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Skilled Nursing Facility Primer

Part 1

Kathleen Dwyer OTR/L, CHT, RAC-CT, CHC
JMD Healthcare Solutions, LLC

- **Presenter Disclosure:** Financial: Kathleen Dwyer has received an honorarium for presenting this course. Non-financial: Kathleen Dwyer has no relevant non-financial relationships to disclose.
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Learning Outcomes

Following this course, participants will be able to:

- Define "skilled" therapy as it relates to skilled nursing facilities
- Describe the different payer types in skilled nursing facilities, including Medicare A, Medicare B, Managed Care A, Managed Care B and Medicaid
- Apply the compliance guidelines from CMS into daily practice

What does it mean to be "Skilled?"

- Medicare A Beneficiary
  - Up to 100 days of benefit per spell of illness
  - Days 1-20: full coverage (2020= $0/day)
  - Days 21-100: co-insurance (2020= $176/day)

Terminology used by Kathleen: "SNF" = skilled nursing facility

Q1

Skilled Criteria

- 3 midnights as an 'inpatient'
  - not 'observation'
- Physician certifies that the patient needs SNF care
- Requires 'skilled' care by:
  - Skilled Nursing: registered nurses: 7 days per week

    and/or
  - Skilled Rehabilitation: physical, occupational, or speech therapists: 5 days a week

Q2

Skilled Criteria, continued

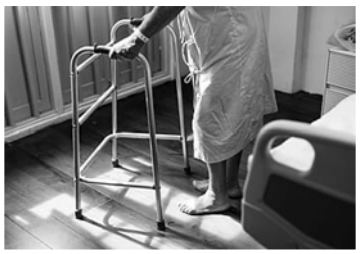
Per Centers for Medicare & Medicaid Services – CMS

- *Services must be rendered for a condition for which the patient received inpatient hospital services or a condition that arose while receiving care in a SNF for a condition for which the resident received inpatient hospital services.*
- *The daily skilled services can be provided only on an inpatient bases in a SNF.*
- *Services delivered are reasonable and necessary for the treatment of the resident's illness or injury.*

Skilled Nursing / Skilled Rehab

- Per Centers for Medicare & Medicaid Services - CMS

In order to be deemed skilled, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.



Skilled Rehabilitation

√ RESOURCE: Medicare Benefit Policy Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

Chapter 8- Coverage of Extended Care (SNF) Services

Section 30.2- Skilled Nursing and Skilled Rehabilitation Services

- Daily (5x/week) Therapy
  - Define day = 15 minutes minimum
- Inherently complex
- Requires the sophisticated skills of the therapist

Medicare vs Managed Care

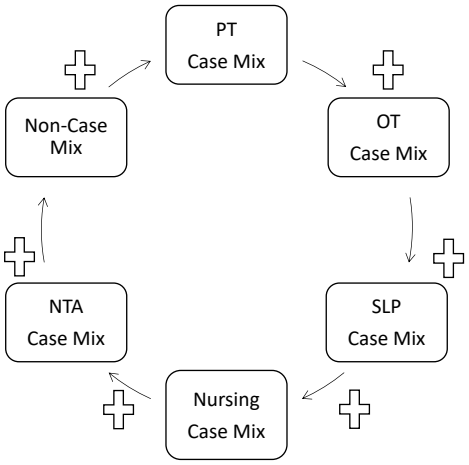
- Managed Care
  - Medicare Part C : Medicare Advantage Plans or “MA”s
    - Offered by private companies approved by Medicare
    - Provides all Part A benefits for Hospital and SNF coverage
    - Private companies must follow Medicare rules however can charge differently
  - HMO / PPO / POS Plans
    - Health Maintenance Organizations (HMO) usually only pay for care within the network. You choose a primary care doctor who coordinates most of your care.
    - Preferred Provider Organizations (PPO) usually pay more if you get care within the network. They still pay part of the cost if you go outside the network.
    - Point of Service (POS) plans let you choose between an HMO or a PPO each time you need care.

