Centers for Medicare & Medicaid Services
Skilled Nursing Facility Prospective Payment System Minimum Data Set 3.0 and Resource Utilization Group–Version 4, Policies and Clarifications National Provider Call
Moderator: Leah Nguyen
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Contents

Operator: At this time, I would like to welcome everyone to the Skilled Nursing Facility Prospective Payment System Minimum Data Set 3.0 and Resource Utilization Group–Version 4 Policies and Clarifications National Provider Call.

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

Thank you for your participation in today's call. I will now turn the call over to Leah Nguyen.

Introduction

Leah Nguyen: Thank you, Holley.

Hello. I'm Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to the Skilled Nursing Facility Prospective Payment System Minimum Data Set 3.0 and Resource Utilization Group–Version 4, Policies and Clarifications National Provider Call.

CMS subject-matter experts will provide a brief overview of the policies, along with clarifications on the SNF PPS FY2012 policies related to Minimum Data Set 3.0. A question and answer session will follow the presentation.

Before we get started, there are a few items 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 Web site located at www.cms.gov/SNFPPS . At the left side of the Web page, click on FY2012 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, Jeanette Kranacs, Acting Director of the

Division of Institutional Post-Acute Care. I will now turn the call over to Ms. Kranacs.

Overview

Jeanette Kranacs: Thanks, Leah.

Good afternoon. As Leah said, my name is Jeanette Kranacs. You probably are all familiar with Sheila Lambowitz and her recent retirement. I'm stepping into Sheila's shoes, at least temporarily. I want to welcome you to today's call and thank you for participating.

Today's call represents the third training call we've offered on the FY12 MDS 3.0 and RUG-IV policy changes. As indicated, slides, transcripts, and other materials related to the two previous calls are available on the SNF PPS Web site.

The questions received during the registration period for today's call ranged from wanting to understand the basic policies to referring to very specific situations. Today's call will provide a general overview of the policies, and therefore some of the presentation will overlap with previous presentations.

Also, we have received questions and feedback from the stakeholder community since our last calls, and we have updated our material to include additional clarifications and examples. We've incorporated this information in responding to your questions in a generalized way.

For those questions that are less general, we will respond by either updating the clarifications document on the SNF PPS Web page or, in some instances, responding specifically to the questioners.

We plan on updating the clarifications memo, if necessary, after today's call. Give us a little while to incorporate changes and get them out—say, a week or so. We appreciate your patience as we try to be as responsive as possible to addressing all of your questions about the complex changes now being implemented.

At this point, I'll turn it over to Penny Gershman, who will start by going through some of the policies for you.

Updates on Assessment Schedules, Group Therapy Minutes, Student Supervision, and EOT OMRA Items

Penny Gershman: Thanks, Jeanette.

Thank you for joining us for today's call. We have a full agenda, and you should be able to follow along with the slides provided.

Once again, if you came late to the call, if you haven't downloaded the slides yet, they can be found at www.cms.gov/SNFPPS . On the left side of the page, click on the FY2012 RUG-IV Education and Training page. Once you're on that page, scroll down to the Downloads section, which will contain the slides for today's national provider call.

As Jeanette said, since the last national provider call in August, the RAI Manual has been updated and we have issued several clarifications based on the questions we've received. The links to the manual and the clarifications can be found at the end of this slide presentation.

Our agenda for today's call includes the following topics: the new MDS assessment schedule, the allocation of group therapy minutes, the revised student supervision provisions, the End of Therapy OMRA and new resumption items, the Change of Therapy OMRA, and finally we'll discuss several clarifications of the policy changes we have made.

Beginning with slide number 3, we'll talk about the revised MDS assessment schedule. By now, you should all be using the new MDS assessment schedule, which went into effect on October 1st. Once again, we've made these changes to the schedule in order to reduce the amount of duplicated information gathered during overlapping look-back periods.

The scheduled MDS assessment should now have the following ARD windows:

- The 5-day assessment hasn't changed. The ARD window is still Days 1 to 5, with days 6 through 8 as grace days.
- The 14-day assessment should have an ARD window of Days 13 or 14, with grace days of 15 through 18.
- The 30-day assessment should have an ARD window of Days 27 through 29 with grace days of 30 through 33.
- The 60-day assessment should have an ARD window of Days 57 through 59, with grace days of 60 through 63.
- The 90-day assessment should have an ARD window of Days 87 through 89, with grace days of 90 to 93.

The scheduled assessments will continue to pay for the same days as in the past. You can see the full chart on slide number 3.

Many providers have asked about the general policies when combining scheduled and unscheduled PPS assessments. Before discussing these, let's define what we mean by scheduled and unscheduled assessment.

We're considering scheduled assessments to mean the regularly scheduled PPS assessment—the 5-day, the 14-day, the 30-day, and so forth. Unscheduled PPS assessments are the Start of Therapy OMRA, the End of Therapy OMRA, and the new Change of Therapy OMRA.

The general combination policy is as follows: If the ARD for an unscheduled PPS assessment falls within the ARD window, including grace days, of a scheduled PPS assessment, and the ARD for the scheduled assessment would be set for a day after that of the unscheduled assessment, then the assessments must be combined.

The example on slide number 4 illustrates this policy. If the ARD for an End of Therapy OMRA is Day 14 of a resident's stay, and the 14-day scheduled PPS assessment is not set for prior to Day 14, then the assessments must be combined and facilities should use the appropriate AI code to indicate the combined assessment.

This policy clarification has provided us with questions from a number of different providers, and we'll address them on slide number 5. In combining a scheduled and an unscheduled assessment, the scheduled assessment item set should be used. However, once again, the AI code should reflect that this is a combined assessment so payment can reflect this.

The ARD for the combined assessment is the ARD that would have been used for the unscheduled assessment. In our example on slide 4, the ARD for the EOT OMRA was Day 14, and the ARD for the 14-day scheduled PPS assessment had not yet been set. In this case, the two would be combined, with an ARD date of Day 14. Finally, if for some reason the ARD is mistakenly set for a day that is after the ARD for the unscheduled assessment, then the scheduled assessment is deemed invalid and payment is set as if the assessments had been combined properly.

Moving on to slide number 6, we'll talk about group therapy. As stated in the FY12 Final Rule, the Part A definition of group therapy has been modified. Group therapy is now defined as therapy provided simultaneously to four patients, regardless of payer source, who are performing the same or similar activities.

We'd like to remind you that this is the Part A definition of group therapy. We use the words "regardless of payer source" in our definition because there may be group therapy participants who are not covered under Part A. Nevertheless, the group is still a valid group.

For example, a physical therapy group may consist of two Part A patients and two Part B patients, all of whom are performing the same activity. For the Part A patients, this is considered a valid group. For the Part B patients, the group still must adhere to the definition of group therapy for Part B.

The RAI Manual makes a distinction between Part A and Part B patients as a reminder that the payment policies for group therapy for each provider are different.

