



**Centers for Medicare & Medicaid Services
IRF PPS: New IRF-PAI Items Effective October 1, 2015
MLN Connects National Provider Call
Moderator: Leah Nguyen
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This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Operator: At this time, I would 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 Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I'm Leah Nguyen from the Provider Communications Group here at CMS, and I'm your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on the New Inpatient Rehabilitation Facility, Patient Assessment Instrument Items. MLN Connects Calls are part of the Medicare Learning Network.

In that fiscal year 2015, IRF Perspective Payment System final rule, CMS finalized two new items on IRF PAI—an arthritis attestation item and the therapy information section. This MLN Connects Call will focus on training providers on how to code and complete these items on the new IRF-PAI, which will become effective for IRF discharges occurring on or after October 1st, 2015.

Additionally, CMS subject-matter experts will clarify the signature page requirements. A question-and-answer session will follow the presentation. Before we get started, I have a couple of announcements. You should have received a link to the slide presentation for today's call in previous registration emails. If you've not already done so, please view or download the presentation from the following URL: www.cms.gov/npc. Again that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the January 15th call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. The announcement will be placed in the MLN Connects Provider eNews when these are available.

And last, for this call, registrants were given the opportunity to submit questions. Questions about the new IRF-PAI items were used to prepare the presentation content. If you need answers to questions on other IRF-PPS topics, please submit those to the resource box listed on slide 24. We thank everyone who submitted their questions.

At this time, I would like to introduce our CMS subject-matter experts for today. We are pleased to have with us Kadie Thomas, Penny Gershman, and Susanne Seagrave from the Division of Institutional Post Acute Care.

And now it's my pleasure to turn the call over to Kadie Thomas who'll begin our presentation.

Presentation

Kadie Thomas: Thank you Leah. I'd first like to start out by saying welcome to today's IRF-PAI training presentation. We are very encouraged that so many folks are participating in today's call to learn more about the new IRF-PAI items that will become effective this October 1st, 2015.

Secondly, I wanted to acknowledge and to thank the providers that submitted questions during the registration process of today's phone call. We received a few questions that we hope will be answered through today's training. However, many of the questions that we received did not directly relate to the topics in which we plan on discussing today.

For those providers that submitted questions that didn't directly relate to today's training session, we would be happy to answer them if you send them to our IRF mailbox. That email is listed on slide 24 of today's presentation.

On that note, during the Q&A session at the end of today's call, we will only be fielding questions that pertain to the information we are discussing today. As much as we'd like to be able to answer any and all questions that you have, we unfortunately don't have time to do so on this call.

If you click on slide 4, you'll see our agenda for today's call. It's pretty short and very straightforward. We want to go over the two new IRF-PAI items that were finalized in the 2015 IRF-PPS final rule, the first item being the arthritis attestation, which is on the IRF-PAI item 24 and, secondly, the therapy information section, which are items O0401 and O0402. Just in case some folks didn't know or may have missed it, we did issue a new iteration of the IRF-PAI Training Manual that does include the information discussed on today's call. The sections that were updated are the Helpful Resources page and Section Two, the item-by-item coding instructions of the IRF-PAI. Those updated sections are available on our IRF website. The link to that website is also located on the slide 24 of this presentation.

If you click on slide 5, in addition to the discussing the new — the two new items that were finalized, we also wanted to take the opportunity to clarify some updates that we've made regarding the signature page item that was implemented October 1, 2014. As we've stated a few times thus far already, it was in the fiscal year 2015 final rule that was published August 1st, 2014, that we've finalized the two new IRF-PAI items: the arthritis attestation and the therapy information section that we will be discussing today. For those of you that need a refresher or haven't taken the time to look at the regulation, you may — the link is included on this slide.

I'll now hand the call over to my colleague Susanne Seagraves, who will walk through the new arthritis attestation time on the IRF-PAI.

Arthritis Attestation

Susanne Seagraves: Thank you Kadie. So as Kadie said, there will be a new item that providers will be asked to complete beginning with discharges, beginning on or after October 1, 2015. This item is to identify for us whether there are any arthritis conditions recorded on that patient's IRF-PAI, either in item number 21, which is the impairment group code item, item number 22, which is the etiologic diagnosis item, or item number 24, which lists the patient comorbidities.

If any of the codes in these three items meets all of the regulatory requirements for IRF classification that can be found in 42CFR412.29B2 x, xi, and xiii —I realize that that is in the regulations and sometimes not readily available to the providers at the time that they're coding. However, we did place the language that you need to be meeting if you mark this item "yes" — we placed that in IRF-PAI Training Manual that's available on our website that Kadie just mentioned.

So providers will be asked to record either "yes" or "no" in response to this question. If the provider — that's on slide 6. On slide 7, if a provider codes one, which is a yes for this item, since that claim may be selected by the Medicare administrative contractor, the MAC, for review of the documentation to verify that the patient did indeed meet the requirements in 412.29B2 x, , xi, or xiii, depending on which is applicable.

This includes for both — for all of them, x, xi, and xiii -- that the patient completed an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the IRF admission. In the IRF-PAI manual, you can find a definition of what we believe meets the definition of an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings.

CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or from the therapy services provided in other less intensive rehabilitative — or other less intensive settings by including them in the patient's medical record in a section for prior records. So this needs to be available for the MAC if this claim is chosen and for verification that the patient's case does meet the requirement.

So at the end of this call, I will field any questions that you may have about this arthritis item. Meanwhile I will turn this — the rest of the presentation over to Kadie.

Therapy Reporting Information

Kadie Thomas: Thanks Susanne. We will now discuss the therapy reporting information section beginning on slide 8. Starting October 1st, 2015, IRFs will be required to report the amount and mode of therapy services provided to each IRF patient within each therapy discipline. Specifically for occupational, physical, and speech therapy services, IRFs will be required to report how much individual, concurrent, group, and cotreatment

each patient receives while at the IRF. This policy will be effective for all assessments of patients who are discharged from IRFs on or after October 1, 2015, and will be reported on the patient's discharge assessment for week one and week two of each patient's stay.

Moving on to slide 9, and before we get into the real details of this new item, we do want to reiterate that we are not using this new therapy item information as a minutes-counting exercise. The sole purpose of this data collection exercise is to determine what services Medicare is paying for under the IRF Prospective Payment System, which will then allow us to analyze whether we are paying appropriately for services currently rendered in the IRF. With that being said, providers must continue to satisfy all IRF coverage requirements regarding intensive therapy.

