What You Need to Know if You Work in a SNF

AOTA Analysis of the 2010 Skilled Nursing Facility (SNF)
Prospective Payment System (PPS)

The Final Rule governing the 2010 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) payment rate introduces a number of updates and policy changes to the SNF environment. Some of the changes are complex and will require therapist education. American Occupational Therapy Association (AOTA) staff is working to obtain clarification from the Centers for Medicare & Medicaid Services (CMS) in certain areas, realizing that the SNF policy changes may represent new responsibilities for occupational therapy practitioners. Should you have questions or comments, you can e-mail us at rrpd@aota.org. The policy changes relevant to occupational therapy practitioners are described in detail below.

I. SNF Payment Cuts

The SNF PPS case-mix recalibration will cut more than $1 billion from SNF funding in fiscal year (FY) 2010. According to CMS, this cut will be partially mitigated by a 2.2 percent market basket increase; thus, funding for SNFs is projected to decline by $360 million in FY 2010. Please note the timeline for this change compared to the timeline for the policy changes discussed below. The payment rate change was effective on **January 1, 2010**, however, several policy changes relevant to occupational therapy will not be effective until October 1, 2010 in order to permit facilities the time needed to train staff on new responsibilities and alter computer systems to comply with new CMS requirements.

II. Concurrent Therapy

In the SNF PPS Proposed Rule, CMS stated that concurrent therapy is a legitimate mode of delivering therapy, it should be an adjunct to individual (1:1) delivery, and it should represent an exception rather than the standard of care.

CMS proposed to allocate the total minutes among the patients on the basis of the **therapist's clinical judgment** of how much **therapist time** was actually provided to **each** patient. CMS also invited public comment on whether there should be other restrictions relating to concurrent therapy such as:

> 1) a percentage limit to the number of concurrent therapy minutes that may be counted in the Minimum Data Set (MDS) for any individual or
> 2) the number of people that can be concurrently treated by the same therapist.

In the SNF PPS Final Rule, CMS followed through on the proposals related to allocation of concurrent therapy minutes. **Effective October 1, 2010, with the introduction of RUG–IV**, CMS will implement the following concurrent therapy policy, which:

- Requires the minutes of treatment be allocated on the basis of individual therapist time with an individual patient, and the allocated minutes will be used to establish the RUG–IV group to which the patient is assigned
- Requires therapists code on the MDS the minutes of each mode of therapy (i.e., individual, concurrent, group) provided to patients
- **Limits the number of patients** treated concurrently to **two** patients, but CMS did not place any cap on the percentage of time a patient can spend in concurrent therapy.

CMS admits that the agency made an incorrect statement in the Proposed Rule about the Staff Time Resource Intensity Verification (STRIVE) project data percentage of all concurrent therapy time collected as being two-thirds of total treatment time, stating "Our contractor located a mistake made in the computation for this statistic alone that substantially inflated this percentage . . . the correct percentage of concurrent time is 28.26 percent." Nonetheless, CMS chose to adopt this concurrent therapy proposal in the Final Rule.

In fact, in the Final Rule, CMS introduces an example of how clinicians may allocate minutes among patients concurrently treated; CMS calls this the "time slice" method. AOTA finds the example to be unclear as written. The example uses three patients rather than highlighting the new limitation to two patients. As noted above, AOTA plans to obtain further clarification of this policy.

To simplify, AOTA believes CMS is stating the following policy:

If two patients are treated concurrently for 30 minutes with the same beginning and end time, each patient under CMS's "time slice" method would be allocated 15 minutes of 1:1 therapy. If the beginning and end times differ among patients, CMS requires that the time spent individually with each patient be allocated as a percentage of the total concurrent therapy treatment time spent with all patients.

Several issues led CMS to these decisions on concurrent therapy. In response to comments, CMS states the following about the decision to limit the number of concurrently treated patients to two:

> *Both the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) recommended limiting concurrent therapy to two patients. In fact, the AOTA reports in their comment on the FY 2010 SNF PPS proposed rule, and on their web site at www.aota.org/Practitioners/Reimb/Pay/Medicare/FactSheets/37784.aspx, that they have been advising their members to limit the provision of concurrent therapy in this manner for some time: "For a number of years, AOTA has been informally advising members that the number of patients should be limited to 2 as a best practice standard." We believe the clinical knowledge and expertise of the therapy associations*

> *is a proper benchmark for determining the allowable number of patients during a concurrent session, and we agree that a therapist (or assistant) should treat no more than two patients concurrently.*

In addition, CMS responds to comments opposing the allocation of minutes as follows:

> *The SNF PPS is based on resource utilization and costs. When a therapist treats two patients concurrently for an hour, it does not cost the SNF twice the amount (or 2 hours of the therapist's salary) to provide those services. The therapist would appropriately receive one hour's salary for the hour of therapy provided, regardless of whether the therapist treated one patient individually or two patients concurrently for that hour. Therefore, Medicare should pay for the one hour of the therapist's time.*

For more information about concurrent therapy, read *Concurrent v. Group Therapy*.

