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Navigating Your Financial Future: The Top SNF PPS Final Rule Questions Answered

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The Centers for Medicare & Medicaid Services (CMS) released the final rule for SNF PPS and consolidated billing for fiscal year (FY) 2012 on July 29. An important provision included in this rule will reduce Medicare SNF PPS payments in FY 2012 by $3.87 billion—11.1% lower than payments for FY 2011. CMS states that the reason for this rate reduction is to correct an unintended spike in payment levels and better align Medicare payments with costs.

"CMS is committed to providing high quality care to those in skilled nursing facilities and to pay those facilities properly for that care," CMS Administrator Donald M. Berwick, MD, said in a CMS press release. "The adjustments to the payment rates for next year reflect that policy."

CMS is blaming the spike in payment levels on a forecast error that occurred with the transition from RUG-III to RUG-IV.

According to the CMS press release, the parity adjustment made in FY 2011, which was intended to ensure that the RUG-IV system would not change overall spending levels from the prior year, instead resulted in a significant increase in Medicare expenditures. This increase was mainly due to shifts in the utilization of therapy modes under RUG-IV that differed significantly from the projections on which the parity adjustment was based.

Facilities that are primarily focused on rehab will experience the hardest hit due to these rate cuts. But those facilities that have a more traditional case mix that balances residents in therapy and residents spread across the clinical RUG categories won't feel the effects of a full 11.1% decrease.

A final rule breakdown

Along with the payment updates, the SNF PPS final rule for FY 2012 includes a few other significant changes for nursing facilities. Some of these changes are as follows:

- **Affordable Care Act initiatives:**
  - CMS is in the process of developing the SNF value-based purchasing plan and will submit a report to Congress by October 1.
  - The Secretary of the U.S. Department of Health and Human Services (HHS) will evaluate the possibility of expanding

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the hospital-acquired condition policy from acute care hospitals to a variety of other settings, including SNFs, and will submit a report to Congress by January 1, 2012.

- The nursing home transparency and improvement act will require SNFs to report expenditures separately for direct care staff wages and benefits on the Medicare cost report, and for cost reporting periods beginning on or after two years after enactment, and also requires the Secretary of HHS to perform certain related activities.

- **Therapy student supervision.** The final rule will discontinue the policy requiring line-of-sight supervision of therapy students in SNFs. Instead, effective October 1, each SNF will determine for itself the appropriate manner of therapy student supervision consistent with state and local laws and practice standards.
- **Group therapy clarifications.** Effective October 1, group therapy will be defined as therapy provided simultaneously to four patients who are performing the same or similar activities, and group therapy time will be divided by four in determining the reimbursable therapy minutes for each group therapy participant and, therefore, the appropriate RUG-IV group.
- **Five- or seven-day-a-week therapy clarification.** The final rule will eliminate the distinction between facilities regularly furnishing therapy services on a five- or seven-day basis for purposes of setting the date for the End of Therapy (EOT) Other Medicare Required Assessment (OMRA).
- **Introduction of the End of Therapy–Resumption (EOT-R) OMRA.** Effective for services provided on or after October 1, when an EOT OMRA has been completed and therapy subsequently resumes, SNFs may complete an EOT-R OMRA rather than a Start of Therapy (SOT) OMRA in cases where the resumption of therapy date is no more than five consecutive days after the last day of therapy provided and the therapy services have resumed at the same RUG-IV level that had been in effect prior to the EOT OMRA.
- **Introduction of the Change of Therapy (COT) OMRA.** Effective for services provided on or after October 1, SNFs will be required to complete a COT OMRA for patients classified into a RUG-IV therapy group whenever the intensity of therapy—that is, the total reimbursable therapy minutes provided—changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on that resident's most recent assessment used for Medicare payment. The assessment reference date (ARD) of the COT OMRA would be set for day seven of a COT observation period, which is a successive

seven-day window beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment and ending every seven calendar days thereafter.