Continuing with the explanation of the modified Part A definition of group therapy, facilities must plan for groups to include no more and no less than four participants. If for some reason a group is planned and at the last minute a participant can't make it, the group may still continue. However, the minutes will still be allocated and divided by four, which brings us to slide number 7.

The allocation of group therapy occurs as follows: A therapist will treat a group of four patients. For each Part A patient, the full time spent in the group will be reported on the MDS. The RUG-IV grouper will then allocate those minutes for each patient.

For example, a speech therapist sees a group of four for a communication group, which lasts 60 minutes. Those 60 minutes will be entered in the MDS under group minutes. The RUG-IV grouper will then allocate those minutes, and 15 minutes will be the RTMs, or reimbursable therapy minutes, that can be counted toward the calculation of the RUG classification of each Part A patient.

On slide number 8, we outline the new therapy student supervision policy. As of October 1st, students are no longer required to be under the line-of-sight supervision of their supervising therapist.

Once again, we remind you that supervising therapists are expected to exercise their own judgment regarding the level of supervision a student may require. Additionally, the APTA, AOTA, and ASHA have provided suggested guidelines for student supervision, which can be found on our Web site at cms.gov/SNFPPS, on the Spotlight page, in the Download section, under Student Supervision Guidelines.

Instructions for coding student and therapy time can be found in the RAI Manual in Chapter 3, Section O.

The End of Therapy OMRA continues to be a hot topic of discussion for SNF providers. Let's discuss this.

As written on slide number 9, an End of Therapy, or EOT, OMRA must be completed when a resident who is in a RUG-IV Rehab Plus Extensive Services or Rehabilitation group does not receive any therapy services for three or more consecutive calendar days for any reason.

The purpose of the EOT OMRA is to adequately capture non-therapy days in an SNF. The ARD for an EOT OMRA must be set for day 1, 2, or 3 after the date of the last therapy session. For example, if a resident receives therapy on Monday, which is Day 17 of her stay, but misses therapy on Tuesday, Wednesday and Thursday, the ARD for the EOT OMRA would be set for either Tuesday (Day 18 of her stay), or Wednesday (Day 19), or Thursday (Day 20 of her stay).

An EOT OMRA is expected to be performed for three consecutive missed-therapy days, regardless of whether therapy is missed on a weekday, weekend, or holiday. Beginning October 1st of this year, the resumption item was added to the End of Therapy OMRA.

As explained on slide 10, an EOT with resumption, or an EOT-R, is not a new assessment. Rather, it is an EOT assessment with the resumption item filled in. The EOT-R may be used when a resident will resume therapy at the same therapy level as prior to the discontinuation of therapy, and when the resumption of therapy occurs no more than five days after the last day therapy was provided.

Let’s consider an example. Mr. G has therapy on Friday, which is Day 16 of his Part A SNF stay. The facility he is in does not provide weekend therapy, so he misses therapy on Saturday and Sunday. On Monday, Mr. G’s family comes to visit and he refuses therapy.

Since Mr. G missed three days of therapy, an EOT OMRA is required. The facility can choose to set the ARD for day 1, 2, or 3 after the last day of therapy. As a reminder, Mr. G last had therapy on Friday. Therefore, the ARD for the EOT OMRA may be set for Saturday, Sunday, or Monday.

The facility believes that, barring any unforeseen circumstances, Mr. G will resume therapy on Tuesday. Also, since his lapse in therapy was not caused by any medical reason, his therapy is expected to resume at the same RUG level as prior to the lapse in therapy—therapy with the date of resumption, which is item O0450B, filled out with Tuesday's date.

But how is an EOT-R billed? Slide 11 illustrates this. When an EOT-R is used, the facility will bill the non-therapy RUG for all days of missed therapy. In Mr. G's case, that would be Saturday, Sunday, and Monday. Beginning Tuesday, which is the day Mr. G resumed therapy, the facility would bill the therapy RUG in effect prior to his lapse in therapy.

As a side point, it should be noted that facilities are not required to consider possible ADL changes when determining whether resumption of therapy will occur at the same level as prior to the lapse in group therapy. As long as the therapy plan of care remains the same for that RUG level, and therapy has resumed no more than five days following the last day of therapy, the EOT-R can be done.

Slide 12 addresses several clarifications we'd like to make regarding the End of Therapy OMRA. First of all, if a resident is discharged from the Medicare Part A portion of the stay prior to missing three full days of therapy, then the EOT OMRA would not be required.

Obviously, this only applies in cases where the resident was receiving some type of skilled service for each of those days prior to discharge. If therapy was the only skilled service the resident was receiving, then the discharge from both Part A and therapy would occur concurrently.

The second clarification on slide 12 addresses EOT-R billing. In cases where an EOT-R is completed, the HIPPS code used to bill the days affected by the assessment should include the AI code used on the EOT-R, with the second character being A, B, or C.
Now I'll pass the call on to John Kane, who will be talking about the COT OMRA as well as some other recent clarifications.

COT OMRAs and Other Policy Clarifications

John Kane: Thank you, Penny.

Let's begin with the Change of Therapy, or COT, OMRA. As outlined on slide 13, we will discuss a variety of topics related to the COT OMRA, such as when a COT OMRA must be completed and how the COT OMRA will affect provider billing. We'll also discuss some recent clarifications of the COT OMRA policy.

Moving to slide 14. The purpose of the COT OMRA is to capture changes in the provision of therapy services to SNF residents outside the standard observation period associated with the scheduled PPS assessments. In other words, the COT OMRA is designed to highlight when the therapy provided to a resident in a given week does not reflect the therapy the patient should be receiving, given the RUG-IV therapy level in which the patient is currently classified.

As a formal definition, a COT OMRA must be completed for a resident receiving any amount of skilled therapy services if the 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.

Clearly, some terms and jargon in that definition need to be explained further. The COT observation period refers to a successive 7-day window, beginning the date following the ARD of the resident's last PPS assessment used for payment.

For example, if a provider were to set the ARD for a resident's 14-day assessment for Day 14, then the COT observation period will begin on Day 15 and end on Day 21, assuming no intervening assessments.

If there were an intervening assessment used for payment, whether it be a scheduled or unscheduled PPS assessment, then the COT observation period would be reset based on the ARD of the intervening assessment.

We say *successive* windows because the possibility of a COT OMRA must be considered every 7 days for patients receiving any amount of skilled therapy services. If during a given week the patient receives an amount of skilled therapy appropriate to their determined therapy level, then the provider need not complete a COT OMRA at that time, and will instead begin considering therapy provided in the following or succeeding week.

I should point out that the COT observation period begins 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, or EOT-R. In such cases, the COT observation period begins on the resumption dates listed in O0450B on the EOT OMRA. The definition also refers to therapy that does not reflect the patient's RUG-IV therapy classification level.

But what exactly does this mean? In other words, how should a facility determine when a COT OMRA must be completed? As we discuss on slide 15, providers 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 changed sufficiently.

