Centers for Medicare & Medicaid Services
Skilled Nursing Facility Prospective Payment System Fiscal Year 2012 Policy Changes Relating to the Minimum Data Set Version 3.0 National Provider Call
Moderator: Leah Nguyen
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Introduction

Leah Nguyen: Hello, I am Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to the Skilled Nursing Facility Prospective Payment System Fiscal Year 2012 Policy Changes Relating to the Minimum Data Set Version 3.0 National Provider Call.

Subject matter experts will discuss new MDS 3.0 policy that will be implemented on October 1, 2011. A question and answer session will follow the presentation. At the end of the presentation we will open up the phone lines to give you an opportunity to ask questions of our subject matter experts.

Before we get started, there are few items that I need to cover. There is a slide presentation for this call. If you have not already done so, this presentation may be downloaded now from the SNF PPS website located at www.cms.gov/snfpps. At the left side of the web page, click on Fiscal Year 2012 RUG-IV Training and Education and scroll down the page to the Downloads section. Also, this call is being recorded and transcribed.

We have a lot to cover today, so without further delay, we will get started.

At this time, I would like to introduce Sheila Lambowitz, Director of the Division of Institutional Post Acute Care. I will now turn the call over to Ms. Lambowitz.

Sheila Lambowitz: Thank you very much. Thanks everybody, I really appreciate your participating in this call I think we're going to have a busy afternoon. We've gotten a lot of questions from you in advance. We're going to try to answer as many as we can during the session. Those that we can't, we will be posting on our website and continuing to distribute information so that this is only the first of the training sessions that will be available.

I want to turn this over now without too much of my talking to the people who developed and will be presenting the material, Jeanette Kranacs is our Deputy Director for the Division of Institutional Post Acute Care. Penny Gershman is our clinical specialist; John Kane is our SNF analyst and between them, they're going to go through all the materials and hopefully answer some of your questions. Jeanette.

Jeanette Kranacs: Thank you, Sheila. I did want to thank everybody for coming today and participating in our first training opportunity. Because of the overwhelming demand of this call we have arranged additional outlets for training. One that I wanted to make them aware of is that the regularly scheduled SNF Long-Term Care Open Door Forum on September the 1st, has been changed to be a Special Open Door Forum to provide a training opportunity during that call. We've extended that one hour so the call will now be from 2:00 to 4:00 p.m., and we will extend the encore availability of that call to allow additional time to secure the training material.

That training session will pretty much reflect the exact same material that we're going to present here today, and we'll give the same slides, so if you participate in today's call that will be a repeat for you.

In addition to that call as Sheila mentioned we're putting additional information on the SNF PPS website and right now that consist of the slides available for these training opportunities and we will be developing what we're going to call clarifications memos.

We've received a lot of questions and comments and we've tried to incorporate some of the broader context into these training slides. However, there will maybe some additional questions or some more detail answers that you want and those will be included in a clarifications document that we'll post after we get additional questions today.

So with that being said, I am going to turn it over to our two presenters and our presenter will be Penny Gershman.

Slides 1 thru 34

Penny Gershman: Thanks, Jeanette. I will now go through the agenda for today's call. You can follow along with the slides, and I am going to start on slide two. Today, we will be talking about the new MDS assessment schedule, the allocation of group therapy minutes, to revised student supervision provision, to End of Therapy OMRA and new resumption items and the new PPS assessment for the Change of Therapy OMRA or the COT OMRA.

Moving on to slide three, in the past, the MDS assessment schedule allows for significant duplication of information gathered during overlap in book fact period.

We decided to change the MDS assessment schedule in order to more appropriately capture the changes in the patients' statuses. Therefore we've modified the current MDS assessment schedule. As outlined on slide three, beginning in Fiscal Year 2012, facilities must use the updated MDS assessment schedule for setting the adjustment reference date for scheduled PPS assessments.

The new schedule will be effective for all assessments where ARDs fall on or after October 1, 2011.

Moving on to slide four, as we can see for the exception of the five-day assessment, all ARD windows and grace days have been modified. We recognized that some duplication of information still exists. But the new schedule will alleviate a fair amount of this.

I'm going to skip to slide six now. For assessments with an ARD set for on or after October 1, 2011, the ARD must be in compliance with the revised MDS assessment schedule. Otherwise early or late assessment penalties may apply.

For example, if the ARD for a 14-day assessment is set for October 1, 2011, and this date is equivalent to Day 19 of the resident's stay, then the late assessment penalty will apply and the facility must bill the default RUG for Days 15 through 18.

Another example, if the ARD for 14-day assessment is set for October 1, 2011, and this date is equivalent to Day 12 of the resident's stay, which should be one day early, an early assessment penalty will apply and the facility must bill the default RUG the first day of the next payment period, which is Day 15.

In general moving back to slide five, when October 1, 2011, is Day 19, 34, 64, or 94 of the Medicare Part A SNF stay, assessments should be completed by

September 30th, or the assessments will be considered late and payment penalties will apply.

And now I would like to offer some guidance on combining scheduled and unscheduled assessment. We're moving to slide seven. This policy is outlined in the "Medicare Claims Processing Manual" and it's found in Chapters Two and Six of the updated "RAI Manual," which will available in September.

If the ARD for an unscheduled PPS assessment falls within the ARD window including grace days of a scheduled PPS assessment and the scheduled assessment has not yet been completed, then the assessments must be combined. If the ARD for a COT OMRA is Day 14 of a resident's stay and the 14-day scheduled PPS assessment has not yet been completed, then the assessments must be combined and facilities should use the appropriate AI code to indicate the combined assessment.

Moving on to slide eight. When combining the assessment the Item Set for the scheduled assessment should be used, when combining scheduled and unscheduled assessments.

The ARD for the combined assessment is what would have been used for the ARD for the unscheduled assessment.

Moving on we'll now talk about Group Therapy Allocation. Included in this discussion will be the modified definition of group therapy, the allocation of group therapy minutes and clarification of documentation requirements. Later on in the training, we'll discuss how to bill for group therapy with student supervision.

Moving to slide 10. In order to code minutes of group therapy for a patient group covered under Medicare Part A. Group therapy will be defined as therapy provided simultaneously to four patients regardless of payer source who are performing the same or similar activities.

Facilities must plan group therapy sessions to include no more or less than four participants.

We chose four because larger than four group – larger groups than four make it difficult to manage all of the patients effectively. Smaller groups limit the ability of patients to interact and learn collectively.

