Skilled Nursing Facility Primer - Part 1
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- [Fawn] Today's course is Skilled Nursing Facility Primer. Our presenter today is Kathleen Dwyer. She is an occupational therapist with over 20 years of experience in the healthcare industry, which includes professional leadership in the corporate setting. Following her graduation from Eastern Michigan University, she focused on earning her certification in hand therapy and also specialized in aquatic therapy. Her experience in therapy management began as the director of rehabilitation for a vast campus, which included a skilled nursing facility, a long term acute care hospital, and an outpatient therapy center. Kathleen has also served as the director of operations for a chain of 56 skilled nursing facilities. She is certified in healthcare compliance and has also earned the RAC-CT, which designates her as an expert in skilled nursing facility prospective payment system and the minimum data set assessment. She's currently working as the executive vice president for JMD Healthcare Solutions. Welcome Kathleen.

- [Kathleen] Thanks Fawn, and appreciate you having me back as well as everyone joining us today. So let's just dive right in as I would like to first go over my disclosures, so there they are. And today's goal, you're gonna be able to define what skilled therapy is as it relates to the skilled nursing facilities. And we're gonna describe the different payer types in skilled nursing facilities, including Medicare Part A, Medicare Part B, Managed Care A, Managed Care B, and Medicaid. We're going to take into consideration all the things that we can learn from the compliance guidelines at the centers for Medicare and Medicaid services or CMS into our daily practice. So what does it mean to be skilled? So if you are brand new to working in a skilled nursing facility or if you've had 15 plus years of working in a different setting, but maybe are looking to switch to PRN or transition to the SNF setting, today's presentation will be giving you a very high level overview of therapy within the SNFS. And I did do the poll prior to us starting, so I was able to get an idea of who my audience is today. I'm glad that we've got a good mix of both OTs and COTAs, as well as many different years of experience. So we're gonna take this across the board so it might be a little bit

overwhelming but I hope that you can gather some good nuggets today that you can take back with you to your clinic.

So let's start with what does it mean to be skilled. You're gonna hear that someone has been admitted "skilled" to the nursing home. This is a term used to describe when a beneficiary of Medicare Part A uses their benefit post hospital care. So this beneficiary is entitled to up to 100 days during each spell of illness. And according to the center of Medicare advocacy, a spell of illness begins the first day that the patient receives Medicare covered care and ends when the patient has spent 60 consecutive days outside of the facility or if they remain in the facility, they're not using any of the Medicare covered care for 60 consecutive days. So there's lots of points of criteria that we're gonna go through over the next few slides, but what I'd like you to know is that if a beneficiary meets those criteria requirements, then they are entitled to full coverage for the first 20 days, so that's 100% paid. And then as of day 21, the beneficiary is required to pay a co-insurance. So you might be in the facility and hear that one of your patients is really trying to get out of the facility by day 21. Well, now you know that probably is because they just don't wanna pay that co-insurance. And as of 2020, that rate per day is $176. Again, that's just the co-insurance.

So let's start talking a little bit about the skilled criteria. What makes the person skilled? Well, first of all, they have to have spent three midnights as an inpatient in the hospital. So what that means, is that the patient has been hospitalized and admitted as an inpatient and they've also spent a period of time that includes at least three midnights. So we do hear that term, did they get their midnights or did they have their three nights stay? That's what that means. The patient has to be admitted into acute care hospital for at least three midnights to kick in that benefit. The key here also is that admission. So sometimes a patient is in the acute care, but they're not admitted. They're actually in what's called observation. So it's important for us to know if that was someone who was actually admitted or were they observed? Because if they were just an

observation, then the benefit for skilled care does not kick in. The next criteria is that the physician must be signing off that this patient requires skilled nursing facility care or SNF care. I will use that term kind of interchangeably throughout the presentation. SNF is a skilled nursing facility. So it has to be documented that the physician is actually attesting, that they require the SNF care. And then finally, they are required to have the needs for skilled care. And skilled care is defined by either requiring seven days a week of nursing care, so the registered nurses and the care they provide them, and or five days a week of skilled rehabilitation, PT, OT or speech. And we're gonna get into the details of that throughout the presentation.

So I've got some quotes here from our center of Medicare and Medicaid services, also CMS. But to paraphrase what this says, their skilled criteria is saying that the patient has to have been admitted into the hospital and they were admitted for a condition that now that condition is continuing to be treated at the SNF level of care and that they require the continued care for that condition or illness or onset of disease that they recently have had. They also expect that we are considering the SNF as a level of care that's both economic and efficient for this patient, that they require the daily services that can only be provided at the skilled nursing facility level. And that is an economic decision, that is a requirement. And finally, what I think means the most to us therapists is that these services that are delivered, which includes therapy, must be reasonable and necessary for the treatment of the resident's illness or injury. So that would mean as an occupational therapist doing an eval, let's say that we find someone who comes into the facility, they are admitted for our care, but they're very high functioning, let's say that they're almost modified independent or supervision for their ADL, then perhaps we would deem that patient would only need an eval or maybe they would only need a couple of days to establish a home program and then discharged. So that reasonable unnecessary is very important, and that is something we're gonna talk more about today.