We say this is an *informal* evaluation because there is no paperwork 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, in considering changes to the intensity of therapy, providers must consider changes to all therapy category qualifying conditions, such as total Reimbursable Therapy Minutes, or RTMs; number of days the therapy was provided; or number of therapy disciplines.

Just to clarify: The term Reimbursable Therapy Minutes, or RTMs, refers to the minutes used to determine the resident's RUG-IV classification. Effectively, a patient's RTMs are his or her individual therapy minutes plus any allocated concurrent or allocated group therapy minutes.

Providers must determine if changes in the intensity of therapy as just described would cause the resident to be classified into a different RUG-IV category.

What do we mean by RUG-IV categories? On slide 16, we offer a bit of a shortcut for understanding what it means to change to a different therapy category. As you can see, the RUG-IV therapy category is captured by the second character in the therapy RUG code.

For example, a person in the Ultra-High Rehab category will have a U as the second character in the therapy RUG code. If that second character changes to a V, for example, then this would be classified as a change in the therapy RUG category. If the U remains the same, but the third character changes from an A to C, or vice versa, this would not constitute a change in the therapy category.

As noted earlier, a COT OMRA is necessary if the therapy received during the COT observation period will be sufficient for the patient to be classified into a different RUG-IV category. Therefore, if the patient's RUG-IV category does not change, then a COT OMRA need not be completed.

As a more precise example, if a resident is classified into Rehabilitation Very High, and his RTMs were to increase from 510 minutes on the previous assessment to 600 minutes during the COT observation period, assuming all else is equal, then the COT OMRA would not be required, as the resident's RTMs still reflect the reimbursable therapy minutes necessary to qualify for Rehabilitation Very High.

Moving to slide 17. Providers should consider the following concepts for determining if the 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 providers should consider whether or not the therapy provided to the resident during this COT observation period was consistent with the patient's current RUG-IV classification.

For example, if the patient was classified into the Rehabilitation High category, did the resident receive 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 is yes, then no COT OMRA is required. If the answer is no, due either to the number of RTMs or the number of days each therapy discipline was provided, then a COT OMRA would be necessary, and the new RUG would be billed from the first day of the relevant COT observation period.

I would take this opportunity to note that in addition to the questions on this process chart, providers should also be asking themselves the most important question not listed here, which is "Why?"

Why did the resident experience a change in therapy? Was the resident too sick to perform the requisite therapy? Were there more refusals during that week than normal? Why were there so many refusals? Did the resident receive the proper pain medication to ensure he or she could perform the therapy appropriately?

Asking why when such changes occur can help ensure that fewer such changes occur unnecessarily, that patients receive a consistent level of care, and patient issues are identified earlier so as to prevent them from becoming worse.

Returning to the slides. On the next two slides we provide examples of how one might complete the COT evaluation for a given case to determine if a COT OMRA is necessary. I can tell you that the chart in front of you is simply a spreadsheet with some simple formulas to calculate total RTMs and such. Nothing complicated, but it does provide a visual example of how you might keep track of a resident's therapy to determine if a COT OMRA would be necessary.

On slide 18, the patient's current RUG-IV therapy classification is Ultra-High Rehab. However, after reviewing the number of RTMs and other therapy qualifiers, we find that the resident did not meet the RTM requirement for Ultra-High Rehab. Instead, the resident only qualifies for Very High Rehab; therefore, a COT OMRA would be required.

Moving to slide 19. The only real difference here is that the resident's starting therapy category is High Rehab. As shown in the chart, the resident again qualifies for Very High Rehab due to the therapy provided to the resident. As such, a COT OMRA would be necessary to classify the resident into the higher rehab category.

We use these examples to demonstrate that a COT OMRA can be used to classify a resident into a lower or higher therapy category.

In terms of billing and payment, as noted on slide 20, 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 continuing until the next scheduled or unscheduled PPS assessment.

In other words, a COT OMRA retroactively establishes a new RUG, beginning on day 1 of the COT observation period for which the COT OMRA was completed.

For example, if a resident's last assessment had an ARD of Day 30, the COT observation period would begin Day 31, assuming the last assessment was not an EOT with resumption.If at the end of the COT observation period, which in this case would be Day 37, the provider were to determine that a COT OMRA was necessary, then a COT OMRA would be completed, and the new RUG payment resulting from the COT OMRA would be billed from Day 31 and forward until the next scheduled or unscheduled PPS assessment.

Moving to slide 21. There seem to be remaining 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 a resident 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 were to simultaneously qualify for both HB2, with an FY2012 per diem payment of approximately $397, and RHB, with an FY2012 per diem payment for approximately $376, then the facility would bill for HB2.

As noted on slide 21, even if a resident index maximizes into a non-therapy RUG, the provider must still perform a change of therapy evaluation, which is to consider the potential necessity of a COT OMRA, as long as the patient is still receiving skilled therapy services. Plainly, a COT OMRA should be considered for any patient receiving any amount of skilled therapy services, no matter what RUG group they might classify into for billing purposes.

As noted on slide 22, however, a COT OMRA is only required in such cases where changes in the intensity of therapy provided to the resident during the COT observation period cause a change to the resident’s RUG category used for billing.

Consider the two examples on slide 22. In the first case, a COT OMRA is not required because, even though changes to the intensity of therapy the resident received would impact the resident’s therapy RUG category, the resident’s RUG classification used for billing remained unchanged.

In contrast, in the second example on slide 22, 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’s therapy RUG category and the resident’s RUG classification used for billing.

With all the basics in place, we can now turn to some of the recent clarifications we have made with regards to the COT OMRA policy. The first,

as noted on slide 23, is related to the necessity of the COT OMRA around the day of discharge.

The clarification we have issued is that if day 7 of the COT observation period is also the day of discharge, then a COT OMRA would not be required. To be clear, if the COT observation period ends prior to discharge, then the COT OMRA may be required. However, if the patient is discharged from Part A on or prior to day 7 of the COT observation period, then no COT OMRA would be required.

The second clarification on this slide refers to the relationship between the COT OMRA and scheduled PPS assessments. As stated there, if the ARD of a scheduled PPS assessment is set for on or prior to day 7 of the COT observation period, then no COT OMRA would be required.

We understand that the major change here is where we say “on or prior to,” while the current MDS Manual only refers to “prior.” This change should appear in the April update of the RAI Manual.

We want to take this opportunity to formally clarify that if the ARD for a scheduled PPS assessment used for payment (and it really should say “scheduled PPS assessment used for payment” to be consistent with the way this concept is discussed in the proposed and final rules for FY 2012 and as discussed on slide 14) is set for on or prior to day 7 of the COT observation period, no COT OMRA would be required. We would note, in response to questions we received prior to this call, that this does not eliminate the option of combining these two assessments. It only clarifies that this is not a requirement.

The final clarification we will discuss with regard to the COT OMRA is related to the completion of the resident interview questions, as noted on slide 24. A number of providers told us that there will be cases where setting the ARD of the COT OMRA might not be possible on day 7 due to various logistical issues.