- **Changes to MDS 3.0 SNF PPS assessment schedule.** The final rule modifies the Medicare-required assessment schedule to incorporate new assessment windows and grace days, which will more appropriately capture patient status changes, in-services, and treatments provided over the course of the stay. This will also reduce the possibility that information from the same days of the stay may be used on different scheduled MDS assessments.

You asked, we answered

Surviving the impending reduction in payment may seem daunting, so HCPro's long-term care experts answered 25 tough questions to help you survive the FY 2012 cuts. Let these answers be your guide in navigating the ever-changing world of long-term care.

Q Do you need to do both an EOT OMRA and an EOT-R OMRA?

A You must complete an EOT OMRA when therapy services cease for three consecutive days, regardless of the reason. Then, if therapy resumes within five days after the last day of therapy at the same RUG-IV classification level, you have the option of completing an EOT-R OMRA rather than the EOT OMRA. It is not mandatory, just an option.

In situations where an EOT-R OMRA can be completed, the therapist will not need to conduct a new therapy evaluation or establish a new care plan because the resident will be resuming therapy at the same level.

However, if that level changes, or if the resident goes more than five days from the last day of therapy before resuming therapy services, the therapist would be required to conduct a new evaluation and establish a new care plan. Also, the facility could complete the optional SOT OMRA to ensure payment at the new RUG rate.

Q Does the COT allow us to re-RUG to a higher rehab level? Also, does the new RUG category take effect the day after the COT ARD?

A If a resident starts receiving enough therapy to classify into a RUG-IV category that is higher than his or her current category, then yes, completing a COT would allow you to re-RUG at the higher, more appropriate RUG level. The ARD for the COT OMRA would be set for day seven of the observation period, which is a rolling seven-day window beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment and ending every seven calendar days thereafter. In cases where the last assessment was an EOT-R, then the COT observation period

begins on the resumption date listed in O0450B. The new RUG-IV group resulting from the COT OMRA would be billed starting the first day of the COT observation period and would remain at this level until a new assessment is completed that changes the resident's RUG-IV classification.

Let's look at an example. If a SNF sets the ARD for its 14-day assessment to day 14, then day one for the purposes of the COT observation period would be day 15 of the SNF stay, and the facility would be required to review its therapy minutes for that resident for the week consisting of days 15–21. If the SNF determines that the total therapy minutes received has changed such that the RUG classification from the 14-day assessment is no longer accurate, then the SNF would complete a COT OMRA with an ARD of day 21. Payment at the RUG rate determined by the COT OMRA would begin on the first day of the COT observation period, which was day 15.

Q Does the EOT need to be done for all discontinuation of therapy or just those receiving Medicare Part A services? Do we need to do the EOT each time we discharge physical therapy (PT), occupational therapy (OT), and Medicare Part A services?

A An EOT OMRA only needs to be done when all therapy services cease for three consecutive days and the resident remains on Medicare Part A. The purpose of the EOT OMRA is to switch the resident from the rehab RUG to a new RUG based on the nursing services and other skilled care he or she is receiving. If you are discharging the resident from both therapy and Medicare Part A, you would not need to do an EOT OMRA because you would not need to obtain a new RUG score for Medicare Part A payment.

Q For the COT MDS, what date is covered by the new COT RUG score? Does payment change on the ARD?

A The new RUG-IV group resulting from the COT OMRA would be billed starting the first day of the COT observation period and would remain at this level until a new assessment is completed that changes the resident's RUG-IV classification.

Q For the COT, do you have to choose the ARD date on the specific date that the RUG changes, and what are your options for ARD choice?

A The ARD for the COT OMRA would be set for day seven of the observation period, which is a rolling seven-day window beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment and ending every seven calendar days thereafter. In cases where the last assessment was an EOT-R, then the COT observation period begins on the resumption date listed in O0450B.

Q What happens when you only have two residents in group therapy?