- Mrs. Davis
  - Assisted Living resident, required set up for most ADL
  - 3 nights admitted as inpatient
  - Physician documented conditions required SNF care
  - Physician recommends SNF for next level of care
  - Goals set for near PLOF – at a level that AL can support
  - Discharge planning starts at the time of admission

PDPM

- Patient Driven Payment Model – PDPM
  - Old system: Resource Utilization Groups (RUG)
    - $ based on therapy minutes
  - New system: As of October 1, 2019: PDPM
    - $ patient classification
    - 5 payment groups

PDPM Case Mix Groups



Total Rate = Sum of all the PDPM Case Mix Groups combined

PDPM, continued

- Minimum Data Set (MDS)
  - Detailed assessment
  - Interdisciplinary
  - Must be completed within 8 days of admission
  - Must be completed at discharge
  - Required by CMS (Centers for Medicare & Medicaid Services)
  - Instructions are in RAI Manual (Resident Assessment Instrument)

√ RESOURCE: Resident Assessment Instrument
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual
https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

PDPM: Therapy

- Section GG MDS: Functional Abilities and Goals
  - Prior Function
  - Admission Performance
  - Discharge Goals
  - Discharge Performance

* Most OTs are asked to contribute to this section for payment under PDPM

Q3

CONTINUED

Section GG : Decision Tree

Does the patient complete the activity with or without assistance devices - by themselves with no assistance? → 06-Independent

Does the patient need only set up/clean-up assistance from one helper? → 05- Set up / Clean Up

Does the patient need only verbal/nonverbal cueing or steadying/touching/CGA from one helper? → 04- Supervision/ Touching Assistance

CONTINUED

Section GG : Decision Tree

Does the patient need physical assistance - from one helper providing less than half of the effort? → 03- Partial / moderate assistance

Does the patient need physical assistance from one helper with the helper providing more than half of the effort? → 02- Substantial / maximal assistance

Does the helper provide all the effort to complete the activity OR is the assistance of 2 or more helpers required? → 01- Dependent

√ RESOURCE: RAI Manual Link
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

Steps for Assessment

- Activities may be completed with or without assistive device(s)
- Assessment should be conducted prior to the resident benefitting from treatment interventions in order to truly reflect the patient's baseline
- Do not record the patient's best performance
- Do not record the patient's worst performance
- Record the patient's usual performance

Steps for Assessment, continued

- Assess self-care performance based on direct observation
- Patient should be allowed to perform activity as independently as possible, as long as they are safe
- A "helper" is defined as facility staff
  - helper assistance is required because of a resident's performance is unsafe or of poor quality

CONTINUED

Define Helper

- Per the RAI Manual, a helper is defined as facility staff. This includes:
  - Rehab Staff (including contract therapy staff)
  - Nursing Staff (including agency staff)
- This does **not** include:
  - Hired individuals
  - Hospice staff
  - Students

Q4

CONTINUED

Language Translation

- Therapy and Nursing have different languages about coding assistance
- It is very important for the therapists to understand the nursing language to code Section GG
- The *RAI Manual* is the guide for coding Section GG, not as described in our textbooks, ie: *Physical Rehabilitation*

√ RESOURCE: RAI Manual Link

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

Other areas of MDS

- Section C: "BIMS" Brief Interview for Mental Status
  - Cognition screen
- Section D: "PHQ9" Resident Mood Interview
  - Mood interview
- Section G: Daily Preferences
  - Daily preferences and activity preferences interview
- Section G: Functional Status
  - Another section that looks at ADL performance, normally done by nursing
- Section J: Pain
  - Pain interview

Other areas of MDS, continued

- Section K
  - Swallowing/Nutritional status
  - Therapeutic diets
  - Parenteral/IV Feeding
  - Feeding Tube
  - Mechanically altered Diet
- Speech Therapy Assessments help
- OT likely could contribute to this area too

