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Long-Term Care Survey Alert

MDS, Compliance & Clinical News to Use

During CMS' Nov. 3 national provider call on the MDS 3.0, the agency's **John Kane** clarified an Oct. 1 RAI manual revision on Part A therapy co-treatment. "As a formal definition, co-treatment refers to a case of two clinicians, which is two therapists, two therapy assistants, or some combination thereof, from different disciplines, treating one Part A resident at the same time with different treatments," said Kane. "For example, if a speech language pathologist and an occupational therapist do a meal with a patient, the OT is working on feeding skills and fine motor coordination of the utensils while the SLP is working on swallowing skills," he added.

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

A slide from the call also quotes from the RAI manual, which states: "The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented in the plan of care for each patient." "This is because," said Kane, "co-treatment, as defined here, would only be appropriate for specific clinical circumstances and not necessarily for every patient."

Kane and CMS' **Penny Gershman** also explained recent PPS clarifications. (For details, see the lead **During CMS' Nov. 3 national provider call on the MDS 3.0,** the agency's **John Kane** clarified an Oct. 1 RAI manual revision on Part A therapy co-treatment. "As a formal definition, co-treatment refers to a case of two clinicians, which is two therapists, two therapy assistants, or some combination thereof, from different disciplines, treating one Part A resident at the same time with different treatments," said Kane. "For example, if a speech language pathologist and an occupational therapist do a meal with a patient, the OT is working on feeding skills and fine motor coordination of the utensils while the SLP is working on swallowing skills," he added.

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Kane and CMS' **Penny Gershman** also explained recent PPS clarifications. (For details, see the lead "The fact that might be a standard in the market doesn't make it legal," Sanders warns. "Nursing homes should make sure their staff, including their social workers, who usually deal with hospice, are aware of the anti-kickback requirements."

Sanders also notes that one frequent compliance issue related to hospice in nursing facilities is "inconsistent billing where the nursing home pharmacy is billing the resident separately [or a payer] for medications covered by the hospice."

"Sometimes it's a judgment call and a clinical decision where you have to sit down as a team and evaluate the patient and figure out which drugs are related to the terminal illness that hospice is responsible for," says attorney **Connie Raffa** with Arent Fox in New York City.

Another issue, which represents a "huge survey and care risk" involves "poor communication and poor documentation between the hospice and nursing home [so that] the care plans don't align -- or the nurses at the respective

organizations don't understand the delineation of their responsibilities," adds Sanders, with Post & Schell in Harrisburg, Pa.

Editor's note: For more information on the OIG's views on hospice and nursing homes, see the transcript from an OIG podcast on the agency's recent report, "Medicare Hospices That Focus on Nursing Facility Residents," at http://oig.hhs.gov/newsroom/podcasts/2011/nudelman.asp. Also read that report at http://www.oig.hhs.gov/oei/reports/oei-02-10-00070.pdf.