MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
IRF-PAI Therapy Information Data Collection Call
MLN Connects National Provider Call
Moderator: Nicole Cooney
January 12, 2017
1:30 pm ET

Contents

Operator: At this time, I'd like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements and Introduction

Nicole Cooney: Hi, everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'll be your moderator today. I'd like to welcome you to this MLN Connects IRF-PAI Therapy Information Data Collection Call. MLN Connects Calls are part of the Medicare Learning Network®.

In the fiscal year 2015, Inpatient Rehabilitation Facility—or IRF—Prospective Payment System—PPS—final rule, CMS finalized a new therapy information section on the IRF Patient Assessment Instrument, PAI.

Before we begin, I have several announcements. Today's call is via teleconference only. It is not a webinar. You should have received a link to the slide presentation for today's call in your confirmation and reminder emails. You can follow along with our speakers using this presentation.

If you've not already done so, please view and download the presentation from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. Once you're on this page, find the date of today's call to access the call materials.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects newsletter when these are available.

I'd like to thank everyone who to okay the opportunity to submit questions when they registered for this call. Before we begin today's Q&A session, subject matter experts will address some of the most frequently asked questions and answers.

At this time, it's my pleasure to turn the call over to Kadie Derby from our Division of Institutional Post-Acute Care to deliver the welcome. Kadie.

Presentation

Kadie Derby: Thank you, Nicole. Good afternoon and welcome to everyone that is able to join us for today's call. In the room from CMS, we have myself, Kadie Derby; my colleague, Penny Gershman; and our new Director for the Division of Institutional Post-Acute Care, Todd Smith, as well as our acting Deputy Director Susanne Seagrave is joining us on today's call.

We are excited to be able to host this call at the start of the new year, and we ultimately hope everyone finds some benefit in today's refresher training regarding the therapy information data collection on the IRF-PAI.

Before we jump into our information, we did want to take just a quick minute to say thank you to everyone on this call. We sincerely appreciate your patience with us while we continue collecting and analyzing the therapy data as part of our process in order to create and clarify Medicare policy. We could not adequately do any of this without your help and expert knowledge. And for that, we wanted to say thank you very much.

If you are following along with today's slide presentation, I did want to quickly direct your attention to slide 3. While we will be only fielding questions that are inside of the scope of today's call on the therapy information data collection on the IRF-PAI, please feel free to contact our IRF email box with any additional questions you may have, and we'll be happy to respond at our earliest convenience.

At this time, I'm going to hand the call off to my colleague, Penny Gershman, as she will begin today's presentation with the agenda. If you are following along with our slides, this starts on slide 4.

Penny Gershman: Thanks, Kadie. Good afternoon and good morning to everyone. We'll start by reviewing the IRF-PAI Therapy Information Collection Section, specifically items O0401 and O0402. We will then respond to some frequently asked questions received as registration came in for this call. And, finally, if there are any related questions that have not already been answered, we will open up the phones for a live question-and-answer session.

IRF-PAI Therapy Information Section, Items: O0401 and O0402

Moving on to slide 5—some background information. In the fiscal year 2015 IRF Prospective Payment final rule, CMS finalized the new IRF-PAI therapy information section for data collection purposes. We introduced items O0401 and O0402 at that time. If you are looking for more information on that final rule, please use the link found in this slide.

On slide 6 we will talk about items O0401 and O0402, the gist of the final rule mentioned on the last slide. Effective for IRF discharges that occurred on or after October 1st, 2015, all IRFs were and are required to report the amount and mode of therapy minutes provided to each IRF patient for each discipline. Specifically, IRFs are reporting on individual, concurrent, and group therapy, as well as co-treatment for all patients seen by OT, PT, and SLPs. This information is reported on the patient's discharge assessment for two time periods during the IRF stay—Week 1 and Week 2.

Moving on to slide 7. We've said this before and we'll probably repeat it again, but it is important to note that the therapy items on the IRF-PAI are used strictly for data collection exercises for Weeks 1 and 2 of the IRF stay. These items are not documented as a way to verify the amount of therapy provided to meet the IRF intensity of therapy requirements. While IRFs are still obligated to ensure that the coverage requirements regarding intensive therapy are being met, once again, these therapy items are not what is used to document them.

