the MDS coding process. But, you know, I think, it is good that you are having these conferences that include not only the appropriate professionals, but the beneficiary and the family. So we'll get back to you on it.

Chris Evans: OK, thank you.

Operator: Your next question comes from the line of Chris Cavanaugh. Your line is open.

Chris Cavanaugh: I just wanted to see if we are combining group and concurrent minutes on the MDS or if we're allowed – what I heard was like 25 percent concurrent and 25 percent group minutes to be billed on the MDS?

Ellen Berry: What's coded on the MDS is your actual minutes in each – for the resident that he or she spends in each of the therapy modes. Individual would be one line, concurrent is another line, and group is the third line. You will code the actual minutes.

So if a person received individual one-on-one physical therapy over seven days and that totaled 300 minutes, you enter 300 minutes. If they had 100 minutes of concurrent therapy, so if they were seen along with somebody else – the definition of concurrent therapy was met – say for 100 minutes, you enter 100. You do not divide that by two. All right?

For group, you'll – this is where we differ from RUG-III. RUG-III, you had to apply the 25 percent cap for your Part A resident. With MDS 3.0, we are able to have the grouper do that for you. So if they were in a group for one day, for 50 minutes which is again the definition of group under Part A is two to

four residents conducting the same or similar activities under the supervision of a therapist or an assistant, you would enter the 50 minutes there and the grouper is going to determine whether or not you have exceeded the 25 percent limit.

We do not have a limit at this time on concurrent therapy. We did discuss that in our final rule last year. It does not mean that we will not propose one in the future. But at this point, we have not done such and I'm trying to look to see what page we might have talked about that on. But – so there is no limit there.

Sheila Lambowitz: Alright. And the thing you really have to remember is that we have finally discovered that computers are good at math. And so you need to just put down the total minutes in each of those three categories – individual, concurrent, and group – and the computer will do the calculations to figure out how that should be applied for classification purposes. So it was basically getting you out of – a little bit of math and letting the machine do it.

Chris Cavanaugh: Thank you.

Sheila Lambowitz: You're welcome.

Question and Answer Session (continued)

Operator: Your next question comes from the line of Jane April. Your line is open.

Sheila Lambowitz: Well, maybe we can come back to that one and can – are there any other questions?

Operator: The next question comes from the line of Linda Benson. Your line is now open.

Linda Benson: Yes. Our question was for counting the aide time in individual therapy. Is there a clear definition of what is included in set-up?

Ellen Berry: I guess we might not have thought that set-up would need to be defined. But it would be set-up for individual treatment. I believe an example we might

provide in the manual is the physical therapist is going to conduct wound debridement and so the aide might set up the utensils and – that are required for the therapist to carry out the treatment.

If you find that we need to provide a better guidance on that, please let me know. This is Ellen. You can reach me at ellen.berry – oh, nope. OK.

Sheila Lambowitz: Alright. Where can people ask questions?

Ellen Berry: OK. Submit your questions to mds30comments@cms.hhs.gov.

Sheila Lambowitz: OK. OK?

Linda Benson: Thank you.

Ellen Berry: Thank you.

Operator: And for your next question, comes from the line of Monty Steger. Your line is open.

Monty Steger: Yes. This is Monty Steger in Alabama. I just wanted to know the website to go and print the PowerPoint presentation. I missed the – I got cms.gov\ and what was after the backslash?

Geanelle Griffith: SNFPPS/02_Spotlight.asp

Monty Steger: OK. Thank you.

Geanelle Griffith: You're welcome. Next question.

Operator: Your next question comes from the line of Terri Rein. Your line is open.

Terri Rein: Yes. Our question's already been answered. Thank you.

Geanelle Griffith: Thank you. Next question.

Operator: Your next question comes from Christen Walker. Your line is open.

Christen Walker: Yes. Our question is what will happen to the QI/QM Report and the Five-Star Rating?

Ellen Berry: We don't have the staff here to answer that. This is specifically about SNF PPS and RUG-IV. However, I know that this information has been provided on the SNF long-term care open door forum and, if need be, we can have that addressed on our future call.

Sheila Lambowitz: And I believe we're going to be addressing some of these in future training programs. So we'll make sure that the appropriate people know that this question came up.