On slide 10, we've included a screenshot of the new therapy information section for your convenience. If you look at the right-side column, you will see that the data collection is separated into week one, total number of minutes of therapy provided, and week two, total number of minutes of therapy provided. Under each of those, we have given providers space to complete the therapy mode and discipline.

As a quick FYI, this is the IRF-PAI that is currently in the new iteration of the IRF-PAI Training Manual that came out in December 2014.

At this time I'll hand the call over to my colleague Penny Gershman, who will walk through our therapy definitions, examples, and some coding tips to keep in mind when completing this section.

Therapy Recording Information

Penny Gershman: Thanks Kadie. Moving on to slide number 11, item O0401 will record the total number of therapy minutes provided for week one of the IRF stay. For each discipline, the amount of individual, concurrent, and group therapy as well as cotreatment minutes will be recorded. For purposes of recording therapy, week one is defined as 7 consecutive — a 7 consecutive calendar day period starting with the day of admission to the IRF, regardless of whether the patient stays a full 7 days. Let's look at an example.

Mr. W is admitted to the IRF on November 1st, 2015, and is discharged on November 5th, 2015. Week one should include therapy minutes provided beginning November 1st, which is day 1 of the IRF stay, through November 5th, which is day 5 of the IRF stay. Even though this isn't a full week of therapy, it will be recorded as week one and is being recorded in the patient's discharge assessment.

Slide number 12 addresses the week two information, item O0402. Like item O0401, this will be recorded in the patient's discharge assessment, and this item contains the

amounts of individual, concurrent, and group therapy as well as cotreatment for each therapy discipline.

Like week one, a week is defined as the 7 consecutive calendar day period. However, week two starts on day 8 of the IRF stay. Week two will be recorded regardless of whether the patient is in the IRF for a full 7 days during that week, or in other words, a full 14 days in the IRF.

Slide number 13 provides two different examples to illustrate reporting therapy for weeks one and two in the IRF. In the first example, Mrs. C is admitted to the IRF on November 1st, 2015, and is discharged on November 14th, 2015. Week one should include therapy minutes provided beginning November 1st, which is day one of the IRF stay, through November 7th, which is day 7 of the IRF stay. Week two should include therapy minutes provided beginning on November 8th, which is day 8 of the IRF stay, through November 14th, which is day 14 of the IRF stay.

The second example illustrates how to report less than a week of therapy. Mr. T is admitted to the IRF on November 1st, 2015, and is discharged on November 11th, 2015. Week one, or item O0401, should include the therapy minutes provided on November 1st, which is day one of the IRF stay, through November 7th, which is day 7 of the IRF stay. Week two, or item O0402, should include therapy minutes provided beginning November 8th, which is day 8 of the IRF stay, through November 11th, which is day 11 of the IRF stay.

Moving on to slide number 14, we will now define the different modes of therapy. Individual therapy is defined as a provision of therapy services by one licensed or certified therapist or therapy assistant to one patient at a time. This can also be referred to as one-on-one therapy. For example, if a speech-language pathologist treats only Mr. A for 30 minutes for aphasia therapy following a stroke, Mr. A's speech-language therapy would be coded as 30 minutes of individual therapy on the IRF-PAI.

Slide number 15 defines concurrent therapy, which is a provision of therapy services by one licensed or certified therapist or therapy assistant treating two patients at the same time who are performing different activities. For example, one physical therapist is treating Mr. F, who is working on lower extremities strengthening exercises. The same physical therapist is also treating Ms. A, who is working on upper extremities strengthening exercises. Both patients begin a therapy session at 9 a.m. and end at 10 a.m. Both Mr. F's and Ms. A's physical therapy would be coded as 60 minutes of concurrent therapy on the IRF-PAI. It is important to note that concurrent therapy sessions must begin and end at the same time for both patients involved.

Moving on to slide 16, group therapy is defined as the provision of therapy services by one licensed or certified therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities. For example, one physical

therapist is working on a group balance activity with five IRF patients for 55 minutes. All patients begin and end the group therapy session at the same time. Therefore, when coding the IRF-PAI, a total of 55 minutes of group therapy — of group physical therapy, excuse me — would be coded for each patient present in the group. Please note that the therapist may only provide therapy to one group at a time. For example, one therapist is not allowed to provide therapy to two groups of six patients. This will not meet the definition of group therapy discussed previously.

Slide 17 discusses cotreatment, which is a provision of therapy services by more than one licensed or certified therapist or a therapy assistant from different therapy disciplines to one patient at the same time. For example, a physical therapist and occupational therapist does a transfer exercise with Mr. D for 30 minutes. A total of 30 minutes of cotreatment time would be coded for both PT and OT on the IRF-PAI for this session, assuming each discipline is treating Mr. D for the full treatment time.

Slide number 18 is a reminder that cotreatment is appropriate for specific clinical circumstances and would not be suitable for all patients. Therefore, cotreatment should only be used in limited instances. Cotreatment may not be used for the accommodation of staffing schedules and the specific benefit to the patient of the cotreatment must be well documented in the IRF medical record.

Slide 19 includes some coding tips to remember when filling out the new therapy reporting sections on the IRF-PAI. First, therapy minutes cannot be rounded for the purposes of documenting therapy provided in an IRF. So for example, if a patient receives 37 minutes of individual speech therapy, those minutes should be recorded as 37 and not 40.

Another coding tip: therapy evaluations do count as the initiation of therapy services. So the time it takes to complete the therapy evaluation can be coded on the IRF-PAI. The time spent in family conferences does not count towards coding, counting therapy minutes on the IRF-PAI. There are a couple of more coding tips on slide 20. Therapy time is considered time spent in direct contact with the patient. Time spent in documenting — time spent, excuse me, documenting in the patient's chart or medical record, unsupervised modalities and significant periods of rest are considered time not spent in direct contact with the patient and may not be documented in this section of the IRF-PAI.

And, finally, if the patient has an interrupted stay, the IRF should record the total number of minutes of therapy the patient received in the IRF for that week. The same as if the interrupted stay did not occur. As long as the IRF records the interrupted stay in items 42 and 43 of the IRF-PAI, those days will be subtracted and that data will be compared to the data for the same length of stay. On that I'll pass to Leah.

