# Getting Ready for PDPM: Group and Concurrent Therapy

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- [Fawn] Today's course on occupationaltherapy.com is Getting Ready for PDPM, Group and Concurrent Therapy. Our presenter today is Dr. Kathleen Weissberg. In her 20 plus years of practice, Kathleen has worked in long term care as a researcher, educator and has established various programs and nursing facilities including dementia care and staging, wellness, incontinence management and evidence-based falls management. Welcome Kathleen, so happy to have you back.

- [Kathleen] Thank you so much for that introduction. And thank you so much for listening in to everyone who is on this very important topic. There's just been a lot of talk as we've gotten ready for PDPM and now are in the throes of PDPM, a lot of talk about group and concurrent. I think we all understand the rules now. We understand the IPA and the ICD-10 and the CMI and all those other acronyms that have been thrown at us. But a lot of talk about group and concurrent, when is it appropriate? How do we build for it? How should we document? How do we justify this and marry that really with what maybe the expectations are of the provider for whom we work and really what Medicare's expectations are. I think that's the critical, the most important thing. So everything I'm talking about today, I will tell you has been taken from various CMS centers for Medicare and Medicaid Services documents, and some other resources that you have available to you in the reference handout associated with today's session. So with that, I'm gonna start with some learning objectives. Upon completion of this course, learners will be able to define the terms group and concurrent therapy as these are indicated by Medicare. Describe some best practice guidelines for scheduling and planning group and concurrent therapy with patients. And finally, to accurately list three elements to be included in the documentation. To demonstrate medical necessity and skill.

So before we get into the nitty gritty, I wanna give a little bit of the background under the PDPM. So if you remember if we go back, just a few short weeks ago, under RUG-IV there was no more than 25% of the therapy services deliver to sniff patients for

each discipline that could be provided in a group therapy setting. And there was no limit on concurrent therapy and that has changed significantly. Now we know that the sniff PDPM is not going to be using minutes of therapy provided to a resident to classify the patient for payment purposes. We know that the payment is being driven by the characteristics of the patient. And because of that, it is possible, and this is coming directly from Medicare, they say that it is possible that skilled nursing facilities may become incentivized to emphasize group and concurrent therapy over the kind of individualized therapy which is really tailored to address each patient's, each beneficiary specific care needs. And what they feel, and I think we as clinicians oftentimes feel as well, is the most appropriate mode of therapy for skilled nursing facility patients.

So in order to mitigate that potential effect of the PDPM, the Patient Driven Payment Model, I should probably define that, CMS impose a limit of 25% on group and concurrent therapy. So we're gonna talk a little bit more about this. But CMS has also distributed several fact sheets about this that you can get on their websites that explain it a little bit more. And we'll talk more about this but that 25% just to throw in there is based on the episode of care. So per discipline, per episode. So that means the entire length of stay for that particular patient. And some additional background, I find this is really interesting, CMS in the past had a lot of concerns specifically about group therapy. They had a concern that any group that consisted of more than four participants would not allow for adequate supervision of each participant, as well as cause maybe some difficulty for participants to engage with one another in the most effective way. On the flip side, again, historically they maintained, CMS maintained that a group of fewer than four individuals would not allow for effective interaction really to best achieve the goals of the group. And for those reasons, CMS has always historically defined group therapy as exactly four participants. Now fast forward, CMS found with some of the research that they've done, that therapists do seem capable and obviously we know this, we're all therapists, that we do seem capable of managing

groups of various sizes. And CMS stated that based on their research, they do believe the therapist have the clinical judgment to determine whether groups of different sizes would clinically benefit their patients. Which they should be able to demonstrate with adequate documentation. So this is why they changed the definition because they researched it and they do agree that it's up to us, the clinical judgment of the therapist to determine how many patients can realistically be in a group.

Now they also go on to say that while group therapy can play an important role in skilled nursing facility patient care for certain patients and for certain conditions, that we'll be talking about, it is primarily in their eyes a supplement to individual therapy. And CMS continues to maintain that a therapist providing one-on-one care with his or her full attention on one patient should be considered the primary mode of therapy and the standard of care. And CMS has gone on to say that they plan to implement, in their words, a robust monitoring program to assess compliance with the 25% cap, and they may address that in future rulemaking specifically as it relates to a penalty. And again, all of this is directly from CMS. So they changed the definition of group therapy for the reasons that we just talked about, and effective October first 2019 under the SNF Prospective Payment System, group therapy is defined as a qualified rehabilitation therapist or therapy assistant, treating two to six patients at the same time who are performing the same or similar activities. And they've altered this definition so that it's similar to the definition, excuse me, the definition and an inpatient rehab facility. So if you're in the definition of group is between two and six. So we're in alignment with them. There's been some questions about what do we have, what if we have a student? How do we code that, what do we do? And I will just say that that has not changed. If you go back to the RAI, which is the Resident Assessment Instrument, the RAI manual for the MDS. It gives you various specific instructions on how to code appropriately a student's time under Medicare Part A for concurrent and group. So you're highly advise to go back to the RAI for that. Now additionally from Medicare, they indicate that sniffs should include in the patient's plan of care an explicit

justification for the use of group rather than individual or rather than concurrent therapy. So if we're going to use group, we need a description, we need a justification. And that should include but it's not limited to the specific benefits to that particular patient, including the documented type, the amount of group therapy and that is how that prescribed type and amount of group therapy is gonna meet the patient's needs and assist that patient in reaching his or her documented goals.

