

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Skilled Nursing Facility (SNF)/Long-Term Care (LTC)  
Additional Training on FY 2012 SNF PPS Policy Changes  
Thursday, September 1, 2011  
2:00PM – 4:00PM ET  
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum that will be focused on Skilled Nursing Facility (SNF) Prospective Payment System (PPS) FY 2012 policy changes relating to the Minimum Data Set (MDS) 3.0. Subject matter experts will discuss new MDS 3.0 policies that will be implemented on October 1, 2011. A question and answer session for questions related to the FY 2012 policy changes discussed during the call will follow the presentations.

Target Audience: SNF providers, RAI coordinators, State RAI coordinators, therapists  
Conference Leaders: Sheila Lambowitz, Gregory Price.

The following topics will be discussed:

- \* Allocation of group therapy
- \* Student supervision
- \* Changes to the MDS Assessment Schedule
- \* End of Therapy (EOT) Other Medicare Required Assessment (OMRA) Clarifications
- \* End of Therapy with Resumption (EOT-R)
- \* COT OMRA
- \* Transition timeline for new policies

Additional Training Opportunities: CMS has made available a number of alternative training sites and materials, as listed below:

- Training Slides used in August 23<sup>rd</sup> National Provider Training Call and to be used during the SNF/LTC Special ODF are available on the SNF PPS FY 2012 training page at [http://www.cms.gov/SNFPPS/03\\_RUGIVEdu12.asp](http://www.cms.gov/SNFPPS/03_RUGIVEdu12.asp);
- A YouTube presentation of the August 23<sup>rd</sup> National Provider Training Call will be available on the SNF PPS FY 2012 training page at [http://www.cms.gov/SNFPPS/03\\_RUGIVEdu12.asp](http://www.cms.gov/SNFPPS/03_RUGIVEdu12.asp);
- Training and clarification materials will be available on the SNF PPS spotlight page at [http://www.cms.gov/SNFPPS/02\\_Spotlight.asp](http://www.cms.gov/SNFPPS/02_Spotlight.asp).

SNF/LTC Special Open Door Forum Participation Instructions:

To participate by phone: 1-866-501-5502 & Reference Conference ID#: 83517254.

TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Note: The lines for this call are limited and will be filled on a first-come, first-served basis. Those who wish to participate are encouraged to call-in as early as possible (up to 30 minutes prior to the start time for the conference) in order to have the best chance of participating. Additionally, as this conference will serve primarily as a repeat of the August 23<sup>rd</sup> National Provider Training call, we would ask that those who participated in that training call refrain from participating in this Special ODF, so as to reserve the limited space for those who were unable to participate in the August 23<sup>rd</sup> training.

SNF/LTC ODF September 1, 2011 Encore: 1-800-642-1687; Conference ID#: 83517254.

Encore is an audio recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conference ID. Encores for this ODF will be available four hours after the conclusion of the call and will continue to be available until Friday, September 9, 2011.

For ODF schedule updates, E-Mailing List registration and Frequently Asked Questions, visit our website at <http://www.cms.gov/opendoorforums>.

Thank you

Audio File for Transcript: <http://downloads.cms.gov/media/audio/SODFLTCSNF090111.mp3>

## **Centers for Medicare & Medicaid Services**

**Moderator: Gregory Price**  
**September 1, 2011**  
**2:00 p.m. ET**

Operator: Good afternoon my name is (Stephanie) and I will be your conference operator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Skilled Nursing Facility, Long Term Care Additional Training on fiscal year 2012 Skilled Nursing Facility PPS Policy Change and Special Open-Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then the number one on your telephone keypad.

If you would like to withdraw your questions, please press the pound key. Thank you I would now like to turn the call over to Mr. Gregory Price. Please go ahead sir.

Gregory Price: Thank you (Stephanie), good afternoon and good morning to those folks on early afternoon on the West Coast.

Welcome to the Special Open Door Forum, again as mentioned this is on the Skilled Nursing Facility PPS FY 2012 policy changes relating to the Minimum Data Set 3.0.

Before I turn this over to the chair I just want to go through a few quick items here. The encore presentation for this open door forum will be available at 6 PM Eastern Standard Time and it'll be available until September 9<sup>th</sup>. That's Friday a week from tomorrow Friday at 12 midnight.

So the encore will be available and I believe that is it. So let me turn (Sheila Lambowitz) to the Chair she will elaborate it, (inaudible).

(Sheila Lambowitz): Thank you very much and thank you everyone for attending this training session. It is a repeat session for the training that we conducted on August 23rd; we are going to be using the same materials and hopefully giving you the same information.

We are going to have a question and answer session at the end and we have the slides on our website and we are going to be posting additional comments and clarification responses on the website hopefully within the next week. So we will get you much information as we can see.

The session today is going to be conducted by two of our (SNF) team analysts, (Penny Gershman) who is a speech therapist, she's going to handle

the clinical information and (John Kane) who is our right person for the policy changes that have no being enacted for October 2011.

So right now I am going to turn it over to Penny.

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

Moving to slide three, in the past the MDS assessment schedule allowed for significant duplication of information gathered during overlapping look back periods, we decided to change the MDS assessment schedule in order to more appropriately capture the changes in patient statuses.

Therefore we have 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 ARD for schedule PPS assessment.

The new schedule is effective for all assessments where the ARD falls on or after October 1st 2011. Moving to slide four, you can see the changes in the MDS assessment schedule, as you can see with the exception of the 5-day assessments all ARD windows and grace days have been modified.

We recognize that some duplication of information still exists but the new schedule will alleviate a fair amount of it. I am skipping ahead to slide six now. For assessments with an ARD set on or after October 1, 2011 the ARD must be in compliance with the revised MDS assessment schedule otherwise early and late assessment penalties may apply.

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

In general when October 1st, 2011 is day 19, 34, 64 or 94 of the Medicare Part A SNF stay, assessments should be completed by September 30 or they will be considered late and payment penalties will apply. Moving on; to slide seven, now I would like to offer some guidance on combining scheduled and unscheduled assessments. This policy is outlined in the Medicare Claims Processing Manual and will also be available in the update RAI manual which is actually available today. If the ARD for an unscheduled PPS assessment falls within the ARD window (including grace days) of a scheduled PPS assessment and a scheduled assessment has not yet been completed then the assessments must be combined. For example, if the ARD for a Change of Therapy 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 the facility should use the appropriate AI code to indicate the combined assessments.

When combining the assessments the item set for the scheduled assessment should be used and the ARD for the combined assessment is what would have been the ARD used for the unscheduled assessment. Moving on to slide nine, we will now talk about group therapy allocation. Included in this discussion will be the modified definition of group therapy, the allocation of group minutes, and documentation requirements. Later on in the training we will discuss how to bill for group therapy with student supervision.

In order to code minutes as group therapy for patients who are covered under Medicare Part A, the definition of group therapy is: 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 choose four as the number for group because larger groups make it difficult to manage all of the patients effectively and smaller groups limit the ability of patients to interact and learn collectively.

I am moving to slide 11; we have received the following question both in our Proposed Rule comments and after the Final Rule publication. Many providers have asked what happens if one of the participants get sick or refuses to show up to a group therapy session and we respond that as long as the facility has originally planned the session for four participants then the group session can still be counted for other group members. Please note the minutes in this case will still be divided by four for each remaining patient. 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 is divided by four by the RUG IV grouper and used RUG classification. to offer an example (I'm on slide 13) if four residents in a specific SNF participate in a group session for a total of 60 minutes then the facility would report 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 would be 15 minutes in this case are then used to determine each patients RUG classification. Another commonly asked question is whether the group therapy cap, which is that a resident's group minutes cannot constitute more than 25 percent of his or her total therapy time, still apply and the answer is that yes the cap will still apply and will apply to the patient's reimbursable therapy minutes after allocation. In our Final Rule we reiterated our documentation expectations.

SNFs must ensure that patient care follows a prescribed and documented plan of care. You may see the relevant regulatory guidelines in the code of federal regulations section 409.23 and 409.17 (b) through (d).