Slide 8 shows a screenshot of the IRF-PAI and specifically items O0401 and O0402. This view should be very familiar to all of you by now.

Slide 9 explains item O0401. Week 1: total number of therapy minutes provided. This item is completed as part of the IRF-PAI discharge assessment. In this part, providers record the total minutes of individual, concurrent, and group therapy, as well as co-treatment that the patient received per discipline during Week 1 of the stay.

Week 1 is defined as a 7-consecutive-calendar-day period starting with the day of admission to the IRF. And this item should be completed regardless of whether the patient is in the IRF for a full 7 days.

Slide 10 provides an example that you can read along with me. Mr. W is admitted to an IRF on January 1st and is discharged on January 5th. Week 1 will include total therapy

minutes by mode and discipline provided beginning January 1st, which is Day 1 of the IRF stay, through January 5th, which is Day 5 of the IRF stay.

Moving on to item O0402: Week 2 documentation. We're on slide 11 now. For Week 2, record the total number of therapy minutes provided. Similar to Week 1, this item is completed as part of the discharge assessment.

In this section, the IRF records the total number of individual, concurrent, and group therapy minutes, as well as co-treatment minutes that the patient received at each discipline during the second week of the IRF stay. And like Week 1, Week 2 of the second consecutive calendar day period starting with Day 8 of the IRF stay, item O0402 should be completed regardless of whether the patient is in the IRF all 7 days of Week 2.

Slide 12 provides two examples. In Example 1, Mrs. C is admitted to the IRF on January 1st and is discharged on January 16th. When documenting the therapy items, Week 1 should include the total minutes of therapy provided by mode and discipline beginning on January 1st, which is Day 1 of the IRF stay, through January 7th, which is Day 7 of the IRF stay. Week 2 should be documented with the total therapy minutes provided beginning on January 8th, which is Day 8 of the IRF stay, through January 14th, which is Day 14 of the IRF stay.

Example 2 gives us Mr. T, who is admitted to the IRF on January 1st and discharged on January 11th. This is an example of a patient who isn't in the IRF for the full 2 weeks. Nevertheless, we can still fill out Week 1 and 2 of the IRF-PAI.

Week 1 includes therapy minutes by mode and discipline for therapy given between January 1st and January 7th. Week 2 includes the therapy minutes beginning on January 8th and ending on January 11th.

Let's define the different modes of therapy that we've mentioned until now. Slide 13 offers the definition of individual therapy, that is, provision of therapy services by one licensed or certified therapist or assistant under the license or certified therapy therapist to one patient at a time. This can also be referred to as one-on-one therapy.

An example of an individual or one on – of individual or one-on-one therapy can be found on slide 14. An SLP treats only patient A for 30 minutes for aphasia therapy

following a stroke. Patient A's speech language therapy would be coded as 30 minutes of individual therapy in the therapy information section of the IRF-PAI.

Continuing on to slide 15. Concurrent therapy is defined as the provision of therapy services by one licensed or certified therapist or assistant under the appropriate direction of a licensed or certified therapist who is treating two patients at the same time who are performing different activities.

And here's where things get a little complicated. When conducting concurrent and group therapy sessions, start and end times don't need to be the same for all participating patients. The exact time spent for each patient in a concurrent or group therapy session should be reported as such. Any additional time either prior to or following participating in a group or concurrent therapy session that a patient receives, – excuse me – one-on-one therapy should be reported as individual therapy. We believe this is doable for providers.

Slide 16 provides an example of this. Patient A begins PT to address lower extremity strengthening at 9 am. Patient B enters at 9:30 and begins working with the same therapist on upper extremity range of motion. Both patients engage with the PT until 10 am. At this time, Patient A leaves and Patient B continues her exercises until 10:30 am. So how do we record this on the IRF-PAI?

Patient A should be recorded as receiving individual therapy from 9 to 9:30 am and concurrent therapy from 9:30 to 10 am. Because the two patients are performing different activities, Patient B should also be recorded as receiving concurrent therapy from 9:30 to 10 and individual therapy from 10 to 10:30. So both patients would receive a total of 30 minutes of individual PT and 30 minutes of concurrent PT.