Christen Walker: OK, thank you.

Sheila Lambowitz: You're welcome.

Operator: Your next question comes from the line of Mary Getty. Your line is open.

Mary Getty: Hi. This is regard to Section O, the therapy. Would the difference in definitions for concurrent and group for Part A and Part B… How would you complete that section if the patient begins as a Part A stay but moves into as a Part B stay either for exhausting benefits or becoming no longer a skilled service?

Sheila Lambowitz: That's a good question.

Ellen Berry: That's a good question. I could give you a response but I would like to check with our staff to make sure I have the right response.

Mary Getty: And I guess, one other question somewhat related to that is in the definitions that were in the manual. They're defined as with group and concurrent. It says regardless of payer source?

Ellen Berry: Yes.

Mary Getty: But, yes. Defining it for Part A and Part B is in a sense defining it based on payer source?

Ellen Berry: OK what, yes. OK. When you're completing an assessment for Mrs. Jones and she's receiving therapy with Mr. Smith, Mr. Smith may not have an assessment due and he could be under – he could be a long-term care resident. So he might be receiving services under Part B.

But for Mrs. Jones, because you're treating her along with Mr. Smith at the same time and you're meeting the definition for Part A because she's a Part A resident, it does not matter what that other resident payer's source is. You're completing the assessment for a particular resident not for the group of residents.

Mary Getty: Alright, but what if Mrs. Jones moved – I guess that's my first question would be, if Mrs. Jones moved from A to B during …

Sheila Lambowitz: I – we'll have to get back to you and that was …

Ellen Berry: Yes. I guessed on that.

Sheila Lambowitz: I need to get back to you.

Mary Getty: OK, thank you.

Operator: Your next question comes from Pat Bacon. Your line is now open.

Pat Bacon: Hello, my question is since we do not have the restorative nurses' aide in our unit, can we have aide perform the duty so we can, code Section O in the restorative nursing program?

Ellen Berry: CMS does not have a requirement that the person who provides restorative nursing is a "restorative aide". Some facilities do have that hierarchy within their system. What you have to ensure is that, the definitions for restorative are met which starts around page 27 of the Section O, of whether or not the restorative nursing program is met. The program must be overseen by nursing, so, in a nutshell possibly, yes those minutes and might be able to be counted in the restorative nursing section of the MDS.

Sheila Lambowitz: Right, you just want to make sure that the aide you assigned that task, has been trained to do it and is capable of performing that function. We don't particularly care what title you give that type of staff person.

Pat Bacon: Yes, of course, they are trained to perform their duty, so is it OK to code that restorative nursing if it was performed…

Ellen Berry: You have to make sure that the requirements for a restorative nursing program are met and they are outlined in Section O of the manual and they have not changed.

Pat Bacon: OK.

Operator: Your next question comes from Dianne Dopler. Your line is now open.

Dianne Dopler: Thank you. My question is with regards to the start of therapy date. It states that the date initial therapy eval is conducted regardless if treatment is rendered or not. Will that date didn't count as the start date? Even though we don't do an actual treatment just an eval?

Ellen Berry: Yes. Standard clinical practices, that treatment is rendered during the evaluation does not happen in all cases. But yes the date of the evaluation whether or not treatment was provided is the start of therapy date.

Dianne Dopler: OK. But the minutes that it takes to do the evaluation don't count for being entered as an individual segment?

Ellen Berry: Correct.

Dianne Dopler: OK, thank you.

Ellen Berry: You're welcome.

Operator: Your next question comes from Gerald Zander. Your line is now open.

Gerald Zander: Hi, this Gerry Zander from Bourgeois Gardens in Kalamazoo. And I apologize for not having this straight but in concurrent therapy will we count all the minutes for both residents for their RUG score?

Ellen Berry: When, I am trying to help you out here. When you are completing the MDS for a particular resident, you would add up his or her minutes that extends and concurrent. In some cases you do have where, residents move in and out of therapy treatment.

Gerald Zander: Right.

Ellen Berry: So, the therapist is going to have to track when they send individual time versus concurrent versus group. In the manual, we do provide an example on this so, if you review that, hopefully that will help, If not, you know to make your questions to the MDS 3.0 comment e-mail box.