So exactly what does it mean to be skilled for nursing versus skilled for rehab? Well, what I want you to know is that it's an either or, or both. A patient can be skilled just for nursing. A patient can be skilled just for therapy or both, not to be forgotten. But what's important for us both to know whether it's the nursing is skilling them or rehab is skilling them, is that they must require our skillset. That's to be skilled. It must be per CMS, so inherently complex that it can be safely and effectively performed only by or under the supervision of a professional or technical personnel. So that's us. In order to be skilled they have to require our sophisticated skillset and all of these requirements and kind of guidelines are all in the Medicare benefit policy manual. So I've made a little check mark here as a resource for you in where this information has come from. In case you're looking for something extra to read you can review these manuals that I'll put throughout the presentation. But what I really wanna focus in on is what are those requirements for skilled care, for therapy or rehab? I'll use those terms interchangeably today.

The first thing is that it is a requirement for at least one discipline to be in for five days a week, that makes them skilled for rehab. And a definition per Medicare, is that a day is defined, as a receiving at least 15 minutes of care. So in order for us to count the day, we have to provide at least 15 minutes of one discipline and one discipline has to treat for at least five days in a week. Something else that I think is important to bring up, 'cause I've seen a lot of confusion around this is that Medicare defines the week from the date of the eval is day one, and then the next seven-day period is that week. So if I do the eval on Tuesday, we actually have until the following Monday to complete those five treatments. The confusion that I've heard when I've been in facilities is that they think the week is a Sunday through Saturday week and that's not the case. So the week is actually defined by the eval. So if the OT eval starts on Tuesday, then we must treat that person five days between the eval date and within the seven days. So some people have asked me, well what's the requirement if a person is sick? I think what's really important is to remember for that patient to maintain their skilled level of care,

they are to receive five days in that seven-day period. So if they are missing a day 'cause they're out of the facility or they're sick, it's really important that we try to get in that five days for them. And if it doesn't happen, then you just need to make sure that your documentation supports the reason for why that person didn't have therapy. But we really need to do our best to make sure that the patient is seen and that they're getting the provided therapy that is required for skilled care. So just to make another mention of it, I know I mentioned it in the earlier slide, but in order to be considered skilled, the rehab must be inherently complex. So what does that mean? Basically what it means is that our skillset is required in order for the activities to be performed safely and effectively and also that they need to be done under our supervision. I know and I think that that's really important because that shows that we are different from a nurse's aid or we're different than a therapy aid. It actually is required to have our professional skillset that we have because we're licensed individuals and we've gone through a lot of work to get to that level. So keep in mind that it is part of your skillset that keeps that person considered skilled.

And there again at the end of my bullet points here is it requires the sophisticated skills of a therapist. And people who know me, know I say this all the time, it requires your sophistication and that is not my word, that is a Medicare word that is out of the manual. And it's just important that we weave that into our daily treatments, that we provide our patients with our sophisticated skills, because really again, that is whether or not they need those skills, keeps them skilled, keeps them under that benefit. So some people think it's the diagnosis that keeps somebody under a skilled care and it's truly not in fact the diagnosis. The key is whether or not they need the skillset of the therapist under skilled rehab care. All right, so that's enough on that. Let's move on a little bit to insurances because I think moving yourself into the skilled nursing facility, it's important for you to know that there's a lot of different insurances out there. And so far I've only been talking about Medicare Part A. So Managed Care is growing rapidly across the US and I just wanna dive into a little bit of the difference between the

managed care products. First of all, Medicare Part C is the Medicare Advantage Plans, also known as MA's. So if you're eligible for Part A, meaning that you're over 65, you are also eligible to choose a Medicare Advantage Plan.

The Medicare Advantage Plans are more on the commercial side, but they follow Medicare guidelines. So the difference is that they're run by private companies. They follow the Medicare guidelines or rules, but they can charge differently. So you might see that somebody comes in under a Medicare Advantage Plan or you might see that someone has come into the facility using a commercial insurance plan. So that would be your HMOs, your PPOs, your POSs. Typically, these are the patients who are under 65 who come in with these commercial plans. And what's the important detail for us therapists to understand is the coverage requirements. Medicare Advantage follows the Medicare rules, the criteria I just talked about, but Medicare advantage, I'm sorry, not to be confused with the HMO and the PPO and the POSs, they have their own rules and guidelines. So for example, you might have someone who is in your facility with a commercial insurance plan and that insurance plan might only cover 60 minutes a day of all disciplines. If you've got all three in, you're gonna have to make good decisions because they're only being paid for an allowed amount of minutes per day. And I don't wanna get into the weeds of the details because each plan and each contract is very different, state to state and contract to contract. But I bring it up because I think it's an important piece for you to ask about when you're in your facilities, what are the typical insurance plans that patients are coming in with, and what is the coverage that that insurance plan offers them and know that it could be different from patient to patient.