So you're gonna see throughout our conversation today is we're gonna go back to documentation, the rationale, the justification for the group needs to be documented. So CMS also states that although they recognize that group and concurrent therapy may have clinical merit in specific situations, they believe that individual therapy is generally the best way of providing therapy to a resident, because it's most tailored to that specific resident's care needs. And again, just reiterating here. To that end, this is where that 25% cap per residents therapy minutes by discipline over the episode of care, the length of stay comes into play. And again, you can read the quote here, we believe that individual therapy is the best mode as it permits the greatest degree of interaction between the resident therapist and should therefore represent at a minimum the majority of therapy provided to a skilled nursing facility resident.

Now, the other thing just to keep in mind is that chapter eight of the Medicare benefit policy manual still applies. So there's no treatment minimums, remember under RUG-IV it was 720, 500, so on and so forth. But so there's no minimums, but under the PDPM CMS still expects reasonable and necessary care as per chapter eight. So if you go back to chapter eight, it talks about, five days of skill for therapy, what is reasonable and necessary? What is skilled care? Et cetera. So none of that has changed. They took away those minute thresholds but nothing else as it relates to skilled care has changed. Okay, so let's go through now and talk a little bit about some definition. So this first definition, again, this comes directly from the RAI manual and it's concurrent therapy. Concurrent therapy is defined as the treatment of two residents at the same

time when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line of sight of the treating therapist or the assistant for Medicare Part A. When part A resident receives therapy that needs this definition it is defined as concurrent therapy for the Part A resident, regardless of the payer source for the second residence.

So what does that mean? Basically what that's saying is if you have two individuals together, one is covered by Medicare Part A and one is covered by some other insurance type. Maybe it's a an independent insurance or a managed care or something like that. That Part A resident must be documented as concurrent therapy, because they are with another individual providing that the rest of this definition fits. Now one thing I just wanna talk about is, I think, to a degree, some of this is a little gray. What does quote unquote, not the same or similar mean? So we can take an easy example. Let's say we had an individual, two individuals we're working with at the same time. And one is doing an upper extremity therapeutic exercise program, and somebody else we're working on transfers or bed mobility or something like that. Now, we don't technically bill CPT codes for our Part A patients because they are covered by consolidated billing, but I think it's the best practice. I think most of us probably use therapy logs and we do code what we did with that person using CPT codes. We're not technically billing them, but we are applying a code to describe what it was that we do with that patient. So in this example, that person who's doing the upper extremity thorax, we would code that or document that under 97110 therapeutic exercise. The person that we're doing the transfers or the bed mobility, we'd probably code that or document that under 97530 therapeutic activities, or however you wanna do that.

So that's an easy example. But what happens when you have two individuals, so again, you have one person working on, bed mobility and transfers, perhaps documented under 97530. And you have another person that you're also gonna document under 97530, but they're doing something totally different. They're doing

reaching and bending and lifting and carrying types of activities, which are inherent in the definition of that. The billing code is exactly the same. If I'm a reviewer and I come in and look at that, I'm gonna say, "Well, they were doing the exact same thing. "Shouldn't this be group?" Well, no, it would be concurrent, because they are different. That's when you go back to the documentation. So hopefully that makes sense. We've gotta make sure that in those kind of gray areas, or even if it's not so gray, that the documentation is crystal clear that they were doing completely totally different types of activities working on different goals. So that's particularly important, I think, when the billing codes or the CPT codes might be applied similarly, but definitely important when they're the same. Okay, so hopefully that made sense.

Let's go a little bit more into concurrent. Again, concurrent treatment, again, we defined as one therapist providing different treatments to two patients at the same time. The provision of concurrent does require that the therapist is in the room supervising and performing all minutes provided to each patient. I think that's really important. They have have to be line of sight. So you couldn't have one person in the clinic that you're providing therapy to and another person, still in their room and you're bouncing back and forth, it doesn't work that way, they have to be line of sight. Remember that no more than two patients can be seen concurrently. And the clinical judgment of the therapist ultimately will determine which patients would benefit from concurrent therapy, and we'll talk about that in just a little bit. Again, we went through the definition so we won't go back through that. But I do wanna make a comment. And I know we're talking about Medicare Part A, the prospective payment system in this session, but the question comes up quite a bit about Part B, and how does that work? Well, for Medicare Part B residents may not be treated concurrently. And that is again directly from the RAI. The therapist can treat one person at a time. The minutes during the day when the resident is treated individually would be added up to get a total individual count. But if you treat two people at the same time who are Medicare Part B, that has to be coded as a group session. There is no such thing for concurrent for

Medicare Part B. And again remember, I'll probably say it like 10 more times group and concurrent therapy combined cannot exceed 25% of the minutes per patient per discipline under the patient-driven payment model.

So you might be wondering, well, how in the world are they gonna track that? Or what are they gonna do? There's a discharge assessment, a minimum data set discharge assessment that our providers are already completing. And this is completed at the time of facility discharge. What they've done on this assessment is they've expanded section O, and there's some new items in there. O042581 through O0425C5. And these items are going to capture the, this is where we report the total amount of therapy that's gonna be broken down by therapy mode, individual, concurrent and group and there's also a code treatment in there, though that doesn't factor in here. So it's broken down by the therapy mode. And then it's also broken down by the therapy discipline PTOT speech that the patient received during their entire Part A stay. The look back for that, so you're familiar probably with that terminology. How far do we look back when we count? The look back for those particular items, as we already said, is the entire SNF Part A stay starting at day one of the Part A stay, finishing on the last day of the Part A stay. Then once reported on the MDS, then the CMS group or software actually calculate that percentage of group and concurrent therapy combined, and then they'll look to see if it exceeded the 25%. Any amount of therapy that is exceeding that 25% is deemed as non compliant. And we'll talk about this on another slide. But if they are non-compliant to the provider the facility, the skilled nursing facility would receive an error message when they send in that MDS. It's a non-fatal warning error, which we'll talk about in just a second what that means. But the important piece, I think is that Medicare is definitely going to be monitoring this to see where and when providers are going over that threshold.