Other areas of MDS, continued

- Section 0: Special Treatments, Procedures, and Programs
  - Collects PT, OT and ST minutes and days
  - Individual minutes
  - Concurrent minutes
  - Group minutes
  - Co-Treatment minutes
  - Total days of therapy administered
  - Therapy start and end date

Long Term Care Therapy

- Medicare Part B
  - 80% coverage for Therapy Services
- Managed Care Part B
  - Varies - may only approve a certain number of therapy visits
- Medicaid
  - No therapy coverage

Q5

Documentation

- Part A vs Part B
  - Part B : Requires a therapist visit every 10 sessions or every 30 day whichever comes first
    - Therapist must treat the patient for at least 15 minutes
    - Therapist must write a progress note summary, update goals as needed and adjust plan of care as needed
    - Review skilled interventions
    - Review COTA notes / collaborate with COTA

  * Know your employer's expectations for documentation

Long Term Care Therapy

- Areas of treatment
  - Decline in ADL
  - Splinting / contracture management
  - Wheelchair seating / management
  - Referring to restorative

Q6

- Mr. Smith
  - PLOF:
    - Mod I / set up: feeding; grooming
    - Mod I / set up: Dressing and Bathing Upper Body
    - Dep: Dressing and Bathing Lower Body, Toileting
    - Min - Mod: transfers
  - OT: Plan of care
    - Goals
    - Treatment approaches
    - Recommendations for D/C

A Therapist's view into Compliance

- Medicare Benefit Policy Manual: Chapter 8, Section 30.2
- Medicare Benefit Policy Manual: Chapter 15, Section 222.0

√ RESOURCE: Medicare Benefit Policy Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

A Therapist's view into Compliance

- Billing Practices
  - Local Coverage Determinations (LCD)
  - National Coverage Determinations
- Documentation
  - The documentation must support the medical necessity
  - SNF Primer 2 will cover this in deta¨

√ RESOURCE: Local Coverage Determinations
https://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs

Reasonable and Necessary

1. Services are not considered skilled just because a therapist/assistant provided.
2. If a non-skilled person or a patient can safely and effectively administer a task, it is not skilled.
3. The unavailability of a competent person to provide non-skilled services, does not make it skilled when a therapist performs the task.

Reasonable and Necessary, continued

4. General activities for the good of patients (to promote fitness, flexibility, motivation) are not skilled.
5. Services provided that are not under a plan of care, are not payable.
6. Services provided by staff who are not qualified (or supervised) are not payable.

√ RESOURCE: Medicare Benefit Policy Manual
§30.2 - Skilled Nursing and Skilled Rehabilitation Services

Reasonable and Necessary

Necessary to:

- improve a patient's current condition
- maintain a patient's current condition
- slow further deterioration of the patient's condition

Q7

- Mr. Johnson: PLOF
  - Mod Assist Dressing, Bathing, Toileting
  - Mod I: Feeding and Grooming
  - Mod I: W/C Mobility
  - Mod Assist: Functional Transfers
- Mr. Johnson: Evaluation Status
  - Max A: Dressing, Toileting
  - Dep: Bathing
  - Min A: Feeding and Grooming
  - Dep: W/C Mobility
  - Max A: Functional Transfers

Case Study, continued

- Review skilled criteria:
  - Requires the sophisticated skills of a therapist
  - Measurable, functional improvement toward PLOF
  - Inherently complex services
  - Plan of care under a physician

CONTINUED

Expectations of therapy

- Address recovery, improvement in function, restoration of prior level of function
- Documentation is key
- Objective measurements
- Justify continued treatment
- Continued assessment and analysis
- Instruction for compensation
- Training to family and patient

CONTINUED

Billable Services

Occupational Therapy Evaluation Codes

- 97165 Occupational therapy evaluation, low complexity
  - A brief history including review of medical and/or therapy records
  - An assessment(s) that identifies 1-3 performance deficits
  - Clinical decision making of low complexity
  - Typically, 30 minutes are spent face-to-face with the patient and/or family

