From RUGS IV to PDPM

CHANGING THE MINDSET – THERAPY

Judy Freyermuth PT
March 5, 2019

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JULY 1, 1998

- "Section 4432(a) of the Balanced Budget Act (BBA) of 1997 modified how payment is made for Medicare skilled nursing facility (**SNF**) services.
- **Effective Date:** The PPS system is effective for cost reporting periods beginning on or after July 1, 1998.

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WHAT IS THE "CONSTANT" THROUGH ALL OF THE CHANGES?

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OBRA

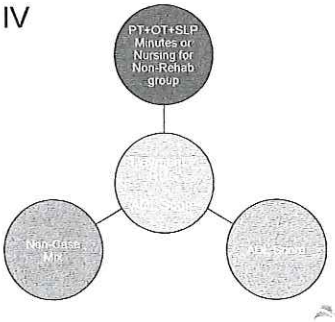
Omnibus Budget Reconciliation Act 1987

"each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care"

OBJECTIVES

- Demonstrate understanding of the difference in reimbursement and therapy service between PPS and PDPM.
- Facilitate IDT Collaboration in order to ensure optimal patient outcomes and appropriate reimbursement under PDPM.
-

RUGS IV



RUG Classification System

8 Major categories, 66 categories

- Rehab Plus Extensive Services
- Rehabilitation: Ultra High, Very High, High, Medium and Low
- Extensive Services (ventilator/respiratory care and tracheostomy only when administered post admission to the SNF
- Special Care High
- Special Care Low
- Clinically Complex
- Behavioral Symptoms
- Cognitive Performance
- Reduced Physical Function

Rehabilitation RUGs Criteria

Based on:

- Total therapy minutes delivered per assessment period
- Number of therapies involved in assessment period
- Frequency of each therapy delivered in assessment period
- Extensive services
- ADL "SUM" score

RUG IV Therapy Minutes

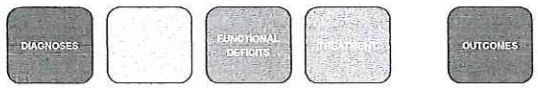
Ultra	720	1 discipline 5 X/week 2nd discipline at least 3X/week
Very	500	At least 1 discipline at least 5X/week
High	325	At least 1 discipline at 5X/week
Medium	150	5 days across any combination of disciplines
Low	45	45 minutes over three days (any combination of disciplines), 2 RNA programs 6x/week @ least 15 minutes each

WHAT DID THE START OF PPS MEAN TO THERAPISTS

- Unknown……
- Changes in Rehab Departments
  - "in house"
  - "out house"
  - Reductions in salary
  - Reductions in force (layoffs)
- Changes in hours
  - Evaluations late in the evening
  - Weekend treatments and evaluations
- Confusion
  - Minutes….days…..minutes….days
  - RUG Scores

PROVIDING MINUTES OR TREATING THE PATIENT?

https://www.youtube.com/watch?v=A1T-eMRPor8



PDPM – CMS Announcement

" The proposed new model is designed to improve the incentives to treat the needs of the whole patient instead of focusing on the volume of services the patient receives, which requires substantial paperwork to track over time."

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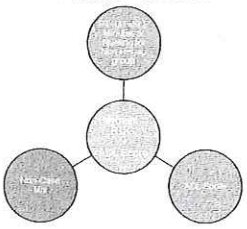
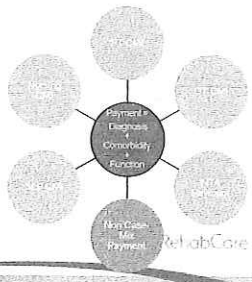
13

PAYMENT MODEL COMPARISON

Volume – RUG IV



Value - PDPM



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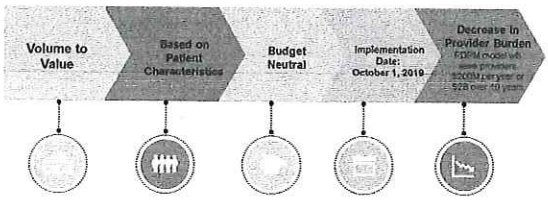
14