So let's switch gears a little bit and talk about group therapy. So group therapy again, definition taken straight from the RAI, is defined for Medicare Part A as the treatment of

two to six residents, regardless of payer source, who are performing the same or similar activities and are supervised by a therapist or an assistant who is not supervising any other individuals. And before I go on, I just wanna make another comment. And this applies to concurrent and to group.

So if you had concurrent, you had two individuals that you treated concurrently for 20 minutes on your log, and again, I think most of us are keeping some sort of daily treatment log, you would give each person 20 minutes. So patient A gets 20 minutes, patient B gets 20 minutes. Same thing with group therapy. If four Medicare Part A patients are treated by one therapist, let's say for an hour in a group setting, all four patients in the group are recorded with billing or minutes, if you will, for that full hour. Each person in the group is credited the total time that they participated in the group. That's really important, and the other piece of that is, again, if I go back to the RUG-IV system, remember if you put in concurrent minutes, they ended up getting divided by two. Or if you put in any group minutes, they will always divide it by four, we call that allocation they were allocated. In this scenario that is not happening. So if I put in 20 minutes of concurrent, the patient gets credited with 20 minutes of concurrent group therapy the same way. So I thought it was important just to make that distinction between what we're doing today versus what we did under RUG-IV. Again a couple notes here.

So I'm gonna make the parallel or the comparison between Part A and Part B. So in order to be considered group therapy under Part A, the skilled nursing facility residents need to be performing similar activities. Under Part B, the therapeutic interventions can be similar or they can be different, it doesn't matter. Remember that the skilled nursing facility therapy services are paid as part of a bundled PPS rate. So under Medicare Part A, it's a bundled rate. And they're not technically reimbursed under the Physician Fee Schedule as they are under Part B. Although typically, again, we do apply CPT codes to describe what skilled service we provided for that person. Now under

Medicare Part B, I already mentioned this, the treatment of two or more patients, regardless of their payer source at the same time would be documented as group treatment. And somebody said to me, not all that long ago, "Wait a second, we're not allowed to provide groups "to Medicare Part B." And the answer is yes, you technically can. You just have to recognize that the definitions are very different. Remember for Part A patients or group therapy session again is specifically focused on meeting a common group goal or a set of goals. The group goal has been formulated and agreed upon ahead of time, prior to offering it to the participants. The group therapy is performed for the therapeutic advantage for that group setting and what it's gonna be able to provide to the individual participant and how that group is going to be able to help that participant to meet his or her individual goals. And again, if we're doing a group for Part B the goals could be the same, different what have you. Remember too that the ratio cannot be exceeded. So that ratio is two to six patients per therapist. And that's the ratio that we need to stick with. And again, if we go over that, we violate that somehow that would cause some sort of fatal warning edit.

Finally, remember that groups need to be administered by a licensed therapist or therapist assistant under the supervision of that licensed therapist. So if you have a rehab aide or a tech or whatever you're calling that person, they can certainly assist you with a group. But they are not considered in the ratio. They can't run the group, they can't build a group. So your ratio is two to six. Just because you have a tech with you doesn't mean that you can bump that up to 12. It's still two to six. And again, you can't set up that group and have the tech run it for you, it doesn't work that way. So the question comes up to why, who, how? How do I figure this out? The decision to provide a concurrent or group treatment to your patients really should depend on your clinical reasoning as a therapist. Which patients do you think are gonna benefit from concurrent or group treatment? And what are the clinical benefits to the patient from this mode of treatment? I'm not hesitant to say I've been a therapist for almost 30 years. And this is historically an intervention. We've run groups and concurrent and

individual for a long, long time. And there are definitely therapeutic benefits to providing these types of scenarios for our patients.

So let's talk about what that clinical rationale is, let's start with concurrent. You put two people together, patients are gonna learn from one another, they're going to encourage one another, they'll motivate each other. And there's social interaction between the two generally. It also helps you as a therapist to really assess and teach generalization and carryover of those skills that they learned in individual therapy. So they learned it in individual, let's put it into a different scenario now and see how they carry over, see how they do. It definitely improves the person's awareness that his or her problems are not unique. And when they're paired up with someone who is similar to them, or maybe even dissimilar, that they can see that they're not unique. Other people have some of the same issues and they're working through them. And it can really facilitate and promote the healing through that support of their peers. And I think too it provides some self-monitoring skills and self-awareness through peer interaction and feedback that they wouldn't necessarily get in an individual session. Now treatments performed concurrently, again, they got to be clinically appropriate. So things that are inappropriate might be evaluations or assessments, wound care types of treatments, bedside treatments, because obviously, everybody still needs to be line of sight or any procedure that requires one-on-one intervention such as an advanced gait or a balanced training. Or some sort of advanced ADL type training, whatever that happens to be.

