MDS Alert

MEDICARE :Take a Look at Part A Current Concurrent Therapy Now

The handwriting appears to be on the wall for this modality.

When CMS expresses concerns about a common practice, as the agency does about concurrent rehab therapy in its May 12 proposed SNF PPS rule, consider yourself forewarned. In the rule, CMS says there are currently no MDS coding restrictions for concurrent therapy in terms of the number of patients that a therapist can treat at the same time.

CMS does, however, say individual therapy is usually the ideal.

Take away message: CMS hasn't clamped down on concurrent therapy but does propose some changes in the rule (see the article on p. 74). Even so, facilities interested in using best practices should take a look at how they are using concurrent therapy now, suggests **Pauline Franko, PT, MCSP,** president and owner of Encompass Consulting & Education LLC in Tamarac, Fla.

"Some therapists report they are forced into providing treatment concurrently by the number of patients on their case loads and unreasonable productivity levels," Franko says. "In some cases, this may be due to PT shortages," she adds.

Beware: So-called "round up therapy" is most problematic and risk prone, opines **GarryWoessner, MA, MBA, CAS,** regional director for Benedictine Health System in Duluth, Minn. As a CARF surveyor of rehab in SNFs and hospitals, Woessner has seen several therapy departments that bring a sizeable number of patients to the therapy gym and put them in a line or circle. Then the therapist "goes down the line to give each person a few minutes of attention, while keeping them in the gym for much longer," he says. If the therapist counts the entire time on the MDS that the resident is in the gym, "that's a big red flag," Woessner cautions. And it's "difficult to justify to an outside reviewer. The patient may be resting or observing what other patients are doing during this time in the gym, but that's not really therapeutic," he adds.

In Woessner's view, "anything more than two patients at a time can potentially be construed as round-up therapy or group therapy. We won't do round-up therapy in my facility because the patient gets shortchanged," he says. Also, "the risk of fraudulent billing is too great."

Tip: "The therapist's daily notations and weekly progress notes should have enough information to justify the treatment and the minutes billed," Woessner urges. That would include the type of treatment provided, the patient's pain and tolerance levels, progress on goals and response to treatment -- "and objective measures of progress."

Nursing should be involved in what's going on with a resident's therapy and make sure the team agrees with the therapy approach for an individual resident, suggests **Darlene Greenhill,** a nursing home consultant in Atlanta.

Sometimes nurses don't realize what's going on "until an auditor asks how a therapist could have billed so many minutes in an eight hour day -- or why concurrent therapy was used for a certain resident when it didn't appear to be appropriate," she says.

Watch for: Sometimes concurrent therapy isn't used when it would be appropriate, Greenhill adds--for example, at the end of therapy when the resident is more independent. (By the same token, low rehab is also underused, she notes.)

MDS compliance tip: The MDS coordinator should not sign the attestation related to the therapy section without checking the therapy logs and documentation, advises **Marilyn Mines, RN, RAC-CT, BC,** manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill. For example, "if the MDS [coordinator] signed the attestation statement, and didn't know that the therapist documented the wrong ARD and started counting from the wrong day, the coordinator is liable."

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