PDPM

Patient Driven Payment Model



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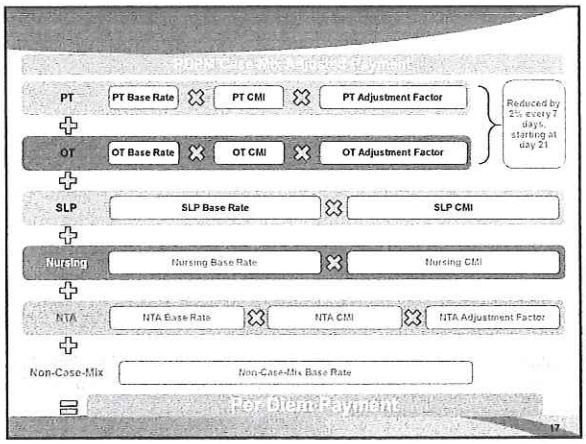
15

Case Mix Components

Determinants of Payment in PDPM

PT	OT	SLP	Nursing	NTA
• Primary reason for SNF care • Functional status	• Primary reason for SNF care • Functional status	• Primary reason for SNF care • Cognitive status • Presence of swallowing disorder or mechanically altered diet • Other SLP-related comorbidities	• Clinical information from SNF stay • Functional status • Extensive services received • Presence of depression • Restorative nursing services received	• Comorbidities present • Extensive services received
• Point in the stay (variable per diem adjustment)	• Point in the stay (variable per diem adjustment)			• Point in the stay (variable per diem adjustment)

15



Base Rate

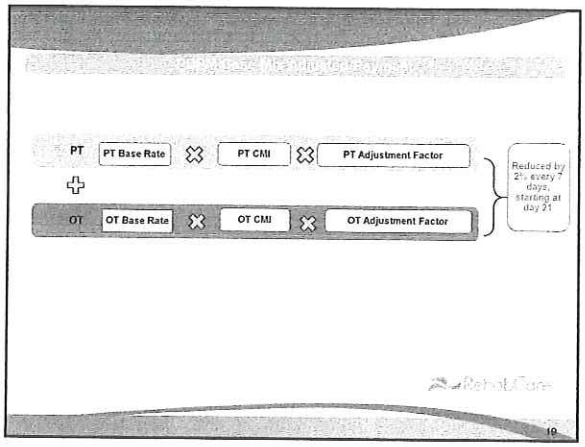
TABLE 12: FY 2019 PDPM Unadjusted Federal Rate Per Diem--Urban[3]

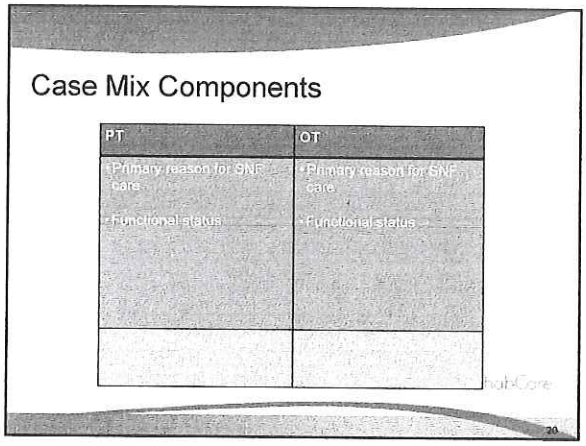
Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$62.63

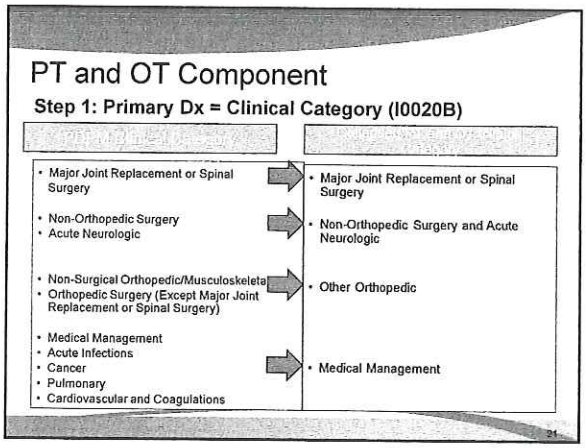
TABLE 13: FY 2019 PDPM Unadjusted Federal Rate Per Diem--Rural

