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**Medicare Program; Prospective Payment
System and Consolidated Billing for
Skilled Nursing Facilities for FY 2010;
Minimum Data Set, Version 3.0 for
Skilled Nursing Facilities and Medicaid
Nursing Facilities; Proposed Rule**

begun its data analysis, using some of the preliminary STRIVE data to focus its data collection efforts. We will continue to work with our Canadian colleagues to confirm our findings and, if possible, to continue our analysis of special populations. For example, the CAN-STRIVE population includes a much larger sample of patients with behavior problems than the STRIVE sample, and the Canadian data may be helpful for future policy analysis.

The STRIVE analyses have shown that the RUG-III model is still effective in determining relative nursing resource use generally across a broad range of conditions for which beneficiaries are treated. At the same time, however, we have found that the resource times associated with specific conditions or service categories, such as diabetes and the use of intravenous fluids or medications, has changed significantly. These analyses have confirmed our initial expectations that the RUG-III model needed to be updated to reflect significant changes in SNF care patterns during the past decade. Therefore, in constructing the analytical data base, we have proposed the changes to the RUG-IV model that are discussed below.

a. Concurrent Therapy

Almost 90 percent of patients in a Medicare Part A SNF stay are receiving therapy services. Under the current RUG-III model, therapy services are case mix-adjusted based on the therapy minutes reported on the MDS. When the RUG-III model was developed, most therapy services were furnished on a one-on-one basis, and the minutes reported on the MDS served as a proxy for the staff resource time needed to provide the therapy care. However, we have long been concerned that the incentives of the current RUG-III classification model have created changes in the way therapy services are delivered in SNFs. Specifically, we have been concerned that, as discussed below, there has been a shift from one-on-one therapy to concurrent therapy that may not represent optimal clinical practice.

Concurrent therapy is the practice of one professional therapist treating multiple patients at the same time while the patients are performing different activities. In the SNF Part A setting, concurrent therapy is distinct from group therapy, where one therapist provides the same services to everyone in the group. In a concurrent model, the therapist works with multiple patients at the same time, each of whom can be receiving different therapy treatments. For concurrent therapy, there are currently no MDS coding restrictions

regarding either the number of patients that may be treated concurrently, or the amount or percentage of concurrent therapy time that can be included on the MDS, whereas with group therapy there are limitations, as discussed in the July 30, 1999 SNF PPS final rule (64 FR 41662).

There are specific MDS coding instructions that limit the amount of group therapy that can be reported on the MDS, and used to calculate the appropriate payment level. For MDS reporting purposes, in order to report the full time as therapy for each participant, the supervising therapist (or assistant) may treat no more than four participants at a time, and may not be supervising any additional patients outside the group. Group therapy minutes may be counted in the MDS, but are limited to no more than 25 percent of the total weekly minutes per discipline for a particular patient.

In the SNF Part A setting, concurrent therapy can be a legitimate mode of delivering therapy services when used properly based on individual care needs as determined by the therapist's professional judgment. Given that Medicare and Medicaid patients are among the most frail and vulnerable populations in nursing homes, we believe that the most appropriate mode of providing therapy would usually be individual and not concurrent therapy. We believe it is in the beneficiary's best interest that concurrent therapy should never be the sole mode of delivering therapy care to any individual in a SNF setting; rather, it should be used as an adjunct to individual therapy when clinically appropriate, as determined by the individual's current medical and physical status based on a therapist's clinical judgment.

Our concern is that concurrent therapy has become the standard of practice rather than a way to supplement needed individual therapy care. The STRIVE data show that approximately two-thirds of all Part A therapy provided in SNFs is now being delivered on a concurrent basis rather than on the individual basis that we believe to be the most clinically appropriate mode of therapy for SNF and NF patients. We are also concerned that the current method for reporting concurrent therapy on the MDS creates an inappropriate payment incentive to perform concurrent therapy in place of individual therapy, because the current method permits concurrent therapy time provided to a patient to be counted in the same manner as individual therapy time. For example, under the current method of reporting, if a therapist furnishes 60 minutes of therapy time to

a group of patients concurrently, then a separate 60 minutes of therapy time is counted for each patient. To test the impact of changing the method of reporting concurrent therapy, we designed the STRIVE analytical data base to distinguish between concurrent and individual therapy minutes. We were also able to identify the number of patients treated under the concurrent model, and allocated the total minutes evenly among the total number of patients receiving concurrent therapy care from the same therapist at the same time.