Moving on to slide 16, this means that documentation in a patient's medical record should be sufficient to justify the plan of care and to identify potential changes in a patient's medical condition.

Skilled services and particularly therapy services should be properly tailored to the individualized goals of the patients. Specifically for group therapy and other modes it is expected that the medical record and the plan of care should include descriptions of the prescribed therapy mode: for example individual, concurrent or group. The discipline; for example, (PT, OT and Speech), the rationale for a particular therapy regimen and who is providing therapy whether it's a therapist or a student. It is vital to keep adequate records; facilities may wish to consider time stamping the start and end of therapy session in order to better capture time spent with the patients.

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

The major therapy associations APTA, AOTA and ASHA have provided recommendations on student supervision guidelines. Their guidance is available on the SNF PPS website at [http://www.cms.gov/SNFPPS/02\\_Spotlight.asp#TopOfPage](http://www.cms.gov/SNFPPS/02_Spotlight.asp#TopOfPage) .

One commonly asked question related to supervision is how to bill when a therapist is supervising a student. We want to remind you that for billing purposes the student is considered as an extension of a therapist. Specifically you may code a session as individual therapy when the therapist or the student is treating one resident while the other is not treating or supervising any other residents or students.

In order to code as concurrent therapy in the MDS there is three options, first you may code as concurrent therapy when the therapist and student are treating one resident each who are performing different activities while not treating or supervising any other residents or students or you may code as

concurrent therapy if the therapist is treating two residents doing different activities while the student is not treating any residents or if the student is treating two residents doing different activities while the therapist is not treating any residents.

In order for students supervision to be coded as group therapy on the MDS, the time for group session may only be counted if the full group of four participants is been run by either of the supervising therapist or the student while the other may not be supervising any other therapist or any other students excuse me or treating residents. For example, if the supervising therapist treats four residents doing the same activity while the student does not treat any other residents this time may be counted as group therapy.

Consequently if a student treats four residents where the supervisor is not doing any other activities this time maybe coded as group therapy.

Moving to slide 25, Can a supervising therapist be supervising other patients and students while his or student is conducting the group session? As we just discussed consistent with current policy, the supervising therapist may not be supervising any other patients or students at that time.

Another question: can the supervising therapist bill for a group therapy session in cases where the supervising therapist is treating two patients while the therapy students simultaneously treats two patients all of whom are doing the same activity? And the answer is no.

A group therapy session must be a single planned session involving four participants working together on the same or similar activities.

And now we will move on to our pop quiz. I will read the question and then pause for a bit for you to think about the response. I am on slide 27, true or false; starting October 1, 2011 all students should provide therapy outside 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 second question regarding group therapy allocation. If the SNF plans a group therapy session for four residents and 10 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 (this is multiple choice,) A, move the session to the sick patient's room, B, return the patients to their room: 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 or D, force the sick resident to participate.

And the answer 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. Please note that this therapy time will still be divided four.

Next question, 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.

And the answer is false, effective for assessments where the ARD is set on or after October 1, 2011 all SNFs must follow their revised MDS assessment schedule. Now I am going to give you three situations and we will then determine which type of therapy for the patient in the following situation.

First scenario, if a therapy student treats Mr. B while the supervising therapist treats Ms. M doing a different activity, this is concurrent therapy. Second scenario, if the supervising therapist treats Mr. E while the student does not treat any patients, this is individual therapy. And finally 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.

This can't be coded as anything because it is inconsistent with all of the therapy mode definitions. I will now pass the call over to (John Kane) who will discuss the rest of the policy changes. John?

(John Kane): Thank you Penny,

I will be taking you through the rest of today's presentation, beginning with the End-of-therapy, or EOT, OMRA. As noted 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 of when it is appropriate to issue an Advanced Beneficiary Notice, or ABN, to a SNF resident, and we will discuss the new Section O items on the EOT OMRA which permit a facility to resume a therapy program after therapy has been discontinued. First, let's discuss the three day policy.

Moving to slide 36, the "Three Day" policy is related to how facilities can 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 2012 SNF PPS Proposed Rule, an EOT OMRA must be completed in all cases when a beneficiary classified into a RUG-IV Rehab 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." Such discontinuations may be planned, that is that the facility had anticipated and expected that the beneficiary would not receive therapy services during that period, or unplanned, that is, that the facility did not expect the discontinuation. It is important to note that whether or not the 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's stay for all facilities, whether it is a weekday, weekend, or holiday.

In order to set the ARD for an EOT OMRA, facilities should set the ARD for Day 1, 2, or 3 from the date of the patient's 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.

Next is our discussion of issuing an ABN to SNF residents. We have received a number of questions regarding how this three day policy relates to issuing the resident an advanced 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 pose the question as “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, is the facility always required to issue the patient 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 likely not be necessary is in the case that a resident’s 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 have also received similar questions about issuing a notice of Medicare non-coverage, or NOMNC, which as noted on slide 39, is not issued when care ends based on beneficiary initiative or for provider business reasons. We hope these two clarifications address many of the questions we have been receiving on these issues.

The final topic related to the EOT OMRA is the new items that have been added to the EOT OMRA, specifically items 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 may be completed on the EOT OMRA to indicate that the discontinued therapy plan will be resumed and that payment at the previous therapy RUG may resume when the therapy resumes. As previously stated, the resumption of therapy can occur no more than five days after the last day of therapy provided. For example, if a resident received his last therapy intervention on Monday, then the last day that 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 regimen, then the provider must complete an EOT OMRA and then may choose to complete a new therapy evaluation and unscheduled assessment (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 assessments 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 items and resume therapy.

In terms of actually completing the EOT-R items on an EOT OMRA, it will depend on whether or not the EOT OMRA without the resumption items filled in has been accepted into the QIES ASAP system. Slide 41 discusses what to do in cases when the EOT OMRA has not yet been accepted into the QIES ASAP system. In such cases, the provider can simply go ahead and code the EOT-R items 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 items in Section O and modify item X0900E to indicate that the reason for modification is the addition of the resumption of therapy date.

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

Moving to slide 44, the purpose of the COT OMRA is to capture changes in the provision of therapy services to SNF residents outside the standard observation periods associated with scheduled PPS assessments. 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 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. 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 7-day window beginning the day 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 on Day 14, then the COT observation period would begin on Day 15 and end on Day 21, assuming no intervening assessments. If there were an intervening assessment, 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 seven 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. As noted by the asterisk on slide 44, 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. 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 assessments 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, 2011 and would end on October 8, 2011, assuming no intervening assessments.

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, 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 significantly. 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 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 or her individual therapy minutes plus any allocated concurrent or allocated group therapy minutes.

So, 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. However, what do we mean by RUG-IV categories? The categories we are 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 the 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 need not be completed. For example, if a resident is classified into Rehabilitation Very High and his RTM were to increase from 510 on the previous assessment to 600 during the COT Observation Period (assuming all else is equal) then a COT OMRA would not be required as the resident's RTM is still reflective of the reimbursable therapy minutes necessary to qualify for 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. 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 32, the COT observation period would begin Day 33, assuming that last assessment was not an EOT with resumption. If at the end of the COT Observation Period, which in this case would be Day 39, 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 33 and forward until the next scheduled or unscheduled PPS assessment. Just to clarify, the way I have described how the COT OMRA would affect billing here is a slight variation on how it is worded on slide 47, but this should clarify that in cases where multiple COT OMRA's could be possible in a given payment window, the COT OMRA is retroactive only to the beginning of the COT observation period for which the COT OMRA is completed. An example of this is illustrated on slide 49, which we will get to shortly.

Moving to slide 48, providers should consider the following 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 providers 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, did the resident receive between 325 and 499 reimbursable therapy minutes during that week and was at least 1 rehabilitation discipline provided for 5 days during the week? If the answer is Yes, then no COT OMRA is required. If the answer is No, due either to the number of RTM 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.

Let's now put everything together and consider the example on slide 49. This example illustrates well the concept of successive COT observation periods. In this example, a resident's 30-day assessment is completed with an ARD set for Day 30 of the resident's stay. On Day 37, which is Day 7 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's RTM was higher than that appropriate 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 could be required 7 days later.

