MDS Alert

Case Management: Plan to Manage RUG-IV Rehab Payment Realities With These 4 Strategies

Experts suggest concurrent therapy has a role in these scenarios.

RUG-IV changes the playing field for rehab, but you can plan now for how to keep your resident care on solid footing and put your SNF on a trajectory for success.

1. T hink through scenarios where concurrent therapy still makes sense. SNFs will only get credit, RUG-wise, for half of the concurrent therapy minutes recorded on the MDS 3.0. The MDS 3.0 RAI manual defines concurrent therapy under Part A as treating two patients at the same time, regardless of payer source, who aren't performing the same or similar activities. Both of the patients "must be in line-of-sight of the treating therapist or assistant for Medicare Part A," the manual states.Even with the payment change, however, concurrent therapy will have its place under RUG-IV, say some experts.

Good point: CMS' "STRIVE study didn't question the efficacy of concurrent therapy -- it questioned the billing method," says **David T ate,** a physical therapist and senior director of client relations with Peoplefirst Rehabilitation in Louisville, Ky.

As a therapist, Tate could see using some concurrent therapy when treating two patients on a B.I.D basis (morning and afternoon) who could benefit from and want a lot of therapy. In that case, Tate might give them 30 minutes each of individual therapy in the morning. Then he'd include them both in a 60-minute concurrent therapy session in the afternoon. And he would record 60 minutes of concurrent therapy for each patient on the MDS 3.0, knowing that only half of those would count toward each resident's RUG placement.

Even so, "I don't lose any efficiency for that hour by seeing both patients," Tate says.

Another example: Concurrent works well for promoting socialization and competition in some cases, says **Katy O 'Connor**, a physical therapist and director of therapy services for Medical Director Services based in the Bronx, N.Y. "The older generation in nursing facilities now often didn't exercise much when they were younger. And you can get a wonderful rapport going between the residents in concurrent" so they aren't just coming to the gym to exercise on their own.

For scheduling purposes, "you could use concurrent to get the number of days of therapy in, but days aren't usually the issue as much as getting the number of minutes," O'Connor adds.

Compliance tip: "If you do concurrent [based on residents' needs] and that's your practice pattern, then follow that pattern all of the time," advises **Marilyn Mines, RN, RACCT, BC,** manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill. In other words, you don't want to have a pattern where you just do individual minutes for residents during the assessment window and a lot of concurrent otherwise.

2. Reap the benefits of group therapy. In a survey, Aegis Therapies found that its clinicians chose group therapy for its competitive and motivational aspects, reports physical therapist **Martha S chram,** president of the Delafield, Wis.-based company. But the clinicians also chose some patients whom you wouldn't normally consider for group -- "that is the people who didn't really see any hope for themselves." says Schram.

An example includes patients "with multiple medical problems and perhaps some depression" who haven't been motivated to participate in therapy, Schram says. "When you put those individuals in the right group with the right facilitator, it can ... engage them more fully than oneon-one therapy."

2 predictions: SNFs may end up providing additional group therapy under RUG-IV, in part, for definitional reasons, predicts **Mark Besch**, a physical therapist and VP of clinical services at Aegis. That's because therapists may realize that what they had been doing as concurrent therapy (treating two or more patients performing similar activities) actually meets the definition for group therapy, he says.

He also foresees SNFs providing two types of groups under RUG-IV. "One will be the very purposeful and planned group that has a name," he says. The other type of group might be a more spontaneous one rather than the "three day a week balance groups," as an example.

3. Hone treatment plans with home visits. Therapists could use home visits more frequently under RUG-IV, says **Garry Woessner, MA, MBA, CAS**, regional director of rehabilitation for Benedictine Health System in Duluth, Minn. Doing so helps make sure the treatment plan is on the mark "and addressing all of the patient's barriers to safe independence."

That approach, in his view, helps maximize use of individual therapy minutes to help a patient achieve a goal of returning home or to the community. Tate agrees that "we need to develop that model more." He points out that "so many patients and their families believe that patients are independent after achieving minimal functional benchmarks in our artificial SNF environment," he says. Yet the SNF "is really nowhere near what they will face at home."

4. Realize documentation is key. "On the front end, the decision to do concurrent, individual, or group has to be a clinical one, and you need the documentation to support that decision," says Schram. Too often "you don't see clinical documentation about a patient being in concurrent therapy," but therapists need to provide it. When providing group therapy, the clinician should "describe the group the person is in, how the group fits into the individual person's treatment plan, and goals, etc."