Gerald Zander: OK.

Sheila Lambowitz: On the very simplest level, if you have two people getting concurrent therapy for an hour. And they are both Part A residents. When you fill out to the MDS for both of those people and they will both have an assessment period, you would put the 60 minutes for that hour for each of those two people. The computer will prorate it and allocate the time for you.

Gerald Zander: OK. So, the computer in the simplest situation will have that time.

Sheila Lambowitz: Yes, that is why you want to enter the actual minutes or else you will potentially impact the group that the person is in at that time.

Gerald Zander: Alright, thank you so much. Thank you.

Sheila Lambowitz: Sure.

Operator: Your next question comes from Tera Asmin. Your line is now open.

Tera Asmin: My question is related to the group therapy. You said that the computer is now going to be calculating that for us, but are we still going to follow the 25 percent rule that has historically been our standard?

Ellen Berry: Yes, because I know our contractors are probably having a… pulling their hair out. It's actually specifications that handle it... the grouper specifications that

handle it. Yes, if the person is in a Part A stay you will get a RUG assignment in the 0-100 A and that would apply the 25 percent rule for your Part A resident.

Tera Asmin: Thank you.

Operator: Your next question comes from Nadine Hydeman. Your line is now open.

Nadine Hydeman: Yes, it is about the OMRA start of care. So, if you could clarify if therapy if a patient comes in on a Friday night and therapy only sees them on Saturday, but we have to use grace days and so we use day six and we went backwards and captured our five days. Would we have to do a therapy OMRA or we would just capture the minutes on the regular assessment period during day six?

Ellen Berry: Today, we did not go over the Start of therapy OMRA or the End of Therapy OMRA, we will be doing that in August. You can look to Chapter Two and Chapter Six for these but just so you know, you don't always have to do it in the Start of Therapy OMRA. That is an optional assessment. And in August we will have more information on that.

Nadine Hydeman: And how do we find out about the August, when?

Geanelle Griffith: I will be making that announcement sometime in July. So, if you are not yet signed up to the CMS mailing list, I would encourage you to do so.

Sheila Lambowitz: And we will also put it on our SNF PPS website so, you know, and we will notify your provider associations so they will probably send around some updates and reminders to you as well.

Geanelle Griffith: And lastly the SNF long-term care open door forum is scheduled for the end of July, so we will have the date sent also.

Operator: Your next question comes from Kristin Plowman. Your line is now open.

Kristin Plowman: Yes. Can you please repeat where we can find this PowerPoint presentation on the website?

Ellen Berry: Yes. If you go to www.cms.gov/snfpps and that will take you to our home page for SNF PPS there is a box on the left and if you click the Spotlight, it will take you to the Spotlight page and you will have to scroll down probably to downloadables or downloads, I like thinking up new words.

Kristin Plowman: OK. We will try again.

Ellen Berry: OK.

Operator: Your next question comes from Mary Ganerman. Your line is now open.

Mary Ganerman: Alright, just a clarification on the Start of Therapy OMRA, is that part of the delay of RUG-IV or will this be initiated October 1?

Sheila Lambowitz: Hi, this is Sheila. The Start of therapy OMRA is actually a function of the MDS 3.0. And that goes into effect October 1, both by our fiscal ten rule that we did last year and also according to statute, so that will be going into place October 1 of this year.

Mary Ganerman: Thank you.

Operator: Your next question comes from Sheryl Torch. Your line is now open.

Sheryl Torch: Thank you. I am not sure that we went over this in the conference call and that would be the Medicare short stay assessment. Is that something that is going to be talked about the next conference call a little bit more?

Ellen Berry: Yes. And you know, I referenced Chapter Two and Chapter Six of the RAI manual and both of those are being formatted to be updated and posted on the website. I suspect Chapter Two will be out sooner than Chapter Six but, most likely within the next week, week and a half, we can have both of them. I suspect Chapter Two actually be within a week.

Sheryl Torch: All right, I appreciate that. I have a question on -- back to hashing out the old stuff -- recording group minutes for therapy. I thought I heard on this conference call group was two to four patients. So if we put the total number

of minutes a patient was within the group that day, how will the grouper know if it was two patients or four patients and how to split the minutes?