I'm on slide 11 now. We've received this upcoming question in both rule comments and after the final rule publication. Many providers have asked, what happens if one of the participants gets sick or refuses to show up for group therapy session?

Our response is that as long as the facility had originally planned the session for four participants, then the group session can still be counted for the other group members. However, the minutes in this case will still be divided by four for each remaining participant..

This new policy will be implemented as follows : effective for assessments with an ARD set on or after October 1, 2011, all group time reported on the MDS will be divided by four when determining each resident's appropriate RUG classification. In other words, unallocated group time reported on the MDS 3.0 is divided by four by the RUG-IV Grouper and used for RUG Classification.

Here is an example of group therapy allocation and I am on slide 13 now. Four residents in SNF X participate in a group session for a total of 60 minutes. Facility records 60 minutes of group therapy for each resident on each MDS. The unallocated group time is divided by four by the RUG-IV grouper. Allocated group therapy minutes, which is 15 minutes, are then used to determine each patient's RUG classification.

Another commonly asked question which we received is, does the group therapy cap, which is the resident's group minutes cannot constitute more than 25 percent of his/her total therapy time, still apply?

And the answer is that the cap will still apply and will apply to the patient's reimbursable therapy minutes after allocation.

Moving on to slide 15, in our final rule, we reiterated our documentation expectations. Specifically we're talking about modes of therapy use. SNFs

must ensure that patient care follows a prescribed and documented plan of care. And you can find the relevant regulatory guidance which we talks about documentation in Federal Regulations Section 409.23 and Section 409.17.

Moving on to slide 16, this means the documentation in patient's medical record should be sufficient to justify plan of care and to identify potential changes in patient's medical condition. Skilled services, particularly therapy services, should be properly tailored to the individualized goals of the patient.

Specifically for group therapy and other modes of therapy it's expected that the medical record and the plan of care should include descriptions of prescribed therapy modes, for example individual, concurrent or group.

Disciplines used, OT, PT, or speech, the rationale for particular therapy regimen, and who is providing the therapy whether that would be a therapist a therapy assistant or student. Remember, patients are individuals and as such it is vital to keep adequate records.

Facilities may wish to considered time stamping as well, at start and end of therapy sessions as well, in order to more appropriately document and show the time that is being spent in therapy.

Another policy change that we have made will affect therapy student supervision and I am on slide 18 now. Effective October 1, 2011, students are no longer required to be under the line-of-sight supervision of a therapist or therapy assistant. However the SNF's supervising therapists and assistants are expected to exercise their own judgment regarding the level of supervision a particular student may require.

I'm on slide 19 now. The therapy associations, APTA, AOTA, and ASHA, have provided recommendations on student supervision guidelines and their guidance is available on the SNF PPS website at www.cms.gov/SNFPPS/Spotlight.

One commonly asked question that we have gotten is, how to bill when supervising a student? We want to remind everybody that for billing purposes, the student is considered an extension of the therapist.

Specifically, in order to code for individual therapy a therapist or student is treating one resident while the other is not treating or supervising any other residents for therapist, then you may code as individual therapy.

I am on slide 22 now. In order to code as concurrent therapy in the MDS, there are three ways to do so when a student is involved. You may code as concurrent therapy when the therapists and student are treating one resident each who are performing different activities while not treating or supervising any other residents or therapists.

Or, code as concurrent therapy, if the therapist his/her self is treating two residents doing different activities while the student is not treating any residents or if the student is treating two residents or doing different activities while the therapist is not treating any residents.

Moving on to slide 24, in order to code as 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 therapists or assistants or the students, while the other may not be supervising any other therapists or treating residents.

If a supervising therapist treats four residents doing the same activity; while the student does not treat any residents then the group minutes may be counted. Consequently the student may treat four residents while the supervisor is not treating any other residents or supervising any other students and this time may be counted as group therapy.

We're on slide 25 now. The question we have been asked, can a supervising therapist be supervising other patients or students while his/her student is conducting the group session?

And as said before, no. Consistent with current policy, the supervising therapist may not be supervising any other patients or students at that time.

I am on slide 26 now. The questions is, can the supervising therapist bill for a group therapy session in cases where the supervising therapist is treating two

patients while the therapy student simultaneously treats two patients, all of whom are doing the same activity?

And the answer to this is, no. A group therapy session must be one single planned session involving four participants working together on the same or similar activities.

And now you can all enjoy a little pop quiz. I will read the questions and then pause for a second or two for you to think about the response.

This is a question on student supervision. True or false. Starting October 1, 2011, all students should provide therapy outside of line-of-sight supervision regardless of training or qualification?

And the answer is false. While line-of-sight supervision is no longer required, providers must still exercise discretion over which students are prepared to operate independently.

The next question, we're on slide 29 now. This question is about group therapy allocation. SNF X plans a group therapy session for four residents. Ten minutes into the session, one of the residents becomes ill and must return to his room. In order for the group session to count for the other three patients, the facility should: A, move the session to the sick patient's room. B, return the patients to their rooms. With three people, the session will not count no matter what the facility does. C, since the session was originally planned for four participants, the facility can continue with the session and the minutes will count for the remaining participants. D, force the sick resident to participate.

And the answer to this question is C. Since the session was originally planned for four participants, the facility can continue with the session and the minutes will count for the remaining participants.

And once again please note that the therapy time will still be divided by four.

Moving on to slide 31, the third question in the pop quiz. True or false. On or after October 1, 2011, SNFs will be given the opportunity to choose whether to use the old or new MDS assessment schedule.

And the answer is false. Effective for assessments where the assessment reference date is set on or after October 1, 2011, all SNFs must follow the revised MDS assessment schedule.

Question four involves student supervision. What type of therapy should be billed for each patient in following situations?

If a therapy student treats Mr. B while the supervising therapist treats Ms. M doing a different activities. What mode of therapy should be coded?

And the answer in that situation is concurrent therapy.

The next one. Supervising therapist treats Mr. E while the student does not treat any patients?

This should be coded as individual therapy.

And the final question. The supervising therapist treats Ms. P and Mr. T while his therapy student treats Ms. L and Mr. H, all of whom are doing the same activity.

In this case none of the therapies should be coded. It's inconsistent with all therapy definition.

Slides 35 thru 58

John Kane: Thank you very much everyone for participating on today's call. I'll be taking you through the rest of today's presentation. Beginning with the End of Therapy, or EOT OMRA.