I'm going to pass things back to Nicole for a minute.

Keypad Polling

Nicole Cooney: Thanks, Penny. At this time, we'll pause for a few minutes to complete keypad polling. Holley, we're ready to start the polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. 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, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please continue to hold while we complete the polling. Again, thank you for holding while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Nicole Cooney.

Nicole Cooney: Thanks, Holley. We're going to go back to our presentation with Kadie.

Presentation (Continued)

Kadie Derby: Thanks, Nicole. Moving on to slide 17, group therapy definition. Group therapy is the provision of therapy services by one licensed or certified therapist or licensed therapy assistant under the appropriate direction of a licensed or certified therapist treating two to six patients at the same time who are performing the same or similar activities.

Please take note though: The therapist may only provide therapy to one group of patients at a time. For example, one therapist is not allowed to provide therapy to two groups of six patients. This would absolutely not meet the definition of group therapy. Likewise, a therapist may not have more than six patients in a group.

We've received several questions in our IRF email box regarding how providers should document therapy for a group of eight patients. Again, a group of eight patients would not meet any of our requirements for group therapy, so that would not be documented on the IRF-PAI as it did not meet any of the defined types of therapy.

Moving on to slide 18 as an example of group therapy, as follows. A speech-language pathologist has Patient A, B, C, and D in a group working on communication. At 2 pm, the group begins with all four patients present together. At 2:12, Patient A needs to use the restroom and later returns at 2:28 pm. At 2:37, Patient B needs to leave for an appointment, but does not return. The group ends at 3 pm.

In this example, the IRF-PAI should be coded as follows. Patient A, who left for a restroom break for 16 minutes engaged in therapy for a total of 44 minutes. Therefore, on Patient A's IRF-PAI, 44 minutes of group therapy should be recorded.

Patient B was in the group from 2 pm to 2:37 when they left for an appointment and did not return. On Patient B's IRF-PAI, 37 minutes of group therapy should be recorded.

Patient C and Patient D were in the group from start to finish, 2 pm to 3 pm. Both patients' IRF-PAIs should reflect 60 minutes of group therapy.

Please note, if at any time the group dwindles down to one patient from the original group, then the same time with the – then the time spent with this patient would be coded as individual therapy.

For example: Patient A went to the restroom at 2:12 pm and never came back. Patient B left for an appointment at 2:37 and never returned. Patient C fell ill in the middle of therapy and could not continue, needing to leave at 2:45 pm. Only Patient D is left from 2:45 pm to 3 pm. Patient D's therapy time should be recorded as follows—45 minutes of group therapy and 15 minutes of individual therapy.

As slide 19 states, the definition of co-treatment therapy is the provision of therapy services by more than one licensed or certified therapist or licensed therapy assistant under the appropriate direction of a licensed therapist from different therapy disciplines to one patient at the same time.

We've had a few providers ask us if two therapists from the same disciplines, such as two OTs or two PTs, treating one patient would be considered co-treatment. Per our definition, no. This would not meet the definition for co-treatment as it specifically states from two different therapy disciplines.

We do not believe that co-treatment is suitable for all patients. This type of therapy should rarely be given and, in those rare instances where it is in the best interest of the patient, it should thoroughly be documented as to why this therapy was the best choice for the patient's goals and the patient's progress. Additionally, please note that co-treatment should not be used to satisfy scheduling for the patient and/or the therapist.

Moving to slide 20, an example of co-treatment. A physical therapist and occupational therapist do a transfer exercise with Mr. D for 30 minutes. In this example, the provider would indicate that the patient received 30 minutes of co-treatment for PT and 30 minutes of co-treatment for OT on the patient's IRF-PAI, assuming both therapists used the full 30 minutes.

It's important to note that each therapy discipline is documenting the appropriate time spent with the patient. As a reminder, time documenting or time waiting for another therapist to complete an activity would not be documented as therapy time.

Slide 21. So the next few slides that we have are some coding tips that we have put together for you providers. Therapy minutes cannot be rounded. We are trying to collect this data to create future policy and clarify future, or, I'm sorry, clarify present policy that we have. And in order to do so we need to have the most accurate data that we can possibly have.