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$95.81	$74.96	$57.63	$52.11	$17.90	$64.34

18

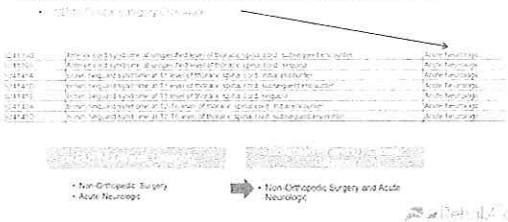

PT
PT Base Rate
PT CMI
PT Adjustment Factor
OT
OT Base Rate
OT CMI
OT Adjustment Factor
Reduced by 2% every 7 days, starting at day 21


Case Mix Components
PT
OT
Primary reason for SNF care
Functional status
Primary reason for SNF care
Functional status


PT and OT Component
Step 1: Primary Dx = Clinical Category (I0020B)
Major Joint Replacement or Spinal Surgery
Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery
Acute Neurologic
Non-Orthopedic Surgery and Acute Neurologic
Non-Surgical Orthopedic/Musculoskeletal
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
Other Orthopedic
Medical Management
Acute Infections
Cancer
Pulmonary
Cardiovascular and Coagulations
Medical Management

Mapping

- Primary reason for admission to the SNF I0020B
  - May be different than primary reason to the hospital
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html



- Non-Orthopedic Surgery
- Acute Neurologic

→

- Non-Orthopedic Surgery and Acute Neurologic

22

Surgery

- Sections J2100-J5000
  - May impact clinical reason for SNF stay
  - "In cases where the patient had a surgical intervention during the preceding hospital stay associated with that diagnosis." *(CMS PDPM Fact Sheet: PDPM Patient Classification)*
  - *DRAFT MDS ITEM SETS example:*

23

PT/OT Functional Component

Step 2: Functional Score

Under PDPM, the functional score for the PT and OT components is calculated based on ten **Section GG** items that were all found to be highly predictive of PT and OT costs per day:

- Two bed mobility items
- Three transfer items
- One eating item
- One toileting item
- One oral hygiene item
- Two walking items

24

PT/OT Functional Component

Functional Score

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

25

PT/OT Functional Score

More Independent, Higher Score

PT & OT Function Score Construction (Except Walking Items)		
Response		Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted	0

PT & OT Function Score Construction for Walking Items		
Response		Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk*	0

*Coded based on response to GG0170I1 (Walk 10 feet?)

26

PT and OT Categories

Clinical Category	PT & OT Function Score	PT & OT Case-Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.60	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.83	1.65
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.69	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.56
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

- Missing section GG responses will receive zero points for the function score calculation
- Under PDPM, there is not a direct relationship between increasing dependence and increasing payment.

27

Adjustment Factor: PT Example

Days 1-20 = 67.63 x 1.52 x 1.00 = **$102.79**
Day 21 = 67.63 x 1.52 x .98 = **$100.74**
Day 28 = 67.63 x 1.52 x .96 = **$ 98.68**

1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-83	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

28

Daily Rate for PT and OT

RURAL	PT	OT
PT/OT Category	TO	TO
Base rate	67.63	62.11
CMI	1.55	1.55
Total	$104.82	$96.27

29

Section GG

Assess the resident's self-care performance based on direct observation, as well as the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. *CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.*

30

Usual Performance

USUAL PERFORMANCE

- A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

- RAI Manual, Chapter 3, p GG-9

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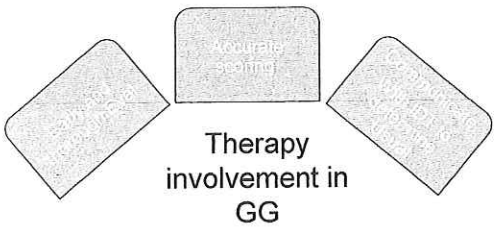