On slide 35, we will cover three topics in our discussion of the EOT OMRA, specifically a clarification of the Three Day Policy related to setting the ARD for an EOT OMRA. A clarification on when it is appropriate to issue an Advance Beneficiary Notice or ABN to SNF resident. And we will discuss a

new section item on the EOT OMRA which permits the facility to resume a therapy program after therapy has been discontinued.

First, let's start the Three Day Policy. As outlined on slide 36, the Three Day Policy is a way that the health facility can be determine if an EOT OMRA is necessary and how the ARD for the EOT OMRA must be set. As discussed on page 26389 of the FY 12 SNF PPS proposed rule, an EOT OMRA must be completed in all cases when a beneficiary classified into a RUG-IV Rehabilitation Plus Extensive or Rehab Group did not receive any therapy services for three or more consecutive calendar days.

We refer to this period when the patient did not receive any therapy services as a discontinuation of therapy services. First, discontinuations may be planned, that is if the facility has anticipated and expected that the beneficiary would not receive therapy services during that period or unplanned, that is if the facilities do not expect the discontinuation.

It is important to note that no matter if discontinuation of therapy services was planned or unplanned an EOT OMRA must be completed if the discontinuation persists for three or more consecutive calendar days. We would also note that the discontinuation applies to any calendar day of a patient stay for all facilities whether it is a weekday, weekend or holiday.

In order to set the ARD for EOT OMRA, the facility should set the ARD for day one, two, or three from the date of the patient last therapy session. In other words, if a patient's last therapy session occurred on Wednesday, then the ARD for the EOT OMRA may be set on Thursday, Friday or Saturday of that week.

Moving to slide 37. We'll now discuss issuing an ABN to SNF resident. We received the number of questions regarding how this Three Day Policy relates to issuing the resident an Advance Beneficiary Notice or ABN. Specifically, this question arises for residents who are not receiving any skilled services beyond therapy services and would therefore be at risk of having the Medicare part A coverage of their SNF stay dropped if the therapy services are discontinued.

On slide 37, we posed the question, if the only skilled service a patient is receiving is therapy-related and the patient does not receive any therapy for three consecutive calendar days, it is the facility always required to issue the patients an ABN.

As you will note on slide 38, the answer is no. An EOT OMRA, even in these circumstances, does not necessarily mean that a patient will lose Part A coverage of their SNF stay. Instead, the SNF ABN is intended to give the beneficiary a reasonable amount of time to make a decision regarding their care based on the provider's belief that Medicare will not cover the stay. A case where an ABN would not likely be necessary is it's indicated that resident therapy is discontinued but resumes four days later. In such a case, the patient would not necessarily be dropped from Part A coverage and the provider would not necessarily need to issue the resident an ABN.

We've also received similar questions about issuing a Notice of Medicare Non-Coverage, or NOMNC, which is noted on slide 39, is not issued when the care ends based on beneficiary initiative or for provider business reasons. We hope these two clarifications address many of the questions we've been receiving on these issues.

The final topic related to the EOT OMRA is the new item that have been added to the EOT OMRA specifically item O0450A and O0450B which allow providers to resume a therapy program that has been discontinued for no more than five consecutive calendar days.

As noted on slide 40, we would like to highlight and stress that the EOT-R is not a new PPS assessment. The EOT-R refers to a subset of items that maybe completed on the EOT OMRA to indicate that the discontinued therapy plan will be resumed and the payment at the previous therapy RUG may resume when the therapy resumes.

As previously stated, the resumption of the therapy can occur no more than five days after the last day of therapy provided. For example, the resident receives his last therapy intervention on Monday, then the last day that the resident is eligible to resume therapy at the previous level is Saturday. This

policy is discussed in greater detail in the "MDS RAI Manual" and beginning on page 26390 of the FY 2012 proposed rule.

Basically, an EOT-R may be used in cases when the resident will resume therapy at the same therapy level as prior to the discontinuation of therapy. If the provider is unsure if this is possible or is sure that the resident will be unable to resume his previous therapy regime, then the provider must complete an EOT OMRA and then may choose to complete a new therapy evaluation and unscheduled assessment such as an SOT OMRA or wait until the next scheduled PPS assessment to classify the patient back into a therapy RUG.

Also as noted on slide 40, this policy will be effective for all EOT OMRA assessment with an ARD on or after October 1, 2011. In other words, if the ARD for the EOT OMRA is not set for on or after October 1, 2011, then the provider may not choose to complete the EOT-R item and resume therapy.

In terms of actually completing the EOT-R item on EOT OMRA, it will depend on whether or not the EOT OMRA without the resumption item still in has been accepted into QIES ASAP system.

Slide 41 discusses what to do in cases when the EOT OMRA has not yet been accepted in QIES ASAP system. In such cases, the provider can simply go ahead and collect and code the EOT-R item and submit the assessment.

Slide 42 discusses what to do if the EOT OMRA without the EOT-R items completed has already been accepted into the QIES ASAP system. In this case the provider would submit a modification request for the EOT OMRA and change only the EOT-R item in section O, and modify item X0900E to indicate that the reason for modification is the addition of the resumption of the therapy date.

As always, I have to discuss some policy changes related to the EOT OMRA. So, there will be a question and answer period to follow the formal presentation and see through any additional questions or concerns.

We will now discuss a new PPS assessment that has being implemented in FY 2012, the Change of Therapy or COT OMRA. We will discuss a variety of topics related to the COT OMRA. Those listed on slide 43. We will discuss a variety of topics related to COT OMRA such as when a COT OMRA must be completed, how a COT OMRA will affect provider billing, and some clarifications of the COT OMRA policy based on questions we received prior to the call.

The purpose of the COT OMRA is to capture change and then provision of therapy services to SNF residents outside the standard observation period associated with a scheduled PPS assessment. In other words, the COT OMRA is designed to highlight when the therapy provided to a resident in a given week is not reflective of the therapy the patient should be receiving given the RUG-IV therapy level into which the patient is currently classified.

As a formal definition, a COT OMRA must be completed for residents receiving any amounts of skilled therapy services. If a therapy received by the resident during the COT observation period does not reflect the RUG-IV classification level on the patient's most recent PPS assessment used for payment. Now, there are clearly some terms and jargon in that definition that should be explained further which I will go over now.

The COT observation period refers to a successive seven-day window beginning the day following, the ARD of the resident's last PPS assessment used for payment. For example, when a provider were to assess the ARD for a resident 14-day assessment on Day 14, then the COT observation period will begin on Day 15, and end on Day 21 assuming no intervening assessment.