The data showed that under our current RUG-III methodology, which does not allocate time, patients treated concurrently are typically assigned to higher therapy groups (with higher payments) than appropriate based on the therapy resources actually used to provide care for those patients. In order to eliminate this inappropriate incentive, and to better reflect our policy that individual therapy is usually the most appropriate mode of therapy for SNF residents, we are proposing to use allocated concurrent therapy minutes in developing the RUG-IV therapy model. Thus, a therapist who is treating patients concurrently would allocate the total minutes among the patients based on the therapist's clinical judgment of how much therapist time was actually provided to each patient. We note that this change is consistent with our longstanding policy for payment of timed codes (that is, codes that are billed per time unit rather than per visit) for Part B therapy services. As stated in the *Medicare Benefit Policy Manual*, Pub. 100-2, chapter 15, section 230, "Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity." Therefore, in outpatient settings, concurrent therapy is billed the same way as group treatment (and the therapist would bill the HCPCS code for group therapy, not individual therapy, for each individual involved).

Consistent with this policy and with our initiative "to improve consistency in the standards and conditions for Part A and Part B therapy services" (as discussed in the Medicare Physician Fee Schedule final rule with comment period for CY 2008, 72 FR 66222, 66332, November 27, 2007), effective with the introduction of RUG-IV, concurrent therapy time provided in a Part A SNF

setting would no longer be counted as individual therapy time for each of the patients involved. However, we note that, unlike the Part B policy described above, in the SNF setting we are not proposing to treat concurrent therapy minutes the same way we treat group therapy minutes, and instead are proposing to allocate concurrent therapy minutes among the patients being treated (as stated above, the full therapy time can be reported for each group therapy participant as long as no more than four participants are being treated at a time). As discussed above, we believe that with the frail and vulnerable population in SNFs and NFs, concurrent therapy is appropriate only as an adjunct to individual therapy and that individual therapy is the most appropriate mode of therapy for this population. Therefore, unlike our policy for group therapy, we do not believe it is appropriate to count the full therapy time for each patient being treated concurrently. In a group setting, the patients are performing similar activities. By interacting with one another, the patients observe and learn from each other. They then apply this new information into their own therapy program to progress and, thus, benefit from the group setting. By contrast, during concurrent therapy, the patients are not performing similar activities and often do not interact at all with each other. Therefore, the patients are not benefiting from each other's therapy intervention. Furthermore, as discussed above, we believe that allowing concurrent therapy to be counted as individual therapy would create an inappropriate incentive to replace individual therapy with concurrent therapy.

As we stated previously, in the SNF Part A setting, concurrent therapy can be a legitimate mode of delivering therapy services when used properly based on individual care needs as determined by the therapist's professional judgment. CMS requires that the actual total therapy time be documented on the MDS. However, we have not to date required that the facility staff separately report the amount of time for each individual therapy technique or delivery mode (individual, concurrent, and group). Without this documentation, it is difficult for CMS to evaluate the appropriateness of reimbursement.

As discussed above, we are proposing that, for each discipline, concurrent therapy minutes must be allocated before reporting total therapy minutes

on the MDS 3.0. For this reason, we are soliciting comments concerning whether therapy data need to be reported separately by therapy mode (that is, individual, concurrent, or group) on the MDS or whether it will be sufficient to include a record of therapy usage by therapy mode in the medical record. While we are not prescribing the specific facility process for the documentation of therapy services (for example, therapy log, therapy daily progress note), we note that, in the absence of further changes to the MDS 3.0, the amount of time for each mode of therapy would need to be distinguished in the individual's clinical record effective with the MDS 3.0, and it would be up to facility staff to make the correct time allocations for reporting on the MDS.

We want to reiterate that concurrent therapy—

- Can represent a legitimate mode of delivering therapy services when used properly, based on individual care needs as determined by the therapist's professional judgment;
- Should be an adjunct to individual therapy, not the primary mode of delivery of care; and,
- Should represent an exception rather than the standard of care.

As discussed above, while we limit the percentage of group therapy minutes that may be counted on the MDS, and limit the number of patients that may be treated simultaneously in group therapy for purposes of counting therapy minutes in full for each patient (64 FR 41662), we have not, to date, placed a limit on the percentage of concurrent therapy that may be coded on the MDS or on the number of patients that can be treated concurrently. Therefore, we are also inviting public comments on whether there should be other restrictions relating to concurrent therapy such as a limit to the percentage of concurrent therapy minutes that may be counted on the MDS for any individual or to the number of people that can be treated concurrently by the same therapist.