All right, so a little case study here. Let's talk about Mrs. Davis. She is an 82-year-old who lives in an assisted living prior to the onset of this recent condition. And there she was quite independent. She only required setup or supervision for her ADL and she was sent to the hospital due to a change of mental status and required increased care

and support. She was admitted to the hospital and she spent three nights there and the physician at the hospital diagnosed her with a UTI and sepsis. They were able to stabilize her, but due to the level of the deconditioning, the physician recommended SNF care, including therapy. So upon admission to the SNF, she had all three disciplines screened her and both PT and OT established plan of cares with goals for her to return to that prior level of function. And the goals for OT for Mrs. Davis were to be modified independent with her eating and grooming post set up and dressing and toilet and goals were set to supervision and bathing was set to contact guard assist, knowing that the patient can be returned to her assisted living requiring some assist. So as therapists writing the plan of care, we need to remember that our goals should be written for that next level of care. So in this example, we're writing our goals for that assisted living and what level of care can they handle at that lowest level at that level of care. So just like the physician at the acute care recommended SNF for their discharge, our goals should be a reflection of what that next level of care can handle for them. And it should be that lowest level, 'cause again, the insurances and Medicare are expecting us to be efficient and also economic with our decision making here. So when we initiate that care, it's our responsibility to learn exactly what the level of assistance the patient can have for discharge planning. And that should begin from the date of eval. So we should be planning their discharge and knowing exactly what therapy needs to do to efficiently and effectively attain their goals.

So PDPM, maybe you've heard of it, the Patient Driven Payment System. As of October 1st, 2019, this is the new payment model in place that replaced our former RUG system. So if you haven't been in the SNFs for some time, this is a big change from the previous system for payment. The RUG system, primarily relied on our old therapy minutes to reimburse for payment as to be skilled in a nursing home. And that has now been replaced with the Patient Driven Payment Model or PDPM. And this payment model classifies patients into different groups based on mostly diagnosis characteristics. And then that is what determines their rate. So let's take a deeper look

into it, just kind of a high level review of PDPM, but you can see that there are six case mix groups, five of which are clinical. So we have PT, OT, speech, nursing, the NTA, which is the non therapy ancillary and then finally, there's this last group, then the non-case mix group. And what that is, is it's based basically on location, whether you're rural or urban and what state you're in, those are varied amount. But what happens is, when a patient is admitted to the facility, they are classified into these groups and each group has a different associated rate. We add up all of those rates and that is what gives us the total rate per day for a patient to be in a skilled nursing facility. So to get into PDPM, I think what's important for us to know is that the information that we're gathering for those rates or those diagnosis, those groups, all come from what's called the minimum data set or the MDS. This is an assessment that is completed for every Medicare skilled patient and any insurance that's following the Medicare guidelines. It's a very detailed long assessment that's required by CMS and the rules for coding this assessment are contained within a manual that is 1,300 pages long.

So we are definitely not getting into the details of that, but I am gonna do some reviewing because I do think it's really important for us therapists to understand how we are contributing to the MDS, which contributes to payment for PDPM. So this is an assessment that has to be completed within eight days of admission. It's done again at the time of discharge and as I mentioned, the instructions are all in the RAI Manual, which is the Resident Assessment Instrument. And I have another check mark there for you for a link to it. The latest version was released in October of 2019 when PDPM was released. So if you wanna check it out, there's the link for you. So as I mentioned, it does relate to therapy. We are contributing to quite often actually, the skilled nursing facilities are relying on an OT and PT to contribute to section GG, which is the functional abilities and goals section. This is where we have our functional outcome measurements and there's a lot of data that comes into the MDS, but specifically for the section GG, we are looking at the patient's functional abilities and their goals. It

includes the items that focus on prior function, how they're doing at admission, what their goals are going to be for discharge, and then again, they're discharge performance.

So the functional status is assessed for the need of assistance for both self-care and mobility. And that's why we see mostly OTs and PTs are contributing to this. So what happens in the nursing homes is that the person who's responsible for submitting and completing this MDS assessment is the MDS nurse. And she is the one who gathers and collects the data that is needed for all of the areas. And this is the section where we see mostly PT and OTs are responsible for gathering the information and then giving it to the MDS nurse or she collects that off of our evals. That's why it's important for us to understand the rules behind the section because a lot of us are contributing to section GG in our evaluations. In fact, a lot of the therapy softwares now are embedding this information right into our evals.