If there were intervening assessment whether it would be a scheduled or unscheduled PPS assessment, then the COT observation period will be reset based on the ARD of the intervening assessment. We say successive windows because the possibility of the COT OMRA must be considered every seven days for patients receiving any amount of skilled therapy services.

If during a given week, the patient received any amount of skilled therapy appropriate to their determined therapy level, then the provider need not

complete the COT OMRA at that time and we instead begin considering therapy provided in the following or succeeding week.

As noted by the asterisk on slide 44. I should point out that the COT observation period begin on the day following the ARD of the last PPS assessment used for payment except in cases where the previous assessment is an EOT OMRA with the resumption items completed. In such cases, the COT observation period begins on the resumption date listed in item O0450B on the EOT OMRA.

Finally, I would point out that the COT OMRA policy becomes effective for assessment with an ARD on or after October 1, 2011. For example, if the ARD for a resident's 30-day assessment is set for October 1, 2011, then the COT observation period begins October 2, of 2011, and would end on October 8, 2011, assuming no intervening assessment.

Moving to slide 45. The definition also refers to therapy not being reflective of the patient's RUG-IV classification. But, what exactly does this mean. In other words, how should a facility determine if a COT OMRA must be completed? As we discuss on slide 45, provider should perform an informal change of therapy evaluation to consider whether or not the intensity of the therapy services provided to the resident during the COT observation period change significantly.

We say that this is an informal evaluation because there is no paper required for this evaluation. Providers are free to decide for themselves what process they feel is most appropriate to determine the need for a COT OMRA. However, considering changes to the intensity of therapy, providers must consider changes to all therapy category qualifying conditions, such as total Reimbursable Therapy Minutes, or RTM, number of days therapy was provided or the number of therapy disciplines.

Just to clarify, the term Reimbursable Therapy Minutes, or RTM, refers to the minutes used to determine the resident's RUG-IV classification. Effectively, a patient's RTM are his/her individual therapy minutes plus allocated concurrent or allocated group therapy minutes. So, providers must determine

if changes in the intensity of therapy has just described would cause the residents to be classified into a different RUG-IV category. However, what do we mean by RUG-IV categories.

The categories we referring to are listed on slide 46. As noted earlier, a COT OMRA is necessary if the therapy received during the COT observation period would be sufficient for a patient to be classified into a different RUG-IV category. Therefore, if the patient's RUG-IV category would not change, then a COT OMRA would not need to be completed.

For example, if a resident is classified into rehabilitation, very high, and his RTM were to increase from 510 minutes on the previous assessment to 600 minutes during the COT observation period assuming all else is equal, then a COT OMRA would be not required as the resident's RTM is still reflective of the RTM necessary for classification in rehabilitation, very high.

In terms of billing and payment as noted on slide 47, the COT OMRA establishes a new RUG and new payment retroactively back to the beginning of the COT observation period for which the COT OMRA was completed and continues until the next scheduled or unscheduled PPS assessment. So, in terms of billing and payment, I'm going to repeat a little bit. In terms of billing and payment as noted on slide 47, the COT OMRA establishes a new RUG and new payment retroactively back to the beginning of the COT observation period for which the COT OMRA was completed and continues until the next scheduled or unscheduled PPS assessment.

For example, if the resident's last assessment had an ARD of Day 32, the COT observation period would begin on Day 33. If at the end the COT period observation period, which in this case will be Day 39, the provider were to determine that a COT OMRA was necessary. Then a COT OMRA would be completed and the new drug payment resulting from the COT OMRA would be billed from Day 33 and forward until the next scheduled or unscheduled PPS assessment.

Moving to slide 48, providers should consider the following the questions when determining if a COT OMRA may be necessary. First, providers should

consider whether or not the resident is receiving any skilled therapy services. If the answer is no, then no COT OMRA would be required. If the answer is yes, then provide should consider whether or not the therapy provided to that resident during the COT observation period was consistent with the patient's current RUG-IV classification.

For example, if the patient was classified into category rehabilitation high, then the resident received between 325 and 499 reimbursable therapy minutes during that week and was at least one rehabilitation discipline provided for five days during that week. If the answer yes, then no COT OMRA is required. If the answer is no, either it's the number of RTM or the number of days of each therapy discipline was provided then a COT OMRA would be necessary and the new RUG will be billed from the first day of the relevant COT observation period.

Let's now put everything together and consider the example on slide 49. This example illustrates well the concept of the successive COT observation period. In this example, a resident 30-day assessment is completed with an ARD set for Day 30 of the resident's set. On Day 37, which is day seven of the COT observation period, the provider evaluates the resident's therapy over the past week and determines that no COT OMRA is necessary.

The next COT observation period begins on Day 38 and ends on Day 44. On Day 44, the provider determines that a COT OMRA is necessary perhaps because the resident RTM was higher and that appropriates to the resident's current RUG category. A COT OMRA is completed and the provider begins billing the new RUG beginning on Day 38 and continuing until the next scheduled or unscheduled PPS assessment, which may itself be a subsequent COT OMRA that can be required seven days later.

In preparation for this training call, we received a number of questions related to residents who might index maximize into a non-therapy RUG group even though they are receiving skilled therapy services. To be clear, when we use the term, index maximize, we mean a case where residents meets the qualifying criteria for both a therapy and non-therapy RUG and the per diem

payment for the non-therapy RUG is higher than the per diem payment for the therapy RUG.

For example, if a patient in an urban facility is simultaneously qualified for both HE2 which is – with FY 2012 per diem payment of approximately $397 and RHB with a FY 2012 per diem of approximately $376 then the facility would bill for HE2. As noted on slide 50, even if a resident index maximizes into a non-therapy RUG, providers must still perform a change of therapy evaluation which is to consider the potential necessity of a COT OMRA so long as the patient is still receiving skilled therapy services.

Put plainly, a COT OMRA should be considered for any patient receiving any amount of skilled therapy services no matter what RUG group that might – they might classify into for billing purposes.

However, as noted on slide 51, a COT OMRA is only required in such cases that changes in the intensity of the therapy provided to the resident during a COT observation period are such that it would change the resident's RUG category into a say index maximize.

Consider the two examples on slide 51. In the first case, a COT OMRA is not required because even though there are changes in intensity of therapy that resident receive that would impact on a resident therapy RUG category. The resident's RUG classification in terms of index maximizing remains unchanged.