Ellen Berry: Well, because the definition is two to four patients, in order to code it and in order to consider it therapy, we presume you're meeting that definition and you would just enter. We don't split the group minutes by a half, by a third, or by a quarter, we just apply a 25 percent cap which is group therapy cannot account towards the RUG grouper for more than 25 percent of the total therapy minutes for that discipline.

Sheryl Torch: Got it. So, if we report and say that the group was 50 minutes… 50 minutes would count towards that 25 percent for anybody in that group.

Ellen Berry: You would record 50 minutes on their MDS and whether or not the group cap applies depends on how much individual and concurrent therapy you provided. Right, so if you only provided 100 minutes of individual therapy and 50 minutes of group, that 50, I have to think that through but anyway we have…

Sheila Lambowitz: We'll give you some examples with the math but…

Ellen Berry: We have examples in the updated Chapter Six, there's an example there, so we look forward to that coming out.

Sheryl Torch: OK.

Sheila Lambowitz: That's why we want the computer to this math and not us.

Question and Answer Session (continued)

Operator: Your next question comes from Sheryl Schaefer. Your line is now open.

Sheryl Schaefer: Yes, this is Sheryl Shaefer, State RAI, Texas. There's been a private company is doing therapy training in the State of Texas and one of the companies has generated quite a bit of calls because their definition of concurrent therapy does not match the RAI manual. What they're training is that it's the

treatment of two Medicare Part A residents at the same time who are not doing similar activities and any number of other residents from other payment sources can also be included. This has generated many calls to me asking when the words "regardless of payer source" will be taken out of the RAI manual.

Ellen Berry: No, they won't be. So, you are correct. The definitions were listed last year on our final rule, they've been carried forward into the RAI manual. So, unfortunately some providers are paying for some inappropriate training.

Sheila Lambowitz: We will clarify what we mean by "regardless of payer source". And we will also notify the Medicare Contractors to be alerted to this situation when they review claims.

Sheryl Schaefer: Thank you.

Sheila Lambowitz: OK.

Operator: Your next question comes from Sharon Thomanson. Your line is now open.

Sharon Thomanson: Yes, can you just restate the address that we could submit questions to you said something MDS 3.0 and I miss the last part of it.

Ellen Berry: MDS 3 and actually it is zero, not O, comments@cms.hhs.gov.

Sharon Thomanson: Thank you.

Sheila Lambowitz: You're welcome.

Operator: Your next question comes from Perry Candince. Your line is now open.

Perry Candince: Hi, yes, I just I want to clarify again on concurrent therapy. So, you have two patients, 60 minutes each that you did concurrent together when it goes in the MDS… So, are they only putting in half that time to 30 minutes or do they get the full 60?

Ellen Berry: You enter the full 60.

Perry Candince: Do they get counted the full 60 on the MDS? on concurrent?

Ellen Berry: Well, if they are a Part A resident, the grouper will take that 60 and divide it by two. If they're not in the Part A today but your state Medicaid applies our concurrent definition than, you know, their grouper will take care of it.

Sheila Lambowitz: And what happens is when you're calculating , once you make the adjustments for concurrent therapy, then you add up the therapy for the whole week, you get the total number of minutes and that helps slot you into the appropriate therapy level but the adjustment is done in the grouper program before the classification is made.

Ellen Berry: I need to make the clarification when I stated your state if they are under Medicaid, will take care of that if they are a Part B Medicare recipient, you have to follow the Part B definition so that time would be counted as group.

Perry Candince: OK. Well, because I kind of need to know, 'cause if they're only going to count 30 minutes, you know, you're looking at your RUG level of say 500 minutes. Are they going to count 60, they only going to count 30, I'm not…

Sheila Lambowitz: You do have to be aware that when you put in the full number of minutes for concurrent therapy that is going to be adjusted, before you get your RUG group. We just didn't want you to have to do the math all the time but you will need to keep your records so that you can distinguish between how much was individual, how much was concurrent, and how much was group. So, that if you have a question and you think the RUG group was wrong, you can go back and check it. We just didn't want to have you doing the math after every single session.