So I'm gonna go through this in detail and bear with me 'cause I'm gonna read these slides but what I want you to know is I pulled this algorithm or this decision tree, out of the RAI Manual. So this is where I think it makes it the easiest for us to figure out how we code our residents in section GG. It's 'cause obviously we were trained as therapists through the physical rehabilitation model of min, mod, max, modified independent, contact guard. You're all familiar with those words. So what I wanna point out is that the wording here is actually quite different. All right, so I'm gonna start from the very top here and I'm gonna read, does the patient complete the activity with or without assistive devices, by themselves with no assistance? If you can answer yes to that, you would score them as 06-independent. If you would say no, then you move down here to the next question, does the patient need only set up, clean up assistance from one helper? If you can answer yes, you code them as a 05-set up, cleanup. If you can answer no, come down here, does the patient need only verbal, nonverbal cuing or steadying, touching, contact guard assist from one helper? If the answer is yes, we

code them as a 04-supervision, touching assistance. If it's no, then we move over here to our next one, does the patient need physical assistance from one helper providing less than half of the effort? That's key. If the answer is yes, we code them as a 03-partial moderate assistance. If we can say no, the next question is, does the patient need physical assistance from one helper with the help of providing more than half of the effort? If the answer is yes, we code them as a 02-maximal assistance, substantial. If the answer is no, then we come down here, does the helper provide all of the effort to complete the activity or very important here team, is the assistance of two or more helpers required? So at any point if we require the assist of two or more helpers then they are coded as a 01-dependent. And I did put in another resource check mark here at the bottom. So if you're having any desire to look in and read, you can find that at the website there.

So I think it's really important for us to understand that. And I also pulled out some of the keys for steps of this assessment where I think therapists can really kind of have some good knowledge here is know that activities can be completed with or without assistive devices. It does not and should not affect the coding of the activity. Also we should be assessing the patient for this coding prior to giving them our interventions. As therapists we like to give cues and we do compensatory strategies and we use our words and our hands that help the patient. But we really should be holding off from that and letting the patient to perform the activity without our help. We are not to record the worst performance, we are not to record the best performance we are, per the RAI Manual, to code the patient's usual performance. So that's really, really important. What do we consider usual performance? And just to mention also, this is an assessment that needs to be completed within that first three days and you should be considering the usual performance over that three-day period. Continuing on, we're assessing the self-care based upon our direct observation. So what did we see? And we need to allow that patient to be as independent as possible, as long as they are safe. And finally, a helper, as I read helper quite a bit through that algorithm, is defined

as facility staff. So helper assistance is required because a resident's performance is unsafe or of poor quality without it. So when we are using that helper term, it's because they need the assistance, otherwise it would not be safe or it would be of poor quality. And let's define helper. So again, these definitions come from the RAI Manual and a helper is defined as facility staff and that would include rehab staff, nursing staff, agency staff, contracted staff, as long as they are rehab or nursing. It does not require any privately hired individuals, hospice staff or students. So gathering this information for the assessment is supposed to be a very interdisciplinary approach. It's supposed to be both nursing and therapy gathering in the admission and collecting the status of the patient within the first three days. And the MDS nurse is then responsible for coding it. And I know this process probably varies from facility to facility as far as who exactly is the driver. But I do know that a lot of evaluating therapists are being asked to contribute this. And I also know that when it comes to coding levels of assist, nursing and therapy speak different languages.

So it's really important if you are gonna be working in a SNF that you understand the rules behind coding this section. So just as an easy example, you might have noticed that in the example that I did, zero six is an independent, where's modified independent? We didn't see that in their little bubble decision tree. That's because modified independent kind of falls actually under independent because that assistive device can be used in independence. So you see that's a little bit where that confusion can be and that's why I think it's really important to use that decision tree if you are the one that's gathering the information and make sure you also use the resources. Here is another link to that RAI Manual. Just wanna bring up that there are quite a few other areas of the MDS that I'm seeing therapists being asked to contribute to. So let's do a high level review of those. Section C has the BIMS, which is a Brief Interview for Mental Status. This is a just an interview basically with very specific instructions that helps to assess their cognition. And if you're being asked to contribute to section C, I would make sure you have the instructions from the RAI Manual, how to perform the BIMS,