Finally, we are concerned that placing limits on the use of concurrent therapy could result in an inappropriate substitution of therapy aides for therapists and assistants. We note that therapy aides are expected to provide support services to the therapists and cannot be used to provide skilled therapy services. We also note that, under Part B, services rendered by therapy aides are not considered outpatient therapy services. In our

analysis of the STRIVE data, it appears that therapy aides are being used appropriately; that is, for supportive services and not for the provision of skilled therapy services. However, we intend to monitor the use of therapy aides and, if necessary, to propose changes to MDS reporting requirements in the future.

b. Adjustments to STRIVE Therapy Minutes

The STRIVE analysis also included an examination of therapy services reimbursed under RUG-III. While nursing services are fully reimbursed using a prospective case-mix adjusted algorithm, payment for therapy services is more closely linked to the amount of therapy actually received at a particular time. In the RUG-III model, there are five levels of therapy services: Ultra High, Very High, High, Medium, and Low therapy. Each of these levels is assigned based on the actual minutes of therapy care provided to a beneficiary as reported on the MDS assessment. Each level of therapy is assigned a CMI. Payment is determined by multiplying the CMI by the therapy portion of the SNF PPS rate. This therapy payment is then included in the SNF PPS bundled per diem payment.

We are aware that there are some inherent limitations associated with the voluntary collection of data at a facility site. During the STRIVE time study, we collected nursing staff time for two weekdays, primarily with hand-held computers called personal data assistants (PDAs). We collected therapy staff time for 7 days, generally with PDAs only for the first three weekdays and then with a paper tool for the remaining 4 days, including weekends. We needed to clean the PDAs of all data and ship them to a new facility for availability at the beginning of the next week, which restricted PDA usage to only 3 days. In addition, during weekend days, different therapy staff were present and received substantially less oversight for the therapy data collection using the paper tools.

There were three different data collection schedules: Therapy data collection on Schedules A and B both began on Tuesday continuing through the following Monday. With Schedule C, data collection began on Wednesday continuing through the following Tuesday. In all cases, the therapy data collection continued for a complete one-week period. Table 9 below shows the percentage of weekly therapy time for the three data collection schedules.

TABLE 9—DATA COLLECTION SCHEDULES WITH PERCENTAGE OF WEEKLY THERAPY BY DAY

Collection schedule	N	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Mon.	Tues.
A	8012	26%	25%	22%	12%	2%	1%	12%	.....
B	1193	25%	27%	26%	12%	1%	0%	10%	.....
C	516	.....	30%	26%	21%	1%	1%	12%	9%
Total	9721	24%	26%	23%	13%	2%	1%	12%	1%

Shaded cells indicate days where therapy data were collected using the paper tool.

Including only residents present for the full week of therapy data collection, Schedule A and Schedule B show similar percentages of reported weekly therapy across the seven days. Tuesday, Wednesday, and Thursday each had between 22 percent and 27 percent of the total weekly reported therapy, and together had between 73 and 78 percent of the total weekly reported therapy. Of the remaining total, 12 percent occurred on Friday, 10–12 percent on Monday, and very little (zero to two percent) occurred on weekend days.

For Schedules A and B, Tuesday, Wednesday, and Thursday therapy time was collected by PDA; the paper tool was utilized Friday through Monday. For Schedule C, PDAs were used Wednesday through Friday, with paper tools utilized Saturday through Tuesday. While utilizing a PDA, all three schedules reported similar percentages: 22 to 30 percent, for Wednesdays and Thursdays, and 21 percent on Friday for Schedule C. In contrast, utilizing paper tools, Friday therapy time was 12 percent for Schedules A and B, and 9 percent on Tuesday for Schedule C. These observations lead us to believe that it was possible that therapy was being underreported when the paper tool was utilized.

In order to determine if the therapy data collected seemed reasonable, we compared the STRIVE Medicare Part A data to the national distribution of RUG-III rehabilitation groups as reported on Medicare claims. The STRIVE data had fewer patients in the Ultra High, Very High, and High rehabilitation groups and more patients in the Medium rehabilitation groups. This Medicare Part A claims comparison indicated that STRIVE therapy time was probably being underreported. Possible explanations of the underreporting include both the use of paper forms and the less intense oversight on weekends.

In order to mitigate potential paper tool shortfalls with respect to therapy times, we developed a methodology to determine adjusted weekly therapy time based on the PDA time. Our proposed methodology allows us to avoid direct use of the potentially underreported

therapy minutes from the paper tools and best match the Medicare Part A claims information.