CPT = Current Procedural Terminology

Q8

Evaluation codes, continued

- 97166 Occupational therapy evaluation, moderate complexity
  - Expanded review of medical and/or therapy records
  - Identifies 3-5 performance deficits
  - Clinical decision making of moderate analytic complexity
  - Typically, 45 minutes are spent face-to-face with the patient and/or family

Q8

Evaluation codes, continued

- 97167 Occupational therapy evaluation, high complexity
  - Includes review of medical and/or therapy records extensive additional review of physical, cognitive, or psychosocial history
  - An assessment(s) that identifies 5 or more performance deficits
  - Clinical decision making of high analytic complexity,
  - Typically, 60 minutes are spent face-to-face with the patient and/or family

Q8

CONTINUED

Billable Services

- Common OT CPT Codes for SNF
  - 97535 - Self-Care
  - 97112 - Neuromuscular re-education
  - 97110 - Therapeutic exercises
  - 97530 - Therapeutic activities
  - 97129 - Cognitive function
  - 97542 - Wheelchair management
  - 97010 - Hot or cold packs

√ RESOURCE: AOTA (members only) 2020-Selected-Occupational-Therapy-CPT-Codes.pdf
https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/Coding.aspx

CONTINUED

Maintenance Therapy

- 2013 class-action lawsuit
  - Jimmo versus Sebelius Case
  - "Improvement Standard" inappropriately applied
  - Argued Medicare coverage should be based on need not on potential to improve
  - Allows for a maintenance program to maintain the patient's current condition and to prevent or slow further deterioration - as long as the beneficiary requires "skilled care" for the safe and effective performance of the program

Q9

Non-Billable Services

- Documentation time – unless you are completing your documentation with the patient
- Family meetings - unless the patient is present, but only then can you count the time you spent providing skilled information / updates on POC
- Planning for a treatment session
- Screens
- Transporting a patient

Q10

Wrap up

Resources:

OT.com

American Occupational Therapy Association

OT state Organizations

CMS.gov

Medicare Benefit Policy Manual

Local Coverage Determinations

Resident Assessment Instrument

CONTINUED

Acronyms in this presentation

- ADL: Activity of daily living
- AANAC: American Association of Nurse Assessment Coordination
- AOTA: American Occupational Therapy Association
- BIMS: Brief Interview for Mental Status
- CMS: Centers for Medicare & Medicaid Services
- COTA: certified occupational therapy assistant
- CPT: Current Procedural Terminology
- HMO: Health Maintenance Organizations
- LCD: Local Coverage Determinations
- MDS: Minimum Data Set
- OT: Occupational Therapy
- PDPM: Patient Driven Payment Model
- PHQ9: Resident Mood Interview
- PLOF: Prior level of function
- POC: Plan of Care
- POS: Point of Service
- PPO: Preferred Provider Organizations
- PT: Physical Therapy
- RAI: Resident Assessment Instrument
- RUG: Resource Utilization Groups
- SNF: Skilled Nursing Facility
- ST: Speech Therapy
- W/C: Wheelchair

CONTINUED

Questions

- Kathleen Dwyer
  - KDwyer@JMDhealthcare.com

CONTINUED

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References

American Association of Nurse Assessment Coordination, Copyright 2019, American Association of Post-Acute Care Nursing, d/b/a American Association of Nurse Assessment Coordination. All Rights Reserved. AANAC.org, Released Aug. 2019

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Center for Medicare Advocacy: Medicare Cost-Sharing Rates (Premiums & Deductibles for 2019 & 2020)

Center for Medicare Advocacy:Toolkit: Medicare SNF Coverage and Jimmo v. Sebelius Toolkit https://www.medicareadvocacy.org/toolkit-medicare-skilled-nursing-coverage-and-jimmo-v-sebelius/Medicare SNF Coverage and Jimmo v. Sebelius Toolkit.pdf

CPT® Assistant February 2017 / Volume 27 Issue 2 New Occupational Therapy Evaluation Codes

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Medicare Benefit Policy Manual, Chapter 8, section 30.2 and Chapter 15, section 220: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

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