Therapy involvement in GG

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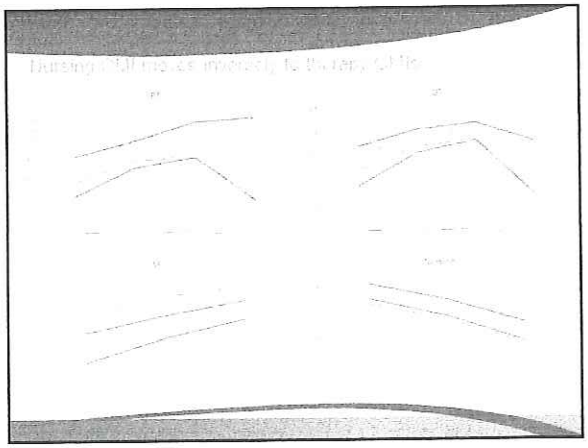

SLP Base Rate | SLP CMI

Case Mix Components

SLP

- Primary reason for SNF care
- Cognitive status
- Presence of swallowing disorder or mechanically altered diet
- Other SLP-related comorbidities

SLP Component

Step 1A: Diagnosis (I0020B)

SLP Clinical Category	
Major Joint Replacement or Spinal Surgery	Non-Neurologic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Non-Neurologic
Non-Orthopedic Surgery	Non-Neurologic
Acute Infections	Non-Neurologic
Cardiovascular and Coagulations	Non-Neurologic
Pulmonary	Non-Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Non-Neurologic
Acute Neurologic	Acute Neurologic
Cancer	Non-Neurologic
Medical Management	Non-Neurologic

SLP Component

Step 1B: Determine if one or more SLP Comorbidities

- SLP Related Comorbidity

SLP-Related Comorbidities	
Aphasia	Laryngeal Caner
CVA, TIA or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

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37

SLP-Related Comorbidities	
Aphasia	I4300
CVA, TIA or Stroke	I4500
Hemiplegia or Hemiparesis	I4900
Traumatic Brain Injury	I5500
Tracheostomy Care (While a Resident)	O0100E2
Ventilator or Respirator (While a Resident)	O010F2
Laryngeal Cancer	I8000
Apraxia	I8000
Dysphagia	I8000
ALS	I8000
Oral Cancers	I8000
Speech and Language Deficits	I8000

Step 1C

- Determine Cognitive Impairment
  - Cognitive Impairment (BIMS or CPS)
  - Section C/MDS
- CMS You Tube BIMS video:
- https://www.youtube.com/watch?v=DAj3TA5w11Y

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13 - 15	0
Mildly Impaired	8 - 12	1 - 2
Moderately Impaired	0 - 7	3 - 4
Severely Impaired		5 - 6

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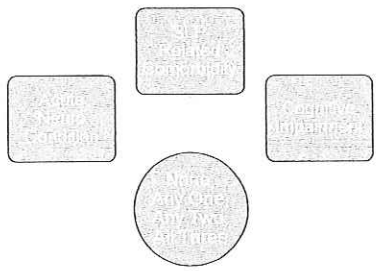
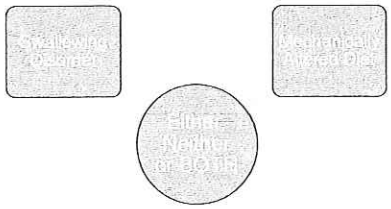
Step #1: Determine how many conditions are present



Step #2: Determine whether resident has a swallowing disorder or a mechanically altered Diet

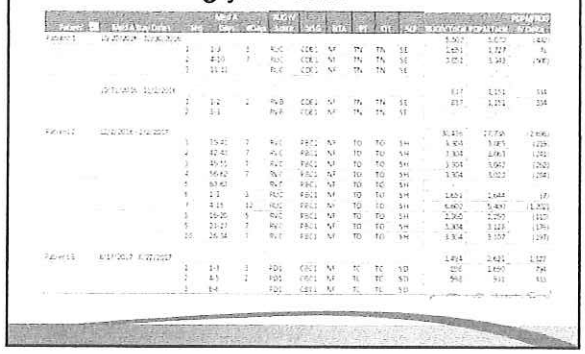


- Swallow=K0100A through K0100D
- Mechanically Altered Diet=K0510C2 (mechanically altered diet while a resident)

Speech Categories

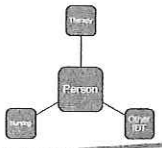
Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
None	Neither	SA	0.68
None	Either	SB	1.62
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.66
All three	Both	SL	4.19