We heard this concern and responded by clarifying that the ARD for the COT OMRA could be set for day 7 of the COT observation period, meaning that the assessment could be opened and the ARD inputted into item A2300 after day 7 has passed.

An example we have used, and we will discuss this concept more broadly in just a minute, is the situation where day 7 of the COT observation period happens to fall on July 4th, and the MDS coordinator is not there to set the ARD for the assessment that day. We have clarified that the assessment can be opened and the ARD set for day 7 the following day. However, this raised concern over the interview questions on the assessment.

To balance the concern of providers with regard to setting the ARD properly against the importance of actually hearing from the patient on the assessment, which was one of the major improvements to the MDS assessment in the transition to MDS 3.0, we have clarified that the interviews on the assessment may be completed one to two days after the ARD of the COT OMRA.

We do not expect this to occur very often. But we want to encourage providers to make every possible effort to provide an opportunity for the resident's voice to be heard. Again, this is one of the major improvements with the MDS 3.0, and we do not want to compromise the improvement for the sake of logistical concerns.

We hope this clarifies our policy with regard to the patient interviews in these rare cases.

Switching gears a bit, slide 25 discusses a clarification we have made with regard to co-treatment within an SNF. As a formal definition, co-treatment refers to a case of two clinicians—that is, two therapists, two therapy assistants, or some combination thereof from different disciplines—treating one Part A resident at the same time with different treatments.

For example, a speech language pathologist and an occupational therapist do a meal with a patient. The OT is working on feeding skills and fine motor coordination of the utensils, while the SLP is working on swallowing skills.

This would be an example of a proper co-treatment session. In such cases of co-treatment, both disciplines may code the full treatment session. Therefore, in the example just presented, both the OT and the SLP could code the full session as individual therapy.

Moving to slide 26. We would note that all policies regarding the mode, modalities, and student supervision must be followed. We would also note that the decision to co-treat should be made on a case-by-case basis, and a need for co-treatment should be well documented in the plan of care for each patient. This is because co-treatment, as defined here, would only be appropriate for specific clinical circumstances and not necessarily for every patient.

Turning back to recent clarifications, we want to discuss two other areas where we have issued clarifications.

The first is with regard to setting the ARD for scheduled and unscheduled PPS assessments. As noted on slide 27, for scheduled PPS assessments, the ARD for such assessments must be set for a day within the ARD window for that scheduled assessment, including grace days, by the end of the allowable ARD window for that assessment, including grace days.

In other words, the decision on which day within the ARD window will be used for the ARD of the scheduled assessment must be made by the end of the ARD window. The distinction we hope to draw here is between the ARD being set *for* a given day, which really is referring to the actual date listed in item A2300, and the ARD being set *on* a given day, which is referring to the day the decision is made for which day the ARD will be set for.

We feel this provides sufficient flexibility to providers to set the ARDs for their assessments in such a manner as to capture the most accurate assessment of the resident’s condition without compromising the overall integrity of the assessment. That is a big phrase for us here: “without compromising the integrity of the assessment.”

As much as the PPS assessments are used to set payments for providers, they're also used to capture all of the items and help give us a better idea of the type of patients the providers are treating. By ensuring you are capturing the most accurate and appropriate information on your assessments, you can help us to get a better idea of the types of patients being treated within SNFs and the manner in which they are being treated, which then ultimately influences our policies going forward.

We also have an example on slide 27 that outlines what I said earlier regarding setting the ARD on the assessment by the end of the assessment window. Just to highlight the last part of that example, providers should be aware that once outside the ARD window, the ARD on the assessment cannot be set for any earlier than the day the decision is made.

To return to the distinction we made earlier, in the case where the ARD is not set by the end of the ARD window, the ARD "set for" date and "set on" date must be the same.

Moving to the discussion of unscheduled assessments on slide 28. For the COT OMRA, EOT OMRA, and SOT OMRA, the decision of which day within the allowable ARD window the ARD of the assessment will be set may be made after the window has passed.

Our example here is similar to the one I provided earlier, except here it is related to the EOT OMRA. We have been asked how long after the ARD window has passed facilities can open the assessment and set the ARD. While we have not given any specific timeframe for when this decision must be made, we would again return to the concept of not compromising the integrity of the assessment. Specifically, returning to the idea of capturing the patient's voice, we expect the facilities will only use this added flexibility in the case of unscheduled assessment when it is necessary, and we expect doing so will not compromise the provider's ability to complete the assessment accurately and include the patient's voice.

We now turn to the second area of clarification, for which I will turn back to Penny Gershman.

Penny Gershman: Thanks, John.

We received many questions about the Leave Of Absence policy and how it relates to unscheduled assessments and, specifically, the COT and EOT OMRAs. Before we discuss the unscheduled assessments, let's look at slide number 29 and talk about leave of absence, or LOA, policy and its effect on scheduled PPS assessments.

The Medicare assessment schedule is adjusted to exclude Leave Of Absence days when determining the ARD for a given assessment. For example, if a resident leaves your facility on Day 27 of his stay, which is Wednesday, at 6:00 p.m., and returns to the same facility the next day, Thursday, at 9:00 a.m., Wednesday becomes a Medicare non-billable day. The Medicare schedule is adjusted and Thursday becomes Day 27 of the resident's stay. Therefore, that Wednesday would not be a day that could have been used as the ARD for the resident's 30-day assessment.

On the contrary, as explained on slide number 30, the days on which a resident experiences an LOA must be counted towards the ARD for a given unscheduled PPS assessment (that is, the SOT, EOT, or COT OMRA).

For example, Mrs. L doesn't receive therapy on Monday, Tuesday, and Wednesday. She goes to the E.R. at 9:00 p.m. on Wednesday and returns to the facility on Thursday at 10:00 a.m. Regardless of whether Mrs. L gets therapy on Thursday, the EOT OMRA would be required, with an ARD set for Monday, Tuesday, or Wednesday.

Slide 31 gives an example of how a leave of absence may affect the COT OMRA. As we mentioned, days during which a resident experiences an LOA must be counted towards the ARD for the COT OMRA. In the example, if a facility chose November 7th as the ARD for Mr. B's 30-day assessment, the COT observation period would begin on November 8th. But let's say Mr. B went to the E.R. on November 9th at 11:00 p.m. and returned to the facility at 2:00 p.m. on November 10. Regardless of this LOA, day 7 of the COT observation period would remain November 14th. Thus, when a Leave Of

Absence occurs, the COT evaluation process and payment implications remain unchanged.

Slides 32 and 33 include several other common questions we've received.

First, can the ARD of an unscheduled PPS assessment be set for a Leave Of Absence day? The answer is yes, it is possible the ARD for a given unscheduled PPS assessment may be set for a Leave Of Absence day.

Second, if a resident experiences an LOA during the observation period for an assessment, can the services provided to that resident during the LOA be coded on the MDS? The answer is yes, these services may be coded on the MDS, although only in cases where doing so wouldn't violate any other provisions of the RAI Manual or other SNF guidelines.