'cause they're in there and they're very specific. Section D is the PHQ9, and this is a resident mood interview. Once again, it has very detailed rules and guidelines and I know that some OTs are being asked to also perform this interview in a SNF. So you wanna make sure you get those guidelines. But actually it should be section F for daily preferences. I've seen that some evaluations are being now cued to ask the patient what their daily preferences are And those answers can contribute to the MDS. And also section G, functional status. Not to be confused with section GG, but this is another area where most of the time it's nurses that are gathering this information on their ADL performance. And section J is pain interview. So obviously another area where therapists can be asked to contribute to. But once again there's guidelines with that interview. So you wanna make sure that you're gathering that information. Section K is a quite an impactful area right now under PDPM, so a lot of speech therapists are being asked to contribute to this area. However, there is some overlap into our OT scope of practice here. So I wouldn't be surprised if you're being asked to pick up some information and gather it for the MDS nurse in this area. And finally section O, this is an area where we do contribute quite a bit of information to, but it's mostly data analytics. Most of the time this is information that's coming directly out of our therapy software, so you're not having to really do anything with it. But I just wanted to point it out 'cause CMS looks at this information and this is what they use for some of their analytics.

So overall, section GG is definitely the area where I'm seeing that the OTs are contributing the most to with the MDS. But like I've mentioned, there are a lot of areas where we could be asked to contribute to. So my advice to you is that if you are being asked to contribute to these areas, make sure you've gotten the training, make sure you're asking your therapy manager or your corporate resource person for more information and you're welcome to reach out to me. I'm happy to answer questions in this area and ot.com and I are actually working on another course that we're gonna put out in June that dives into the details a little bit more. If you're interested in that, you

can keep your eye open for it. So another area that you're definitely going to have to get used to working in a nursing home is treating the longterm care patients. And so who are they and what does this mean? These are the patients who reside in the nursing home who are no longer under that skilled Medicare benefit. They no longer qualify for skilled services. So whether they're paying privately or using a longterm care insurance plan they are living now in the nursing home and they too could have therapy need. And there's also different benefits that contribute to coverage for those therapy needs.

So let's kind of walk through each of them. Medicare Part B is very common in the nursing home to be coverage for the longterm care side of OT services. What I think is important for you to know is that for all three disciplines, PT, OT and speech, it is covered for only 80%. So that is important because that's a 20% remaining portion that might need to be out of pocket for your residents. Now, if they have a secondary insurance, that secondary insurance might pick up some of that 20, or maybe even all of it. But that's why facilities typically have some sort of internal policy of how we go about making sure that there's payment for that other 20%. So if you're new to the SNF industry, I would add this to your list of questions is what's the company policy or specific procedure for when someone has Part B therapy services? Do we need to contact the family or can the patient sign off on it and give it the okay that they're gonna pay that remaining 20%? What is the company policy 'cause there's a variety depending on where you are, but I think it's important to know. So just like there's Managed Care A, there's also Managed Care B, and this is where it really has a huge variety of coverage. Let me just tell you about what's typical. So typically what happens if a patient has a Managed Care Part B, so this would be like one of those commercial insurances, Aetna or Humana, whether they're a replacement plan or just a commercial insurance, typically what we have to do is provide the insurance company with our evaluations and then they tell us what they'll approve, like how many visits so we might be authorized to treat. Oh, I've seen as little as four visits being authorized or

maybe you'll get lucky and you'll get 10 visits. So you really need to kind of pay attention to what these patients' benefits are and what they're going to cover for therapy because there's a huge variety here. Also just another little kind of question to your facility manager is what's the process here? Who's responsible for finding out what's covered? Who's responsible for submitting that evaluation to the insurance company? And if we don't hear back who's responsible for following up? Most of the time that falls to the facility or somebody at the facility, maybe the business office manager, but you would wanna know that process if you're new to the SNF. And then what is the process? Do you have to wait to treat the patient until you've heard it's been approved? Or are you okay to just start treating and have your fingers crossed that the insurance company approves your plan of care?

Another payer that's very common throughout the nursing home is Medicaid. And when a patient is living inside a nursing home, their services for therapy are actually not covered through Medicaid. So this is gonna be an expense to the facility and I think that's something important for us to know because there might be a process there that the facility has. Maybe the facility administrator approves how many visits that we can provide to them. So again, might be another question to ask when you're entering into your new facility. Regardless though of payer, it's just important to know that we always need to be efficient and effective with our treatment plans and our documentation really needs to support why we're doing a skilled service. What is it that is keeping our skillset at the forefront of our treatment and our documentation needs to support that. What I wanna point out here today is that there are different requirements for our skilled population than there is for that Part B population. And specifically, Medicare Part B. This is important if you're new and you're a registered therapist because you are actually required to do the documentation every 10 sessions or every 30 days, whichever comes first. In order to meet the guidelines, you actually must treat the patient for at least 15 minutes, but I recommend longer and go through basically a progress note with them, update their goals, update the plan of care, review the skilled

interventions that you've written in your order, review and collaborate with your COTA. How is it going? How's the treatment? Are they progressing? Do you need to make any changes to that plan? And make sure that when you write this note, you're covering that span of the last 10 sessions or 30 days, whichever comes first. So just a side note, this is a requirement for Part B, but I'm seeing in the facilities that they do expand this to other payers. So I'm just presenting the Medicare requirements. You might find that your facility might have a more strict guideline, so you definitely wanna find out what are the expectations of the documentation at your facility. And just as a side note, we will be diving deep into documentation on part two of our series here. So if you're looking for documentation tips and tricks, I promise that we will go over that in part two.