III. Changes to the Minimum Data Set (MDS)

CMS clarified concerns expressed in comments about the draft MDS 3.0 item set. CMS stated that these issues will be addressed with the MDS 3.0 RAI Manual and MDS 3.0 Final Item Set that is scheduled to be published on the CMS Web site in October 2010. The specific recommendations for new or revised items for the MDS 3.0 instrument were forwarded to the MDS 3.0 development team at CMS for review and consideration. The MDS 3.0 RAI Manual, Data Set, and Data Specifications were scheduled to be published in October 2009, with subsequent implementation of the MDS 3.0 in October 2010. CMS believes that this time frame provides for an entire year for CMS, its contractors, and SNFs to prepare and train in anticipation of the **October 1, 2010 implementation date of the MDS 3.0**. Publication of some items was delayed, however, they are now posted to CMS' MDS 3.0 web site at http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp. CMS also posted a Q&A document to address specific questions.

Deletes Projection of Anticipated Therapy Services (Section T of RAI)

Effective October 1, 2010, CMS will delete the section T **(T1b, c, d)** projection of anticipated therapy services from the RAI and MDS 3.0 as proposed. In addition, CMS will implement the optional start-of-therapy Other Medicare Required Assessment (OMRA), which may be completed when therapy starts in between assessment windows as well as when therapy has started in a Medicare-required assessment window. CMS states that the option to use the start-of-therapy OMRA, regardless of when therapy starts, eliminates the risk that therapy data would not be captured for some patient days.

In comments, AOTA voiced concern that the elimination of the projection of anticipated therapy services during the 5-day PPS assessment would impact beneficiary access to quality care and potentially delay access to therapy, especially in rural or small SNFs. These facilities typically staff one part-time licensed occupational therapist who may treat patients in collaboration with an occupational therapy assistant.

With regard to the start-of-therapy OMRA, CMS states that they will continue to look to the clinician's judgment to make decisions on the need for, volume, and frequency of therapy services. CMS states, "We do not believe that a projection methodology can serve to provide clinical guidance to a therapist and, thus, we do not expect that the elimination of this particular documentation requirement will adversely affect patient care."

Under current practice, the assessment reference date (ARD) for the OMRA is required to be set within 8 to 10 days of the end of all therapies. The change adopted in the Final Rule would require the ARD for the end-of-therapy OMRA to be set in a shorter time frame, that is, no more than 3 days following the cessation of all therapies. The change would not increase the number of assessments. According to CMS, the start-of therapy OMRA is completely voluntary and is not required; thus, CMS does not believe it is an additional burden. However, in response to concerns expressed by commenters regarding the increased number of assessments, CMS states that the agency will provide for an abbreviated OMRA for the stand-alone start-of-therapy OMRA.

Use of Aides in SNFs (RAI Manual, Chapter 3, Section O)

The MDS 3.0 RAI Manual was revised to restrict the use of aides in SNFs effective October 1, 2010. The policy provides that aides cannot provide skilled services, and only the time an aide spends on set-up for skilled services may be coded on the MDS.

IV. ADL Scale

CMS finalized the initiative to create an activities of daily living (ADL) scale that is more sensitive to functional status and allows for a finer analysis of changes in functional status over time. AOTA supported this change and also agreed with the introduction of an index, which will make the use and interpretation of the ADL scoring scale clearer for occupational therapy practitioners.

V. Elimination of ''Look-Back'' Period

In the Proposed Rule, CMS proposed to eliminate the look-back period for items in the MDS because CMS stated its use could trigger a RUG assignment on the basis of services that occurred solely during the prior acute hospital stay and were no longer being furnished upon SNF admission. AOTA is concerned that the removal of the look-back period to the hospital stay would negatively affect the quality of care for SNF beneficiaries. The look-back period for rehabilitation counts actual days and minutes of therapy back from the ARD for the previous 7 days to determine the appropriate RUG category and treatment needs (i.e., number of days of treatment) for the beneficiary.

Nonetheless, **effective October 1, 2010**, CMS will eliminate the look-back period into the hospital stay for those specific services in **section P1a on MDS 2.0**. CMS responded to comments voicing concern about care planning issues by stating that the agency will maintain the ability for the provider to code those services provided prior to admission to the SNF on the MDS 3.0 by expanding the MDS 3.0 for these items to two columns, stating that "coding for these preadmission services on the MDS 3.0 will allow providers to effectively capture these services for care planning purposes."

Health Care Reform and RUG-IV

The Patient Protection and Affordable Care Act (PPACA) included an amendment to delay implementation of RUG-IV by one year to October 1, 2011. However, the law maintains other planned changes such as implementation of MDS 3.0, new requirements for concurrent therapy and look-back revisions. The nursing home industry and CMS are moving forward with implementation of RUG-IV as scheduled due to the significant and adverse consequences that would result from a partial delay. CMS is currently developing a hybrid RUG-III system to accommodate the delay of RUG-IV. Starting October 1, 2010, CMS will make temporary payments based on RUG-IV. Once the hybrid RUG-III system is built, CMS will go back and make retroactive changes to payment. CMS believes this approach will result in the least disruption for providers and beneficiaries.

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Additional Resources

SNF PPS Final Rule in the *Federal Register*

AOTA's official comment letter on the SNF PPS Proposed Rule

MDS 3.0 RAI Manual. For concurrent therapy coding instructions and restrictions on the use of aides in SNFs, see the MDS 3.0 RAI Manual document at the bottom of the web page and go to Chapter 3, Section O in the zip file.

For detailed information about changes to student supervision policies, read AOTA's article on CMS changes to student supervision.

For more information about concurrent and group therapy policies, read *Concurrent v. Group Therapy*.

AOTA will continue to monitor changes to SNF policies. Please email questions to rrpd@aota.org. Please email rrpd@aota.org to provide us with information about how the implementation of these policies is affecting your facility so that we may use your input to inform our advocacy with CMS.