For example, a patient is in an individual therapy session with PT beginning at 2 pm and needs a restroom break at 2:13, but doesn't return until 2:21. They finish out the therapy session at 3 pm. The total time recorded should be 39 minutes, not 40 minutes, but 39 minutes because that is the exact amount of time the patient engaged in therapy.

Therapy evaluations do count as the initiation of therapy services and, therefore, they do count as therapy time that should be recorded on the IRF-PAI. We believe that therapy evaluations are a very important part of determining the patient's goals and, therefore, we definitely want providers to code that time on the IRF-PAI. Family conferences do not count as therapy time. We get this question quite often in our IRF coverage email box, and we just want to reiterate that that time should not be coded on the IRF-PAI in any capacity.

Sorry. We have some questions about whether providers can code this and use the time to document in the patient's medical record. No. This time should never be considered therapy time. Therapy time is time spent in direct contact with the patient. So, on that note, significant periods of rest in between exercises should not be coded as time the patient engaged in therapy. Lastly, unsupervised modality should also not be coded on the IRF-PAI in the therapy information section.

Next, slide 22. We receive a lot of questions on how to code therapy time when a patient has an interrupted stay because it, quote/unquote, appears the patient does not meet the intensive therapy requirement.

First of all, I do want to reiterate the therapy information section on the IRF-PAI is a data collection section only. It is not for CMS to make sure you are meeting the intensity of therapy requirements. Therefore, the total number of minutes that the patient received should be accurately documented assuming it meets the definition of one of the types of therapy we have defined.

If the patient only receives 80 minutes total before the interruption occurred, then only 80 minutes should be recorded. Please keep in mind, too, that providers should be documenting on the IRF-PAI in items 42 and 43 information if the patient had an interrupted stay. Assuming that everything is documented correctly, those days of interruption would be subtracted and the data would be compared to data for the same length of stay.

Moving to slide 23. The next few slides we included are some questions we've received from providers since we have implemented the therapy information section on the IRF-PAI and our responses to them.

We touched on this question a little bit earlier but thought it was interesting to include since it discusses the patient's insurance coverage. Question 1: Can a therapy – or can a therapy group session consisting of six Medicare patients include additional non-Medicare patients? It does not matter – our answer is it does not matter what the patient's insurance is. A group of six patients is considered group therapy.

The second question: In the event that a patient meets the appropriate criteria for an admission to the IRF and the admission is planned and approved on a given day, can the

therapist perform the initial therapy evaluation in the acute care unit or hospital the patient is being discharged from if the time permits?

And our answer to that is evaluations and/or therapy done in the referring hospital do not count in the IRF for purposes of meeting the intensity of therapy requirements.

Slide 24. Are the evaluation minutes to be recorded in the total number of minutes provided to each therapy discipline section or is it just the treatment minutes? Again, we have covered this question during the coding tips but wanted to reiterate that, yes, therapy evaluations should be coded on the IRF-PAI.

Should the therapy be – should therapy given on the day of discharge be coded? Yes, as long as it meets one of the defined therapy types and modalities.

And the last question on this slide: How would you code co-treatment from the same discipline under the new IRF-PAI? The definition of the IRF-PAI training manual states from different therapy disciplines, so this would not be an example of co-treatment.

Moving on slide 25. If one therapist is treating three patients at the same time, but all three patients are performing different activities, how should the modes be recorded? The answer that we have is three patients completing different activities with one therapist meets none of our therapy definitions outlined in the IRF-PAI training manual. Therefore, we would see this as additional therapy received by the patient that should be documented in the patient's medical record, but not in the therapy information section on the IRF-PAI.

You can only code therapy time given as it meets one of the definitions we have outlined in this presentation or in the IRF-PAI training manual. If it does not meet those definitions, then you should consider it additional therapy time, but it should not be reflected on the IRF-PAI in the therapy information section.

And the last question on slide 25: If an SLP has a cognitive group and one of the patients in the group is also being seen by a PT working on balance and sitting, how would you document time for each discipline?

Again, this is not a situation that should be occurring at all. The patient cannot be in group therapy while receiving individual therapy as well. This example meets none of

the definitions of therapy we have outlined in this presentation or in the IRF-PAI training manual.