So those advanced skills that definitely require one-on-one. Again, patients need to be clinically appropriate to be treated concurrently. So they should be medically stable, alert. Able to follow instructions, at least one step instructions. Able to complete activities with just supervision. Maybe a higher level of function. So maybe your person who has an orthopedic condition, arthritis or a higher level neurological type of condition, and they need to be able to be safely supervised without constant direct

physical contact of another person. If they need that constant contact, it might be that they're not going to be safe. If you walk away to assist someone else or you step away. Inappropriate patients might be the significantly cognitively impaired and I just wanna make a comment about that before I go on. Even if somebody has a level of cognitive impairment, it doesn't mean that they couldn't participate concurrently or in a group. We say significant cognitive impairment, we're talking probably like our, late stage dementia types of patients. Cognitive impairment does not preclude somebody from participating in one of these types of sessions.

Again, it's gonna really depend on the level of cognitive impairment. Your lower functioning individuals, especially those low level neurological brain injury, spinal cord injury, those types of patients. Individuals who are not able to be safely supervised, again without physical contact of another person or someone who is unsafe, you have safety concerns with that person or perhaps safety concerns, that they may have with being with another individual. Some additional guidelines again, concurrent therapy performed by a licensed PTOT speech PTA, COTA. So anybody in our clinical setting would be able to perform a concurrent treatment other, excuse me, except, obviously a tech or a rehab aide. Remember that both individuals must be in line of sight of the treating therapist or the assistant. When we code concurrent treatment, again, we don't bill it per se, but we're probably coding it to describe the skilled services. You use the CPT code that best reflects the treatment that's being conducted.

So people ask me, "Oh gosh, group has a CPT code. "What do I do for concurrent?" It depends on what you're doing. If you're doing an ADL task, you would put that or you'd code that or document it under 97535. Or if you're doing something orthotic related you would code it under that. So it's using the code that most reflects what you're doing. Constant attendance modalities. So CPT is 97032 through 97039 cannot be performed when concurrently treating another patient. We've already said Medicare Part B doesn't recognize concurrent, and then remember that every person treated

concurrently is credited the total time that they participated in that session, it's not split, it's not allocated. Okay, so how do you document it? The use of concurrent, as we already said, for Medicare needs to include the detailed justification in the plan of care.

So what do you wanna get in there? The specific benefits to that patient for the use of concurrent therapy, the specific amount of therapy. The discipline, who is receiving that or the discipline who is delivering that. A description of how this mode of therapy will help the patient's needs and assist that patient in reaching his or her goals. A description perhaps of how these concurrent services will help that person to attain their highest level of physical, mental or psychosocial well being. What's the benefit to the patient of performing an activity concurrently? Is it motivation? Is it increased independence? Is it peer support? And how do you as the therapist expect that that might be evident? So is it improved performance, increased engagement, better carry over of a skill, I don't know what it is. But again, you can see from this list, it is justification of this particular mode.

So here's an example. Mrs. Jones was seeing concurrently focusing on safety training during transitional movements. Safety for task performance, activity analysis during meal preparation. Patient demonstrated increased safety awareness and independence requiring verbal cues, improve carry over noted from last session. Session provided opportunity to assess and demonstrate carry over of learned skills. That's a highly skilled note, that last sentence, I think is the really important one. That's justifying concurrent. This session provided that opportunity to assess the skills and assess how well they demonstrated the carry over. And again, that's what you need to get in your documentation. Okay, so let's switch gears and talk about the clinical rationale for group. And you'll see that a lot of these are very similar to what we just talked about. Providing therapy in a group definitely has both clinical benefits and operational benefits. The clinical benefits. Clinically again, participants learn from one

another, they encourage they motivate each other. And this implies that there are advantages to the participant for being in a group. In a group setting multiple goals can be addressed for a particular participant.

So let's say it's a cooking group. You could work on functional mobility, coordination, balance, safety, problem solving, attention to task and the list can go on and on. So you can go over a lot of different goals in one particular session. The group treatment also may allow the participant to practice tasks in a very practical, realistic setting, which further prepares the participant for discharge to a less restrictive environment. And as an aside, I've been looking at a lot of the different group protocols. In different groups that we share some of this information, I will tell you some of the activities that I'm seeing come through on a group are really creative, and really engaging, and the patients just seem to love them. It's very different from the traditional, sit there and do your thorax or what have you. They're very engaged and they're definitely enjoying it.

So this is a great opportunity to get creative and certainly have fun with our patients as well. Some additional benefits, it again, it allows us as a therapist to observe and teach generalization and carry over. It improves their awareness again, that their problems aren't unique. They're getting that peer support, they're self-monitoring and self-awareness. And I think too that it's a place where it can be a facsimile for social interaction. And allows for improvements in social behavior. It provides a safe place to attempt new behavior or new communication skills, whether that's coming from us as OT or maybe we're partnering with a speech language pathologist. And it's a place where the participant can learn how his or her behavior impacts others. So I think there's that socialization, that social interaction component that's really important here. Are there disadvantages? Sure. Group members could potentially be disruptive, and if they are, they're gonna have a negative effect or an impact on the other people in the group. And those unhealthy attitudes, unfortunately, are sometimes contagious. Participants who may need to participate, you really want them to jump in and get

involved, they may stay uninvolved and just stay on the fringes of the group, when we really want them to jump in. So maybe that isn't the best avenue for them. It also could become a safe place or a safe haven, if you will, where it prevents maximum changes.