In contrast, in the second example on slide 51, a COT OMRA would be required because the changes in the intensity of therapy provided to the resident during the COT observation period are sufficient to change both the resident therapy RUG category and the resident RUG classification used for billing.

Ultimately, the requirement to complete the COT OMRA comes down to two questions. First, is the resident receiving skilled therapy services? Second, if so, did the intensity of the resident's therapy change during the COT observation period to such an extent that the therapy received is not reflective

of the resident's current therapy RUG category and would cause a change in the patient's index maximized RUG classification.

If the answer to these questions is yes, then a COT OMRA is required. If not, then no COT OMRA is required. We hope that this discussion clarifies both the intent and operation of the COT OMRA and illustrates the limited circumstances in which this assessment much be completed.

In the final few moments of our formal presentation, I want to discuss the transition to FY 2012 billing. As noted in slide 52, providers can expect to receive the following information in preparation for the transition into FY 2012 on October 1st. If the billing period is split between FY 2011 and FY 2012, then both FY 11 RUG-IV and FY 12 RUG-IV groups will be needed to establish payment for the entire billing period.

On or around September 18, the system will be upgraded to calculate both the FY11 RUG-IV and FY 12 RUG-IV groups for assessments with ARDs between August 22nd, and October 31st. The validation reports associated with these assessments will reflect both RUG groups. For FY 2011, the FY 12 RUG group will be shown in error message number 1059. For FY2012, the FY11 RUG group will be shown in error message number 1060.

That brings us to the end of the formal presentation. And to solidify in your mind the clarifications and policy definitions we've just discussed, we have another pop quiz.

Consider question five on slide 53. In this situation Mr. E is currently classified into RUG-IV group RHB. He received therapy Monday through Friday and is not scheduled to receive therapy that weekend. On the following Monday, Mr. E. refuses therapy due to a family visit. The question is should the facility complete an EOT OMRA for Mr. E?

The answer is A, yes. Since Mr. E did not receive three consecutive calendar days of therapy an EOT OMRA would be required for this resident.

The next question is a bit harder. Question six, Mr. T receives enough skilled therapy services to qualify for RHC but, due to his medical condition, he index maximizes into group HE2.

Question, is the facility required to evaluate whether a COT OMRA is necessary?

The answer to this question is also yes, choice C. This might seem confusing with what we just talked. But, remember the change of therapy evaluation must be done for all patients receiving any amount of skilled therapy services. This doesn't mean however, that the COT OMRA would be necessary – would necessarily have to be completed. This is an important distinction that providers should keep in mind to not have mistakenly skip a required COT OMRA or mistakenly complete the COT OMRA that was unnecessary.

Perhaps the hardest question of them all, question seven. Is it true or false that you have had enough pop quiz questions? As we say on slide 57, we both know the answer is false, but we will move on any way.

Before we jump into the Q&A portion of the call, I just want to take a moment to highlight other training resources available to you. First, we're hosting a special SNF/LTC open door forum on September 1st. I realize that this is basically the potential resource here. But, we would have that those of you who are fortunate enough to be able to be on the line today, please refrain from calling in to the ODF on September 1st. We have a limited number of lines and we plan on using that ODF as a repeat performance of this training call for those individuals who are unable to participate with us today and we appreciate your understanding on that.

There are also other training resources which may be found on the MDS 3.0 website with the address given on slide 58. Also, we encourage interested parties to review additional training resources on the QTSO website which may be found at www.qtso.com or the SNF PPS website and training page which may be found at the address on slide 58.

That is all the formal comments and I'll turn the call back over to Sheila Lambowitz.

Sheila Lambowitz: Thank you very much John. Thanks also to Penny and Jeanette. All right, we're ready to accept questions. I'm sure you have some. So, if you can just give the instructions on how to get into the question queue.

Question and Answer Session

Leah Nguyen: Thank you, Sheila. We have now completed the presentation portion of this call and we will move on to the question and answer session. Before we begin, I would like to remind everyone this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get as many as your questions as possible, we ask that you to limit your questions to just one.

Carol Ramsey: Hi this is Carol Ramsey for Pinnacle Healthcare in Oregon. I have a question on combining the COT OMRA with the 14-day. If the five-day you picked day six and so your change of therapy OMRA evaluation will be due on Day 13 and you complete it, do you combine it with the 14-day and that backs up any change in RUGs to day seven or is that an incorrect assumption?

John Kane: If your five-day were set for day six and the COT observation period would end on Day 13 and you had not completed your 14-day then you would have combine the COT and the 14-day with an ARD of Day 13 and if it – and that's assuming that the COT OMRA will be necessary. If the COT OMRA were necessary then that payment would go back to day seven, yes.

Charlene Keaton: I'm from Manistee County Medical Care in Michigan. My question is on our MDS, when we have to put in the date of discharge from therapy. We put in the day after the last date of therapy but our billers are seeing that as incorrect. On the billing side, it showing the actual last day of therapy, which one should it be because this is going to be real important with starting and stopping therapy.

Sheila Lambowitz: I don't think we have anyone from our billing area here. But, it's a really good question. We'll get an answer and we'll get it posted just as soon as possible.

Charlene Keaton: OK. Can I ask another question then?

Sheila Lambowitz: Sure.

Charlene Keaton: OK. On slide 40, the end of therapy resumption can be used when the resident resume at the same level as prior. How we are going to know this if they are going to come back into the same levels? I mean are you talking the same RUG level or what do you – what do you mean by that?

Penny Gershman: Based on your clinical knowledge, if you can tell that – Jeanette.

Jeanette Kranacs: I think at certain instances such as the examples that we given here where therapy wasn't provided over the weekend and on Monday, the patient refused therapy. There are probably no indication in your mind for most of those situation that there was any clinical change in the person's status that would require them to be in a different therapy level than what they were in prior to those three days. I think that's probably going to be the case in most situations. You should do an evaluation of the patient – not a formal evaluation - to determine whether or not there were clinical changes that resulted in that missed therapy. In situations where the clinical change, such as somebody fell and got hurt and wasn't able to participate for three days, that maybe a situation where we actually need to do a formal evaluation to determine what's RUG level they go back into.

Linda Jones: We are from Trinity. My name is Linda Jones and we would like to know when we will get the assessment indicators for the billing?

Penny Gershman: I think we have processed them. We'll have to double check actually when they'll be released. Are they in the manual?