Let's talk about what areas of treatment, like what would you normally be treating for somebody if you're the OT in the nursing home? So for longterm care, mostly what we are referrals for are due to one of these bullet points. So a decline in their ADL, perhaps nursing has noticed that they're kind of having a change in how they're dressing themselves or feeding themselves. That would be an area where we would come in and do a plan of care. Splinting, contracture management, another area that we typically see in the nursing home. This might be another question to the facility if you're new, what's the policy? Are we ordering splints? Are they prefabbed or are we going to be making splints? Do you have the parts and pieces that you need to make splints? I would find out what the method is that they're using at the facility. Regardless though, you're probably gonna be setting up splint schedules, so I would become familiar with that. Another very common area is wheelchair seating and positioning. Also wanna find out what your facility is doing, what vendors they work with. So as an OT, working in a longterm care facility, you're gonna have to know how to do a seating eval. If you're not familiar with this area, then I would recommend you seek out another CEU on wheelchair seating and positioning, and ot.com has some great resources for this. And finally, restorative. This is another area that's very facility specific, but restorative is a

great way to kind of carry out our plan of care to the next level of care. So common restorative programs include walk to dine, there's feeding programs, toileting programs, range of motion programs. So I would ask your facility, what is your restorative programs and what is the process to refer someone to restorative.

All right, so let's take a moment and do another case study. Mr. Smith is a longterm care resident. He resides at the Silver Springs Nursing Home and he has a history of COPD and end stage renal disease. He is able to perform his eating and grooming with modified independence post setup. And prior to the onset of this recent change of condition, he was able to dress and wash his upper body at wheelchair level. But he's been dependent for lower body care for a long time and toileting too. He's required assist for transfers and depending on his dialysis schedule, those range from Min to Mod. He's had a change of status noticed by the nursing staff. He's declining with his ability to dress and wash his upper body. He's also requiring more assist with transfers. The nurse has documented that he's also had the decline in his strength. An order for OT was placed by the physician in hopes to return him to his baseline. So for this patient, as the occupational therapist, we would wanna establish a plan of care that's meaningful for Mr. Smith and one that takes into consideration his prior level of function. And due to the fact that he lives in a nursing home, he can be provided with around the clock care and he has a history of being dependent for certain areas of care. We wanna make sure that our plan of care focuses on the areas that have had a recent decline. So your plan of care should be written to address the specific areas that nursing has documented a change. So we would write goals to improve the upper body dressing and the upper body bathing. Perhaps the goal for his transfer status, as well as a goal to compliment with upper body strengthening. So your frequency and duration for longterm care patients just can't be at a skilled level. So typically it's less than five times a week. So perhaps it would be two to three times a week for four weeks. And our treatment interventions would be ADL, self training, therapeutic exercise, therapeutic activity. Our focus would be on getting him back to his prior level

of function. So that's what's most important with treatments in the longterm care setting.

So we're gonna talk a little bit now about compliance and skilled nursing facilities are monitored and surveyed by government entities. So it's important for us to know that we do have to follow the regulations and guidelines. And the Medicare benefit policy manual is a 16-chapter manual with detailed instructions of these guidelines and rules and directives. Chapter 15 and chapter eight have a lot of details about therapy. So we're gonna dive right into some of those expectations. But first, I wanna just mention to you where you can get some resources on billing practices because we're not gonna get into that too much today. But if you're looking for a resource the local coverage determination can be found at cms.gov and you can search for local coverage determination. This breaks down the requirements for each CPT code that's billed. You can also ask your facility manager for resources on CPT codes and billing practices. And like I said, we're going into documentation in our second presentation. So I'm not gonna get into the details today on documentation.

So what does it mean to be reasonable and necessary? We need to make sure that our documentation supports these things 'cause this is what's required through that Medicare benefit policy manual, it's a reoccurring theme. Things have to be medically necessary, they have to be reasonable, they have to be documented, very, very black and white area. So the first one here is services are not considered skilled just because we provided them. So what did we do that made it therapeutic? Did we grade the activity? Did we offer compensatory strategies? Those things you should be documenting. If a non-skilled person or patient can safely, effectively administer a task, it's not skilled. So this comes into place, if we can pass the task to a therapy aid or a nurses aid or the patient can do it themselves, at this point, our services are no longer needed and therefore that particular activity or exercise is no longer considered skilled. Three, the unavailability of a competent person to provide non-skilled services does

not make it skilled when a therapist perform the tasks. So I've seen this come into play when the patient is ready for discharge from therapy, but there is nowhere to discharge them to like there isn't a restorative program. Well that is not a legitimate reason to continue to treat them under our services. Four, general activities for the good of patients to promote fitness, flexibility and motivation are not considered skilled. I think that's pretty self explanatory. Those are all good things but they're not considered skilled. Services provided that are not under a plan of care are not payable, so that's a very black and white. And services provided by staff who are not qualified or not supervised are not payable. So again, very black and white area here.