So again, I go back to the fact that identification to anybody who's gonna participate in group therapy really should be a clinical decision to reduce the risks of the disadvantages that we've just talked about. So it always goes back to that clinical decision making process. And when we bill or code as it were for group treatment, it's important too that at all times in your documentation, so let's step away from coding. But in your documentation, there needs to be a clear distinction between what was done individually what was done concurrently, what was done in code treatment, what was done in group. And those have to be coded separately on any logs that we do, because again, that has to get over onto the MDS because CMS is tracking that. For occupational therapy, the CPT code that would be utilized for documentation and recording purposes is 97150. And again, every person in the group would be credited the total time that they participated in the group. So if you're doing a group, it's going to be coded or documented under 97150. You wouldn't also use some other CPT codes, let's say you're doing a whole management type of group, you wouldn't also use 97535, you only use the group code. Additionally, anybody who's going to participate in group treatment should have group treatment included in their clarification order. So you may not be doing clarification orders in your site. I think most of us that's a standard of practice. If you were you wanna make sure that group is in there.

So for example, OT five times a week for four weeks for therapeutic activities, ADL retraining, neuromuscular re-education in either a group or an individual setting, so you have that in there. Additionally, and I think this is important participants can only be documented or coded as being in the group treatment if they're active in the group. So you do have that person sitting on the fringes, who never gets involved, never does a

whole lot. Did we really do anything with them? And you have to look back, take billing, coding, what out of it, did you provide anything to that person? Or did they get any sort of therapeutic benefit? Probably not. So they have to be an active participant in order to have that documented. So now we talk about documentation. All documentation for group treatments for the individual participant.

Again, it just needs to be incorporated into the daily documentation. I think most of us are doing daily and if we're not it will go into weekly note. It just has to be part of that medical record. As with every therapeutic intervention that we are doing, the group treatment needs to be medically necessary. You always go back to clinical need for that particular patient. How is this gonna benefit them? Medical necessity is that term that's used to refer to a course of treatment that is most helpful for specific symptoms or issues or impairments that the patient is experiencing. The course of treatment is determined by the patient by the healthcare team in conjunction and collaboration. We already talked about the CPT code, and that's what would be documented on the daily record of treatment. And remember too that each resident participating in the group must have an individualized treatment plan for group treatment, including interventions short and long term goals.

Now, you may not have a specific group goal. So you may not have a goal that says that they'll do XY and Z in the group. But you do have to have some recognition of how and which goals might be best met by a group format. So some of us will, in fact, have group goals. Others will just have goals for the patient like we've always had. But then we need to show in the documentation how that group helped facilitate performance of that goal or helped facilitate improvement in that goal. And how group was the best avenue versus concurrent or individual or anything else to achieve that goal. And when you document group, what you need to consider, the number of minutes that the person participated in the group therapy. The number of people participating in the group. What specific treatment technique or techniques were used in that group? What

did you do as a therapist? What did you do to train reinforce, cue, whatever, either cognitively or physically helping that person again to reach their weekly goals. On a weekly basis, you'll document the residents progress toward their individual and or group goals. You wanna talk about in your note any modifications that had to be made in that group, and how the participant reacted to those. Explain if the participants goals were met during the week and how again, that group assisted toward reaching those goals. You can document any important feedback outside of therapy that denotes generalization of skills.

So again you've done something in a group and then they're able to carry it over on the nursing unit or maybe with their family. Any family or caregiver training, the interactions which occurred. Again in showing that progress toward goals, the justification for continuing any sort of group treatment, and the participants therapeutic benefit to group therapy. So again, a lot involved. This isn't just a matter of pulling some folks together and doing a group, you need to show the clinical rationale. So these next couple slides show you some examples and I'm not gonna read them at you. I'll read one on each. So this first one is a balanced group, responded well to group therapy as evidenced by ability to consistently hit the balloon with the left upper extremity for 10 minutes without requesting a break. This allows the participant to achieve his or her goal to dry hair in 10 minutes, there were four people in the group. Here's a cooking group. Participant responded well to group therapy as evidenced by ability to manipulate an orange while cutting and peeling it. Able to pick grapes off the stems with distance supervision demonstrating sufficient fine motor coordination for simple meal prep procedures when returning home for people in the group. So again, we're not just saying that they participated in the group, we're talking about some very specific things that they're doing and how we're able to translate that to one of their larger goals.

Okay, so I'm gonna jump back again and talk a little bit about that 25% threshold. The next couple slides just go through how CMS is going to be calculating compliance with that group and concurrent 25% limit. So step one is taking the total therapy minutes by discipline. So you can see these are the items directly from section O on the MDS. It's O0425123 and that X is in there just to show that it would be replaced by another letter. So for example, physical therapy is C, speech therapy is A I believe and OT is B. And we'll look at that again in just a second. So that X is just noting that it would be replaced by a different letter. Step two is to get those total concurrent and group therapy minutes by discipline, figure out the ratio. So take the step two result divided by the step one result, if step three is greater than 25%, then the provider is non-compliant. It really is as easy as that.

So here's an example. So OT is B, the total individual minutes are 2000. The total concurrent minutes are 600. The total group minutes are 1000. And if we look at that, step one, total them all up we get 3600. Then we look at just the total group and concurrent, that's 1600. Divide the two we get .44, so that's 44%. Obviously 44% is greater than 25%. Therefore, in this particular scenario, this is non-compliant. So it's something obviously that needs to be tracked. And individuals have asked me, how do we track this? We track it daily, weekly. I wish I had an answer for that, I don't. You need to do what's best for your clinical practice and how you track that. I think most of us are using electronic medical records at this point, and probably the EMR is tracking that. But it is something that you definitely wanna stay on top of, particularly, what happens if you do a lot of group and concurrent at the beginning and then that patient is discharged early, and something happens, you just don't wanna be out of compliance. It's something that you do wanna keep on top of.