Moving to slide 50, we received a number of questions in preparation for this call 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 FY 2012 per diem payment of approximately \$397) and RHB (with an FY 2012 per diem payment of approximately \$376), then the facility would bill for HB2. As noted on slide 50, 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, 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 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 therapy provided to the resident during the COT observation period are such that it would change the resident's RUG category used for billing. Consider the two examples on slide 51. In the first case, a COT OMRA is not required because even though there are changes to the intensity of therapy the resident received that would impact on the resident's therapy RUG category, the resident's RUG classification used for billing 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's therapy RUG category and the resident RUG classification used for billing.

Ultimately, the requirement to complete a COT OMRA comes down to two questions:

1. Is the resident receiving skilled therapy services?
2. 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 billed RUG classification?

If the answer to these two questions is yes, then a COT OMRA is required. If not, then no COT OMRA is required. I should note that index maximization occurs on a very limited number of assessments. As such, the basic process outlined on slide 48 should be sufficient for most SNF residents who are receiving skilled therapy services. We hope that this discussion clarifies both the intent and operation of the COT OMRA and illustrates the limited circumstances in which this assessment must 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 1. 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. For assessments submitted on or after September 18th, the system will be upgraded to calculate both the FY 11 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, though the group for the fiscal year in which the assessment occurs will only be shown on the validation report if the RUG code listed on the assessment was incorrect. For assessments submitted during FY 2011, specifically between September 18th and September 30th, the appropriate FY 12 RUG-IV group will be shown in Error Message #1059. For assessments submitted during the early portion of FY 2012, the appropriate FY 11 RUG-IV group will be shown in Error Message #1060.

That brings us to the end of the formal presentation, though to solidify in your minds the clarifications and policy definitions we have just discussed, we have another pop quiz. Consider question 5 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?”

As noted on slide 54, the answer is A, yes. Since Mr. E did not receive therapy for three consecutive calendar days, an EOT OMRA would be required for this resident. The next question is a bit harder.

Question 6; on slide 55. 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?

Moving to slide 56, the answer to this question is also yes, choice B. This might seem confusing with what we just talked about, but remember that a change of therapy evaluation must be done for all patients receiving any amount of skilled therapy services. This does not mean, however, that a COT OMRA would necessarily have to be completed. This is an important

distinction that providers should keep in mind so as not to mistakenly skip a required COT OMRA or mistakenly complete a COT OMRA that was unnecessary.

Perhaps the hardest question of them all, Question 7, 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 anyway.

Before we jump into the Q and A portion of the call, I just want to take a moment to highlight the other training resources available to you, outlined on slide 58. Obviously the first resource is the call you are participating in today. While it is not listed there, the formal comments you have heard today are basically a repeat of those given during the provider training call we hosted on August 23rd. The slides for that presentation, which are the same as those used for today's presentation, as well as an audio transcription of the August 23rd call may be found on the SNF PPS website at [www.cms.gov/SNFPPS](http://www.cms.gov/SNFPPS) and then clicking on the FY 2012 RUG-IV Education and Training link.

There are also training resources which may be found on the MDS 3.0 website and the address is 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](http://www.qtso.com) or the SNF PPS website and training page. I will now turn the call back to Sheila Lambowitz.

(Sheila Lambowitz): Thanks John, thanks Penny, I really appreciate your efforts. We are ready now for the Q&A part of the discussion. So if you can take this back and start looking for callers.

Operator: Certainly at this time if you would like to ask a questions please press star then the number one on your telephone keypad. We will pause for just a moment to compile the Q&A roster.

And your next question comes from the line of (Hazel Smith Brent) with Gulf Coast Healthcare Medicare Consultants. Your line is open.

(Hazel Smith Brent): Good afternoon this is (Hazel Smith Brent) Gulf Coast Healthcare I have a question if we do the COT (inaudible) because...

(Sheila Lambowitz): I am sorry you are fading out we can't hear you.

(Hazel Smith Brent): For example in (inaudible) discharge of resident and (inaudible) but it did lower our RUG to somewhat RU to RV, would we also be required to do an ABN sort of reduction of the speech.

(John Kane): To answer the first part of your question if the resident's therapy had changed from RU to RV I believe are the two that you used then yes the COT OMRA would be required. Can you repeat the second part of the question I didn't catch it early.

(Hazel Smith Brent): Would we need to an issue an ABN for the reduction in with speech even though they are continued in COT and most things.

(Penny Gershman): No if you basically had to determine that the speech therapy regimen had reached its potential and the therapist has discharged that patient from therapy that's not a situation where you have to do an ABN.

(Hazel Smith Brent): The reason why I sited this by a survey or because we did not an issue an ABN on a Part A resident when one discipline came out and the other two disciplines continued.

(Donna Williamson): Hi, this is Donna Williamson(Donna Williamson) from the Division of Appeals Policy and I think that well number one we are currently in the process of revising our SNF ABN instructions and the CMS online manual. So hopefully that will help clarify but just so you know the only time that you would issue for a reduction in individual services let's say for example in the speech therapy if the resident wanted to continue speech therapy however it's been determined by the SNF that it is no longer medical necessary then you would issue an ABN only if the resident wanted to continue receiving those services because they would then be liable on the basis of it's not reasonable and not necessary.

(Hazel Smith Brent): OK so that's for Part A is there any where I can find this in writing? Chapter 30 does not gave it in that fashion so there is a billing.

(Donna Williamson): Yes let me take a look at that and in section 30 in Chapter 30 the Claims Processing Manual but again in the revised instructions which will be coming out soon we are working very hard and we get a lot of feedback and a lot of

these types of questions so we are sure that we are zeroing in and we are making it very, very clear. So thank you for your questions.

(Hazel Smith Brent): Thank you so much and so at this point we do not issue a speech comes out under Part A residents.

(Donna Williamson): Correct.

(Hazel Smith Brent): Unless they want to come, unless the resident wants to continue therapy.

(Donna Williamson): Yes that's correct.

(Hazel Smith Brent): Thank you so much.

(Donna Williamson): You're welcome.

Operator: And your next question comes from the line of Rebecca Willey with Trinity Medical Center, Nursing Unit. Your line is open.

(Rebecca Willey): Yes my question is how do we inform CMS if there is a change of therapy if there is no formal documentation.

(John Kane): There is formal documentation for the actual COT OMRA the area where there is no formal documentation is for the change on therapy evaluation, the evaluation that you would use to determine if you had to complete a COT OMRA that's something that's informal for your guys to do on your own.

The COT OMRA is an official assessment and is outlined in the (RAI) manual.

(Rebecca Willey): OK and then who needs to participate in change of therapy assessment because currently we have all disciplines do their own little section and then reimbursement coordinator review all that, is that still going to be the case or is it something that I will just be able to do my on my own.

(John Kane): The COT OMRA is using the EOT item set and so if COT OMRA is completed then you can use your basic judgment in terms of what you do for an EOT as far as who needs to be involved.

(Rebecca Willey): OK all right I think that's all I have. Thank you very much.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (inaudible) Wilmer from Midwest Administration Services. Your line is open.

Female: Yes my question refers to slide number seven and I just need to clarify that word completed in the first paragraph. If the ARD for an unscheduled assessment falls within the ARD window of a scheduled assessment and the scheduled assessment has not been completed do you mean signed off on the 0500B, do you mean ARD date set or submitted to the repository?

(John Kane): No OK this is a great question and thank you for bringing it up and this is something that will be corrected online. We didn't want to post too many versions of slides to confuse everyone. On this slide what we are really referring to is that if you have an unscheduled assessment as to the scheduled assessment the ARD has not been set for this scheduled assessment. So for example if you have a COT due on Day 13 but you have not yet set the ARD for your scheduled assessment because your 14- day will only be able to start on Day 13 then you would have to combine the two assessments together.

So it's referring to the ARD not to completion.

