Eli's Rehab Report

SNFs :Say Hello to Big-Time Proposed Changes to SNF PPS

Proposed RUG-IV ditches therapy projection, and more.

The proposed Skilled Nursing Facility PPS update unveils significant changes to the SNF payment landscape \" and Part A therapy got a fair share of changes too.From no more therapy projections to a higher scrutiny over dovetailing, some workflow adjustments may be in store.

Bottom line: Adjusting is going to be a big challenge, experts say. "The SNF rule has the feel of the level of changes in the 1998 rule implementing PPS," observes **Peter Clendenin,** executive VP of the National Association for the Support of Long-Term Care.

CMS Goes to Work on RUGs and ADLs

Make sure you know these RUG and ADL changes, as they may trickle down to affect your workflow. The RUG-IV system, which incorporates the Staff Time and Resource Intensity Verification (STRIVE) findings, has 66 RUGs, compared to the 53 RUGs in place now.

Rehab Plus Extensive Services, rehab, Extensive Services, Special Care, and Clinically Complex are still in the RUG line up. But Special Care now has a low and high, says **Ron Orth, RN, NHA, CPC, RAC-MT,** president of Clinical Reimbursement Solutions LLC in Milwaukee. The proposed RUG-IV system combines the RUG-III impaired cognition and behavioral categories into Behavioral Symptoms and Cognitive Performance.

Don't miss: Proposed ADL changes would affect RUG categories in terms of the ADL point ranges. Instead of the ADL index going from 4 to 18, as it does under RUG-III, it will go from 0 to 16, which is a "huge change," notes **Peter Arbuthnot,** regulatory analyst with American HealthTech in Jackson, Miss.

To compute the RUG-IV ADL Index, the Centers for Medicare & Medicaid Services proposed adding the component of the ADL scores, which would include both self-performance and support, for bed mobility, transfer, eating, and toileting. As for calculating individual late-loss ADLs, it looks like CMS is reverting back to the old way of scoring ADLs with a few additional changes in coding, Orth says.

Key In to These Therapy Changes

The proposed rule seeks to eliminate the therapy projection now in Section T of the MDS 2.0. CMS is proposing a person be assigned a RUG score based on how much therapy he received while in the SNF only for a few days, Orth says.

However, Section T is still on the MDS 3.0 draft, which is surprising, says consultant **Pauline Franko, PT, MCSP,** president and owner of Encompass Consulting & Education LLC in Tamarac, Fla.

Another change: SNFs would be required to do an Other Medicare Required Assessment not only when therapy ends but also when therapy starts. This would allow CMS to more accurately account for how much therapy the resident actually received so the RUG classification is more accurate, says **Roberta Reed, MSN, RN,** a consultant with Plante & Morgan Clinical Group in Cleveland, Ohio

Watch out: The proposed rule also hones in on concurrent rehab therapy, which CMS defines as a professional therapist treating multiple patients at the same time while the patient performs different activities.

CMS notes that Medicare currently has no restrictions on the amount of concurrent rehab that a SNF can code on the MDS. But STRIVE data show that approximately two thirds of all Part A therapy provided in a SNF is now being delivered

on a concurrent basis rather than individually, the rule pointed out.

The data also showed that under RUG-III, patients treated concurrently typically go in higher therapy groups than appropriate "based on the therapy resources actually used to provide care for those patients." CMS thus proposed that each therapy discipline allocate concurrent therapy minutes before reporting total therapy minutes on the MDS 3.0. CMS is soliciting comments as to whether therapy data need to be reported separately by therapy mode (individual, concurrent, group) on the MDS 3.0 or whether it will be sufficient to document that information in the medical record.

Not all bad: CMS admits that concurrent therapy can be a legitimate modality when used properly based on individual care needs as determined by the professional therapist's clinical judgment. However, the agency warns that concurrent therapy should be an adjunct to individual therapy and an exception rather than the standard of care.

Prediction: Concurrent therapy could end up being something that the SNF can count but only a portion of it, Franko says. "For example, currently, group therapy can only contribute 25 percent to the RUG levels."