Sheila Lambowitz: They're in the manual. They're part of the specification. We can post them separately on our website in next few days.

Bob Godbout: They are posted in the Grouper package.

Sheila Lambowitz: OK. They're already posted in the Grouper package. If you are not familiar with that, someone at your facility who does some of your IT work or your vendor should be able to open the Grouper package and pull those codes

for you.

Bob Godbout: Yes, this is separate document that gives you second digit, the AI codes for the EOT-R and the COT and it's also in the computer code if you want to read that.

Linda Jones: Do you have anything on the website.

Bob Godbout: It's in the Grouper package, RUG-IV v1.01.

Shelia Lambowitz: Right, it's on a website. It's not the part of the website that clinicians usually use.

Bob Godbout: It's a technical information page off the MDS 3.0 main page.

Linda Jones: So, is it on CMS' website.

Sheila Lambowitz: Why don't you send in an e-mail. You can send it me at Sheila.lambowitz@cms.hhs.gov and I will ask one of our staff people to actually pull that and send it to you and we will put it on our website for those of you who need it.

Debbie Malaforina: We are from Fort Collins, Colorado and our question relates to whether or not, if a person misses their three days of therapy and they don't participate on Monday, do we give them an end of therapy notice and charge them private pay if they don't quality in the skilled nursing category.

Sheila Lambowitz: We did address that in the rule and I suggest that first thing you do is go back and look at that. John did you have any thing you wanted to add?

John Kane: I believe it has a little bit more clarification in the MDS Manual. But, it hasn't talked about in this slide and I need to look back to see exactly which slide talks about it. But, if the person has missed therapy for three days and they are going to resume - if they had missed Friday, Saturday and Sunday and we're going to resume on Monday, then the ABN wouldn't necessarily need to be issued and it's important to remember the intent of the ABN which is to provide the beneficiary with reasonable amount of time to know or to make an

informed decision on whether or not they will continue if Medicare were not to cover the stay. So, again not all cases when a person ends therapy and that is there only skilled service would an ABN need to be issued.

Sheila Lambowitz: This is Sheila again, we are working with our ABN staff and we'll try to get as much clarification as possible. But, the crux of the matter is that there is a lot of judgment involved here and each patient is a little bit different. There is nothing that says that because patient A has not had therapy for more than 48 hours that you have to discontinue Medicare coverage. There is a lot more to it. We'll continue to post things to help you understand the process. So, just keep watching the website and your other avenues of information. We'll get you more.

Lin Gravel: This is from May Veterans Homes. I just wanted to double-check on when you count a day of therapy. Is it 15 minutes or more or therapy is like for 10 minutes, does that count in that three day of this therapy that you're discussing.

Penny Gershman: This is Penny. I'm assuming that you are talking about when determining whether an EOT OMRA has to be completed and a day of therapy is considered 15 minutes, no less than that.

Glenda: Hello, this is Glenda from Woodbine. My question for John is when I'm looking at slide 46 and slide 50, I'm very confused because if the patient runs into a non-rehab RUG and you're using the index maximization. What would be the priority for you there? What would be the determination for you to do a COT there because when you look at slide 46, it's telling you what the RUG categories are but then when you reading slide 50, it's tells you to look at both the RUG category and the maximization. So, which one would you do?

John Kane: You would look to see if the person, again, the questions that were laid out that if the therapy category were to changed. If they are, therapy qualifiers will change such that the therapy category will change and it would have made a difference in index maximizing to non-therapy RUG. So, for example, if you use the example that's in the slide. If the person was in LE2 and they move from rehab medium to rehab low, if the person still index maximizes

intoLE2, then the COT OMRA would not be required. So, it is actually considering both of those things at the same time.

Glenda: In other words you're going to be looking at what is maximized and also looking at how many minutes?

John Kane: You mean looking at how much time of therapy we provided as well as other therapy qualifiers but also looking at for those few cases where a patient might index maximize into a non-therapy RUG.

Dave Bantalino: Yes, this is Dave Bantalino from Cedar and Bar Lake Richmond, Virginia. Can you let us know how we can view the slides so we can print off, what you guys were talking about.

Sheila Lambowitz: Yes, I'm not sure why there was an issue or if it had anything to do with some of the technical difficulties we've had here. But, we'll check that once we can get back to our desk and make sure that the links are working.

Jeanette Kranacs: You might want to try it again to. I know for a few minutes whenour BlackBerries and phones weren't working. So, it may have affected our computer capability. but, it looks like everything is back online now.

Dave Bantalino: Just to make sure between the SNF PPS/02, is there an underline between that and Spotlight.

Leah Nguyen: Let me give you that. You can see that on SNF PPS website at www.cms.gov/snfpps. And then on the left side of the web page, you want to click on FY 2012 RUG-IV Training and Education and the presentation is in the Download section of that page.

Andrea Wright: Hi, my name is Andrea Wright from Bethel Healthcare Center. I have a variation on the first question. If there are less than seven days between the five-day scheduled PPS and the 14-day scheduled PPS. Do you still then need to do a combined 14-day and COT if the RUG level is lower than the five-day?

John Kane: If you have not – the important thing to remember here if you have not yet completed the scheduled assessment. So, for example if you have done your five-day late in the assessment, you're going to negate that. And you completed the scheduled assessment prior to the end of the COT observation period then you would not need to combine it. You can just do that standalone scheduled assessment and you would actually reset the COT observation period.

If however, you have not done the – if you have not done your scheduled assessment at that point, then you would need to combine the two assessments again, if the COT was necessary.

Andrea Wright: So, essentially, then if you do your 14-day assessment before the seven day look back has – seven day COT is due then there is, you don't potentially have a change in the reimbursement rate on Day nine if there is a change in RUG level between the five-day and the 14-day assessment.

John Kane: Right. If you do the 14-day on Day 13, then the COT observation period will begin at that point which starts on Day 14 and goes until Day 20.

Andrea Wright: OK. Can I ask just one other real quick question about group therapy since 15 minutes is a minimal for a day, if a group of four people is less 15 minutes, let's say it ends up being a 30 minute group, then the minutes that will go towards the PPS calculation will be less than 15 minutes. Does that still count for the day?

Penny Gershman: It counts for the day because you are coding it as 30 minutes on the MDS. It just that the grouper will then allocate the money- the minutes, excuse me.

Andrea Wright: And then, on the example that you gave where the person was sick after 10 minutes. I would assume you would still put the 10 minutes in as group time provided they could have had some other treatment during the day as well.