Understanding your data



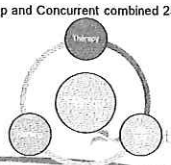
RUGS IV

- Medical necessity
- Needs of the patient/resident
- Patient centered care
- Reimbursement
  - Volume driven, case mix group
  - Quantity
- Group therapy limit 25%



PDPM

- Medical necessity
- Needs of the patient/resident
- Patient centered care
- Reimbursement
  - Focus on unique, individualized needs, characteristics and goals of each patient
  - Quality Outcomes
- Group and Concurrent combined 25%



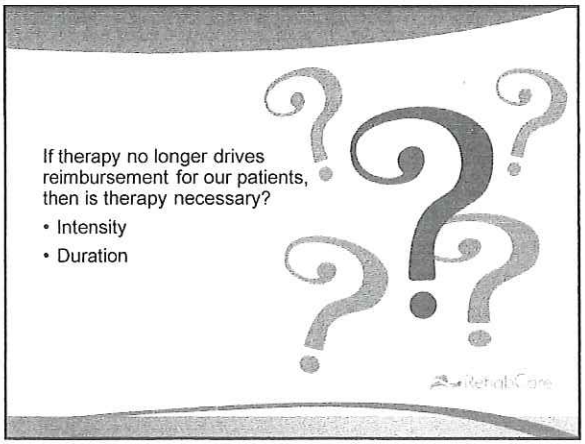
Put the Person in Person Centered!

Health-related Quality of Life –Section Q

- *Residents who actively participate in the assessment process and in development of their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.*
  - RAI Manual, Chapter 3, Q-500 Participation in Assessment and Goal Setting Page Q-1

Planning for Care – Section F

- *Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident.*
- *Interviews allow the resident's voice to be reflected in the care plan.*
- *Information about preferences that comes directly from the resident provides specific information for individualized daily care and activity planning.*
  - RAI Manual, Chapter 3, Section F- Preferences for Customary Routines and Activities, page F-1



Final Rule

page 242

- *However, we continue to be concerned that under PDPM, providers may reduce the amount of therapy provided to SNF patients because of financial considerations. We agree with commenters that quality and outcomes measures (like those in the SNF Quality Reporting Program) would be a positive way to evaluate the efficacy of therapy provision, and we will take this into consideration for future policy development.*
- *Should we discover that the amount of therapy under PDPM is distinctly different from the amount of therapy under RUG-IV, we will evaluate the potential reasons for this change and consider potential actions, either at the provider or systemic level, to address these issues.*

F676-F677

- ***§483.24(a) …facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.***
- ***§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section …***
- ***§483.24(b) Activities of daily living. (includes communication)***
- ***§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene…***

F 684 Quality of Care

- *"To ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs."*

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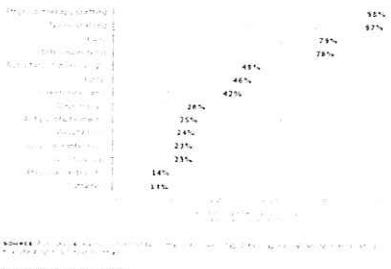
SNF QRP QUALITY MEASURES
SNF QRP Measure #1: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
SNF QRP Measure #2: Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
SNF QRP Measure #3: Medicare Spending Per Beneficiary-PAC SNF QRP
SNF QRP Measure #4: Discharge to Community-PAC SNF QRP
SNF QRP Measure #5: Potentially Preventable 30-Day Post-Discharge Readmission Measure – SNF QRP
SNF QRP Measure #6: Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC SNF QRP
SNF QRP Measure #7: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
SNF QRP Measure #8: Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
SNF QRP Measure #9: Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
SNF QRP Measure #10: Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
SNF QRP Measure #11: Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

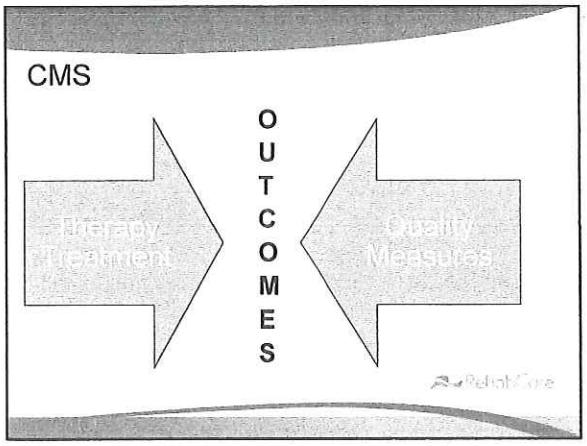
Patients choose PT Staffing as primary quality measure when selecting a SNF