Female: Perfect and last question I had was on slide 49, if you cannot evaluate the COT period until the seventh day of that period how will interviews will be completed because the evaluation would not be completed until day seven and at that point of completing that the folks who do that interviews may already be gone for the day and it appears that the interviews in section C and D are still going to be required even with a COT OMRA is that correct?

(Penny Gershman): Hi this is Penny, I think what the confuse might be similar to the confusion in your first question in the word completion, what we mean here really is that the ARD for the COT should be set for seven days following the day after the last ARD of PPS assessment...

Female: What we need to identify really before that if the RUG is going to change or not so that the team can complete the interviews if necessary I just don't want to see more dashes after the last memo that came out on dashes.

(John Kane): Right the assessment itself is not something that should be overly cumbersome it really only requires an evaluation of the therapy items which O400 and O500 and if so those items were to be different in such a way it's to create a change in the intensity of therapy then you would know that the COT would be necessary. So the actual evaluation itself shouldn't be something that should go on for much longer than that.

Female: OK.

(Sheila Lambowitz): You still sound a little confused, we are operating from the assumption and this is (Sheila) by the way that in most cases when you start looking at the therapy during the COT observation period you are going to find that people are progressing along the same planned therapy regime and that in most cases you are not going to have to do a Change of Therapy OMRA and that makes the question of the interview questions kind of a moot point but as you start looking at the therapy during this observation period if things are changing you are going to know about that prior to the absolute seventh day and if you knew to do other parts of the COT OMRA you have some time to get it all completed.

Female: OK. Thank you.

(Sheila Lambowitz): You're welcome.

Operator: Your next question comes from the line of (Kim Good) Please state your company name before asking your question. Your line is open.

(Kim Good): I'm from (inaudible) or (inaudible) Rehab Center and my question is that seven day period is not a rolling seven days, right? It's a definite seven days after. So say, if your fourteen day was due on the fourteenth day, then the fifteenth day start that next seven day period, correct?

Male: I think, (inaudible) for day fourteen. Sorry, at the ARD for your fourteen day assessment was set for day fourteen. Then the COT OMRA would begin on day fifteen.

(John Kane): Yes.

(Kim Good): And it would end of the twenty first?

(John Kane): Yes.

(Kim Good): So was that a rolling time period?

(John Kane): But then here is the thing, the idea of rolling versus successive. Successive in the sense, that if no COT OMRA was due on day twenty one, then reevaluate on day twenty eighth.

(Kim Good): OK, so every seven days.

(John Kane): Yes, every seven days.

(Kim Good): OK. I think it's (inaudible).

(John Kane): Thank you.

Operator: Your next question comes from the line of (Sharon Coleman) with (Future Cares of Gold springs). Your line is open.

(Sharon Coleman): This is (Deborah Witham) with Futurecare. Do you know when the (RAI) will be released, the updated (RAI) manual?

(John Kane): I believe the updated (RAI) manual is actually on the CMS website. I believe it says V1.07.

(Deborah Witham): OK.

(John Kane): With the posting date of August 31st.

(Deborah Witham): Alright. Thank you so much.



(John Kane): No problem.

Operator: Your next question comes from the line of (Natalie Hogg) with (Spalding NorthShore). Your line is open.

(Natalie Hogg): Hi, my question is if the COT OMRA is due on the day of discharge, does it need to be completed and if so; can it be combined with the discharge assessment?

(John Kane): No what we've been saying is that, if day seven falls on the day of discharge, then a COT OMRA would not be required and that goes for if the day of discharge is also at any point during the COT OMRA observation period. However, if the day of discharge is day eight then a COT observation I am sorry then a COT should be evaluated in terms of whether or not it will be necessary. We should also note that because we understand that this is something that is a potential area of vulnerability it is something that we will be paying special attention to in terms of the types of therapies and reviews of therapy that occur during that last week.

(Natalie Hogg): OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (inaudible) from Alliance Training Center. Your line is open.

Female: Thank you. My question relates to the question that was just asked if they say the 6th of the observation period is the day of discharge and we are in a period between required PPS assessments and the therapy level during that observation period did change and show a change in the RUG category. Then you are saying that the COT will not be completed on that case?

(John Kane): Again if the COT if the person is discharged prior to the day of if the day of discharge occurs prior to the end of the COT observation period.

Female: Right.

(John Kane): Then a COT OMRA would not be required. However we would stress that if there was a change in therapy it should be something that should be evaluated in terms of why it occur and whether or not some other type of unscheduled assessment that might be due prior to that will be necessary.

Female: Well but the therapy let's just say it's a different RUG category let's say if the person is preparing for discharge their independence is increasing and so what for the previous observation period might have been an RV would move down to an RH.

(John Kane): In terms of the number of days that therapy was given?

Female: And the intensity of the therapy, number of minutes came down but before the observation period for that seven days is over the resident is discharged.

(Sheila Lambowitz): This is (Sheila).

Female: Yes.

(Sheila Lambowitz): OK you have excellent point however the regulation as it's written and as it's in fact that the COT requires a seven day observation period and you are right that there could be changes however we are going to monitor that situation this year and you know we will be looking to see if we need to change the policy for next year but for now if everything is written you need seven days otherwise you don't have to do the COT.

Female: OK I don't see that answer in our in the material, and then just one question going back to the where some of these cases change rather subtly and I agree with the person couple of questions back about you know if all of a sudden on the seventh day we realize this that this rather subtle change in the residents participation or condition produces the need for a change in therapy we may very well be in the position where on the 7th of the observation period we realize we have this change and we don't have staff available to complete interviews and get and get things done so I am just curious about your continuing response on that because I can see that that could very well happen.

(John Kane): OK again the assessment does not need to be completed on day seven the ARD for the assessment must be set for day 7th.

Female: Yes but if the ARD but you have to do your interview at the end of the assessment reference period.

(Sheila Lambowitz): OK, (inaudible) this is Sheila again, again it's a good point I think what you're saying and probably what you are going to be telling your clients is that they really can't wait for mid-afternoon on Day seven in order to start looking at the record just to see if there has been a change.

Female: They are going to start to look at is that the change would occur with the therapy delivery on Day seven.

(Sheila Lambowitz): There may be a few instances where that does occur where everything was fine and that there was the change was only happening on day seven we are hoping that is not a common occurrence if that does become a pattern we are going to have to look at it through role making next year and we would appreciate any comments you have in the interim let us know if you are seeing this but for now this is what it is.

Female: OK well thank you and thanks for responding to that again.

(Sheila Lambowitz): Sure.

Female: Thank you.

Operator: Your next question comes from the line of (inaudible). Your line is open.

Female: I have a couple of questions the first is so do you have to pretty much look to see if you need to do a COT every seven days.

(John Kane): I am sorry is the question do you have to look at to see if COT OMRA is do every seven days?

Female: Yes.

(John Kane): Yes the COT observation period ends every seven days and so a COT evaluation should be done every seven days unless there is some intervening assessments.

Female: OK so if you have another scheduled assessment you go ahead and do that scheduled assessment and then the day after the ARD you can go ahead and plan for the 7th day after to look for your COT.

If you understood that?

(John Kane): Yes that's exactly right.

Female: OK. Thank you.

(John Kane): No problem.

Operator: Your next question comes from the line of (inaudible) from Laguna Honda Hospital & Rehabilitation Center. Your line is open.

Female: OK. Thank you yes we had a question regarding 36 the end of therapy OMRA it says that it has to be the ARD 1,2, 3 but suppose like over a holiday weekend or something you did not, it was the 4th day that you realized that you found out that the patients didn't get therapy for three consecutive days. So would you be late in setting the ARD on the 4th day, can you go back and say day three was the last day and set that as the ARD?

(John Kane): That will be fine, we are going to be looking at the issue of the phrase setting the ARD and trying to get a little bit more clarity as to what that should mean for providers but in this case if you if the third day was the July 4th and on July 5th you realized that's fine for expect the ARD for within the allowable window, OK so we still have to be set for day one, two or three but it's fine if we were to do that on July 5th.

Female: And it would not be considered that you are doing it late year entering in it system the day after?