For example, as discussed on slide 34, Mrs. S. received therapy on Monday morning but left the SNF to go to the E.R. Monday at 9:00 p.m. and returned to the SNF on Tuesday at 11:00 a.m. The therapy she received on Monday could be coded on MDS as part of the therapy look-back for the COT, with an ARD set for Thursday.

This brings us to the end of our formal presentation. As you can see, additional training resources can be found at the Web sites listed on slide 35. Thanks.

Question and Answer Session

Leah Nguyen: Thank you, Penny.

We have now completed the presentation portion of this call and will move on to the question and answer session. Before we begin, I would like to remind everyone that this call is being recorded and transcribed.

Before asking a question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask you to limit your questions to just one.

Holly, you may open the line for questions.

Operator: We will now open the line for our question and answer session. To ask a question, press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question. Pick up your handset before asking your question, to assure clarity. Please note that your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Laura Liccione.

Laura Liccione: I just want to ask you one question. I come in to work, and I'm going to attend my PPS meeting. Today happens to be the last day that I can set a 30-day; it's Day 33, and depending on how the patient does that day, I'm going to use either Day 32 or 30-day for my ARD.

But say I get called away and don't return to the facility for two days, maybe even three days. How do I set that ARD?

John Kane: That's a very good question. There are two things I would say.

First, there are two main ways to set the ARD in such a scenario. You can open the assessment in its electronic form and actually input a date into A2300, or you can take a paper version of the MDS and input a date into A2300. Either way would constitute setting the ARD.

Second, I don't believe there's anything that identifies one person as the person who must set the ARD. I think facilities have chosen to delegate this responsibility to individuals.

If someone else were there, and you were to say, "Hey, I just left the building, and I'm not coming back for two days. Can you get a paper form of the MDS and put this resident's name, number, etc., into A2300?" That would constitute setting the ARD, which I think would be a prudent way of dealing with it.

Laura Liccione: OK. The facility must come up with a way to set the ARD for scheduled assessments no matter what the circumstances.

John Kane: Right.

Laura Liccione: Also, if I put it on paper, does that paper have to be maintained, or can someone take that piece of paper and put it into the computer a few days later?

John Kane: Yes, as long as it's set on that day, then you can input it into the electronic record if that's how your facility will be sending over the record.

Laura Liccione: Could you discard your proof that you sent it on paper?

John Kane: No, the actual paper you used should go into the patient's record. It shouldn't be disposed of in any way.

Laura Liccione: Would that be a separate piece of paper in addition to the electronic record?

John Kane: Right. It would demonstrate that the ARD was set on the day it was given, so you would want to maintain that as part of the patient's record, but you'd submit the electronic assessment for the MDS.

Laura Liccione: Thank you very much.

John Kane: You're welcome.

Laura Liccione: One more question from slide 12 about the EOT OMRA. Let's say the patient had therapy Monday through Friday, they were scheduled for discharge on Sunday, but Saturday they refused, and they wouldn't have had therapy on Sunday. Are you saying that the last covered day of Medicare Part A would be the same day they last had therapy? If so, how would we bill for that Saturday, if they refused, because they didn't miss a consecutive three days?

John Kane: Can you clarify?

Laura Liccione: For example, I have a resident who was receiving therapy and is planning to be discharged on Sunday. We would not give them therapy on Sunday, the day of discharge, and they happen to refuse on Saturday.

When you were going over this slide, you said that if therapy is the only thing skilling this resident, and they miss therapy but not three consecutive days of it, then the last day would be the same as the last covered day under Medicare. In such a case, how would we bill for the day that the resident refused therapy?

John Kane: You thought the resident had a discharge planned for Sunday and they refused Saturday. Their only skill was therapy, and they had not missed the three consecutive days. Let's say they got therapy on Friday. Correct?

Laura Liccione: Correct.

John Kane: This is a good question. I actually would like to see it in an e-mail. Instinctively, I would say if there is an unplanned discharge on that Saturday, you might want to go that way. But if you're still maintaining a discharge for Sunday, then I wouldn't necessarily say an EOT OMRA would be required in that case. But if you want to e-mail the question in, we can put something out as a formal clarification for that specific scenario. It's an interesting scenario.

Laura Liccione: Thank you.

John Kane: No problem.

Operator: Your next question comes from the line of Sonya Carollo.

Sonya Carollo: I have a question related to the Change of Therapy. If I have a patient who will be discharged on the 15th day and will not require a 14-day assessment for payment, and the change of therapy is also scheduled on day 14—can I just do a Change of Therapy without combining it with the 14-day PPS assessment, or must they still be combined?

John Kane: Let me be very cautious here. As long as you absolutely know that person will be out of Part A by day 15, then, yes, you can just do the COT because you wouldn't need to bill anything beyond day 14. You could just do the COT in that case. But if that person was in for even day 15, even just that one day, you would need to have that 14-day assessment to be able to bill that day.

Sonya Carollo: Then they must be combined?

John Kane: Right.

Sonya Carollo: Thank you.

John Kane: Thank you.

Operator: Your next question comes from the line of Bonnie Nutter.

Bonnie Nutter: I have a question on slide 5, the very last question there, about a case where the ARD of a scheduled assessment is set after the ARD for an unscheduled assessment. Slide 5 says the scheduled assessment is deemed valid and I understand that. But when you say payment is set as if the assessments had been combined properly, what does that mean from a billing perspective? Do we bill just the unscheduled assessment through the end of that particular payment period?

John Kane: Right. Let's say the two assessments had been combined properly, and let's say they were an EOT and a 14-day. Let's also say they were combined with an ARD of Day 13. If they were combined on Day 13, the EOT really would be controlling payments, and it would continue through the 14-day payment window. That's how the billing would be affected; the EOT would control the payment through that 14-day window as if they had been combined.

Bonnie Nutter: So, when we bill it, we bill just the unscheduled assessment with that AI code?

John Kane: Right.

Bonnie Nutter: With no penalties involved?

John Kane: Right.

Bonnie Nutter: Thank you.

John Kane: You're welcome.

Operator: Your next question comes from the line of Richard Fabing.

Richard Fabing: My question is about when you have an EOT assessment at the tail end of a month and you billed an end-of-the-month claim using a HIPPS code with an 04 for the assessment indicator. On the third or fourth day, conceivably, of the next month, the patient resumes therapy. From what I've read, it sounds like when we do the end of therapy resumption, we would now have to use a HIPPS code with an A as the last character of the assessment indicator. But since it's a modification to the end of therapy, what happens with the HIPPS code assessment indicators? Do I just let the prior ones stand, and then the next month bill the days with the HIPPS code having an assessment indicator ending in A?

John Kane: Richard, that's a really good question. I don't want to say just go with the old HIPPS code if it's no longer accurate, because that actually will affect a lot of the data analysis and things we do as far as looking at what AI codes are present and the types of assessments being done.