Before we begin today's live Q&A session, we wanted take this opportunity to answer a few of the most frequently asked questions that were submitted during the registration process for this call so that if you're waiting in the queue to ask the same, or a similar question, you don't have to.

Again, as a friendly reminder, please keep your questions inside the scope of this call, that is, only those issues related to coding therapy time in the therapy information section on the IRF-PAI. If you have additional questions regarding the IRF coverage requirements, such as the intensive level of therapy requirement, the 60 percent rule, IRF completion time, etc., please submit these questions to our IRF email box at irfcoverage@cms.hhs.gov. And again, this information can be found on slide 3 of today's presentation.

The first question that we have is, in the initial training held in January of 2015, CMS indicated that the therapy minute information and categories of therapy—individual, group, concurrent and co-treatment—were for data collection purposes only. Is that still the case? Have any policy decisions been made regarding limits?

And our answer to that is, yes, the development of the therapy information section on the IRF-PAI was always and continues to be part of our thoughtful and deliberate process of gathering therapy data in order to thoroughly analyze the data and make an informed decision regarding future policy that will greatly benefit IRF patients.

As we have stated in our final year 2015 rule, we are considering using these data to propose limits on the amount of group therapy that may be provided in IRFs through future rulemaking. At this time, no policy decisions have been made regarding any kind of therapy limits; however, we do plan to use this data to create future policy in this area.

Our next question. The description of this call suggests that further guidance is required for the collection of this therapy information. Has initial data been inconsistent and, if so, what does that say about the reliability and validity of the measure of this data?

Our answer to that is that we always want to keep providers informed and offer refresher training as needed. As with all of our data collection efforts, we view the initial portions of our data collection efforts as a learning curve as we've heard from some providers who have had inconsistent or inaccurate coding issues. And as the question suggests, we obviously want to be sure that we are analyzing the most reliable and accurate data that providers document and, for that exact reason, we are having this call.

And, lastly, how do we code the therapy time if there is an interrupted stay or short-stay transfer? I know we covered this in our answer – in our slides, but we wanted to just reiterate it and cover it again.

We do want to reiterate the appropriateness of the way to handle these situations. The provider should always record the exact amount of time, type, and modality that the patient received prior to the interruption or transfer. Please keep in mind that this is not an exercise for us to make sure the facility is meeting the intensity of – intensive level of therapy requirement. It is simply a data collection exercise for CMS to interpret the data and make informed decisions. In instances such as an interrupted stay or a transfer, we are analyzing the data with data from similar lengths of stay to ensure consistency.

And, with that, I'll hand it back over to Nicole.

Question and Answer Session

Nicole Cooney: Thanks, Kadie. Our experts will now take your questions. Before we begin, I want to remind you again that this call is being recorded and transcribed.

Before asking your question, please state your name and the name of your organization. We have a lot of people today on the line, so in an effort to get to as many questions as possible, we ask that you limit your question to just one. If you'd like to ask a followup question or have more than one question, you may press star one to get back into the queue, and we'll address additional questions as time permits.

Holley, we're ready for our first question.

Operator: To ask a question, press star, followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line

will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

And our first question will come from the line of Glenda Mack.

Glenda Mack: Hi.

Nicole Cooney: Hello.

Glenda Mack: Hi, there. This is Glenda Mack from Kindred. I wanted to ask about – I understand that this is a data collection tool only not to be used for review. However, are the supplemental medical review contractors—ZPICs, MACs, and others—are they permitted to use this data as a tool to select claims for medical review?

Nicole Cooney: Give us one second.

Glenda Mack: Okay.

Todd Smith: Hi. This is Todd Smith. No, at this time, that is not the situation. This is simply a data collection exercise for policy efforts.

Operator: And our next question will come from the line of Pat Blaisdell.

Pat Blaisdell: Good afternoon. Thanks very much for this call. This has been very helpful, and I especially appreciate the clarification that this remains a data collection process and I'm particularly interested in that response in that we have gotten some reports from third parties using this data under the intensive therapy requirement to limit authorizations for IRF admissions. So I do think – I really very much appreciate that clarification.