Keypad Polling

Leah Nguyen: Thank you Penny. At this time we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there'll be a few moments of silence while we tabulate the results. Salema, we're ready to start 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.

Once 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. Thank you for your participation.

I'd now like to turn the call back over to Leah Nguyen.

Presentation continued

Leah Nguyen: Thank you Salema. I'm now going to turn the call back over to Kadie Thomas to continue the presentation.

Signature Page Update

Kadie Thomas: Thank you Leah.

Moving on to slide 21. At this time, we want to transition from the two new IRF-PAI items to briefly discuss some updated signature page information. When CMS began requiring the IRF-PAI be part of the patient's IRF medical records, that meant that providers would need to begin signing the document in order to adhere to the hospital COPs at 482.24C1. Until the signature page was implemented, providers were allowed to sign the IRF-PAI however they liked. Some reported signing a cover page; some signed every page of the IRF-PAI, etc.

We received many inquiries from providers asking for us to give them a designated spot to sign the documents. Thus came the implementation of the signature page. Who is responsible for signing the signature page? As our training manual states, any staff member of the IRF that completes any items on the IRF-PAI is responsible for signing the signature page. For example, the employee that is responsible for obtaining the information from the medical record and completing the IRF-PAI that will be submitted is responsible for signing the signature page. Employees in the IRF that provide

information and codes that are used to complete the IRF-PAI but are not actually the ones to fill in the IRF-PAI items are not required to sign the page.

The signature page is not transmitted to CMS. The signature page is solely for documentation purposes and should be housed in the IRF patient's medical record.

Moving on to slide 22. We've received quite a number of emails asking if electronic signatures can be used to meet this requirement. At this time, providers may use electronic signatures for the IRF-PAI when permitted to do so by State and local law and when authorized by the facility's policy. We encourage providers to reach out to their State and local entities in order to obtain more specific information regarding this issue.

I'll turn it over to Leah at this time.

Question-and-Answer Session

Leah Nguyen: Thank you Kadie.

Our subject-matter experts will now take your questions about the new IRF-PAI items. Questions on other IRF-PPS topics will not be addressed on this call, but you could submit them to the resource box listed on slide 24.

Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your questions, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one.

If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue and we'll address additional questions as time permits.

All right Salema, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up the handset before asking your questions to assure clarity. Please note your line will remain open during the time you are asking your questions, so anything that you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

The first question comes from the line of Kim Kawaski. Kim, your line is open.

Michael Tamarish: Hi, this is actually Michael Tamarish. Kim is in the room. My question is, it's defined that the majority of therapy should be individual for the next calendar year starting October 1st. What do you define as the majority?

Leah Nguyen: Could you hold on for one moment?

Jeanette Kranacs: Thanks a lot for your question. I think the focus again here today of what we're talking about is not things that we've discussed prior in the rule about preponderance or any particular enforcement of that policy. What we'd like to keep the focus here on is the material that we've presented and whether or not everybody understands how to properly code the different modes of therapy on the IRF-PAI. Again, this is a data collection effort at this point in time and we're not using it to meet a particular number threshold at this point.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Debbie Conick.

Dianna Diacus: Hi, this is Dianna Diacus and I have a question regarding the arthritis item number 24A. If you say no there, does that then exclude that case from the presumptive eligibility report as being a good diagnosis?

Susanne Seagrave: Hi, this is Susanne. The answer to your question is it does if the case only counts because of being an arthritis case. So if it would only count for the presumptive methodology due to the arthritis code and you say no, then that case will not count toward the presumptive methodology. However, if there is another code on the case for, you know, for example, a stroke or something, then that case will continue to count because of the other codes. But if the only reason for counting is arthritis, then yes, saying no to that item will not allow the case to count.

Dianna Diacus: OK, good, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Michael Getlemet.

Michael Getlemet: Hi. I'm not sure if you're going to be able to answer this question given the parameters that you've set, but you've alluded to the fact that there are minute require — there are certain minute requirements on the short week, and I was just hoping that you might be able to clarify what those requirements might be in the example that you'd given with 11-day stay, week two only taking up 4 or 5 days.

Leah Nguyen: Hold on one moment.

Jeanette Kranacs: Hi, thanks again for your question. This is Jeanette Kranacs. I should say I'm the Division Director for the Division of Institutional Post Acute Care, and I really appreciate everybody's questions and concerns in this area. And I just want to reiterate again, and you know we said it in the rule, but we want to say it again, that the purpose of this question at this point in time is to simply get a feeling for what the provision of therapy services look like now. We have not set any kind of minute threshold.

This data at this point in time is not being used to establish a threshold or enforce any particular policy. At which point in time we would want to use the data to do that if there were any threshold to be set. We would go through a notice of comment period to propose such a policy. So again, this is a data collection exercise. We're asking you report the data that will allow us to analyze the services that are being provided and the mode of service, the different therapy disciplines that are providing those services, but there is not any requirement for minutes.

Leah Nguyen: Thank you.

Operator: The next question comes from the line of Cheryl Miller.

Cheryl Miller: Good morning, on slide 15, you guys state that "concurrent therapy sessions must begin and end at the same time for both patients involved." I don't recall seeing that in the regs, but what if two patients overlap in some way, maybe because they're scheduled that way. For example, if we have patient A coming from 9 to 10, half-hour individual, and then the second patient comes in at 9:30 and continues to 10:30 so that they each have a half-hour of individual and a half-hour of concurrent. How do we code that if they're not starting and ending at the same time?

Jeanette Kranacs: Hold on one moment, please.

Kadie Thomas: Hi, so as we did mention on slide 15, both patients would need to start at the same time and end at the same time in order for minutes to be counted on the IRF-PAI. If they do not start in the example that you gave, if the first patient starts at 9 a.m. and goes to 10 and the second patient comes in at 9:30 and goes till 10:30, that time that was spent with both patients would simply be extra therapy time that was given. It would not be counted in this exercise.

Leah Nguyen: Thank you.

Operator: Once again, to ask a question, please press star then the number 1. The next question comes from Debra Ebol. Debra, your line is open.

Debra Ebol: Yes, I think my question; I'm from Mercy Medical Center. I think my question was answered earlier. This is for data collection only. I was just wondering

what would happen if for some reason they didn't meet minutes because of a medical reason, but that's not what you're looking at right now.

Leah Nguyen: Hold on one moment.