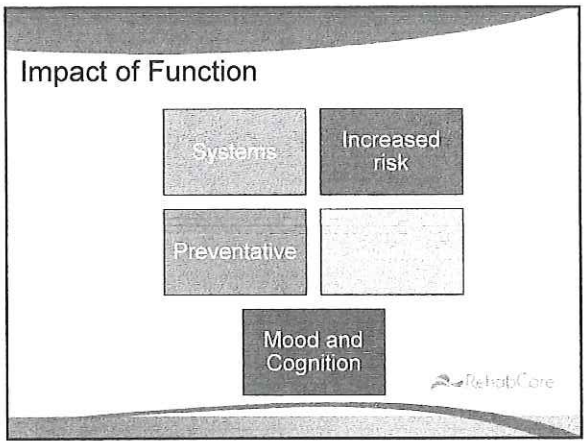
EXHIBIT 1

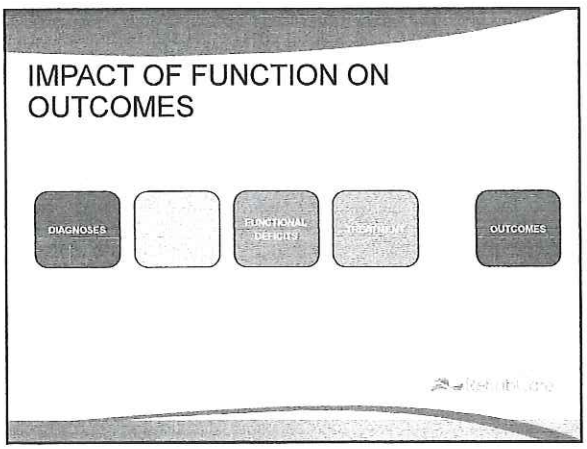
Patients' choices of performance measures for their personalized composite, February 2014–August 2015



Health Affairs, April 2016

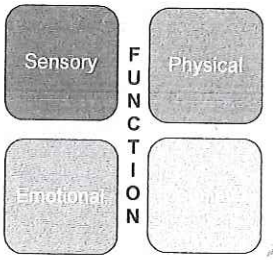

CMS
Therapy (Treatment)
OUTCOMES
Quality Measures


Impact of Function
Systems
Increased risk
Preventative
Mood and Cognition


IMPACT OF FUNCTION ON OUTCOMES
DIAGNOSES
OUTCOMES

Components of FUNCTION

Impact Independence



Cognitive Impact on Outcomes

- Cognition Paradigm Shift:
  - Negative versus positive outcomes
  - Disability versus ability
  - Rehabilitative versus habilitative
  - When we look at people negatively, we get a negative outcome
  - When we look at people positively, we get a positive outcome

56 | Page

NEGATIVE

- Wanderers

POSITIVE

- Still has ability to walk
  - Create safe environment and opportunity for walking
  - Provide alternate means of movement (wc, rocker etc)
  - May require a variety of interventions throughout the day
  - Promote participation and engagement in meaningful activities at their level of function. Educate Activities

57 | Page

Body-Brain Connection

- How exercise could lead to a better brain by Gretchen Reynolds. http://www.nytimes.com/2012/04/22/magazine/how-exercise-could-lead-to-a-better-brain.html?pagewanted=1&_r=0
- Walking is good brain exercise by Rich Nauert PhD. http://psychcentral.com/news/2010/08/27/walking-is-good-brain-exercise/17326.html
- Ten Minutes of Intermittent Movement for Every Hour of Sitting May Counteract Ill Health Effects of Prolonged Sitting by Dr. Mercola. http://fitness.mercola.com/sites/fitness/archive/2014/09/19/intermitten-movement

Functional Status Outperforms Comorbidities in Predicting Acute Care Readmissions in Medically Complex Patients

Readmission models based on functional status consistently outperform models based on medical comorbidities. There is an opportunity to improve current national readmission risk models to more accurately predict readmissions by incorporating functional data.