On a related question, I understand that documentation requires a specific rationale for the provision of group therapy or any minutes that occur during a group session. Is there a particular rationale required for the use of concurrent therapy because, again, this has become a point of some concern with third party reviews?

Penny Gershman: Just like – this is Penny Gershman. Just like group and co-treatment, there should be an adequate documentation explaining why concurrent therapy is the therapy that's chosen to be used in specific instances.

Pat Blaisdell: Okay. I believe that would be a change from the original presentation of this when it was initially implemented. So I think that may be an area that requires some clarification with our members, what would constitute appropriate rationale? But thank you for your answer.

Penny Gershman: We appreciate that. Just like with any therapy that's given, appropriate documentation should always be present, especially regarding the rationale in which therapy mode – or modality is used and whether the therapy is reasonable or necessary.

Nicole Cooney: Thank you. Next question?

Operator: Our next question will come from the line of Richard Bryans.

Richard Bryans: Hello. So our question has to do with…

Richard Bryans: Oh, sorry. Richard Bryans from Sacred Heart in Eau Claire, Wisconsin. Our question has to do with concurrent therapy. We're under the understanding that you can provide about 25 percent of your therapy in group. Is there an amount for concurrent therapy, either minutes per day or time per week?

Nicole Cooney: Give us one second.

Kadie Derby: Well, actually at this time we don't have any limits placed on therapy. So that's precisely the reason why we're trying to collect this therapy data.

Operator: And our next question will come from the line of Peggy Raines.

Peggy Raines: Hi. Peggy Raines, Novant Health Rehabilitation. Regarding therapy minutes, and you talked about a bathroom break. If the therapist accompanies the patient to the bathroom to work on toilet transfers, can they count that as therapy minutes?

Penny Gershman: Hi. As with anything, if, let's say it's an occupational therapist and part of their goal is toilet transferring and that's something that they would use for therapy, yes, that would probably – those minutes, assuming that all of those minutes were used for occupational therapy purposes, would be counted.

Nicole Cooney: Thank you. Next question.

Operator: Our next question will come from the line of Becky Windsor.

Becky Windsor: Hi. This is Becky Windsor at Cone Health. My question is regarding community integration where we take two patients on an outing. They are both working on community integration, but they may have very specific different goals. Is that concurrent or is that group?

Nicole Cooney: Give us one second.

Kadie Derby: Thank you for your question. That's a great one. We're going to have to get back to you on that. We would be happy to respond to your question if you would like to send that to the IRF email box? Again, that was listed on slide 3 of the presentation, and we can get back to you with more information. Thank you.

Operator: And our next question, excuse me, will come from the line of Sarah Harwell.

Nicole Cooney: Hi, Sarah. Did you have a question for us?

Sarah Harwell: Yes. We were wondering about the co-treatment. With the 30 minutes, is it 15 minutes for OT and 15 minutes for PT, the split? Or is it 30 minutes for both?

Penny Gershman: As – hi. Thanks for your question. As we stated in the slide presentation, it's 30 minutes for each therapist – for each therapy discipline, assuming that they are actually providing therapy for that full 30 minutes. Obviously, when there's a co-treatment session going on, the therapists have to determine how much of that time they were actually providing treatment because it's quite possible that in a co-treatment session, even though the patient's getting benefit from both therapists, they're not necessarily getting the full amount of time of therapy from each discipline.

Penny Gershman: And again, we're talking about coding that time on the IRF-PAI, because we're not talking about the intensity therapy requirement. We are strictly talking about coding that time on the IRF-PAI.

Sarah Harwell: Okay. Thank you.

Operator: And our next question will come from the line of Carrie Byrd.

Carrie Byrd: Yes. If the patient is present during a family conference and we're doing some education and training during that time, can we count those therapy minutes?

Nicole Cooney: Give us one second.

Kadie Derby: Thanks for your question. That's another great question. If you can please send that to our IRF coverage email box, we will get back to you with some additional information. Thank you.

Carrie Byrd: Thank you.

Operator: Okay. And once again, if you would like to ask a question, press star one on your telephone keypad. If you'd like to withdraw a question or if your question has been answered, you can removed yourself from the queue by pressing the pound key.