Susanne Seagrave: Yes, I think you started out answering your own question again. This is only a data collection exercise at this point in time. So, the data would not be used for that purpose. We're just not looking at it for that reason as this point.

Debra Ebol: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Mary Ann Ambros. Mary Ann, your line is open.

Mary Ann Ambros: Hi, I wanted to ask you, do you need all of this data collection for all of our patients or just our Medicare and senior advantage patients?

Susanne Seagrave: We currently, our systems only accept IRF-PAIs for Medicare fee-for-service Part A patients and Medicare Advantage, Medicare Part C patients. So those are the only patients if they're either primary or secondary payer of one of those two — are the only types of patients that can get submitted to our systems. So those are the patients that you would be completing IRF-PAIs on and filling out this information. If it's a strictly private-pay patient, we wouldn't be obtaining an IRF-PAI on that patient, and so we would not require this information to be submitted.

Mary Ann Ambros: The reason I asked you that is because we do IRF-PAIs on all of our patients, even though we only transmit, you know, on the Medicares.

Susanne Seagrave: Right. Well, we don't collect the IRF-PAIs on the non-Medicare patients, so we're not asking for this information. If you fill out an IRF-PAI on non-Medicare patients and you don't submit it to CMS that's ...

Mary Ann Ambros: Well, we do, we do all of that just so that we can have, you know, measure outcomes and that so we do all of that data collection.

Susanne Seagrave: Right.

Jeanette Kranacs: OK. And certainly it's not a requirement on our part. So if it's not a Medicare Part A or Part C patient, we're not requiring you to fill out information on those patients. However, if you do for your own business purposes and you want to keep that information and it's helpful, by all means do that.

Mary Ann Ambros: OK.

Leah Nguyen: Thank you.

Operator: Your next question comes from Janet Herbols.

Janet Herbols: My question has to do with the arthritis attestation new item 24A. Is 24A required for every single IRF-PAI to be categorized as yes or no, or only those that could be triggered through an etiology or impairment-related to arthritis?

Susanne Seagrave: If there are no arthritis codes on the IRF-PAI, I would suggest that you — that you either, well, actually let me consult with my systems people and figure out the best way to answer that. Can you send that — would you mind sending that to our email resource box irfcoverage@cms.hhs.gov. That's an excellent question. Let me get back to you on that.

Janet Herbols: Thank you.

Leah Nguyen: Thank you.

Operator: The next question comes from Lyn Orbit.

Lyn Orbit: Hi, I just have a quick question. Under the therapy section, there's only 2 weeks. Will there be more for if the patient has a longer length of stay or you're just capturing these first 2 weeks?

Kadie Thomas: For the purpose of this data collection exercise, we're only capturing the first 2 weeks.

Lyn Orbit: OK.

Kadie Thomas: At a subsequent time we may choose to collect for additional weeks, but right now this is what it's going to be.

Lyn Orbit: OK. Thanks.

Kadie Thomas: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from Lisa Moser.

Lisa Moser: Hi this is Lisa Moser from Centra in Lynchburg. I just — for clarification, if the patient – and I'm looking at the IRF-PAI on 24, you code, suppose it's an arthritis

condition just as a comorbid condition, either regardless of impairment code, then you would answer yes on 24A.

Susanne Seagrave: If you code an arthritis ICD – currently ICD-9 code in item 24, which is the comorbidity field, then you need to answer the next question, item 24A on the form. Does that — did that patient meet the requirements in 412.29 for it to count as a 60-percent rule case? And those requirements are — a copy of those requirements is in the IRF-PAI Training Manual. It's a very long — a very long paragraph to read. But those requirements are copied in the IRF-PAI Training Manual for you to look at. So you have to answer yes or no, does that arthritis case in item 24 with the comorbidity, does that case meet the requirements?

Lisa Moser: So if it is a comorbid condition, just nothing related to anything, just the person has some mild arthritis, the answer is no is what you're saying because it's not meeting those requirements?

Susanne Seagrave: Right. Right, if it's a mild arthritis, for example, I'll give an example. In the regulation it says that in order for osteoarthritis to count it must be severe or advanced osteoarthritis involving two or more major weight-bearing joints. If that is not the case in item 24, if it's just a simple osteoarthritis that is not severe or advanced or involving two or more major weight-bearing joints, then you would code item 24A as no.

Lisa Moser: The physician must document — back that up with his documentation?

Susanne Seagrave: Sure. All the information provided on the IRF-PAI must reflect information found in the medical record.

Lisa Mosier: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from April Mundy.

April Mundy: Hi, I'm from John Muir Medical Center in Walnut Creek California. And this actually is kind of a tag-on to the previous question. So just to clarify, if a patient is diagnosed or admitted in number 21 with a CVA, and they have a comorbidity of the arthritis, then we would click no, correct?

Susanne Seagrave: It depends. If the arthritis comorbidity meets the regulatory requirement in 412.29, then you can code yes.

April Mundy: OK.

Susanne Seagrave: The arthritis comorbidity does not meet the regulatory requirements, then you code no.

April Mundy: OK.

Jeanette Kranacs: But in this particular case, the CVA is probably going to count you on the 60-percent rule.

April Mundy: Certainly, yes, OK. And did you have another question? OK, all right, thank you.

Leah Nguyen: Thank you.

Operator: The next question comes from Renee Thorsod. Renee, your line is open.

Renee Thorsod: Hi there, I'm from Ohio State. My question is in regards to the new item 24A. For arthritis patients with dermatomyositis, what happens if a patient has not had the opportunity to be involved in an appropriate, aggressive, sustained course of outpatient therapy or services in other less intensive rehab setting prior to being identified as an IRF candidate? For some of these patients, it's possible that their first entry into our system is at the acute care level. It seems appropriate if medically necessary and requiring intensive rehab for these patients to be admitted directly to the IRF rather than requiring them to attempt and fail an outpatient or SNF rehab setting first.

Susanne Seagrave: This item is not talking about whether it's necessarily appropriate to admit the patient to the IRF or not. It's talking specifically about whether the case meets the requirements for counting under the 60-percent rule. It's a 60-percent rule, so only 60 percent of the patients in the IRF have to meet these requirements; the other 40-percent of the patients should be patients who are – who require admission to an IRF or IRF services but don't necessarily meet the 60-percent rule requirement.