So we've been talking about this compliance again, what happens if you go over the 25%? Well, right now there's not a penalty for exceeding the 25% combined, concurrent and group limit. However, providers have been cautioned that they will

receive a warning edit on their assessment validation report, we'll talk about what that means in a second, that informs and that they've exceeded that 25% limit. So they have this minimum data set, we know that they have to complete it, they have to lock it, submit it and then get it into a system called the QIES ASAP system. When they try to submit it to QIES ASAP they'll get a validation report back saying whether or not it was accepted. And on that validation report, if the provider has gone over 25%, they'll have an error. And it actually reads and you can read it on the slide. The total number of group and or concurrent minutes for one or more therapy disciplines exceeds the 25% limit on concurrent and group therapy. Consistent violation of this limit may result in your facility being flagged for additional medical review. So what that saying is that CMS is going to be monitoring therapy provision under the PDPM to look for those facilities that have exceeded the limit. What they're gonna do, we don't know. But what they've said is that they're gonna try to determine if additional administrative or policy action or some sort of penalty would be necessary. So note to self, don't go over the 25%. I think that's our best option there.

So let's talk a little bit more about the logistics of a group, starting with the types of group treatment. I think the first type of group you might be seeing is something an educational or informational type of group. So the goal of this group treatment is to communicate educational information about the disability or the injury. So this could be hip precautions or shoulder precautions or it could be energy conservation or breathing techniques. Purse lip breathing, work simplification strategies, some sort of other compensatory strategy, et cetera, et cetera. So education, so this, it can also be understanding the disability or the injury, risk factors and prevention related to that I'm thinking maybe about arthritis. That could be a great educational type of program and really understanding the emotional and the behavioral consequences of the disability or the injury. Remember though, if we're gonna do an education group or provide information, regardless of setting, regardless of mode of treatment, it always goes back it has to be skilled. So just providing education, it may or may not be skilled. We have

to show in the documentation why our skills as a therapist were needed and that isn't something that anybody else could have done. So the documentation will support the skill.

The other type of group is an activity group or a skill group. So teaching certain functional activities like dressing or grooming, like kitchen activities, transfers, ambulation, wheelchair mobility. It becomes critical that the admission criteria, if you will, to this group are really clear so that if you are leading this group, you know what to expect and you're physically able to handle the participants to be able to achieve the group goals. The other thing is that for these types of programs or these types of groups the size of the group, the number of group leaders, the number of people in the group need to be considered. Because if you're doing a skill that's maybe a little more involved, maybe six patients isn't the way to go, maybe it's a smaller number. Again, that's where your clinical judgment and rationale come into play. Remember too the participants, again, just observing each other, successes and difficulties. And they do they help each other. I mean, we've done, I don't wanna say dressing groups per se, but things where we practice using some of the long handled equipment or adaptive equipment, or we've done like fashion show kinds of things, and seeing how other people manage their deficits and their impairments is really empowering to other individuals in the group. So how do you prepare for the group? First thing is staff education.

Again, the entire facility needs to be involved and really understand who does what as it relates to this process. If not everybody's on board, the full benefit of the group treatment is not going to be realized. So staff education, role delineation, treatment models, logistics, et cetera, we need to think about all of those. So we think about staff education, explaining and discussing the clinically related advantages to delivering therapy in a group setting. And that's not just maybe educating nursing that's educating ourselves as well, because you may see that you love group as an OT, but

maybe somebody else who just really has never used group doesn't see the clinical benefit, or maybe they're a little resistant to trying it. We need to stress the participant needs and goals will determine placement in a group, nothing else. It's not staff convenience, it's not scheduling, it's nothing else, it really has to be based on the patient. We need to review the types of group therapy that might be beneficial to our patients as well as the documentation requirements. And again, making sure that we as therapists understand the concept, the procedures. So clinical readiness, how to select individuals to be in a group, the group dynamics. Again, we're OT we've been trained in group dynamics, our entire careers, maybe not everybody has that same skill set.

So that's something that we might need to look at. And again, we wanna make sure that documentation, I say billing here coding, however you wanna talk about it, your daily record of treatment is complete and it's correct, and it would be based on whatever your company policy is. So the roles of all of these people in these groups, the role of the therapist, first of all, identify anybody who would benefit from the group treatment. Educating, nursing activities, social service, whoever needs to be educated on the goals. The compensatory strategies that that person needs that again, then we're hopefully going to generalize outside of the group treatment. Documenting the activities of the group, the response to the patient, the status of the goals, we talked about the documentation. Providing feedback back to the facility as to the patient's progress, as well as any modifications that we made to the plan of care. And I think this is important to communicate that, because you'll particularly have family members that will see somebody participating in a group too and say, one of them whatever they doing? Why aren't they doing this? Why are they doing that? And it's helpful that the entire interdisciplinary team nursing included, understands why we're doing what we're doing. Because there may be questions, there may be confusion, and to be able to reiterate that back to them.

Therapists need to be aware of each individual participant's needs, the short term goals addressed by the treatment. We want to choose group activities that are gonna build success, maximize therapeutic gains, know who should be included in a group, as well as when they might not be appropriate for that group, when they need to exit. Some appropriate activities, how to incorporate that into a group. Being able to reflect and evaluate behaviors quickly and as they occur. So you may have some behaviors so being able to address those in a way that doesn't harm the rest of the group. And it continues to push the group or facilitate the group in the right direction. Finding and scheduling space, which we'll just talk about in a second here. We've talked about documentation. But I think the other piece is good interpersonal skills, demonstrating those and accurate perception of the interactions in the group.