(John Kane): That will be fine.

Female: OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (Helen Carnie) with the Ocean Healthcare. Your line is open.

(Helen Carnie): Yes my question I have a couple of questions here. The first question refers to when the index maximization with the change of therapy OMRA if you are looking at somebody who say HP two when you are looking at that change of therapy seven days later are you looking just at that therapy or also at noticing for example if the therapy work has remained the same but the reason for the nursing itself has changed, is the change of therapy required.

(John Kane): No it's actually a very good question, the change of therapy is only required you are only going to look at the therapy items to determine if a COT is necessary OK so that if their therapy category would have changed, if there was a change in the nursing that would not prompt a COT OMRA however if you determine that a therapy category has changed and that the COT OMRA would be required then you would complete the COT OMRA and then bill whatever the COT OMRA were to come off with OK, and that will then pick up potentially changes within the nursing, I would also add that if there was a change in the nursing and not in the therapy that you were to notice then there are other assessments like the significant change that should be considered as to whether or not those will be necessary.

(Helen Carnie): OK thanks so much, we have another question. OK on slide 52 you talk about you are going to upgrade the system on 9/18 to reflect the change in the RUG levels. If we have already transmitted for example a 30 day assessment with an ARD of 8/24, 8/25 how will we get the changed RUG for fiscal year 2012.

(John Kane): Well OK so there are two possibilities, one is to ensure that the days that will be covered by the assessment would be days that would be following within FY 2012 otherwise you wouldn't need it, however if the assessment is submitted before the 18th that you needed to get the FY 2012 RUG what you could do is submit a modification request do not change anything in the

assessment and is resubmitted and then the validation report that you get will have the same error message.

(Helen Carnie): That's a very good clarification for us to consult we would never have known to do that. OK. Thank you.

(John Kane): OK but just again it has to be submitted after the 18th to get that error message on the validation report.

(Helen Carnie): OK I understand that two modification.

(John Kane): OK.

(Helen Carnie): Also can you define the day of discharge what you actually mean by the day of discharge, are you talking about the day the non-billing Medicare day that they have discharged when you are talking about day seven for the COT?

(John Kane): Yes that was at the non-billable day yes.

(Helen Carnie): OK. Thank you.

Operator: And your next question comes from the line of Elma (inaudible) from Queen's Medical Center. Your line is open.

Female: Yes I am from Queen's Medical Center my question is if the therapist hasn't provided three consecutive days of therapy are they supposed to discharge the patient?

(John Kane): It's going to depend on a particular case but they are not required to discharge the patient at that point. So if the only skilled service they were receiving as therapy and say that they were to not to receive three days of therapy but then were to resume say a few days later then the discharge would not be necessary.

Female: OK and another question is if we are doing a COT and there is a significant change, are we allowed to combine COT plus significant change?

(John Kane): The RAI manual should have all of the various assessment combinations, so in that case if you were to determine that both of them were to occur which I think it will be pretty a rare occurrence but both would need to occur but I believe and this is not something to quote me on but I believe that they may be combined.

But again you should look in the RAI manual in terms of the allowable combinations of assessments to see if those will be combined.

Female: OK one last question, if we have to observation for COT on seven day so would the ARD for COT will be within the seven days or after the seven days.

(John Kane): The ARD for the COT OMRA would be on day 7 OK, as one of the assessments were it is only there is one permissible day to set the ARD to be set and that is day seven.

Female: And if I understand it correctly if there is no change on day seven we need to do another seven day observation period for COT which is the next seven day. Well just to clear about one thing if you are looking at the flat seven days as a whole past seven days as a whole to see if there was a change over the past week if there was no change over the past week from the patients current RUG classification then you would continue until for the next seven days and then look seven days later to see if there is a change during that week.

Female: OK. Thank you very much.

(John Kane): You're welcome.

Operator: And your next question comes from the line of (Tiffany Collins) with Universal Health Care. Your line is open.

(Tiffany Collins): Hi I just had a question about the End of Therapy with resumption versus the Start of Therapy, some will confuse this on two if you are doing (inaudible) therapy with resumption how would you know whether you need to do that versus the startup therapy.

(John Kane): Well I am going to say it in general if you are not sure which one to do then it maybe more likely that the person is not able to resume and you may want to consider the startup therapy. The kinds of cases that we have expected or anticipate for end of therapy resumption would be that say therapy was not provided over the weekend and Monday rolls along and the person just did not want to, did not want to do therapy or the or there was a family business or doctor's appointment or something like that and so they said I am not going to do it for three days but I am going to start, I will do my therapy in Tuesday in that case you can reasonably expect that the person is going to resume therapy at the same level.

However, if to say the reason that you missed therapy was that the person had to go, somebody had to go to the ER or something occurred with regard to developing an illness then you might consider whether or not they are going to be able to continue with the same therapy regime.

(Tiffany Collins): OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (Jane Galer) with Sharon Lane Health Services. Your line is open.

(Jane Galer): Thank you, Sharon Lane Health Services. I think most of the questions I have has been answered just one clarification the RUG changes like someone is in RUB and they change to an RUA will we do have to a change of therapy OMRA at that point or just if it changes from an ULTRA to a very high.

(John Kane): Very good question, thank you for bringing that up. No if there is a change due to ADLs which would refer to really to the third letter in the RUG code then no you would not need to do a COT it is only if there was a change as a short hand in the second letter of the RUG code that is the U, V, H, M, L if there was a change in that then you would need to do a COT if the changes in the third letter the ADL changes do not require a COT OMRA.

The clarification document that Sheila referred to will actually as exact clarification.



(Jane Galer): All right. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of Rebecca Willey with Trinity Medical Center. Your line is open.

Rebecca Willey: Hello?

Male: Yes I am sorry I know that we have already asked questions but we had a few that weren't in front of the person that I was speaking so it's not her fault.

(John Kane): You're lucky enough to be in the queue twice but good for you.

Rebecca Willey: But here is the question I do have just to clarify we want to make sure we have had our head wrapped around it correctly.

First off we are a skilled nursing unit that's within a hospital so does any of this apply to us differently?

(John Kane): No the policies apply to all PPS providers.

Rebecca Willey: OK and if we are doing a change of therapy assessment every seven day one if the ARD is set for day 17 is that seven day window then starts day 18th?

(John Kane): Yes we think same thing, I was thinking no it was day 7th. You are right if you were to set the ARD for the COT OMRA on day 17 then the next one would begin on day 18th yes.

Rebecca Willey: OK I just wanted to clarify that and again because we are a skilled nursing hospital how does this ABN apply to us, this is not verbiage that we're used to, we do the letter that we give at the end when we are doing the discharge and getting them prepared to discharge to home the required letter that we give to Medicare notification letter. We are not used to ABN letters been handed out in our type of setting.

(Donna Williamson): OK. This is Donna and I am sorry I missed beginning of what you were saying but are you asking if an ABN if they are been discharged if an ABN is necessary?

Rebecca Willey: No I guess what I am asking is the ABN letter is not something that we frequently are handing out to patients at this point. What we need to know is with the rulings that you are giving is this something that necessarily in our type of setting because we are within hospital halls that we are still going to hand to patients, all of our patients are skilled obviously we don't use Med B and obviously not Medicaid.

We are just strictly Medicare A or a Medicare supplement or private insurance at this point.

(Donna Williamson): OK the ABN would only be necessary if the beneficiary or the resident is going to enter into custodial setting.

Rebecca Willey: Which is a long term care facility?

(Donna Williamson): I think you probably have not used this very much at all. If you had a patient that you felt no longer required skilled care but was would does not want to leave.

Rebecca Willey: Right I do understand that then would be necessary at that time.

(Donna Williamson): That would be required where you do the ABN but in most cases it sounds like you have fairly short stay people they are all getting skilled care, I am not sure if they would be need for you to use ABN notices as there might be in some other kinds of facilities.

Rebecca Willey: OK I just wanted to clarify that because I do understand why they are necessary but in our study they are not long term residents that stay within our walls. They get better and go home and usually all services will be covered in less and I do understand if they can decide they want to utilize the service that we're telling them would probably not be covered or they can no longer stay that's when we would let them have one of those.