We've received this question from a number of people and we want to make sure we provide a clear, formal clarification in terms of how to bill it. Please e-mail me the question to remind me to add this to the clarification document we are preparing.

My e-mail—most of you on this phone call probably know it, but if not, it's John, J-O-H-N, Kane, K-A-N-E, at cms.hhs.gov. Again, that is J-O-H-N, dot, K-A-N-E, at cms.hhs.gov.

Again, Richard, thank you for that question. It will be something we definitely clarify soon.

Richard Fabing: Thank you.

Operator: Your next question comes from the line of Terry Raser.

Terry Raser: This is Terry Raser from Select Plus. I have a question—well, not really a question, but a statement on slide 22 where you talked about index optimization.

John Kane: OK.

Terry Raser: Actually it's slides 21 and 22, where you provided the example of the HB2 being $397 and the RHB being $376. Isn't it important for the RNACs or the MDS coordinators to know what the CMI is for each of these RUG classifications? Because you won't know which one is higher if you don't know what the CMI is?

John Kane: Right, the CMI would be the more direct way of evaluating which one is higher or lower. That's a very good point, as far as which of the RUGs would be higher. What we're getting here is probably a little more simplistic way of looking at index maximization, but you're absolutely right. You would look on the CMI chart to find which CMIs are higher or lower and you would bill whichever one has the highest CMI.

Terry Raser: Thank you.

John Kane: You're absolutely right, Terry. Thank you for bringing that up.

Operator: Your next question comes from the line of Ann Delforge.

Ann Delforge: My question refers to slide 23, about the COT, and whether the first day of the look-back period of the COT occurs after the last day of the ARD of a resident's last PPS assessment. How can the ARD of the next scheduled PPS be the same as the COT on day 7, as you say on slide 23?

John Kane: Slide 23. I think that goes along with slide 15.

Ann Delforge: If the ARD of a scheduled PPS assessment is the same on or prior to day 7—how can they be the same when you have to wait until after that first seven days before you set the ARD for the COT assessment?

John Kane: It's not necessary for you to wait until after that seventh day to monitor therapy. We encourage you to check your therapy levels every day to make sure people are on pace to make their required RTMs, their required days, and all the other therapy qualifiers. It shouldn't be something you necessarily have to wait until after day 7 to do. We issued that clarification really to provide

flexibility for cases such as the first caller raised, where someone, for example, is having a baby and won't be there. When you might not be able to be there on that seventh day, and for whatever reason you cannot set the ARD that day, you can go back and do it. It's not something that would necessarily have to occur. We expect the facilities would know in most cases whether or not the COT was at the end of that week before they actually hit that day 7.

Ann Delforge: Basically you're saying we don't have to wait until after the ARD period to start looking at the change of therapy?

John Kane: No, in fact, we would encourage people to look at it as they go. That way, if the RNAC were to say, "You're not going to make your therapy for this week," the therapist might be able to explain why they're not, or to explain that they actually will, for example, by making up a missed therapy session at the end of the week.

We hope there's that level of communication and foresight in this process.

Ann Delforge: Thank you.

John Kane: You're welcome.

Operator: Your next question comes from the line of Janice Martin.

Janice Martin: My name is Janice and I'm from Medilodge of Plymouth. I'm just checking to make sure I don't have to do a Change of Therapy.

If during the observation period you have a resident who misses three days of therapy, you do the end of therapy along with the resumption, and that resets the clock for the change of therapy. Correct?

John Kane: Correct, as long as the ARD for the EOT is set for a day that is either on or prior to day 7. If it was set for day 8, for example, the day after day 7, then you would have to do both. But as long as the EOT ARD is set for on or prior to day 7, you'd be fine.

Janice Martin: That's what I wanted to know. Thank you.

John Kane: You're welcome.

Operator: Your next question comes from the line of Monica Ogden.

Jennifer: Hi, this is Jennifer. I'm the MDS coordinator at Ripley Crossing. What if we have a scheduled assessment set for Day 15, and we're looking at the change of therapy on Day 22. Could I set the ARD for Day 22, or do I have to wait for the three days after, and set it for day 23, 24, or 25?

John Kane: Are you talking about for a COT or an EOT?

Jennifer: For a change of therapy.

John Kane: For a change of therapy there's really only one day that's allowed for the ARD, and that's at day 7.

Jennifer: That's at day 7.

John Kane: The day 1, 2, or 3 in relation to the EOT.

Jennifer: Thank you.

Operator: Your next question comes from the line of Avery Malate.

Avery Malate: My question is about slide 23, regarding the recent clarification on COT OMRA. It says if day 7 of the COT OMRA observation period is also the day of discharge, the COT OMRA would not be required.

Would that same clarification also apply if day 7 is also the date of exhaustion—like day 7 is the 100th day?

John Kane: Inasmuch as day 100 is the day of discharge from Part A?

Avery Malate: Yes. If day 7 is the exhaustion day and the resident will remain in a long-term facility, would that same clarification apply?

John Kane: As long as day 100 is a Medicare-billable day it would count toward the EOT requirement. When we talk about the day of discharge, we're talking about discharge from Part A, which would be the non-billable day.

Avery Malate: So, physical discharge?

John Kane: Right.

Female: In your example it would have to be day 101.

Avery Malate: So, if day 7 of the COT observation is also day 100 of the rest of stay, meaning date of exhaustion, you still have to do a COT?

John Kane: Yes.

Avery Malate: OK.

Female: If day 7 is day 101?

John Kane: Then, no.

Avery Malate: I have a second question about the EOT-R. For example, you have a resident whose only reason for skilled coverage is skilled rehabilitation. On Friday and Saturday no therapy was provided. On Monday the resident refused and Thursday the resident resumed therapy.

Those three days will have to be billed using the nursing RUG scores, but if you don't have any other skilled nursing services that would price out to the upper 52 categories, would providers then be allowed to bill the lower 14 categories?

John Kane: Whatever comes off the EOT is what you will bill.

Avery Malate: OK.

John Kane: You complete the EOT and whatever comes off of that is your bill.

Operator: Your next question comes from the line of Joanne Hise.

Joanne Hise: My question has to do with the 7-day successive payment window. I recently came upon a situation like this: The ARD for the 5-day assessment is the 30th of the month, and the 14-day assessment is done with an ARD of October 7th. I count out my seven days, and on day 15 I fill my RUG categories. Let's say the patient is in RUC, the Ultra High Rehab category—that's seven days. Day 14, I'm still on category RUC. Day 21, I have now dropped a category. When does my payment change? Does the payment change for just the last successive days, or does it go all the way back to the day after the ARD of the last assessment?

John Kane: No, it goes back to the past seven days. It's day 1 of the COT observation period you were using for that COT OMRA.

Joanne Hise: It's really confusing. In one of the prior transmittals we received, from CMS I assume (and this was from the followup information on the August 23rd provider training), on question numbers 3, 5, and I think 23—it is really like clarifying mud, sir. I don't mean to be disrespectful in any way, but the way I interpreted the 7-day window is that the payment would only go down for the last seven days, not all the way back to the last ARD.

