MDS Alert

REHABILITATION THERAPY:Limits on Concurrent Rehab Therapy Create an Undercurrent of Uncertainty and Concern

CMS puts its foot down on this popular form of rehab delivery.

The final SNF PPS rule gave providers an overview of how the new RUG-IV system will shake out for rehab come Oct. 1, 2010. And at least one provision did leave some in the industry a bit shaken.

The Centers for Medicare & Medicaid Services limited concurrent therapy to no more than two patients at a time within the direct line of sight of the treating therapist or therapist assistant.

Based on the final rule, the therapist can't spend one hour on concurrent therapy and bill for two hours, explains Atlanta consultant **Darlene Greenhill.** "The therapist's time actually spent has to be divided between the time provided to the individual patients on concurrent therapy," she adds.

MDS 3.0 to Include Breakout

The MDS 3.0 will include a place where the facility can break out the amount of individual, concurrent, and group therapy minutes, says **Rena Shephard, MHA, RN, RACMT, C-NE,** founding chair and executive editor of the American Association of Nurse Assessment Coordinators, and president and CEO of RRS Healthcare Consulting in San Diego.

Good news: The rules governing group therapy remained the same. That is, the group can have no more than four residents receiving the same services. "And only 25 percent of the [resident's therapy] time can be in group therapy," says **Marilyn Mines, RN, RAC-CT, BC,** manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill. (The final rule defines concurrent rehab therapy as a therapist providing services to multiple patients at the same time who are performing different therapy activities.)

Coding low-down: "If the therapist or therapist assistant has more than two patients in concurrent therapy,the SNF can't count any of those minutes on the MDS," emphasizes **Pauline Franko, PT, MCSP,** owner of Encompass Consulting & Education LLC in Tamarac, Fla. "The final rule does state that the two patients in concurrent therapy can be different payer types."

Insiders See Significant Impact

The change to concurrent therapy will result in decreased productivity numbers for therapists, which most rehab companies monitor as a standard, opines physical therapist **Shehla Rooney,** a consultant in Cookeville, Tenn. And therapy departments may have to increase staffing to render the same amount of therapy to patients, she adds. The "reining in of concurrent therapy" means we won't see many Ultra-Highs anymore, predicts **Jane Belt, MS, GCNS-BC, RAC-MT,** a consultant with Plante & Moran Clinical Group in Columbus, Ohio.

The limitations could entice some rehab providers to find ways around it, experts caution. "One therapist I know," says consultant **Patricia Boyer, RN, MSM, NHA,** in Brookfield, Wis., is worried that some fairly aggressive therapy groups may provide individual therapy during the lookback when it counts but do group therapy in between assessments.

CMS may not understand yet that certain treatment approaches don't require the therapist to sit there "tapping their foot" while the patient performs the task -- as long as the therapist has the person in line of sight, says **Garry Woessner, MACCC, MBA, CAS,** regional director of rehab for the Benedictine Health System in Duluth, Minn.

Examples include patients receiving diathermy for 30 minutes or exercising on a recumbent bike for 15 minutes, or

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performing upper body exercises, he adds.

"The practicality of the changes to concurrent therapy in the final rule and its impact hasn't been thought through," agrees **Marty Pachciarz, RN, RAC-CT,** a consultant with The Polaris Group in Tampa, Fla. "In spite of the final rule, we're not convinced that the issue is settled."

Stay tuned: "CMS has another year to 'tweak' the rules without really changing the way the [RUG] grouper works," observes **Peter Arbuthnot, a** regulatory analyst with American HealthTech in Jacksonville, Miss., which develops MDS software.

"So we will not know all the details for 2011 ... until Spring 2010 when the proposed rule is announced." Arbuthnot does not, however, expect "large changes because that would disrupt implementation plans. Certainly a change in the [RAI User's Manual] can affect payment more dramatically than a change in the RUG (i.e., lookbacks, etc.)," Arbuthnot points out.

Editor's note: For more coverage on rehab, see "OMRA to Become a Give-and-Take Proposition Under RUG-IV," on page 112.

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