A According to the final rule, a group MUST be planned for four participants only (not two, three or five) in order to be a valid group. However, a resident may not be able to participate on a given day for a variety of reasons. In that case, the total minutes would still be divided by four, regardless of how many members actually participated that day.

Q How much do minutes need to change in order to do a COT?

A SNFs must complete a COT whenever the intensity of therapy minutes changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.

Q How will the therapy minutes provided by a student count for a Medicare Part A MDS now that the line-of-site supervision requirement is removed? Presently a student and supervisor treating different patients must log minutes as concurrent and minutes are split, but how would that work now that the line-of-site supervision is removed?

A CMS responded in the final rule as follows:

In response to those commenters concerned with how to bill therapy student time spent with SNF patients, consistent with our existing policy as set forth in the RAI Manual, Chapter 3, Section O (pages O-20 through O-22), as the therapy student is under the direction of the supervising therapist (even if no longer required to be under line-of-sight supervision), the time the student spends with a patient will continue to be billed as if it were the supervising therapist alone providing the therapy.

In other words, the therapy student, for the purpose of billing, is treated as simply an extension of the supervising therapist rather than being counted as an additional practitioner. It should be noted that all policies and definitions related to the type of therapy provided (individual, concurrent, and group) apply to the supervising therapist and therapy student as set forth in the RAI Manual, Chapter 3, Section O (pages O-20 through O-22) even if the student is no longer required to be under line-of-sight supervision.

Here are some tips to help you code therapy once the line-of-site supervision requirement is removed:

- Individual therapy: Code as individual therapy when the therapist or student is treating one resident, while the other is not treating/supervising any other residents/therapy students

- Concurrent therapy:
  - Code as concurrent therapy when the therapist and student are treating one resident each, while not treating/supervising any other residents/therapy students
  - Code as concurrent therapy if the therapist is treating two residents while the student is not treating any residents
  - If the student is treating two residents while the therapist is not treating any residents
- Group therapy: The time for a group session may only be counted if the full group of four participants is being run by either the supervising therapist or the student, while the other may not be supervising any other therapists or treating residents

Q **If a resident has a five-day only and therapy ends, do we need to do a EOT OMRA?**

A An EOT OMRA only needs to be done when all therapy services end and the resident remains on Medicare Part A. The purpose of the EOT OMRA is to switch the resident from the rehab RUG to a new RUG based on the nursing services and other skilled care he or she is receiving. If you are discharging the resident from both therapy and Medicare Part A, you would not need to do an EOT OMRA because you would not need to obtain a new RUG score for Medicare Part A payment.

Q **If a resident is on two or more therapies and misses three days of one therapy but receives five days of another therapy, is an EOT assessment required?**

A An EOT OMRA only needs to be completed when all therapy ceases for three consecutive days. If a resident is still receiving enough of one therapy to qualify for a rehab RUG, even if he or she has missed the other therapies, you would not have to complete an EOT.

Q **If the COT OMRA indicates a reduction in therapy, when does the decreased payment take effect?**

A The new RUG-IV group resulting from the COT OMRA would be billed starting the first day of the COT observation period and would remain at this level until a new assessment is completed that changes the resident's RUG-IV classification.

Q **What tracking tools will be available for COT? Will my software recognize the change?**

A Most software vendors that we have contacted state that they are planning to provide tools to assist with COT tracking in time

for implementation on October 1. Please contact your vendor to determine its approach.

Q In between assessments should I only be looking at days one through seven for the COT changes, or do I need to look for changes every seven days?

A You need to look for changes every seven days. The COT observation period is a rolling seven-day window beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment and ending every seven calendar days thereafter. In cases where the last assessment was an EOT-R, then the COT observation period begins on the resumption date listed in O0450B.

Q Who can sign the MDS to verify Section O, specifically the PT/OT/speech therapy sections for days and minutes? Can a clerical staff member compare what was billed on the therapy database to what was entered on the MDS and then sign? Or does the verification need to be from a therapist?