(Donna Williamson): Right in the event if they wanted to stay or if they wanted a particular service. I can give you our email address and if you have any other questions or any point in the future you can always send them and I can help to clarify, would you like to get that email address?

Rebecca Willey: Sure.

(Donna Williamson): OK, it's [revisedabn\\_odf@cms.hhs.gov](mailto:revisedabn_odf@cms.hhs.gov).

Rebecca Willey: HHS?

(Donna Williamson): .Gov.

Rebecca Willey: OK.

(Donna Williamson): And I will read it to you again one more time its [revisedabn\\_odf@cms.hhs.gov](mailto:revisedabn_odf@cms.hhs.gov).

Rebecca Willey: OK.

(Donna Williamson): OK. Thank you.

Rebecca Willey: Thank you.

Operator: Your next question comes from the line of Catherine Dale with Jewish Home for the Aging. Your line is open.

Catherine Dale: Hi, my question I don't mean to be the dead horse going back to the question of the I have lost my (inaudible) when we have to do expect for the seven day for the COT and doing that it's a OK looking at a facility that is really a long term long term facility. We have social workers Monday through Friday at MDS coordinators Monday to Friday but with the 7th day would be on a Sunday and we don't, we have therapy seven days a week but we don't know what's happening that Friday, Saturday or Sunday by the end of the day then we come in on Monday and find out that we need to do this they have only 715 minutes versus 720.

How do we do this with social service I mean are we supposed to change the way we run our facilities now?

(John Kane): In terms of doing the interviews? What exactly?

Catherine Dale: Yes the interviews yes how would we do the interviews, how we do this whole process in setting up looking at that seven day and accomplishing these tasks five at seven day is necessary when it falls on weekends holidays.

A typical long term SNF doesn't have everyone there seven days a week.

(John Kane): The interview questions are something that we are going to take under advisement we are going to look at and we will try and issue clarification on that in the near future. As far as the seven day (inaudible) as you were saying the therapies provided seven days a week and so much as the SNF to be based off of daily scale services I am not going to say we would require change in your facilities practices but that the facility be able to accommodate the policies as they are been (inaudible).

But I mean in this case as far as the interview questions again it's something that we will try and get back to you guys on as soon as possible.

Catherine Dale: OK now I also want to have another question back to the slide 52 and talking about the calculations for the RUGs and it says going from 8/22 starting then are you suggesting that we don't transmit our MDS now and wait to hold off to do that so that we get the RUG group for year 12?

(John Kane): You can do that or again you can submit the MOD request and don't change anything in the assessment and you will get the validation report that you get on the MOD request will have the FY '12 as long as it's submitted after 9/18.

Catherine Dale: OK thanks, I am sorry for my in articulate there.

(Donna Williamson): You were fine.

Operator: Your next question comes from the line of (Darcy Weston). Please say your company name before asking your question, your line is open.

(Darcy Weston): I think most of it's been answered, can you clarify one more time can you combine the COT with the discharge assessment if the therapy didn't provide coverage because they knew they were going home that time and they discharged, do we do the COT and can it be combined with the discharge.

(John Kane): If the COT is due prior to the time of the person is discharged then the COT would be required, if the person is discharged either on day seven or prior to that during the COT observation period then a COT is not required and so it wouldn't be need to be combined with anything.

(Darcy Weston): I was just talking about on that day the COT would be required?

(John Kane): On day seven even if the discharge day is on day seven then a COT is not required and wouldn't need to be combined.

(Darcy Weston): OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (Sharon Coleman with Future Care Gold Springs). Your line is open.

Female: Hi, this is (inaudible) from Future Care this question really doesn't pertain to today but I was just curious to find out where we are with possibly getting rid of the discharges to the full assessment for discharge assessment are we going to be going back to where we used to do them and MDS 2.0.

(Sheila Lambowitz): Hi this is (Sheila); our Office of Clinical Standards and Quality has been working on streamlining the discharge assessment and they have not yet issued their final revisions that will be coming probably within the next few months. So there will be a streamlining of these discharge assessment but will not go back to the old way.

Female: OK. Thank you very much.

Operator: Your next question comes from the line of (Tammy Johnson with Kindred Healthcare). Your line is open.

(Tammy Johnson): We are going back to ask a clarification question based on the manual, you may want to take a look at the MDS users guide chapter two, page 68, you have a description on how you combine a change of therapy OMRA and a discharge assessment and based on that it says we have to do if it falls on day seven.

Female: Thank you for pointing that we will check it.

(John Kane): We will take a look at that.

(Tammy Johnson): Thank you.

(John Kane): Thank you.

Operator: Your next question comes from the line of Stacey Hunter with River View Health Services. Your line is open.

Stacey Hunter: Just questioning about this special MDS done for change of therapy that goes both ways so two we have a resident that is becoming stronger that has additional therapies ordered then we would also do one print increase in RUG category, right?

(John Kane): Absolutely if we were somewhere to go from very high to ultra then that would require a COT.

Stacey Hunter: Thank you.

Operator: Your next question comes from the line of (Donna Hubert) with (inaudible). Your line is open.

(John Kane): Hello Donna.

Operator: (Donna Hubert) your line is open.

(John Kane): OK.

Operator: Your next question comes from the line of Teresa Adams with Blakely Care Center. Your line is open.

Teresa Adams: Thank you. I was wondering if there is some type of evaluation form or something that could be used with the looking at the change of therapy evaluations timeline, I am not familiar with one I know therapy does their own sort of evaluation but as the MDS nurse I would like to know if there is some kind of form or something that I could use to evaluate change of therapy time.

(John Kane): There is no form or anything that we there is no official form or anything that we have issued because we wanted to allow facilities with flexibility to (inaudible) for themselves how they were going to evaluate this within to comeback to policy. However, what I can tell you is basically what you are looking at is you are comparing the RUG those take index maximization out of it and just make it simple case of person who is classified into say very high rehab, you will look at OK and so on the previous assessment you will be able to see that the hitch code that they receive in section (inaudible) was for a very high rehab category whether it be RVB, A or C.

Teresa Adams: Yes.

(John Kane): You will then look at the therapy that they received during that past week whether it be an evaluation of therapy logs, or how will you choose to evaluate your therapy you will look at the amount of therapy they received as well as the days and disciplines and all the other qualifiers for the therapy category and see if that person remains and very high. Whether or not the ADL change or anything else the only question is, is that person still qualified for very high rehab after that week if they are then you don't have to do a COT.

If for whatever reason they are no longer qualified for very high rehab, then the COT will be required.

Teresa Adams: OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (Helen Carnie) with the Ocean Healthcare. Your line is open.

- (Helen Carnie): My question is for the RAI page 2-50 the first bullet says an evaluation of the necessity for COT OMRA must be completed after the COT observation period is over so if we cannot evaluate until it is over how could we start doing interviews on day five or six and we have to wait until it's over.
- (John Kane): Again the interview issue is something we are going to be looking at in the near future and will issue a clarification on that as soon as possible.
- (Helen Carnie): Thank you.
- Operator: Your next question comes from the line of (inaudible) from Alliance Training. Your line is open.
- Female: Yes one more question, if you evaluate the therapy that the resident is getting during the seven day period and you decide that the therapy delivery the resident has not changed to the point that it is going to change the RUG then we are just going to let the records that are available for that time describe that or should a note be put into the chart that says the therapy as a level of therapy did not change or are they going to be going any documentation requirements to confirm that?
- (John Kane): The documentation that you guys currently have should be sufficient to substantiate the record that the COT was not required if as a short hand if you wanted to put a note in the record saying that a COT was that the necessity of a COT was evaluated and was deemed not to be necessary I think that's good, I think could be certainly helpful but again the documentation if for whatever reasons it would be subject to medical view the documentation should be capable of substantiating whatever decision the facility makes.
- (Helen Carnie): Yes because I see the MDS managers or the MDS nurses being the person that is going to in the end look at this whole picture and be the primary person responsible for making the decision and so you think that might be helpful to if we do not need the assessment and for obvious ways you need the COT assessments then you are going to do it and you don't have to put a note in about that.