John Kane: I don't remember the exact date you used as your example, but let's say your 30-day was set for Day 31, and your COT observation period begins on Day 32 and ends on Day 38. No COT is required. The next one begins on day 39 and ends on day 45 if my math is right, which it may not be. But, on day 45—let's say a COT is due at that point—it only goes back to Day 39. It doesn't go all the way back to day 31.

Joanne Hise: This is what our software vendor basically told us. That's why we wanted to get clarification, because basically it means we've provided the therapy for the first 21 days at the higher level and we are not going to get reimbursed for it. That's what it actually looked like in the first provider call.

Is it only the last seven days prior to the ARD of that change of therapy OMRA that your payment is actually reduced or increased?

John Kane: Right. It goes back to day 1 of that COT observation period.

Female: Yes, the payment reflects the COT observation period. The COT observation period is set by the ARD of the last assessment.

Joanne Hise: Is there any place where this is actually in writing?

Female: We can look at the clarifications memo and if it's not clear, we'll try to clear it up. You referred to questions numbered 3, 5, and 23?

Joanne Hise: Yes. It's on slide 20. In that slide the other thing also inferred is that if you have a Change of Therapy OMRA, and it is in the same window for a scheduled assessment, you have to combine both of them. Yet slide 23 says I can do one or the other.

John Kane: Right. The reason for that is whereas the ARD of the COT actually depends on the ARD of other assessments, the ARD for other kinds of unscheduled assessments such as the EOT or SOT depends on other types of events, such as the beginning or end of therapy. That's why there's a little bit of a difference when it comes to the COT.

Joanne Hise: So, if I'm now at Day 28 and have already set my assessment reference date for my 30-day assessment for Day 28, when we do our look-back, it has me thinking, "Oh, they're going to go drop a RUG schedule."

I don't have to make it a Change of Therapy and a scheduled PPS. I can make it one or the other, or I can combine them. Correct?

John Kane: No, one or the other. You either do the combined or the 30-day at that point.

Joanne Hise: That's what I mean. I didn't mean a Change of Therapy.

John Kane: I just want to make that clear in case someone else might not have understood. You're absolutely right.

Joanne Hise: I appreciate it very much. You have clarified and answered my questions. Thank you.

John Kane: You're welcome.

Operator: Your next question comes from the line of Deleasa Dyess.

Deleasa Dyess: Good afternoon. I have a quick question in relation to COT and Leave of Absence days. I had an incident I was lucky enough to be able to avoid and my therapy RUG did not increase or decrease. But, it made me realize this was possible and I'm not really sure what to do if it ever happens.

If I have a COT review that falls on a leave of absence day, I understand that I am required to complete the COT for that day. However, if this also falls in the window—say, on Day 57 of a scheduled PPS assessment—and I can't do that scheduled assessment for that ARD date because that is not a billable day, what do I do?

John Kane: If it was Day 57, that Day 57 would actually shift forward so it would no longer be in the window. If you had the COT due on Day 57 and that happened to be the LOA day, that LOA day actually doesn't exist as far as the scheduled assessment is concerned and 57 actually shifts forward one day. You're actually in a sense doing it on what you might call 56-forward, and the actual 60-day window begins the following day. You'll be fine if you do one assessment and then the other.

Deleasa Dyess: That didn't even register with me. I appreciate that. Thank you.

Operator: Your next question comes from the line of Elena Kurth.

Bridget Klein: This is Bridget Klein from St. Joseph.

I had a patient admitted to a skilled nursing facility for therapy and IV antibiotics. For the 5-day MDS, which we use to grade Day 8, he fell into Very High. For the 14-day, which is also the 7-day, I just did a 14-day MDS and he also fell into the Very High category. Therefore, I combined a 14-day with end of therapy because therapy was discontinued. This patient is still on our unit for IV antibiotics only. Do I still need to do a change of therapy?

John Kane: Absolutely not.

Bridget Klein: I just wanted to clarify that because I saw your note on page 21. I wanted to make sure—since I did the end of therapy assessment on the 14-day—that no further assessments were needed.

John Kane: Right. Once you've done the EOT you don't have to consider whether they change or not.

Bridget Klein: Great. Thank you.

John Kane: You're welcome.

Operator: Your next question comes from the line of Charlie Hehn.

Charlie Hehn: My question is about what people are calling "the Day 4 black hole," with regard to a short stay assessment. The RAI Manual talks about the short stay algorithm. Under ARD requirement number 5, it says it must be no more than three days after the start of therapy. Thus, you could have a scenario where your therapy start date is October 22nd, and your ARD is October 25th, assuming all other short stay criteria are met. Will the ARD in this scenario prevent the assessment?

I've heard it referred to as the "Day 4 black hole." Do the three days after the start of therapy also include the date the therapy was started?

John Kane: This is actually something we have heard about before from a few people. We're actually taking a look at this. If you could e-mail me the question so we can add it to our roll that would be really helpful. Again, my e-mail address is john.kane@cms.hhs.gov. I appreciate you bringing this up, Charlie. This is something we're looking at now.

Charlie Hehn: Thank you very much.

John Kane: Thank you.

Operator: Your next question comes from the line of Joel VanEaton.

Joel VanEaton: This is Joel VanEaton, with Care Centers Management Consulting, in Johnson City, Tennessee. I'd like to get a couple of clarifications on slide 27. The discussion today has centered on the situation of being outside of a scheduled assessment to set the assessment reference date, and not having to be physically present within that window in order to set that day or to encode it somewhere, on paper or electronically.

I ask you all to please consider how we could really appropriately select the last day of an assessment reference window as an appropriate assessment reference date if we're not allowing the full 24 hours of that day to pass.

For instance, in facilities that track their ADL scores 24/7, multiple episodes per shift—truly, I wouldn't know in that facility until the last day of a scheduled assessment reference period had passed whether the last day of that assessment reference period was appropriate to choose, specifically in relationship to the ADL scores. This effectively eliminates that day for me in actually appropriately or intellectually choosing that particular day.

Would that be a consideration for you all in relationship to allowing us more freedom at the end of the assessment reference period to select days within that period, even though we may be outside the window physically?

Also, just a clarification in relationship to the COT OMRA: Of course, we're allowed the freedom to be outside that window, but the conversation today has slipped over into suggesting it would be better to be prior to—to not compromise the integrity of the assessments we're talking about and to not compromise the residents' ability to give their voice.

Yet, on page 2-5 of the current RAI Manual in relationship to the directions given for completing the COT—and this may be something you will be clarifying—it says, "An evaluation of the necessity for a COT OMRA must be completed after the COT observation period is over." *Must* be completed. That ought to be a consideration as well, that we're really actually being told in the manual that we *have* to wait until after the COT observation period is over with in relationship to selecting that particular assessment.