So again, we're not talking about whether the patient needs to be admitted to the IRF or not. There may be reasons why the patient might need to be admitted to the IRF. However, there are specific requirements of 412.29 about whether the patient meets the 60-percent rule requirement, and that's what these arthritis items number 24A is specifically directed towards — it's directed towards the IRF telling CMS whether the case meets the 60-percent rule requirements of not.

Renee Thorsod: OK. We were just wondering about access of care to the Medicare patients. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Lorie Sholido.

Lorie Sholido: Hi, this question is in regards to concurrent therapy clarification. If two patients are scheduled from 9 to 10 together and say patient number two needs to leave to use the restroom and returns and finishes the session, would you ultimately not report either patient's concurrent minutes? Or what would you recommend?

Jeanette Kranacs: Yes. I think at this point in time, what we're hearing is a lot more diversity in the situation than perhaps we initially thought about patients coming in and coming out and not sort of signing up for a particular session and completing that session in an expected period of time. So I think you bring up, you and a previous caller, bring up a really good question. Let's think about that a little bit more. We want to make sure we give you the right answer and perhaps we can, you know, post something on the CMS web page just clarifying exactly what we mean with regard to that.

Lorie Sholido: I appreciate it. Thank you.

Leah Nguyen: Um-hum.

Operator: And the next question is from Monica Caitlin.

Monica Caitlin: Yes. My question is how much concurrent time is allowed per week according to Medicare. And if again, like previous caller states, patient A is from 9 to 10, patient B is from 9:30 to 10:30, and there's a 30-minute overlap. If this overlap doesn't count as concurrent, then is that covered under individual?

Leah Nguyen: Hold on a moment.

Jeanette Kranacs: Thanks again for your question. What I think is — you've given us a lot of food for thought here. Our intent in saying that the session should begin and end at the same time was to make it easier to report so that people didn't have to worry about patients falling in and out of one kind of therapy and bouncing from one kind of therapy to another kind of therapy to another kind of therapy.

But I think with the amount of questions that we've gotten regarding this particular subject, perhaps the way we've thought about it is not the easiest way for you to report. And I think we'd like to go back and think about this a little bit more just to make sure that given the feedback, and if you've got more feedback, go ahead and send it to the mailbox. If you have a particular view on how that should be counted, we'll take that into consideration.

But I do want to emphasize that at this point in time, there is no requirement, there is no limit on the amount of concurrent therapy or group therapy that should be given outside of our general statement regarding the preponderance of therapy in the IRF

setting should be individual therapy. And that's the standard that we've got in place right now. And if we actually do come up with requirements limiting either concurrent therapy or group therapy, that again — we would do that and in the future under a notice and comments situation where providers could put input to those particular numbers.

So I'm sorry if I'm not answering all of your questions perfectly, but I think the important thing here is to get you the right answers and to make this coding exercise transparent for both you the provider and us CMS.

Leah Nguyen: Thank you.

Operator: Your next question comes from Beth Magico.

Beth Magico: Yes, hi, I have a similar question. Is for the coding for the therapy minutes — I'm not sure that if you can answer it but when we were looking at the timeframes for our patient coming in to therapy, my question was if a person is being treated one-on-one from 9 to 9:30 and then another patient comes into the gym from 9:30 to 10 and you're working with both and then 10 to 10:30 is patient B, why can't patient A be considered individual from 9 to 9:30, both patients be considered concurrent from 9:30 to 10, and then back to patient B who will be back at individual?

Penny Gershman: Thank you. Once again, you're — everybody here is offering very good suggestions, and what we're saying is we will definitely consider these and make you all aware of whatever we decide. Once again, just to reiterate, the original intent was to make it easier for facilities to code and what we're hearing is that our thoughts on ease might be a little bit more complicated than it seemed.

So once again, we will consider all of these questions that people are bringing up and we do appreciate them. Thank you.

Operator: Your next question is from Melissa Du.

Melissa Du: OK, I wanted to ask a question about the arthritis conditions and the need to have the outpatient therapy piece less intensive setting. Are you talking about all of the arthritic conditions? And if you are, my understanding is they are two separate arthritic conditions where there is a disease activation, a systemic disease activation that impacts those that they don't necessarily have to have the outpatient setting.

Susanne Seagrave: Hi, yes this is Susanne. So for the active polyarticular rheumatoid arthritis and the psoriatic arthritis and seronegative arthropathies, there are — you're correct that, and I didn't read all of this, again because it's long to read, it's a mouthful. But for those conditions there either has to be — the patient either has to have had an appropriate, aggressive, and sustained course of outpatient therapy services or services

in other less intensive rehabilitation settings immediately preceding the IRF admission or they have to have resulted from a systemic disease activation immediately before admission and have the potential to improve with more intensive rehabilitation.

So as I kept saying, you really need to look, I think, in the IRF-PAI Training Manual where we have put a copy of these requirements, and you need to read them carefully because as you pointed out, if a patient with one of these first conditions that I listed did have a systemic disease activation immediately before admission, that does mean that the patient possibly didn't have to have the prior course of therapy.

So there are some nuances, some caveats here, and again I just encourage you to read the information we provided in the IRF-PAI Training Manual for this item to make sure that you are actually capturing whether the answer to that question is yes or no.

Melissa Du: OK, thank you very much.

Leah Nguyen: Thank you.

Operator: The next question comes from the line of Dina Jenkins.

Dina Jenkins: Hi, my question is regarding the cotreatment definition. When a PT and OT therapist accompany the patient to their home prior to discharge for say a 1-hour home safety evaluation and the PT is working on say gates, transfers, and stairs, the OT is working on ADLs and home living skills. But they're together the whole time and they're both in direct contact with the patient the entire time. Is this considered a cotreatment or because they're working on different things, do they split the time and do I code it as individual, half an hour for PT and half an hour for OT, or do I code it as 1 hour of cotreatment with both PT and OT?

Leah Nguyen: Hold on one moment.

Penny Gershman: Thanks for your question. This is a very specific example, which is very difficult to answer on the spot with making these kinds of determinations. But just to reiterate, if the physical therapist is providing physical therapy for that amount of time at the same time that the occupational therapist is providing occupational therapy services at the same time, those can both be considered cotreatment at the same time. If they're truly providing their disciplines' services for that amount of time.

Dina Jenkins: OK.

Penny Gershman: Thank you.