OK. Thank you very much.



(John Kane): You're very welcome.

Operator: Your next question comes from the line of (inaudible) with Georgetown Manor. Your line is open.

Female: I was wondering how you do the seven day that you are going to observing them but with that been on October 1st, do we start all of the Medicare on October 1st even though you know until they are set to do again like the ARD date?

(John Kane): As far as, I will speak to the (COT) I think I understood your question, as far as the COT is concerned it would you would be giving the evaluations beginning with the next assessment that hasn't aired on or after October first so if you had an assessment has an ARD that happen to be on October 1st then the COT policy would kick in October 2nd if the next assessment within ARD on or after October 1st occurred with an ARD of October 16 then October 17 would be the first day of the COT period.

Female: OK so we wouldn't have to worry about them until they have ARD date number.

(John Kane): Right it will be difficult to try and do that otherwise.

Female: OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of Julie (inaudible) Saint John's Good Samaritan. Your line is open.

Female: If it changes therapy is indicated do the therapist have to do a new formal evaluation and plan of treatment.

(John Kane): The items that they were using for the COT is same as the EOT is a new therapy evaluation would not be necessary.

Female: Would not be necessary even if it changes drastically?

(John Kane): Well OK let me point out something, if it would changes drastically to the point that you think that some other type of assessment might be necessary that you may have to do some sort of an EOT and then startup therapy to do the new eval.

Female: Right.

(John Kane): Then that certainly possible I mean that's up to the discretion of the particular facility and again something that we will monitor to see whether or not a person going from ultra to low and why that exactly occurred and if there was anything else that may have occurred during that time but prompted such a drastic change.

Female: Right.

(John Kane): Again at the discretion of the facilities to determine what types of assessments they feel more appropriate in that case.

Female: Right but if it would go from a very high to an ultra-high would a formal plan of treatment have to be completed?

(John Kane): No most likely, again let me sort of hedge my bet a little bit in most cases no it would not be necessary plus at the discretion of the facility they were to determine that it was.

Female: OK. Thank you.

Female: If the therapist documentation would have to show what happened with that patients and why the therapy was increased.

(John Kane): Yes.

Female: Or decreased.

Female: Or decreased.

(John Kane): Yes.

Female: OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (inaudible) with Queen's Medical Center. Your line is open.

Female: Hi can somebody provide me with the website on the update for the RA manual?

(John Kane): The update for the RA manual should be on the MDS website which is on slide 58 I believe it was so the second bullet on that is [https://www.cms.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp](https://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp) and probably it will be easier to go to our website and if you were to look at the slide it's the second bullet of slide 58.

Female: Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (Janet Grever with Grever Consulting Services). Your line is open.

(Janet Grever): Thank you this is (Janet Grever from Grever Consulting Services) in Pennsylvania, I had been slowly but surely dissecting chapter two and chapter six after they have been hosted. I had picked up and already had transmitted some of my questions regarding chapter two, in chapter six on page seven example five, it refers to the end of therapy OMRA been completed followed by a 30 day assessment also been completed however it be end of therapy with data this day 24 and if that is the case you would have three days to complete the end of therapy OMRA which would give you the availability of day 27 which would combine with your 30 day should they not be done together this was given in an example and it's those areas of examples that I am just concerned first was my assumption corrected, it should have been combined and two additionally number seven I have some concerns.

If indeed these concerns are valid is there some way that CMS can have them posted out there before we go into the October 1 date.

(John Kane): We will look at the examples; we don't have the updated RA manual in front of us. I will say though that just from the details of the example you described if the EOT was set for day 24 it could be set for day 27 but it's needed to be set for day 27 they can choose to set it for and actually if we set it for day 24 it will be set for 24, 25 or 26 so 27 wouldn't be an available day.

But even if it were...

(Janet Grever): I am sorry the end of the therapy was dated as day 24 so 25, 26, 27 would be your dates and if my assumption if I am correct that you were supposed to combine them if that would be the case.

(John Kane): You are only to combine them in the case that an unskilled assessment is necessary and the ARD for these scheduled assessments has not yet been set so. In this case if the EOT was completed on day with an ARD of day 25 or 26 then the it would not need to be combined. If however, it was set for day 27 then you would combine it.

(Janet Grever): OK but you will have the option of going ahead and doing both I had assumed that you were supposed to combine them, OK. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (Susan Jorgensen) from (inaudible). Your line is open.

(Susan Jorgensen): All right this is (Sue Jorgensen) I just have a simple question after the ARD day I just have a simple question after the ARD date is set and then it is completed within the standard that the (inaudible) is completed within the standard time as the other ones 14 days.

(Penny Gershman): Yes that's correct.

(Susan Jorgensen): That's what I taught; I just wanted to double check myself.

(Penny Gershman): Good job.

Operator: Your next question comes from the line of (Mitchell Shelf with Golden Living). Your line is open.

(Mitchell Shelf): Good afternoon, and you may have addressed in chapter six I have not yet got the chance to crack it open yet but due to the default billing roles supply to early or mid-change of therapy.

(John Kane): I don't think that's it's something that is, I am not sure if it is in chapter six, again it's not in front of us but it's something that if you wanted to do email one of us and we can follow up with you at some future point.

(Mitchell Shelf): OK that will be great. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of Stacey Perry with The Sarah A. Reed Retirement Center. Your line is open.

Stacey Perry: Hi this is Stacey Perry, can you just clarify I am assuming that these new OMRA along with the older OMRAs are only for traditional Medicare and not managed care.

(Penny Gershman): You mean Medicare Part A.

Stacey Perry: Yes.

(Penny Gershman): Yes that's correct.

Stacey Perry: OK. Thank you.

Operator: Your next question comes from the line of (Marie Fico with Daughters of Israel). Your line is open.

(Marie Fico): Yes I have a question going back to the modification that was asked earlier, if we had submitted MDS from 822 to ARD what monthly modification would we do, or we just send them through again?

- (John Kane): I think you just send them through again.
- (Marie Fico): OK. Thank you.
- (John Kane): You're welcome.
- Operator: Your next question comes from the line of (Marie Qin); please state your organization name before asking a question. Your line is open.
- (Marie Qin): Yes it's (Marie Qin) from Genesis Healthcare, just couple of questions, one does (inaudible) over midnight less than 24 hours have an impact on counting days of no therapy for the purposes of end of therapy.
- (Penny Gershman): No it doesn't it's not that, if it's over a midnight the previous day was not a Medicare day and it does not impact accounting days and end of therapy.
- (Marie Qin): Great two, since the change of therapy is retrospective should providers wait until the observation periods have passed before they transmit claims that could be affected because as you know to cross into the next month then you have to go retrospective will there be an issue of a number of claim adjustments or increases for us because they will if you are been paid on one RUG but the end of the observation period goes into the next month and it's retrospect and the days of the prior month.
- (Sheila Lambowitz): That's a very, very good question. Hopefully there aren't going to be too many of these and it might be appropriate to hold those bills because nobody wants to have a lot of adjustments to deal with. We will try to get a clarification on this.
- (Marie Qin): Great and one final one, so we should anticipate the RUG, should we anticipate RUGs build after 10/1 on assessments with ARDs of A22 or later to be different than the RUGs build for the same (inaudible) prior to 10/1 or is it only the rate that will change. I know the rates are changes but you are saying there will be an actual different RUG calculated.

(John Kane): Right the primary reason for that is due to the allocation of group therapy, so that could affect the actual RUG score but you are right the majority of changes will be in the rate.

(Marie Qin): OK but if for example there is a group therapy when you do your ARD in September there was some group the old rules applied so you don't have that new calculation that you might have a higher rehab RUG based on those rules and that would take for days that are available in September but then in October that will be recalculated under the new group rule.

(John Kane): That's correct.

(Marie Qin): If that's what you are talking two on the validation report.

(John Kane): Yes ma'am.

(Marie Qin): Great got it. That's it. Thank you.