Our next question will come from the line of April Mundy.

April Mundy: Hi there. During a provider outreach and education session provided by Noridian in December 2016, we were instructed that the one-on-one therapy should be the standard of care and all of the other therapies, including co-treats, groups, etc., were to be adjunctive, which was different from the original education that we received prior to or in leading into the 2015 rule.

Has there been a change in the expectation there? You know, they very clearly told us in the education for 2015 that the preponderance of therapy must be one-on-one, and it sounds like it's different.

Kadie Derby: That's a great question, and we really appreciate you asking that. But it is outside of the scope of this call regarding coding therapy minutes on the IRF-PAI. If

you'd like to submit your question to our IRF email box, we would be happy to respond to you. Thank you.

Operator: And our next question will come from the line of Glenda Mack.

Glenda Mack: Hi. Thank you for taking another question from me. You said a few times that we're speaking to the coding of the IRF-PAI, we are not speaking to the intensity of therapy requirement. And while I appreciate that you're speaking to a regulatory court requirement for intensity of therapy vs. a reporting requirement, I hope you can understand that that's very confusing to the providers in the field because, for us, providing therapy is one and the same, and we just report what we do.

Could you please take just a minute or so and help people understand why you treat them differently and what it means differently that -- we may provide therapy in the field that doesn't get reported on the IRF-PAI, does that still count towards the intensity even though it doesn't get reported on the IRF-PAI? I think that's incredibly confusing to the field and will leave a lot of people, when they hang up from this call, quite confused.

Nicole Cooney: Give us one second.

Susanne Seagrave: Hi. This is Susanne. Can you hear me?

Glenda Mack: Yes.

Susanne Seagrave: Hi. I think – can you give me an example? I mean, are you talking about, for example, are you talking about when a group is like eight patients? Is that the example that you're talking about? What are you referring to when you say it's not reported on the IRF-PAI, but it may – but it's being provided?

Glenda Mack: So I'm trying – that was one of the times when it was stated on this call, but another time was stated when a patient's receiving an unintended modality as an example. We would not report those minutes on the IRF-PAI. However, that patient is receiving a skilled intervention for that entire time.

So do those minutes count towards the intensity of therapy requirement, however, they can't be counted on the IRF-PAI? That's probably a really good example.

Susanne Seagrave: Well, those are the types of things that I would – we would very appreciate if you could send to our IRF coverage mailbox that Kadie has mentioned several times so that we can respond to the individual issues one at a time. I mean, we can't – in general, and I hope maybe that my colleague Penny Gershman can step in on this, but, in general, the unsupervised modalities – you know, in general, just in general terms, we don't typically consider those to be therapy provided to the patient.

But that's a very, very general statement that, of course, there may – you know, I don't know. There may be certain modalities that we could consider. But, again, we need specific examples. So you can – and providers can feel free to send those to our IRF coverage mailbox…

Glenda Mack: Sure.

Susanne Seagrave: …and we can respond to you on specifics.

But, again, I mean, we want to provide as clear a presentation as possible, and part of this is trying to make the data collection rules and understanding very, very concrete so that providers know when – exactly when they're supposed to code on the IRF-PAI.

Glenda Mack: Right. And thank you – thank you for saying that. I guess maybe the better way to ask the question is, on the IRF-PAI, are we only recording things that Medicare considers skilled therapy intervention based on the definitions provided, and then vis-à-vis, is the only thing that Medicare considers counting towards the intensity of therapy requirement things that Medicare has defined as skilled therapy intervention?

Susanne Seagrave: I – that's not a…

Todd Smith: This is – sorry, Susanne. This is Todd Smith. We – you know, we appreciate your questions, and we understand your concern. But, as we stated at the top of the call, the intensity of level of therapy requirement is not covered in this call. So thank you very much.

Operator: And our next question will come from the line of Amy Sweeney.
And that question has been withdrawn. Our next question will come from the line of Dana Murr.

Kristin Burton: This is Kristin Burton from Good Samaritan. My question is if you have two patients that are concurrent, are you billing one group charge for each of them or are you allowed to bill individually each charge that they were performing during that session?