Penny Gershman: Yes, that's correct.

Jeff Hadley: Hi there. We are trying clarify something on Change of Therapy assessment is done in first six days of a calendar month, it will affect payment for the prior month, correct?

John Kane: The COT OMRA does affect payment retroactively. So, it's possible that would go back to a prior month, yes.

Jeff Hadley: I thought so. Is that also the case for September days, if there is a COT OMRA done October 1st through six, will also affect the September days?

John Kane: Because of the way that the COT OMRA transition policy has been operationalized, the earliest that the COT OMRA observation period could begin is October 2nd, because it begins for assessments that have an ARD of October 1st. So, the earliest that you would need to evaluate for COT will be October 8th. Payment could only go back to October 2nd.

Rusty Smith: Yes, hello my name is Rusty Smith, Louisville Rehab. My question is regarding the documentation supporting the group therapy mode of delivery. Is justification required on both the therapy plan of care for 700, 701 and also on the resident's care plan and what would an example of that type of clinical justification be?

Penny Gershman: A type of justification would just be that the resident required group therapy or concurrent therapy to meet this in the goal and the resident would benefit from the group, concurrent, or individual therapy because and so forth and so on. Something like that.

Sheila Lambowitz: Basically, it's the standard documentation that you have to specify what your objectives are and how you are organizing your modalities in order to meet those objective. So, this is basically standards of clinical practice you know. And I think in many cases you've done that in your head and what we're saying is you should just make sure to put it down in paper.

Rusty Smith: Would it be required on the just the therapy plan of care would also be required on the resident's care plan?

Sheila Lambowitz: I think that, you should really work with your facility on that. But, I would think that on the care plan and your notes, you want to present as good picture as you can as to why you are performing the different modes of therapy. What you expect to happen and also how – what kind of outcomes are you getting?

Are you seeing improvements by the patients as a result the different modalities that you have put in place?

Joe Suttee: Yes, I have a question. Looking at this one week look back period that's rolling, how do we make sure we get other interviews et cetera that go with this assessment or are they're going to be more dashes?

John Kane: It's something that we are looking at now in terms of the interview questions and some of the other items. But, for now, you would complete the COT OMRA using the EOT items set. So it's something that we should be looking at in the near future and we will post clarifications on our website.

Brian Hales: Good afternoon, my name is Brian Hales, I'm from Via Christi Kansas. I'm a physical therapist and my question relates to the Three Day Policy. If somebody misses three consecutive days, but we want to resume on day four clinically would we need to have new evaluations for each of our services?

Penny Gershman: You'd only need a new evaluation if you have not done an end of therapy with resumption. If the circumstances are that you need to do another Start of Therapy OMRA or if you decide to wait until the next scheduled assessment, then you would need to do a new therapy evaluation.

Brian Hales: So, if you want to pick him up on that fourth day that – if they admit Saturday, Sunday and Monday for whatever reason, on Tuesday we would not need to fill out a new 700 form, a new eval?

Penny Gershman: Assuming that there were no changes that would put them in a – no clinical changes that would put them into a different RUG classification, you would not need a new evaluation.

Brian Hales: OK. So they could be seen by a PTA on that day?

Penny Gershman: Yes.

Question and Answer Session Continued

Lalaine Stone: Hi, I think they answered my question a while ago. The COT assessment is going to be like doing an End of Therapy, it's not just a little quick assessment

we can and go in and put numbers and it's going to be like an End of Therapy assessment?

John Kane: This is John, the assessment COT OMRA uses the EOT item set and so it will be necessary then you would have to complete that item set, yes.

Lalaine Stone: OK, thank you.

Andres: This is Andres, the gentleman from Canada just asked my question, so that answered my question because I was going to ask as well if we need to do discharge paperwork and new evaluations after end of therapy with resumption period. But I have no more questions.

Grace O'Dalo: Can you give me again the site; I can go and print out this conference training?

Leah Nguyen: OK, sure. Those are located on the SNF PPS website at www.cms.gov/snfpps. At the left side of the webpage, you want to click on the FY 2012 RUG-IV Training and Education and then scroll down the page to the Download section.

Grace O'Dalo: Hold on a second, we have one more question.

Female: I just want a clarification again with the Change of Therapy. Let's say they miss therapy on Saturday and Sunday. However, one of the therapies is able to get in and then say PT is able to get in with the patient but OT is not. Do we still do the Change of Therapy for that?

John Kane: This is John, as long as you're still meeting the qualifications for the RUG category in which the person is classified then you don't have to do a COT OMRA. Now if, let's say, the person was in rehab ultra and there is a therapy discipline that needs to be for five days. If OT is the one that needs for five days, but they only got in for four days and PT comes in and they do a fourth day, then that wouldn't meet the requirement for the fifth day, the fifth day of that discipline. So, it's just the main – the important thing is to look to see if the therapy category qualifiers for whatever category they happen to be in are being met.

Tanya Wills: Yes, this is Tanya from Garden Isle and Rehab on Hawaii. And I just want a clarification, so you do, if they do not receive therapy for three days, they miss the weekend, refuse Monday, then you do an End of Therapy with resumption. But what happens with the payment for those three days? If there is no skilled nursing and they're just there for rehab. Are we saying, again, the question was do we bill that to the patient?

John Kane: Right. Well, this is John again. I'm going to actually use your question to clarify one other thing. If you do the resumption, if you miss the three days and do the resumption, then you'd be billing at the non-therapy rate for those three days that they missed and then resuming at the therapy rate on the day of resumption. In the case where the person is not receiving any other skilled services, then you'd be billing at the default rates for those three days.

Tanya Wills: OK. Default rate.

Female: Default rates for Medicare then.

Sheila Lambowitz: Basically, what's going to happen is that you are going to get a non-therapy RUG group. In all likelihood, it's going to be in the reduced physical function range. And that's what you would bill. And if the person really had no other services, the lowest of the physical function groups is BA1. Sorry, PA1. But look at what you get back on your, you know, validation report, it'll tell you which of those groups to bill at. But it will most likely be reduced physical functions.

Tanya Wills: OK. But my other question is that let's say, we do an End of Therapy- R, but there is no nursing to skill them. Normally, we would drop to ICF if rehab went out. So, is Medicare still going to pay for those three days even though there is nothing skilled being done?

Tanya Wills: So they will pay that default that lower rates then.