Again, I think as OT is we shine in this area, this is what we do. But it takes something special to be able to facilitate a group and that's something that we all need to be able to educate and train on. What's the role of nursing? I think this first one is really important. Ensure that participants are ready and available at the time that the group is scheduled to meet. So I do think it's important for us as therapists, if we are going to schedule a group that we talk to nursing. May be give them that information the night before, or at least the morning of so that we have a fighting chance of getting everybody ready and collected and together. Whether it's two patients in your group or it's six, it's sometimes incredibly challenging to pull everybody together and transport them to your space. So the more we can communicate, the better off we are there. And again, I think that goes back to the previous slide where we talked about, talking about the importance of group and concurrent and our therapy session. So I think the more that we can talk about that in a way that is very collaborative with nursing, that they can carry some of this over, the better off we're gonna be and the more they'll help us. So the role of nursing too is to enhance those learned skills that they've acquired during the group. So again, we're trying to get them to carry that over to the nursing unit. I think that's really important, particularly if we're trying to facilitate

discharge to a lesser level of care. Regularly updating the therapists on carry over and generalization noticed during non-therapy periods of the day.

So as much as we want to communicate to nursing, we want them to communicate back to us how that person is doing once they leave the group. Nursing needs to be willing to receive education from the therapist about ways to enhance carry over and generalization. And I think part of that is us too presenting that in a way that it is conducive and we're working together. Again, I know the reality of what's out there sometimes, education is really tough, but I think we need to approach it in a way that the nurses are ready to receive it. We ask that the nurses document in the medical record and generalization of skills in the nursing notes, they're gonna be doing a lot of skilled nursing notes under the PDPM. And again, helping the therapists to educate the key family members and support in their participation in their progress. Again, oftentimes those family members are coming in the evening when we're not there. So the more that again we can arm and work together with nursing we can communicate that information. Some other considerations as it relates to group, I mean just things that you wanna think about the space for groups, I don't know where these are gonna occur. Maybe your therapy gym, maybe an activities area, maybe the dining room, a day room, whatever space you have available to you.

Looking at scheduling, again, there's no hard and fast rule here. How many groups? How often? Are you gonna do one a day? Are you gonna do more than that? Is that or do you want to ideally do a couple of week? Which disciplines are going to do those? Again, that's something that you figure out as a team based on the clinical representation of your patients. Transportation, we already talked about this, who is doing this and how is this coordinated? Probably not all of us are lucky enough or have the benefit of having a rehab aide or a tech to transport. So we've gotta figure out how are we going to do that? Is nursing going to help us? Are we gonna do that ourselves? Maybe the person has a wheelchair mobility goal or an ambulation goal or something

that we can incorporate that into getting to the space for the group. What are the equipment needs? Maybe you have something that you wanna do that you'll have specific equipment requirements. Contingency plans for when the group doesn't occur as scheduled, or when the patient can't tolerate or participate or they just out and out refuse.

Remember, they do have the option to refuse services. So we need to kind of have in the back of our mind a backup plan, that how am I still gonna work with this individual to help them to meet their goals? And what about weekends? It's something we really haven't talked about. But are you gonna do groups on the weekends? Are you gonna do concurrent? Are you just gonna do individual? Do your individuals who are working on the weekend, sometimes that's not your regular therapy staff, are they as educated as you? And what do you need to put in place to again, help them to be successful? Looking at some other logistics, to determine, again, the appropriate treatment groups to develop, its first necessary to identify the needs of the participants served in your facility. You can certainly develop, all sorts of protocols, but I think you need to first start by looking at who's in your community, who's in your facility. You could develop this wonderful, I don't know arthritis program or something, but you don't have a single person on your caseload who has arthritis and maybe that's not the best group. So make sense and have the groups need to make sense. Groups need to be identified, obviously by participant need, the indicated treatments. Again, going back to their plan of care, their goals, their functional impairments. And then you select the group that will apply to that particular person who's admitted to the facility. Now, once the basic group treatment interventions have been identified, then you wanna develop the specifics of the group.

So what's the purpose of this group? What are the goals? What discipline or disciplines and staff level will lead and assist in the group? Again, you could have a larger group where you have both PT and OT involved or both OT and speech or PT

and speech. You can certainly mix that up. It doesn't just have to be one discipline. What are the criteria for admitting or including a person in a group and potentially discharging them from a group? What's the appropriate ratio of participants to staff? So should it be a two person group or four person, a six person I don't know. What activities, equipment and materials might be needed? How are you going to schedule them? And again, what involvement will nursing play? I think we've already talked about some of this. But again, the size of the group is truly dependent on the functional task, the functional activity that's being performed, as well as any safety issues that might be involved in its execution. Remember too that the group size ratio is one clinician to a two to six ratio.

So again, not more than any, than two to six participants, to one licensed therapist, and you always have to keep safety in mind. We already said this, but again, important to reiterate, non-licensed personnel can certainly assist with your group, it's nice to have a second set of hands of course. However, they are never included in the participant ratio. When you're scheduling and scheduling treatment groups, again, there are a lot of different variables that you need to look at. The size of the group, the space, the staff schedule, the number of groups that you're going to have. And maybe to schedule your groups and make it successful, you need to coordinate treatment times of the disciplines. I just saw, I heard of a facility where they were doing a group. And I think it was an OT group, but PT had just finished their treatment, their individual treatments with a certain number of people. And then they just stayed in the gym to then participate in the OT group. And that makes a lot of sense that helped with scheduling, that helped with transport, et cetera. And then they broke off after the group and they did their individual OT types of treatments.