Overall, necessary means that our services are improving a patient's current condition. Necessary means that we are maintaining a patient's current condition. And necessary also means that we are slowing further deterioration of the patient's condition. So those things keep in mind too when you're treating a patient, you need to either be improving, maintaining or slowing that further deterioration for this activity to be necessary. So let's get into our final case study of the day. Let's talk about Mr. Johnson. He's been referred to therapy due you do a recent hospitalization. Prior to this he lived in a longterm care facility requiring Mod assist for dressing, bathing and grooming and toileting. He would typically wheel himself to the dining room and he could feed himself after setup. He was modified independent with grooming and moderate assist for transfers. The OT eval was completed and goals were established to return him to his baseline. At the time of evaluation, he required max assist for dressing and toileting and was dependent for bathing. He was unable to propel his wheelchair and was Min assist now for feeding and grooming. Transfers were Max assist. So this patient made great progress in the two weeks and he really enjoyed his therapist and he enjoyed socializing and being in the therapy department, made good friends, so in overall was feeling so much better. And at his 10th visit note with his occupational therapist, he was able to return demonstration of his home exercise program and he returned to his prior level of function. The OT told him that his goals

were met and she was transitioning him to a restorative as of that date. And he became very upset saying he loved therapy. He loved being in the therapy department and working on his health and fitness and he doesn't want therapy to end. And he told her, he heard that at the resident council meeting, they had put restorative on hold 'cause there was no staff to complete it. He begged her to keep him on therapy and said he'd work extra hard to prove that it was needed. So what does the OT do? Well, we know we grow really close to our patients, and of course we wanna take good care of them, we want them to be happy. But after reviewing the plan of care, seeing that goals were met, that he was independent in his home program, he no longer meets the skilled criteria. He has resumed his prior level of function. And although he loves his therapy, it's no longer reasonable to continue. So what we need to do here at this time is that we have to discontinue therapy and let the nurse know that he should be encouraged to complete his home program and that they can incorporate that into their daily care plan, regardless of not if we have that restorative program has been canceled or not.

The expectations of us under CMS are that we make sure we are addressing recovery, improvement in function, restoration towards that prior level of function. Our documentation must reflect that we're providing services that are reasonable and necessary and we should be providing objective measurements that show improvements in function. We must clarify that our treatments are justified to make impactful changes in their functional improvements and everything correlates to function. We have to provide ongoing education and instruction for implementing compensatory skills and we should be training the patient and the family and caregivers to augment the rehabilitation process. Making sure that we're documenting those treatment sessions with instructions and making sure that we progress those areas as well. So as somebody progresses, we need to train the family on the next step. Making sure we include that all in our documentation is so important.

All right, so we're entering into our last section here and what I wanna just go through is some CPT codes and billing practices. Back in 2017 they did update the evaluation codes for three different levels. So the first one is 97165, which is a low complexity. It's a brief medical history review. You find only one to three performance deficits. Your decision making is of low complexity and according to the CPT code, this should take about 30 minutes to do this evaluation. 97166 is occupational therapy eval, moderate complexity takes it one step further, a little bit more expanded chart review, identifying three to five performance deficits of the patient. You're making moderate analytic complex decisions for this patient and typically it takes about 45 minutes. And the last one is high complexity, 97167. This includes an extensive review of the chart. It identifies five or more performance deficits. Your decision making is of high analytic complexity and according to the CPT code, we're spending at least 60 minutes or so with our patients. Treatment codes, these are the most common that I see used in the skilled nursing facility. It's important that you understand the guidelines behind these CPT codes and I've put a check mark there for a great resource for AOTA. If you're not a member of AOTA, join in in part two and we'll take a deeper look. But what I wanted to just bring up is that it's important to always as the evaluating therapists to select the CPT codes that directly impact the plan of care. So you wanna write your goals and then choose the CPT codes that best support that patient's individual needs. And if you're a COTA, we wanna make sure that you're treating the patient based off of your goals, that's always your guide. And if you're ever seeing a CPT code that doesn't really relate to your plan of care, then I would reach out to the OTR and have a discussion with them about that.