Dina Jenkins: That makes sense. Thank you.

Penny Gershman: Thank you.

Operator: The next question comes from April Mundy.

Lorie: Hi this is Lorie from John Muir. We actually have two questions. Going back to the arthritic attestation, if we bring somebody in and had bilateral knee replacement into acute rehab or bilateral hip replacement, do we have to get ahold of those outpatient therapy notes then that they had prior to their surgery?

Susanne Seagrave: The joint replacements — our regulations specifically say that if a joint is replaced, even if it is replaced due to an arthritis condition, that that is no longer an arthritis in the joint. So, they — so you could potentially have a situation where the — in item 22, the etiologic diagnosis could be an arthritis condition. And then — and the patient received a joint replacement.

You're correct that that arthritis etiologic diagnosis in that one particular case would not have to have had a prior treatment requirement. You're just indicating that the arthritis was the cause of the joint replacement. However, you know, one, I just want to make clear, and your question probably wasn't about this, but I feel it is incumbent upon me to make clear here that if you, if the patient has had a joint replacement and they come in to the IRF, that joint can no longer be listed as an arthritis comorbidity.

Lorie: Oh, OK.

Lorie: Did you want to ask that?

April Mundy: Yes, sorry, this is April. In followup to the comment about family conferences are not counting towards therapy minutes on the IRF-PAI —because often if we have a patient, you know the patient has to be physically present for our therapist to bill for a family conference. But we're saying, this is indicating to us that we can't include that in the minutes that are reported in the IRF-PAI then?

Leah Nguyen: Hold on a moment.

Jeanette Kranacs: I'm sorry; we want to make sure that we're understanding your question correctly because I think we all have different interpretations of what you just said. Would you mind rephrasing that just so that we're clear on what you're asking?

April Mundy: OK. So if we have a patient and family conference, our therapists are currently billing time for that because often it is, you know, family and patient education and communication. Despite the therapy time being billed, we can't use those minutes or address those minutes on the IRF-PAI according to what is stated on 19, that's what I'm trying to understand. Or are we billing it incorrectly? And it's only if the patient is physically present for these conferences?

Kadie Thomas: So we just want to be certain we understand what you said. Is the patient actively engaging ...

April Mundy: Yes, yes.

Kadie Thomas: ...for this therapy exercise, like is there — they're displaying what needs to happen at home or are they just present for the conversation?

April Mundy: No, if there's just a conversation, a sit-down, you know, as we're trying to explore discharge planning options and challenging patients. Sometimes we have a sit-down and it's only for patients that are cognitively intact and able to engage. And we have the therapist present, but there is no, you know, functional measures being addressed during this time.

Kadie Thomas: OK, that's really helpful. So, no, that time spent just explaining things with the family while the patient is present, that would not be counted towards therapy time. That should not be counted ever towards therapy time. Not just with the, you know, data collection exercise that we're implementing.

April Mundy: OK, OK, thank you.

Operator: The next question comes from the line of Debbie McKeivitch.

Debbie McKeivitch: Hello. My question is, if we treat on the day of discharge, are we allowed to count those minutes towards like the 3-hour rule? For example, if we miss minutes the day before due to a doctor's appointment, can we make up those minutes on the day of discharge even though we don't bill for it on that day?

Penny Gershman: We actually don't feel like that question pertains to what we're discussing today, but you can certainly send that to the IRF coverage mailbox and you'll hear from someone with a response.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Melissa Smith.

Melissa Smith: Hi, our question has already been answered. Thank you.

Leah Nguyen: Thank you.

Melissa Smith: You know what, can I ask something different?

Leah Nguyen: Sure.

Melissa Smith: So back to the documentation towards arthritic comorbidity. So the person earlier asked if we actually had to have records in the chart from the other facility, and I know you kind of went to talking about the single joint replacement, but in the event that we are trying to use that standard of having completed the intense rehab or outpatient therapy, what length do we have to get to be able to prove that that did occur? Is it simply documented that it did occur or do we have to attain records from another facility?

Susanne Seagrave: Hi, this is Susanne. Yes, you do actually have to obtain copies of the therapy notes from the outpatient therapy or from the therapy services provided in other less intensive settings. This has been in the manual since these regulations were finalized, and you do have to — you do have to obtain the copies of the therapy notes from the prior services. We consider that not only part of the important documentation of this requirement but also it's important for the quality of care of that patient that you understand how they were treated previously. So we do feel that those prior records are very important and should be — and must be included in the IRF medical record if, especially if you're going to check yes on this arthritis item.

Your question also gives me an opportunity to clarify something from before. I want to clarify it because it hadn't dawned on me until after the question — or asked the question that a bilateral joint replacement does meet the 60-percent rule requirement by virtue of being a bilateral joint replacement. That's one of the three conditions for a joint replacement to meet the 60-percent rule requirement. The patient is extremely obese, the patient is over age 85, or the patient is a bilateral joint replacement. So I just want to clarify that the question earlier, if it was a bilateral joint replacement would count anyway.

Leah Nguyen: Thank you.

Melissa Smith: Thank you.

Operator: Once more, to ask a question, please press star then the number 1. Again, to ask a question at this time, please press star then the number 1. There is a question from the line of Debbie McKevivitch.

Debbie McKevivitch: Yes. We're getting back to that question we had asked earlier. Our question is, if someone was transferred out to the hospital at 9 o'clock at night, a Medicare patient, and they had therapy that day on day-of-discharge, do you count those therapy minutes on the IRF-PAI?

Kadie Thomas: You include them.

Leah Nguyen: Hold on a moment.

Kadie Thomas: For the data collection exercise, yes, you would put those therapy minutes down because therapy was provided to the patient while in the IRF.

Debbie McKeivitch: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jennifer Risch.

Jennifer Risch: I have that question, kind of going back to some of the cotreatment questions that we had but slightly different. If you do have those two patients — or those therapists working with one patient, when we are reporting on the IRF-PAI, we are using that full time period reporting it to each of those two therapists' hours of therapy, correct?

Penny Gershman: Hi, this is Penny. That's correct if that time is fully spent by each therapist providing the therapy. So for example, if a physical therapist and an occupational therapist are providing cotreatment and the occupational therapist — let's say they're together for an hour with the patient. But the occupational therapist is only doing occupational therapy for 40 minutes, that can't be coded as a full hour if the occupational therapist isn't working with that patient specifically providing that occupational therapy for 60 minutes. They have to be providing their therapy discipline for that amount of time.