So you have to coordinate, you have to communicate, if it's going to be successful for your patients. The length of the group therapy should be determined again by the needs and the abilities of the group. At all times that group needs to be scheduled to

maximize therapeutic benefits. So again, depending on the activity that you're doing, you may have a group that's only 20 minutes long. You may have something that's longer 60 minutes or 45 minutes or something like that. You have to look at what it is that you're doing with the patient and how long that should be incorporated. So these next couple slides just give you some examples, if you're thinking about protocols and or some sort of group guidelines, if you will, or some sample groups. Anytime you're putting together a protocol, if you will, you wanna first think about who is going to benefit from this? Who should be in this group? So this is a balanced group, for example, who would be participating? Well, individuals who've demonstrated impaired balance or somebody who has a history of frequent falls. What are the objectives for this particular group?

Again, identify what you want out of the group. I think, again, having done groups for a long time, I think you do have to come into the group with an idea of what is the goal for this group, not just willy nilly pulling folks together. So a group objective could be safety awareness during ADL, decreasing potential for falls and injury. Using compensatory strategies, whatever that is that you're teaching for very specific deficits. Maybe its strength, range of motion, maybe it's something else that I don't even have listed here. Then you wanna think about, okay, who could potentially participate but I don't know. Might be, might not want to include them because they've contraindications. So an inability to stand or walk or maybe there's something else. And then you need to start thinking about what is it that I wanna do in the group. So I have a list here functional mobility, instruction in adaptive equipment, strength, reaching for objects, obstacle negotiation.

And as I said earlier, we can do, we can have a lot of freedom here and have a lot of fun with our patients. And then again, going back to the skill documentation, we had some examples of what we would document. Assistive device training, postural control, static or dynamic balance, crossing midline, motor planning, fine motor or

gross motor coordination, environmental awareness, any sort of functional mobility, et cetera, et cetera. So remember, it's not just the group, but it's adding in that skilled piece. What did you as a therapist do in this group that this patient could not have gotten on the nursing unit? This next one is an education example. And again, this is an education group. So who's gonna participate? Somebody who has an orthopedic diagnosis such as a joint replacement or revision fracture, osteoporosis. What are your objectives of the group? So to demonstrate an understanding maybe of precautions, safety awareness, body mechanics. Performing functional daily tasks with a demonstration of energy conservation, work simplification, pain control, maintaining joint integrity. So this is probably some sort of like hip or knee type of group. Who might not be included? Somebody who has severe pain, limited attention span, significant memory impairment.

Again, that list could be anything you want it to be. What are you gonna do? What are the education topics? Total hip precautions, exercises, joint protection, energy conservation work simplification, pain management, again, the list can go on and on. And then your skill documentation. So even though this is an education group, what are we doing in here that is skilled? So it's safety awareness, its energy conservation, dynamic balance maybe, device education, safety, maintenance, you could do return demonstration, you could do whatever you wanted to do a quiz. You could do a game, whatever you wanna do to carry that out to make sure that that person can do that. So there's an example of a group for education. Here's the whole management group activity. So I'll go through this one a little bit faster. Some group objectives, home management skills, safety, adaptive equipment, sequencing, problem solving, and the like. Who would not be in there somebody who has poor attention, direction following et cetera. What are you gonna do? Home management skills. I mean these are the fun groups really, where you're cleaning, you're sweeping, you're doing the windows, you're cooking a meal, whatever you're doing with the patient. And it's again, it's very, very functional and it really prepares them for discharge. But your skill documentation

isn't gonna say that you cooked a meal. It's going to talk about body mechanics, sequencing, practice, bilateral integration, compensatory strategies and the like. So again, always going back to the skilled piece of it.

So again, as you're looking at maybe developing some group examples or protocols, this is a nice format, if you will, to kind of follow so then you can educate your peers as well, so that they have a goal, they have a plan going into this group. Other group ideas, the sky's the limit. Arthritis, meal planning, dining, exercise, craft groups are always popular, household mobility types of groups, pulmonary obstacle courses are a lot of fun or games, Olympics, I could go on and on. So again, the sky's the limit. Just develop something that is going to be medically necessary and be of benefit to your patient.

So just to summarize, and I think we've hit on these points quite a bit, particularly if we're going to use group and concurrent as well, make sure that we have clearly delineated, what are the participants goals? Why are they in this particular mode of treatment? For group specifically? What are their participation and their exit criteria? How frequently that group be done? Who's leading the group? What are the activities, what are the equipment needs. I think we do need to assess the patient's endurance for a planned group to make sure that they can participate fully through the group's duration. And not every groups gonna be an hour long, but you can have shorter groups as well. But even if it's a 20 minute group, you've gotta make sure that that person is going to be able to fully participate in that group. Remember that if we are going to be providing group should be included in the clarification orders. We've said this what, at least 15 different ways. Make sure that we don't exceed that 25% of therapy provided per patient per discipline for the length of stay. Because it is something that is going to be regulated by Medicare Part A, and they will have a robust monitoring system. And finally, remember that you always have to document, the group session, the concurrent session, the individual session, I don't think it matters.

You document that in your notes. The nature of what was done in the group, what did the participant do? How did it impact their goals? What was the benefit to them to having that mode of treatment versus some other mode of treatment. And always, always reflect skilled care. So we're gonna see a combination of group concurrent individual to benefit this patient. Again, make sure that the documentation supports the mode that you've provided. So those are all of my talking points for today. I wanna thank everyone for participating and I will turn it back over to Fawn.

- [Fawn] Thank you Kathleen for a great talk today. I hope everyone has a great rest of the day and you join us again on Continued and occupationaltherapy.com. Thank you.