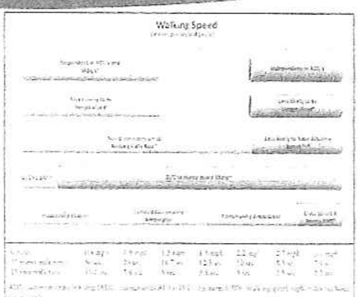
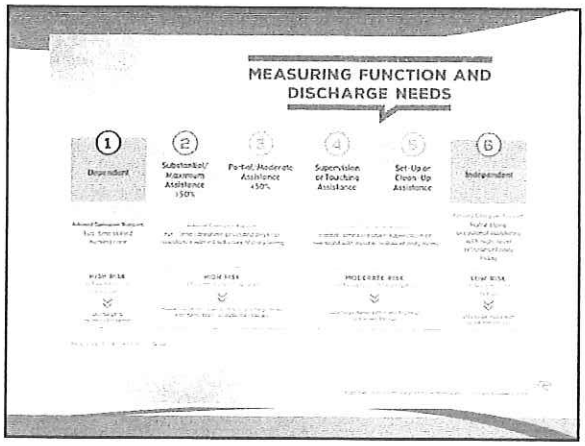


Figure 1. A collection of walking speed times that are linked to dependence, hospitalization, rehabilitation needs, discharge locations, and ambulation category.



NOMS

- Score of 1-7 (higher, more Independent)
- Reporting available

Functional Outcome Measures Examples

- Functional Outcomes (GG)
- NOMS
- Additional Outcome Measures
  - BERG Balance
  - Functional Reach
  - Short Physical Performance Test
  - 6 minute walk test
  - 2 minute walk test
  - Chair rise test (30 second)
  - Timed Up and Go
  - Dynamic Gait Index
- ADLs – Barthel Index
- BORG Scale of Perceived Exertion
- Cognitive Tests
- MASA (Mann Assessment of Swallowing)
- Boston Diagnosic Aphasia Exam

Therapy's Role in Reducing Hospitalization Examples

- Close monitoring of vital signs, skin, pain and other systems during therapy and communicated to nursing can assist in decreasing re-hospitalization
  - Cardiac, pulmonary, skin, infection etc.
- Exercise to improve cardiovascular and pulmonary health
- Exercise to improve strength, balance, mobility, function
- Decrease pain
- Identification of fall risk factors and development of treatment plan to improve balance, mobility, safety
- Medication Management
- Dysphagia – safe swallow strategies
- Cognitive evaluation and development of strategies, approaches and environmental modifications to facilitate use of remaining abilities
  - Decrease behaviors

THERAPY – NURSING COMMUNICATION

- Therapy – Nursing Communication
  - Section GG
  - Co-morbidities
  - Restorative Nursing

Speak the Same Language

RESTORATIVE NURSING

- Do you currently have a Restorative Nursing Program?
  - If so, how is it functioning?
    - Are programs consistent?
  - Who runs the program?
  - Is there a designated aid or are all CNAs responsible?
- Therapy and Nursing Partnership
  - Development of goals
  - Aid in training
- AANAC - Guide to Successful Restorative Programs

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IDT COLLABORATION

- Comprehensive Plan of Care
  - Insure optimal outcomes
  - Quality
- Prevent Re-hospitalizations
- Safe transitions

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Person Centered Meetings

- Pre-Admission
  - Purpose: To review potential patient/residents for admission. Review history and comorbidities. **Discuss d/c planning.**
- Daily
  - GG Huddle
  - Goals
  - Comorbidities and coding

RehabCare

PREPARING FOR SAFE AND EFFECTIVE TRANSITIONS

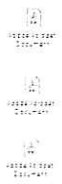
- All Disciplines
- Patient history
  - Medical
  - Prior Level of Function
  - Living Situation
    - Who else lives at home?
    - Stairs
    - Bathrooms
- Support at home
  - Family
  - Cooking
  - ADs
  - Previous services
- Personal Interest Inventory
  - Know your patient/resident
- DC Plan
  - Location
    - Immediate
    - Long Term
    - Available assistance
- Home assessment
  - Gather info early
  - Home assessment
    - Current equipment/assistive devices if previously used
    - Live
    - "Virtual"
  - Simulate home setting during therapy