Sheila Lambowitz: Yes, this is Sheila again. Basically, we are working on the assumption that this is not going to be an extremely common situation. And that the patient is actually going to be resuming the Medicare regimen. And we did not want to affect patient care by saying you absolutely have to move this patient off

Medicare, you know, for this short break. What we are saying is that we also can't pay you at the therapy rate for these short breaks in service.

Tanya Wills: OK.

Jeanette Kranacs: And again, that applies in resumption, if this is a regular EOT and there is no resumption, then the situation that you spoke about would kick in.

Glenda Matt: Hi, thanks, I'm with Kindred Healthcare. And my question goes back to slides 22 and 24. I think this might be a mistake that I just want to clear. As far as in any other residents or therapists is referenced on both of these slides. And therapists don't generally supervise therapists and assistants don't supervise therapists. So, my question is that should that say students instead of therapists?

John Kane: OK, I think I see what you're saying. You're saying our slide 22 where it says while not treating/supervising any other residents/therapists, is it treating residents or supervising students?

Glenda Matt: Right. I think that it says therapists when actually what I think you're intention was at the clinician cannot be supervising any other students because therapists don't supervise therapists.

John Kane: Yes. Thank you for the clarification. Just to clarify, it is the idea that if the student is working with two different people then the supervisor cannot be working with anyone.

Glenda Matt: So, really this is about supervising patient care of any students that that therapist might be actually supervising as well, is what you're trying to get to the point of?

John Kane: Yes.

Glenda Matt: If another student was doing patient care then that would mess up the whole situation.

John Kane: Right.

Glenda Matt: That's a particular therapist supervision standard. So, I just want to be clear because it was creating confusion for our team.

Jeanette Kranacs: We're trying to address the issue too of you can't have a therapist that is supervising but not treating and they are supervising two students. That situation can't occur.

Glenda Matt: That's great. Yes. So I think instead of the word therapists in both these slides it should have said students.

John Kane: OK, we'll make that correction. Thank you very much for bringing that up.

Glenda Matt: Thank you.

Operator: Your next question comes from the line of Aileen Dal. Your line is now open.

Aileen Dal: At any rate, the question is about on slide five and slide six, the word used is to be completed by. And I'm wondering if on both of the slides you mean set by about the ARD? In other words, on slide five, it says that the assessment must be completed by September 30. And on the other slide it talks about the assessment being completed when combining. Are you talking about the ARD set or actually the assessment being completed?

Penny Gershman: And you're correct. We do mean the ARD set, you're right. Thank you for pointing that out.

Aileen Dal: Because especially on slide six, when you were talking about combining assessments, I want to make sure that you are not saying that we don't still have the window to set the reference date. In other words, previously, we could set the reference date anytime within the allowed window and we would not have to combine. Is that still going to hold that we can set the reference date anytime within that window?

John Kane: OK, so just to clarify the combined assessment policy, this is John, by the way. Just to clarify the combined assessment policy. When you have an unscheduled assessment that is due prior to a scheduled assessment being completed in the same window, OK, so the example that we've been using is

that you have, the COT is due on Day 14, the COT observation period ends Day 14. If the 14-day assessment has not been completed by that point then the ARD for both the COT OMRA and the scheduled assessment must be set to Day 14.

John Kane: The ARD must be set for Day 14 on the combined assessment and the AI code should be clear as being a combined COT and 14-day assessment. If however, the scheduled assessment was completed prior to the unscheduled assessment then that would not need to be the case, you would not need to combine them.

Aileen Dal: Well, I'm still a little bit confused, you're saying completed or the ARD set about combining because …?

John Cain: The ARD must be set, if the ARD for the 14-day was set prior to when the ARD would need to be set for the unscheduled. So, if you have ARD for the 14-day assessment set on Day 13, and the COT OMRA would have been set on Day 14 then you don't need to combine them. OK, in fact that actually resets the COT ARD.

Aileen Dal: That's what I wanted to clarify. Thank you very much.

Rita Underwood: Good afternoon, Sheila, and everybody else and thanks for your wonderful insight today. My question comes with sort of dove tails off of the last one actually. When you have the assessment schedules, which by the way are in the proposed rule, not part of the final rule, so you have to be able to download the proposed rule to get the assessment schedule. And I searched and searched on the CMS website for the proposed rule and have been unlucky and not able to find it. So, I'd like an address for the proposed rule, so I can download it.

And then the second item that I'd like to offer some insight on with your opinion Sheila is the combining of an OMRA admission assessment with a PPS 14-day assessment given the new revised schedule that we have with the PPS and the type of different assessments we are looking at now. And I've not been able to find it in the regulatory FIDOF manual which I have the pleasure

of reading more frequently that I would like. As well as the proposed rule of not being required to combine the 14-day PPS and be able to break that apart from the admission OMRA assessment if one chooses if that's an OK thing to do. And then the last item would be the documentation we can expect for regulators to look at as it relates to this informal evaluation, as documentation proves not only that it was done in some suggested format, but you know various companies and facilities are going to be using. And what you're opinion is as far as guidance …

Sheila Lambowitz: Wait, I'm going to stop you here because you're raising some really good points and we're not going to have enough time to answer them now. So, do you have my e-mail address?

Rita Underwood: I sure do.

Sheila Lambowitz: OK, send me those, we will respond to you and give you the websites that we need – you need to find the rule and will also make sure that we get answers to your or other questions and make those available to everyone.

I don't mean to cut you short, but …

Jeanette Kranacs: I would like to point out that the new MDS schedule is in this presentation slides, and that may be the easier avenue to either find that.

Sheila Lambowitz: But send me the e-mail. I think your questions now are how do we do the – how do you reconcile the OMRA and the Medicare schedules? That really hasn't changed much, but we'll get that to you as quickly as we can.

I'm sorry, we do have to wrap up. I wanted to take one last minute to tell you how much I have enjoyed working with all of you for all these years, on training programs, on the open door forum.

For many of you this may be the last time I speak to you. I am in the process of retiring from CMS, but I wanted to thank you for all of the many years of really collegial working where we have been trying to make these systems work, trying to provide good care to residents together. So, thank you very much. And you know, at least for some of you goodbye.

Leah Nguyen: Thank you, Sheila. We would like to thank everyone for joining us, and for your participation in the question and answer portion of the call.

An audio recording and written transcript will be posted through the FY 2012 RUG-IV Training and Education page on the SNF PPS website at www.cms.gov/snfpps.

I would like to thank our subject matter experts for their participation. Have a great day, everyone.

END