(John Kane): You're welcome.

Operator: Your next question comes from the line of (Ed Gira) with Regional (inaudible). Your line is open.

(Ed Gira): My question has to do with actually it's on the meeting of the 23rd I read the final rule and it talked about documentation therapy services and probably encourage a timestamp for all sessions. I think it was a comment on the call on the 23rd that went a bit further and said this will now be a requirement. Is it strongly encouraged or is it a requirement to use timestamps for therapy session.

(Sheila Lambowitz): It's not a requirement, we suggest the timestamps because that's something that's fairly simple and easy but you have to remember that if a claim is reviewed if the reviewers are looking to confirm minutes they need to have an idea of when this service started and stopped and they also need a way to determine whether the service was provided on an individual concurrent or group basis.

So you are going to have to figure out a way to show that in your documentation. We are not mandating now.

(Ed Gira): I read it isn't allowed to document individual versus concurrent versus group then in present does not include the actual timestamps well that is something that we can turn on the system and are considering doing.

(Sheila Lambowitz): I mean again it was a suggestion but you have to remember that if your claims are subject to review you do need to support the minutes that you reported on the MDS.

(Ed Gira): OK that sounds very nice. Thank you very much.

(Sheila Lambowitz): Sure.

Operator: Your next question comes from the line of (Vickie Norman) with (inaudible). Your line is open.

(Vickie Norman): My question is regarding the change of therapy OMRA reimbursement when you are on your 7th day and you look back and you see that your RV it would increase to an RU for example, you will do your change of therapy payment then goes back to seven days ago or eight days ago is that correct and if it does the reverse if my RV improves to an RU two days after my seven day look back period I am waiting an additional five days to get reimbursed to PRU level is that correct?

(John Kane): Yes if the change goes whichever direction the change goes the change is retrospective back to day one of the COT observation period. If a change were to occur two days later which you want to wait until the end of the week to determine if the change was (inaudible) to change the RUG category then it would go back to the beginning of that COT observation period. So the changes is always retrospective at the beginning of that one COT observation period.

(Vickie Norman): Thank you.

(John Kane): You're welcome.



Operator: Your next question comes from the line of Dianna Adams with West Virginia University Hospital. Your line is open.

Dianna Adams: I had a question about the limitations on concurrent therapy, going back to your example of this supervising therapist and student each training two patients concurrently and that not been allowable under any guidelines and my question would be what the limitations are building concurrent therapy?

(Penny Gershman): You asked me how to build concurrent therapy when you have a student?

Dianna Adams: No I am asking if there are limits what the limitations are to treating two people or three people or whatever, where do you draw the line with concurrent therapy that in that example none of that therapy will be considered billable under any guidelines.

(John Kane): The guidelines as far as concurrent therapy haven't changed in terms of their definition and if two patients that are being treated at the same time doing different activities. So that definition remains the same.

Dianna Adams: My question is that is it limited two patients?

(John Kane): Yes concurrent therapy is limited to two patients only.

Dianna Adams: OK that was it. Thanks.

(John Kane): You're welcome.

Operator: And our next question comes from the line of (Marilyn Mines) with Trust Manager of Clinical Services. Your line is open.

(Marilyn Mines): Thank you I have two questions, they both relate to the end of therapy OMRA and the end of therapy OMRA resumption. If you are anticipating that the resident is going to be at the same level of care and you do an EOTR and then you are checking for seven days for the COT and you find that they did not make it to the level that they were at before, do you just resolve that with a COT OMRA retrospect to the first day after the ARD or the date that the therapy was resumed excuse me.

(John Kane): Yes the answer is yes.

(Marilyn Mines): And the other question I think was addressed last time when we talked and that was that if the resident is – category and has missed three days of services are we still – are we able to bill at the default level I think that’s what we said and I just want a clarification on that.

(John Kane): Actually I am really glad that you brought that up for the clarification. Thank you. When we said that your (inaudible) is default it was that is sort of a shorthand for that you will be billing whatever comes off of the EOD OMRA when that’s done.

If a person is not receiving any other skilled services then in many cases they would be receiving the equivalent of a default rate and so that is what we were referring that within that context.

However to be clear if the EOT OMRA is necessary no matter what, what you bill is whatever comes off of the EOT OMRA.

(Marilyn Mines): Thank you very much.

(John Kane): You’re welcome.

Operator: Your next question comes from the line of Carrie (inaudible) with Saint Gabriel's Community. Your line is open.

Female: Hi I have a couple of questions, first of all if you have, if we have a resident who is skilled for Medicare purposes for just therapy services and they do have a four day break and then resume therapy on day five is it appropriate to keep them skilled on Medicare during that five day period?

(John Kane): It may be appropriate to keep them on Medicare and it may be appropriate to issue the ABN what one of the things we want to make clear is that ABN exists to provide the beneficiary with sufficient time and information to make a decision about their care.

We also want to say that it's been our long saying policy that the requirement for daily skilled services should not be interpreted strictly so that it would not

that it wouldn't meet skilled services because there was a temporary interruption for a day or two. It may be that they had a fatigue or something where the discharge from the SNF wouldn't be practical.

So in those cases it's at the facilities discretion to determine if an ABN will be necessary and if the person, if they feel the person still meets the definition of skilled care and then it's something that we would have to justify.

Female: OK my next question is if you have a 30 day ARD set for day 30 and do you determine on 28 that you need to do a change in therapy. Can you keep that change of therapy on day 28 and still keep that 30 day on day 30 or do you have to move that 30 day ARD back to be combined with that change of therapy?

(John Kane): If the COT is due on day 28th and you had planned to do a ARD on day 30 you would actually have to move it up and combine it yes.

Female: OK. And then I have to go back to what you had said earlier about if you have an end of you had a three-day break in therapy and you didn't realize until day four that it was OK for you to go back and set that ARD for day three on day four. Does that apply to everything, I mean that just goes against what (inaudible) says that your ARD must be set within the allowed window.

(John Kane): Right this is something...

Female: Or you would be default.

(John Kane): As far as the idea of setting the ARD OK and normally that's taken to mean open the assessment within the computer system or something side effects, if it set if it's done on the 4th day that is acceptable and again we will working on this and trying to come up with a clarification in the near future.

Female: But does that only apply to the end of therapy or does that apply to the change of therapies to a regular scheduled PPS assessment?

(John Kane): No it applies to all.

Female: You will get defaulted; it's like setting the ARD late.

(John Kane): It's something that we will be clarifying in the near future.

Female: OK.

(John Kane): All right. Thank you.

Female: OK. Thank you.

(Gregory Price) Hey (Stephanie) can we make this the last question please.

Operator: Certainly. Your next question comes from the line of James Evington with Angela James (inaudible). Your line is open.

James Evington: And it's an easy question for you, one of coworkers is out on vacation and I noticed that you had said that there is going to be an encore presentation, you had said I think it was at 6 PM Eastern Standard until 9/9/11, does that mean it's every night till then or just on 9/9?

(Gregory Price) It's only question for me, OK all right I will chime in. Yes I was going to add this towards the end of the while we close in and wrap this up. Yes it will be available tonight at 6 PM Eastern Standard time and all the way through till Friday, September 9th – 24th yes even over the holiday as well.

James Evington: All right. Thank you.

(Gregory Price): You're welcome.

(Gregory Price): OK I think that's.

(Sheila Lambowitz): All right I think that was our last question. I want to thank all of you for participating and we got some very, very good questions. We will research a few of the issues as we stated and we will get out more information to you just as quickly as possible.

And I think based on the kind of questions we had I think we are now in a much better position to move forward to October so thanks a lot and enjoy the labor day weekend. Bye.

(Gregory Price): OK again I'll just repeat what I just said few minutes ago, the encore representation will be available at 6 tonight Eastern Standard time and we will go through till Friday, September 9th next Friday week from tomorrow at midnight and again that can be accessed throughout that time even on labor day.

So with that (Stephanie) we have concluded and again thank you everyone.

Operator: And this concludes today's conference call. You may now disconnect.

END