And maintenance therapy, I wanna bring this up because there was a quite a large case back in 2013 the Jimmo vs Sebelius case. And in this case the plaintiff alleged that Medicare contractors were inappropriately applying improvement standard and making claim to terminations. So this case is what confirmed that Medicare coverage should be determined based on a beneficiary's need for skilled care, not necessarily their

potential for improvement. So what does this mean for you? If someone in your facility is of need of skilled care but probably won't make any measurable progress, we wanna make sure we're following the guidelines for maintenance therapy and we're documenting the reason why the skilled sophisticated services are required to treat this patient. So it's not something you'll see often, but if you do have a patient who fits this description, make sure you're following the guidelines and documenting clearly why your skillset is needed. And finally our non-billable services. So I just wanna go through this one quickly. Documentation, when you are completing your documentation alone it is not billable. If you complete the documentation with the patient, you can bill for that time. Family meetings are only billable when you are with the patient and during the time that you are providing plan of care updates educational instruction. You can't bill for the entire time that you're in a family meeting, but you can bill for the time that you spend providing skilled information. You cannot bill for the time that you're planning a treatment session, and you cannot bill for the time you spend doing screens, chart reviews. And you cannot bill for your time with transporting patients to and from therapy.

So what I wanna wrap up with today is thank you so much for your attention. I've given you a list here of many resources, ot.com, AOTA, cms.gov, these are all of your resources that I used today to provide this information, as well as what I will use in our next presentation. So don't forget to tune in to part two of our SNF primer next week where we will focus in on all of the documentation that you need to be successful in the skilled nursing facility. So I hope you tune in. I'd like to open it up for questions if we have time.

There was a question to qualify under Part A are all payers. The beginning of my presentation was all about the Part A skilled criteria 'cause that's very specific. Medicare is very clear in the guidelines and that's what I was presenting today. Typically, the commercial insurances follow what that skilled criteria is. Some

insurances might have different kind of small little nuances here or there, but typically all commercial payers are looking for that same level of care to be met and needed. I know that's answering Elena's question a little bit generically, but I was very specific with the Part A requirements. All the other payers, you really need to look at the contracts and see exactly how they define it, but it should be similar. So with the CPT codes, there's a question from Angela about pediatric and adult settings. I did pull those CPT codes from the local coverage determination, which that isn't setting specific. So yes, those would be similar and you can look up that resource based off of... Again, it's not setting specific. There's questions that are scrolling right now about CPT codes, let me just get a chance to read those really quick.

So a question about adding CPT codes, so typically you would wanna add a CPT code at the time of a reassessment. So if you're finding that someone has pain and that they need to have some sort of modality that's not in the eval, then I would recommend the occupational therapist do some sort of reassessment that documents that pain and then they can add the CPT code at that time. If you are a COTA, then you would not wanna add a CPT code that's not in your scope of practice. You would wanna definitely speak to your registered therapist about adding a new code to that person's plan of care. Medicaid in Michigan, yes, you are right. Like I said, a lot of this is very state specific. There is some coverage for therapy beneficiaries in Michigan. You're very lucky, you're the minority in the country. So I do wanna add a little asterisk there that typically Medicaid is not being covered, federal is different than state. So state in Medicaid is very state specific, but just be aware of what your coverage is. I guess I should make a correction there to my slides. I'm in Ohio, it is not covered here. I know there's many other states that Medicaid services are not covering therapy services.

So what is it meant by case mix? So the case mix, I believe that was in the slides with PDPM. That is just the kind of the components that make up that area. So it can be a mixture of different diagnoses. That's why I think they use that term kind of case mix.

That, let's say for an example, someone could have a cognitive impairment, they could have a swallow impairment, and they could have like an acute neurologic impairment. All of that would fall under the speech case mix category. That's getting a little bit deeper into PDPM than we intended for today's session. But certainly if you would learn a little bit more about PDPM, we could talk about that in a different webinar.

Last question, yearly monetary cap for Part B. They did release the cap, but there is still something that is called the threshold which automatically puts the patient into an audit through Medicare Part B. And so what this basically means for us as therapists is that we always need to be making sure that we're providing the care that the patients need. That's the most efficient way to provide the care and the most economical. The reason why they have those thresholds is to make sure that they're monitoring cases that are providing an abundance of therapy and making sure that the documentation is there to support it. So I have defended cases that have exceeded that threshold and they have been paid, but I've also defended cases that they haven't been paid. So our documentation is always key. Which I think is a great segue to help you to tune in to the next class because we will talk more about that and how our documentation can support us providing over the threshold. All right, thanks so much everyone. I appreciate your time. I'll pass it over to you Fawn.

- [Fawn] Thank you Kathleen for a great talk today, looking forward to your next one. I hope everyone has a great rest of the day. You join us again on continued and occupationaltherapy.com. Thanks everyone.