Ellen Berry: Alright. And Chapter Six, the work sheet provides methodology for you, so you can look at that to help you track your total minutes.

Perry Candince: OK, thank you.

Operator: For our next question comes from Nanette Stoby. Your line is now open.

Nanette Stoby: Yes, ma'am, my question has been answered. Thank you.

Operator: Your next question comes from Terry Reed. Your line is now open.

Terry Reed: Hello.

Sheila Lambowitz: Hello.

Terry Reed: Hi. We're calling from Pine Heights, Subrado Ville in Vermont. And we're just wondering if there has been any consideration to how the difference between the temporary RUG-IV group and the actual hybrid rates that you determine later will be reconciled.

Sheila Lambowitz: We are working on that now. We have consulted with our contractors and they are developing some preliminary plans but truthfully all of our resources are fully devoted to getting the MDS 3.0 with the RUG-IV. And so we're not going to be able to finalize plans for implementing the hybrid RUG system until we're very, very close to October or even after October 1.

Terry Reed: So, would the difference in those amounts then come to be one lump sum if you determine that the hybrids were… that we were actually paid too much money. Would they be looking to get all that money back in one sum, or would it prorated for a number of years?

Sheila Lambowitz: It will not be prorated over a number of years that much I do know. We have talked about the possibility of doing a lump sum adjustment but the most typical way we handle this kind of issue is to reprocess the claims. And so you would get adjustment bills, you know, and some might end up giving you more payments and others less. And we have not figured out the methodology for how to do that yet.

Terry Reed: Thank you.

Sheila Lambowitz: Sure.

Operator: Your next question comes from Sue Peterson. Your line is now open.

Greg: Yes, this is Greg calling from Burger Rehab in California. I have a question in regards to the therapy start date. You talk about the most recent therapy, is what we want to calculate. So, if I had a PT that did the eval on the Tuesday and an OT that came in and did the eval on the Wednesday, we would be choosing the Wednesday date, is that correct?

Sheila Lambowitz: Well, for the physical therapy started date you would enter the physical therapy started date. So, the occupational therapy started date you would be entering that on MDS.

Greg: OK, so, it's done by discipline.

Sheila Lambowitz: Yes, it's done by discipline.

Greg: OK, thank you.

Operator: Your next question comes from Connie Harmen. Your line is now open.

Jackie: Yes, hi, this is Jackie. And I was wondering if we had a form yet for the Medicare short stay assessment.

Ellen Berry: Yes and no. We speak to item set. It depends on the situation. You might just be doing the start of therapy item set, or you might be doing the PPS item set or you might be doing the comprehensive; it depends on how you're completing the assessment for that particular person at that time.

Jackie: So the nine assessment items set for a nursing facility, there is still just nine, there's not a10th one specific to a short stay?

Ellen Berry: Correct.

Jackie: It would also be the NC?

Ellen Berry: Correct.

Jackie: OK.

Ellen Berry: You're right. There's not one.

Jackie: There's not going to be one.

Ellen Berry: No.

Jackie: OK.

Sheila Lambowitz: There's no need.

Female: Is it no and a no?

Geanelle Griffith: Alright, Christy this is our last question.

Operator: Your last question comes from Bobby Saw. Your line is now open.

Bobby Saw: We were wondering again that Bobby Saw from Mercy Medical Center in Iowa. And we were wondering about the inclusion of the set-up time with the support staff. If we have a support staff who goes to a patient's room to get them ready, prepares them, helps some with dressing or even clothing and then brings him to a central gym for treatment. Is that something that can be included then in a set-up?

Ellen Berry: No.

Bobby Saw: OK. Thank you.

Ellen Berry: You're welcome.

Conclusion

Geanelle Griffith: We would like to thank everyone for joining us today and for your participation in the question and answer session portion of the call. As stated before a transcript in MP3 audio file of the call will be made available at least two weeks after today. You will be able to find that information on the CMS SNF PPS website.

I definitely would like to thank our subject matter experts for their time today. Thank you everyone and have a great day.

Sheila Lambowitz: Bye everybody, thank you.

Operator: This ends today's conference call. You may now disconnect.

END