Jennifer Risch: OK. And how does that impact the 3-hour rule then? Is that just — is that a separate entity or do the billable hours for your 3-hour rule and your IRF-PAI hours all have to match?

Penny Gershman: This recording requirement has nothing to do with any requirements in the 3-hour rule.

Jennifer Risch: OK.

Jeanette Kranacs: If you would like to submit that question to the mailbox, if you have a question specific to the coverage requirements then or intensity of therapy requirements, please go ahead and submit that separately to the mailbox. Again, we wanted to focus this on just the coding of the data collection.

Jennifer Risch: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Artis Glutier.

Artis Glutier: Hi there, my question was just answered. Thank you.

Leah Nguyen: Thank you.

Operator: And the next question comes from Darlene Jones.

Darlene Jones: Hello, this Darlene D'Altorio-Jones from Medware. Earlier when you talked about the Part A and Part C being your only patients that are transmitted to CMS, it's important I think for us to ask because the attestation relies on 100 percent of admissions, and often people are collecting this information through their vendor.

I think that we need to ask individually or at least, you know, the facilities, if they're collecting this day-to-day, they shouldn't just ignore that arthritis question if they're going to be attempting to use those patients for the full attestation, just because they're not submitting to CMS, they will get questioned about all those cases. And the more information they have on them in this unified collection, then the better off I think they'll be. Do you agree with me if they should be collecting this information on all patients, not just A and C?

Susanne Seagrave: OK, I think what you're referring to — there are two methodologies for determining an IRF's compliance with the 60-percent rule. There's the so-called presumptive methodology, which is based on the IRF-PAI submissions. And then there's a second methodology called the medical review methodology that — and so there are two different methodologies. Typically, unless an IRF doesn't meet the presumptive methodology — typically the IRFs are evaluated using the presumptive methodology unless they don't have enough Medicare patients to qualify for that methodology.

So under the presumptive methodology, we only use the Medicare IRF-PAI to evaluate that methodology, and so under the presumptive methodology the attestation, it's not actually an attestation, I'm using the words that you just used, but it's an indicator that for the IRF to tell us whether or not the arthritis case meets the 60-percent rule criteria or not. That indicator will only be on the IRF-PAI and will be used in the presumptive methodology, which Medicare only uses for Medicare cases and not presumptive methodology. And I should be more clear, Medicare Part A and Medicare Part C in either the primary or secondary payer source.

However, what you're referring to as the 100 percent is if a MAC uses the medical review methodology to either evaluate ...

Jeanette Kranacs: Either because that was the preferred methodology for the MAC to use or because the provider had at first failed the presumptive methodology...

Susanne Seagrave: Or because the IRF didn't have enough Medicare cases. It didn't — Medicare wasn't at least 50 percent of the IRF's patient population. So there are a number of different scenarios where a MAC might use the medical review methodology.

The medical review methodology is based on all payer sources in the IRF. So all patients, regardless of payer sources, are included in that medical review methodology and the MAC takes a random sample of the — all of the IRF claims regardless of payer source. And in that case, any case that needs to meet the 60-percent rule criteria because of an arthritis condition would need to meet the requirements in 412.29 that we have been discussing, the requirements for severity, the requirements for an appropriate, aggressive, and sustained course of outpatient therapy or a systemic disease activation immediately before admission.

So these requirements need to be met if that case is selected for the medical review methodology, which means, and I think this maybe speaks to your question, that the IRF needs to include documentation in the medical record of the prior therapy any time that prior therapy is going to be needed in order to meet the 60-percent rule requirement because that case could be selected under the medical review methodology and will need to demonstrate that it meets the requirements or it will not be allowed to count for the 60-percent rule determination.

So does that help? Is that clear enough?

Darlene Jones: Yes, I just didn't want everyone to dispel that because I work in a facility that often didn't have 60 percent Medicare and this is back before they counted Medicare Part C patients, of course. That makes it much more helpful. But we had to do that medical review, and we had to demonstrate that compliance for all patients. So I just didn't want people to like throw away all this information and not put it in on patients that they may need to utilize, especially if they knew their historical preparations didn't always make the 50-percent presumptive criteria. It's just a thought.

Susanne Seagrave: Correct, correct. However, there is not a requirement by Medicare that they check yes or no on item 24A for patients who do not have Medicare in either the primary or secondary payer source.

Darlene Jones: True. But, I think that vendors that are out there for IRF-PAIs utilize that to help them gather this information on whether they need it presumptively or not presumptively, etc., and if they just totally leave it out, that leaves them less tools to validate, you know, both ways should they fall below that 50 percent. It's just a thought.

Jeanette Kranacs: Yes, absolutely, I mean, I think one of the advantages that you do have when you go to medical review is that the entire medical record will be evaluated, so just because the information isn't available on the IRF-PAI for a non-Medicare patient, the documentation in the medical record is really paramount. No matter what

kind of patient it is, you want the information there to be able to support that no matter what the patient — payer resource is.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kerry Tracy. Kerry, your line is open.

Kerry Tracy: Can you hear me? Can you hear me?

Leah Nguyen: Yes, we can hear you.

Kerry Tracy: I'm sorry. I'm calling from Oklahoma City, St. Anthony Hospital, and I just wanted a quick clarification on how you want to count the days on interrupted stays. So if a patient admits on a Monday, for example, and so that's day 1; and then they have an interruption in that first 7 days, do you still want us to report Monday through Sunday, which would be your 7 days? Or do you take out those days of interruption and count them, continue on with your 7-day count? Does that make sense?

Kadie Thomas: Yes, I understand. So you would count that full week as 7 days even if the patient was maybe in acute care for three of them. You would count all 7 days.

Kerry Tracy: Right, OK, that's what I wanted clarification on. And then we would just code it appropriately on the other two interruption items.

Kadie Thomas: Correct, yes, you'd fill out is it ...

Kerry Tracy: ... it's 42 and 43, it's on your slide 20.

Kadie Thomas: Yes, exactly.

Kerry Tracy: OK, perfect, thanks.

Leah Nguyen: Sure. Thank you.

Operator: Once again, if you would like to ask a question, please press star then the number 1 on your telephone keypad. Again to ask a question, please press star 1.

There is a question from Cheryl Miller. Cheryl, your line is open.