Kadie Derby: Again, we just want to reiterate that we're not discussing how to bill for those things. We're discussing how to code on the IRF-PAI, the therapy that was given to the patient. So I would suggest sending your question to our IRF email box as it's currently outside of the scope of this call.

Kristin Burton: Okay.

Operator: Again, if you'd like to ask a question, press star, then one on your telephone keypad. If you'd like to withdraw a question or if your question has been answered, you can remove yourself from the queue by pressing the pound key.

Our next question will come from the line of Stephanie Kaplan.

Stephanie Kaplan: Hi. I'm referring to slide 21 when you have coding tips, and I may get the same answer as we've had before, that it's outside the scope. But the first bullet point about therapy minutes not being rounded for the purposes of documenting therapy provided in IRF, is that only applied to the IRF-PAI coding or would that apply to all therapy being provided to the patient?

Nicole Cooney: Give us one second.

Kadie Derby: Thank you for that question. It's a great question. Can you give us an example of when or why you're rounding?

Stephanie Kaplan: All of us staff, it may be complicated to accurately identify exactly the minute you walked into the room, the minute you left the room. You know, if you come in at 1:01 and you leave at, you know, 1:59. Do you want that to be accounted as 58 minutes?

Kadie Derby: We're looking for the documentation to be accurate at all times. So, from start to finish, we would expect that the time given to the patient – the therapy time

given to the patient is the utmost accuracy. So, if it's 39 minutes, it's 39 minutes. And if it's 42 minutes, we would want that to be recorded or coded as 42 minutes.

Stephanie Kaplan: Thank you.

Operator: Okay, and our next question will come from the line of Jody DiMaria.

Jody DiMaria: Hi. I was wondering, what is the average turnaround time to receive an answer to a question submitted to the email box.

Nicole Cooney: Give us one second.

Kadie Derby: It surely depends on the complexity of the question. If we have to further research it or contact other people within the agency, it could take longer. It also really depends on our – like our work priorities at that time, if we have something else that we're working on and very busy with.

It – we can't give you an average. We can't give you a day number or a week number. It's just what – you know, we try to respond as quickly and as promptly as we can, but we don't really have an average time of when we would get back to you.

Operator: And our next question will come from the line of Stacy McClure.

Stacy McClure: Hi. This is Stacy McClure at the University of Utah Hospital. My question is, for this email queue that all these people are sending their questions to, I would like to know the answer to these as well. Are these questions and answers going to be posted somewhere for all of us to view?

Nicole Cooney: Thank you for your question. This is Nicole. What we will do is we will post a Q&A document on the detail page where we have the presentation for this call. And once that is available, I can also go ahead and send an email out to all the registrants for today's call to let you know that the document is posted.

Next question, please.

Operator: And our final question for the day will come from the line of Amy Sweeney.

Amy Sweeney: Good afternoon. My question has to do with what the MAC instruction has been. In a recent probe audit, we were denied, and I'm going to read the actual denial. "Information in the IRF-PAI must correspond with all information provided in the medical record. The therapy times did not match."

Nicole Cooney: Give us one second.

Kadie Derby: This data collection exercise is solely for the use of CMS to be able to create future policy and clarify current policy, so we can't speak to that question at this time.

Amy Sweeney: Okay. But for data collection, then wouldn't the MAC be restricted from denying payment based on data collection?

Nicole Cooney: Give us one second.

Todd Smith: That's not – thank you for that question. That's not an issue, unfortunately, the people in this room today would be able to handle or answer responsibly to your question.

Operator: Thank you. At this time, we have no further questions.

Additional Information

Nicole Cooney: Okay. That's all the time that we have for today's call. We'll post an audio recording and written transcript of today's call on the MLN Connects Call website, and we'll release an announcement in the MLN Connects newsletter when these are available.

All registrants for today's call will receive an email with the URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary, and we hope you'll take a few minutes to evaluate your MLN Connects Call experience.

Again, my name is Nicole Cooney. I would like to thank our presenters and also thank you for participating in today's MLN Connects IRF-PAI Therapy Information Data Collection Call.
Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES


Medicare
Learning
Network
Official Information Health Care
Professionals Can Trust


MLN Connects®