A The *MDS 3.0 RAI User's Manual* states, "Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response." Although an attorney would need to determine the legalities and associated risk of a clerical staff person signing at Z0400 for the accuracy of the therapy minutes delivered, having a clerical person sign for therapy minutes that they cannot ensure were delivered is not a recommended process or a best practice.

Keep in mind that the person who signs is verifying the accuracy of the minutes delivered, the type of minutes, and the start and stop dates. The question you need to ask yourself before implementing this practice would be, "Can this person attest to the accuracy of therapy delivery without being present?" With all the added emphasis on appropriate therapy delivery, it would be a much better and less risky practice to have the attestation statement signed by the therapist.

Q Would the SNF PPS Non-Therapy Ancillary Payment reimburse for trach supplies, vent supplies, oxygen, and respiratory therapists?

A The *Federal Register* column that you reference, SNF PPS Non-Therapy Ancillary Payment, is a budgetary allocation of dollars rather than a payment category. SNF PPS reimbursement is governed by the RUG-IV categories, and those supplies and services you mention are included in the RUG-IV categories. Each category is an all-inclusive rate with very few exceptions, which are addressed by the consolidated billing rules.

Q Will activities of daily living (ADL) changes affect a COT assessment, or is the COT focusing specifically on therapy services without ADL changes?

A The final rule addresses the relationship between ADLs and the COT OMRA. The purpose (and trigger for completion) of the COT OMRA is to ensure that the patient is placed in the appropriate therapy RUG category based only on minutes of therapy delivered. However, if the patient requires a COT, then ADLs will be captured to classify the resident into the correct RUG category.

Q Is the EOT-R OMRA an optional or required assessment?

A The EOT-R is an optional assessment. If therapy resumes after the completion of an EOT OMRA and the criteria for an EOT-R OMRA are met, the SNF would have the option of performing the EOT-R OMRA and SOT OMRA, or waiting until the next regularly scheduled PPS assessment to assess the resident's condition.

Q Do you monitor each week after the assessment for the COT until the next assessment window? For example, from day 30 to day 60, do you monitor the COT each week?

A Yes. The COT observation period is a rolling seven-day window beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment and ending every seven calendar days thereafter. In cases where the last assessment was an EOT-R, then the COT observation period begins on the resumption date listed in O0450B.

Q Is there a problem if we use the ARD grace days on all the MDS assessments?

A There is no penalty for using grace days on MDS assessments. The *MDS 3.0 RAI User's Manual* states that reasons for using a grace day include illness of the RN assessor, a high volume of assessments due at approximately the same time, or capturing the best payment rate.

Q Do the COT OMRAs follow side by side with the SNF PPS assessments, such as 14-, 30-, 60-, and 90-day assessments?

A The COT OMRAs examine each seven-day interval between SNF PPS assessments and will adhere to a strict schedule. The scheduled Medicare assessments follow the new assessment schedule outlined in the final rule.

Q If a facility does not offer therapy services on a Sunday, do we now have to count Sunday in the three consecutive days for EOT?

A Yes. Effective October 1, an EOT OMRA for a resident in a RUG-IV therapy group would be required if that resident goes three consecutive calendar days without being furnished any therapy services, regardless of whether the facility provides therapy five, six, or seven days a week.

Q **If a resident misses PT for three consecutive days, but receives OT on one of those days, do we need to complete an EOT and a COT?**

A The EOT OMRA would not be required, but effective October 1, 2011, you will be required to determine every week whether it is necessary to complete a COT. For example, let's assume this resident's 14-day Medicare PPS assessment had been completed with an ARD of day 14. In this case, day 21 would become the ARD of a COT, if it is necessary. To determine necessity of this additional assessment, you would calculate whether the minutes received during the assessment window have increased or decreased enough to change the current RUG score. If during that timeframe, from day 15 to day 21, the resident missed PT for three consecutive days, it is very likely that the decreased minutes that were delivered would impact the RUG score thereby making the COT assessment necessary.

Have more questions?

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