Cheryl Miller: Thank you. Again, I have a different question. So on slide 13, there was a question just now about time offered in therapy on the day of discharge and if you plan to offer therapy on the day of discharge. Well, it appears that on slide 13, you're suggesting that we would actually report time spent in therapy on the day —through

the day of discharge, so the effect — in the example you gave, you said through discharge on 11/11. So does that mean you would report time spent on therapy on the day of discharge?

Leah Nguyen: Hold on a moment.

Kadie Thomas: So any therapy that is provided to IRF patients while in the IRF needs to be recorded —needs to be recorded for this collection exercise.

Jeanette Kranacs: From the day of admission through the day of discharge.

Kadie Thomas: Right.

Cheryl Miller: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Janet Harbaugh.

Dianne Gibson: Hi, this is Dianne Gibson on Janet's line. I have a question in regards to the signature page. Is it mandatory that we fill in the time? If so, what time should it be stamped?

Kadie Thomas: Yes, it's mandatory that you fill in the time slot and it should be the time that you have signed the signature page.

Dianne Gibson: OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from Jennifer Risch. Jennifer, your line is open.

Jennifer Risch: Hi, I need just a moment, I have forgotten my question. I apologize. It did have to do with therapy disciplines. I know you just clarified that we are going the day of admission through the day of discharge and counting the weeks by calendar days, not treatment days in the case of an interrupted stay. Do we only include PT, OT, and speech? For example, I'm in a CARF-accredited facility, we offer sometimes TR and PT cotreatment or TR and such. For the purposes of the PAI, do we include that therapy or it's just strictly the regulatory therapies — PT, OT, and speech?

Susanne Seagrave: Yes, you are correct. You may have answered your question at the very end there, and it's only for physical therapy, occupational therapy, and speech-language pathology.

Jennifer Risch: OK.

Leah Nguyen: Thank you.

Operator: Your next question comes from Betty McCarovich.

Betty McCarovich: Yes, we have a question regarding that slide number 20 on the interruptions of stay. So even if the patient stays out for 2 days in the acute care and comes back on the third day, those 2 days you would count in as your minutes — in as your minutes in that first or second week? Because according to the regulations, those days are considered that in — are not counted in your stay, they're interrupted days. So then you would continue on your stay. So if they came in on day number 2, they went out — say they came in on day number 2, they went, when they come back maybe on the fourth day, that's considered their third day.

Leah Nguyen: Hold on a moment.

Susanne Seagrave: Yes, the 7-day period is set. Its day one is the day of admission and day seven is 7 days later; 7 calendar days later, 7 consecutive calendar days later. So that seven-day period is set. If you have, say, a 2-day interrupted stay in the middle of that 7 days, we said on one of our slides that we would subtract those

Betty McCarovich: It does, but it's going to get very confusing because of when you say in the manual on an interrupted stay on the IRF-PAI, it says that you would count those. If it was in that reference period date, your reference period date would go ahead, so this would be very confusing to PPS coordinators or anyone submitting on that IRF-PAI.

Susanne Seagrave: Can you explain more, can you just help us understand what's confusing? We're trying to simplify it and say there's a set 7 days and if the patient leaves the IRF for part of those 7 days we subtract those days out.

Betty McCarovich: Well, the days won't match according to what the regulations call for — that you don't count those interruptions into your stay — into your length of stay.

Susanne Seagrave: No, we won't be counting them because we'll be subtracting those days when the patient is outside the IRF, we will be subtracting them out.

Leah Nguyen: Hold on a moment.

Betty McCarovich: What if it's the second week — it's the first couple of days in the first week, which happens. The second week comes up, and you're counting by the days of, the week two the — or the 7 days match the calendar dates, that's going to come up short in that second week. It's very confusing, and I think they're confused.

Betty McCarovich: It's confusing to me because — I know but when they say that —

Kadie Thomas: So I guess maybe after you clarified, — we're understanding better. So for the 7 days if the patient interrupted — had an interrupted stay for two of those days and you were only able to provide therapy for five of those days in that first week, then those are the only therapy minutes that should be recorded.

Susanne Seagrave: For example, the person is in there for days 1, 2, 3. Days 4 and 5, the patient goes back to the hospital, maybe day 4 they get a little bit of therapy before they go back to the hospital, maybe they don't. If they don't, you write down zero for that day. Day 5, they're in the hospital. When do they return, do they receive any therapy after they return?

If not, again, include zero for that day and then in item 42 and 43, you would indicate that days 4 and 5 would be days that were affected by the interrupted stay, and it becomes obvious then that those were interrupted stay days and maybe therapy was provided or wasn't provided on those days. But we have an accounting for every day of the stay then whether or not therapy was provided.

Kadie Thomas: And again, this is not a minutes collection exercise work. This is a data collection exercise. We just want to see what is being provided per week. We're not adding up the minutes on this to make sure that in that first week minus the 2 days of interrupted stay that you've met the requirement of 3 hours — or, I'm sorry, 15 hours. We're not adding these minutes up to check on that, if that's maybe what you're alluding to.

Penny Gershman: Of course the coverage requirements must be met, but this is not being used to check for the coverage requirements at this point in time and simply adding up things and disqualifying you for the coverage requirements if it doesn't add up to 15 hours in a 7-day period.

Susanne Seagrave: Right, and I want to note one other thing that should make that crystal clear. Orthotics/prosthetics are the fourth leg of our therapy that counts, that are used to document the intensity of therapy requirements that we require under our coverage requirements. And those are not even reflected here at all. So if we were going to add up these minutes to determine whether a case meets the coverage requirements, we would need to include those orthotics/prosthetics minutes, but we do not because that is not our intent here.

Our intent here is to determine how much and what mode and type of therapies — of the physical therapy, occupational therapy, and speech-language pathology are currently being provided in IRFs.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Deborah Schultz.

Deborah Schultz: Hi, thank you, you just answered my question because it was about the orthotic and prosthetics minutes.

Leah Nguyen: Thank you.

Operator: And there are no further questions at this time.

Additional Information

Leah Nguyen: Thank you.

An audio recording and written transcript of today's call will be posted to the MLN Connect Calls website. We will release an announcement in the MLN Connect Provider eNews when these are available. On slide 26 of the presentation, you'll find information at the URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on the new IRF-PAI items. Have a great day, everyone.

Operator: This concludes today's call.

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