DC PLANNING

Physical Therapy	Occupational Therapy	Speech Therapy
• Mobility *(ambulation or wheeled mobility)* • Transfers (including car) • Balance/safety • Energy conservation • Home assessment • Rec. modifications to environment • Equipment needs • Continuation of rehab post discharge – home exercise, home therapy, outpatient, restorative nursing, wellness	• ADLs – eating, bathing, dressing, toileting • IADLs – cooking, cleaning, laundry etc. • Assistive devices • Cognition/safety • Energy conservation • Equipment (toileting, bathing, safety) • Medication Management • Home assessment and rec. for modifications • Patient and family education throughout stay	• Communication – ability to make needs known • Cognition/safety • Diet management and safe swallow strategies and teaching as indicated • Medication Management • Executive functions • Patient and family education throughout stay

DC CHECKLIST…EXAMPLE

HOME ASSESSMENT FORM EXAMPLES



ADDITIONAL THERAPY CONSIDERATIONS

- Staffing
  - Staffing ratio Evaluator to Assistant
  - SLP staffing
- Hours of operation
- Service Delivery

TREATMENT DELIVERY CHANGE

RUGS IV	PDPM

• Reimbursement
  • Volume driven, case mix group
  • Quantity
	• Reimbursement
	  • Focus on unique, individualized needs, characteristics and goals of each patient
	  • Quality Outcomes

• Group therapy limit 25%	• Group and Concurrent combined 25%
• Minutes provided in group were divided by 4 in grouper	• No longer driven by therapy utilization (minutes)
• Minutes for concurrent were divided by 2 in the grouper	

Concurrent and Group Therapy Limits

- Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment (O0425):Providers will report the number of minutes, per mode and per discipline, **for the entirety of the PPS stay**
- If the total number of concurrent and group minutes, combined, comprises more than 25% of the total therapy minutes provided to the patient, for any therapy discipline, then the **provider will receive a warning message on their final validation report**

RehabCare

Mode of Treatment Delivery

- Varied modes of treatment delivery are not new to therapists
  - Individual
  - Concurrent
  - Co-treatment
  - Group
- All modes of delivery are valid and must be:
  - Medically necessary
  - Clinically appropriate
  - Delivered at the appropriate time(s) throughout the course of treatment in order to be effective
- Different modes of delivery are chosen based on clinical appropriateness and patient benefit **not therapist or department convenience**

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MDS GROUP DEFINITION

- Group therapy is defined for Part A as the treatment of 4 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.
- For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment.

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MDS CONCURRENT DEFINITION

- Concurrent therapy is defined as the treatment of 2 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 assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident.
- For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another).
- For all other payers, follow Medicare Part A instructions.

Benefits of Group and Concurrent Therapy

- Creates/imitates a real life atmosphere preparing resident for transition from therapy
- Socialization, peer support, psychosocial needs
- Reinforces learned skills. Patients learn from one another
- Motivation and willingness to participate
- Allows therapists to asses and teach generalization and carry over of skills acquired during individual therapy
- Provides self monitoring skills/awareness through peer interaction and feedback

Barriers

- Patient
  - Refusal
  - Isolation/infection
  - Behavioral issues
- Therapists
  - Lack of understanding the benefits, rules
  - Misconceptions/Myths
  - Organization and planning
- Facility - Operations
  - Physical space
  - Facility "buy in"
  - Supplies
  - Scheduling challenges – readiness, transport

Decisions regarding mode of therapy treatment delivery is:

- **Made by the therapist**
- Must be clinically appropriate and medically necessary
- Related to established plan of care and goals
- Documented clearly in the medical record

Rules of Navigation……

*Stay focused on the destination……**OPTIMAL OUTCOMES***

- ALWAYS KEEP THE PATIENT IN THE CENTER
- All patient's are individuals…..their plan should be as well!
- Know regulations
- Do the "right thing"
- Educate and be educated
- Ask Questions
- Self Assess
- Remember the BASICS
- TEAMWORK
- Keep an open mind
- ADVOCATE