Then, quickly, on slide 11, in relation to the EOT, you say we're not required to consider possible ADL changes when determining if resumption of therapy will occur. When I do an EOT and that slips then into an EOT-R, if I'm billing at a Rehab RUG there for resumption, clearly I'm using the Rehab RUG score from the prior assessment. Which ADL score would I use? The ADL score from the prior assessment or from the EOT?

John Kane: Hey, Joel, this is John. Thank you for your questions. As always, your questions are superb.

Your first question is something we're looking at so I don't want to comment on anything right now. We're looking at it as far as the ADL and the 24-hour rule, and how the scheduled assessment ARD is set, and so on. That's all I can say at the moment.

Joel VanEaton: Great.

John Kane: As far as the second thing, it actually is on our radar, because we wanted to make sure people are not looking at this only after the COT observation period. This is something that's consistently being monitored throughout the period. Thank you for bringing it up here so other people are aware of it.

As far as your third point, when you do the EOT-R, you're basically carrying that RUG from the prior assessment up forward. You bill a non-therapy RUG off the EOT of the previous therapy RUG once the therapy resumes, ADLs and all.

Joel VanEaton: The ADLs that come off the EOT are inconsequential to my resumption?

John Kane: Yes.

Joel VanEaton: OK, thank you.

Operator: Your next question comes from the line of Rita Cole.

Tom McCormick: This is Tom McCormick, from Optima Healthcare Solutions. I had a question about the COT and the day of discharge. The literature says it's not required.

Does the phrase “not required” equate to “not an option”? Is it optional to do the COT or not an option at all?

John Kane: No. When we say not required, we mean exactly that. It’s not a requirement, but it still is a possibility. You’re not required to do it, but you could if you felt it was appropriate.

Tom McCormick: You could do the COT, then, on the day of discharge, if you choose that option.

Operator: Your next question comes from the line of Mike Gorman.

Mike Gorman: I have a question clarifying slide 23 on the change of therapy OMRA, where you say it doesn’t have to be done. For example, the caller earlier said that if the 30-day MDS is due on Day 28, or set for Day 28, and there’s a change of therapy checkpoint on Day 28, you don’t have to do the change of therapy OMRA. Is that true even if the therapy provided during the previous seven days is different from the RUG level that was established?

John Kane: Yes, that’s correct.

Mike Gorman: That answered my question. Thank you.

John Kane: You’re welcome.

Operator: Your next question comes from the line of Tara Essmann.

Tara Essmann: Thank you. I have a question about what happens if the therapy level is different following an end of therapy. When resumption occurs, what happens if the therapy level will not be the same? Say, they’ve been on medical hold, and won’t be able to come off of that tolerating the same level of therapy. How do you deal with that?

John Kane: I think there’s actually a discussion in the RAI Manual, but perhaps it is not as clear. If the person is not resuming at the same level—that is to say, they’re not resuming under the same plan of care—you would have to do the EOT

and then an SOT with the new evaluation to determine what level of therapy that person was going into and what the appropriate plan of care would be.

Tara Essmann: My second question relates somewhat to the end of therapy. What happens if somebody initially comes into the facility and therapy isn't initiated until, say, day 4? Does anything have to happen initially, or do we just wait for that first assessment?

John Kane: You would wait for that first assessment. In fact, the EOT, by rule, can't be the first assessment, so you'd be doing the 5-day as the first assessment at that point, and it would just pick up whatever therapy you provided between day 4, if you started it that day, and when you set the ARD for that first assessment.

Tara Essmann: OK, great. Thank you.

John Kane: You're welcome.

Operator: Your next question comes from the line of Jan Oliver.

Jan Oliver: We have a situation that has just come up. We had planned to provide therapy through Monday the 7th, and the client is being skilled through rehab only at this point. However, this morning, the physician came through and wrote a unilateral "discharge all therapies" order.

We have given a written notice that the last covered day would be Monday the 7th, but now we're in this funny situation where, without communicating with the team, we have no more therapies and no nursing needs.

In this situation, do we just fill the default rate for those remaining days or do we need to withdraw that notice and give notice for a different day?

John Kane: At that point, if the only skilled service is therapy, and they're discontinuing all therapy on the physician's order, then the day they discontinue therapy is now the day they have gone off of Part A.

Jan Oliver: Then how do we reconcile that with the fact that we are required to give a 3-day notice for discharge off of Part A, and that that notice was given differently?

John Kane: We'll have to talk to some of our experts in this area and get back to you. Would you mind e-mailing me that question as a reminder so we can get back to you?

Jan Oliver: I certainly can. I realize it was a little bit off-topic. Thank you very much.

John Kane: No, it's certainly on-topic. Thank you.

Operator: Your next question comes from the line of Nadine Edelman.

Nadine Edelman: I'm calling from New York State. I'm calling from an SNF that has medically fragile frequent admissions and re-hospitalizations. My patients are indicating their displeasure with—and I have serious consequences for—attempts and multiple attempts to complete multiple BIMs and PHQ-9s**.** This has a great effect on my case mix, such as going from an HD1 to an HD2 because my PHQ-9 answers are different and my residents have had me in there maybe even weekly performing these assessments.

Has CMS considered any implications of this?

John Kane: They are looking at the resident interviews as far as their frequency and things like that. It's something that's been brought up by a number of providers, so it's on our radar. We're looking at this to see if there's some way we can rectify it in the future.

Nadine Edelman: Does that mean "soon" future? I am having serious complications fiscally. I was just in there; now I'm asking them to do the BIMs again and I'm doing the PHQ9s again. Also, the answers they're giving me truly aren't the correct answers. It's really not their voice; it's their frustration at me that I'm back in there again.

John Kane: Again, this is something we are looking at. I wish I could provide more details at this point, but it is something we're trying to look at because, again, we are

hearing this. People are frustrated. We want to address this as soon as possible, but it's something we'll have to get back to you on.

Nadine Edelman: OK, thank you.

John Kane: Thank you.

Leah Nguyen: Holly, it looks like we have time for one final question.

Operator: Your final question comes from the line of Diana Turkson.

Diana Turkson: Hi. You said when the discharge date is the 7th of your COT observation, then you don't need to do it?

John Kane: No. If day 7 is the same as the day of discharge, then no COT OMRA will be required.

Diana Turkson: But you also said that day 101 should be the 7th, before you decide you don't need it. I don't know if you get my question.

John Kane: Well, if you're discharged from Part A on or prior to the end of the COT observation period, then you do not need to complete the COT OMRA. If you are discharged from Part A after day 7, you would need to do the COT OMRA.

Diana Turkson: It's kind of close, but I'll process it later.

John Kane: OK, thank you.

Leah Nguyen: Unfortunately, that's all the time we have for questions today. 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 on the FY2012 RUG-IV Training and Education page of the SNF/PPS Web site, at www.cms.gov/SNFPPS .

I would like to thank our subject-matter experts for their participation.

Have a great day, everyone.

Operator: Thank you for participating in today's Skilled Nursing Facility Prospective Payment conference call. You may now disconnect.

END