As discussed in detail in section III.A.2.a. of this proposed rule, we adjusted the therapy minutes to allocate concurrent therapy time; that is, divide the total therapy minutes between the number of patients receiving therapy service from the same therapist at the same time. We then performed separate calculations using the resident time for each of the three therapy disciplines (physical therapy, occupational therapy and speech-language pathology). The steps for making the therapy time adjustment included:

- Totalling each resident’s time for each discipline by adding times across the several practitioners of that discipline (for example, for physical therapy we had therapists, assistants, and aides.)
- Computing the resident’s average therapy session for each separate discipline computed as the sum of the therapy time reported on PDA days and divided by the count of PDA days. There had to be 15 minutes or more of therapy for inclusion in the computation.
- Estimating the total adjusted number of days the resident received that therapy discipline. We considered it a day of therapy only if 15 minutes or more of therapy time was reported on the PDA or the paper tool.

To determine the number of weekdays where therapy was provided, we adjusted the data as follows:

- Three of three PDA days reported: We treated that resident as if there were five weekdays of therapy for that discipline. A resident receiving therapy on all data collection days would most likely indicate a pattern typical of a person receiving daily therapy.
- Two of three PDA days reported: We treated that resident as if there were three weekdays of therapy for that discipline. We note that residents can only qualify for a therapy group if they have had at least 3 days of therapy per week. Thus, facilities typically provide therapy services for at least 3 days per week, in order to qualify the resident for a therapy group. Accordingly, when

therapy was reported on 2 of 3 PDA days, we believed that it was likely that the patient actually received 3 days of therapy during the week. If the paper tool indicated there were 15 or more minutes of a specific therapy on either or both of the remaining weekdays, then an additional day was added for each day with 15 or more minutes; a maximum of two additional weekdays was possible.

- One of three PDA days: We treated that resident as if they had one weekday of that discipline but added additional days for each of the other two weekdays where therapy time of 15 or more minutes was indicated on the paper tool for that discipline.

- No PDA days: We counted any weekday or weekend days reported on a paper tool where there were 15 or more minutes for that discipline. Generally, therapy was not given on weekends and weekend data collection was always done by the paper tool. We accounted for therapy time on the weekends by counting the days reported on a paper tool where there were 15 or more minutes of therapy for that discipline.

Following the steps described above, we calculated an adjusted number of days for each discipline, for each resident. Then, for each discipline and for each resident, we adjusted the reported therapy minutes by multiplying the average therapy session time for each resident by the adjusted days of therapy to obtain adjusted weekly therapy minutes.

After adjusting the therapy minutes, we performed a similar adjustment to add the estimated amount of therapy staff time that had not been captured during the data collection process. First, we divided the adjusted weekly therapy minutes by the reported weekly therapy minutes to calculate an inflation factor. Then, we applied the inflation factor to the reported per diem staff time resulting in the adjusted per diem therapy staff time. The adjusted staff time was then wage weighted (see discussion in II.G.1.b.v of this proposed rule) to produce the final wage-weighted staff time (WWST) for therapy. The WWST was then used as the dependent

(or cost) variable in the subsequent analyses of therapy staff time and also to derive the therapy CMI.

TABLE 10—ADJUSTED THERAPY TIME CALCULATION EXAMPLE

Therapy data	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	Mon.	Total time	Average therapy session	Days with 15+ minutes
Observed	45	40	40	0	0	0	0	125	42	3
Assumed	×	×	×	×	0	0	×	210	42	5

3 days of PDA data with estimated days of therapy = 5.
Adjusted weekly minutes = 5 × 42 = 210 minutes.

When group therapy was reported, we applied the existing 25 percent group time limitation for each discipline, excluding any group time exceeding 25 percent of total time, as follows: First, we calculated the amount of group time exceeding the 25 percent limitation. In order to achieve agreement with the adjusted therapy times, we multiplied the excess group time by the inflation factor before subtracting from the adjusted total time.

This therapy time adjustment provides a better fit to the national RUG-III distribution for rehabilitation groups, and better accounts for all reported therapy staff times. We give the maximum credit possible for any day that therapy time was recorded for 15 or more minutes to avoid underestimating the actual amounts of therapy furnished to patients.

We used the adjusted therapy time to determine the number of residents classifying into the “Rehabilitation” and “Rehabilitation plus Extensive Services” categories in the RUG-IV model and to calculate the CMIs. Though we propose to adjust for therapy time by developing the inflation factor described above, we evaluated the effect of two alternatives. The first alternative we considered was using the reported (unadjusted) times from the PDAs and paper tools. We also looked at therapy CMIs for nursing facilities where the therapy time data collection appeared consistent across the entire week, and examined the wage-weighted unadjusted times from only those 50 facilities. We evaluated the alternatives by determining whether the alternative produced a substantial difference in the CMI computation for the “Rehabilitation” and “Rehabilitation plus Extensive Services” categories compared to the proposed adjusted therapy time methodology.

The three different scenarios produce roughly the same CMIs because the RUG therapy groups use therapy time cutoffs, for example, the High rehabilitation groups require 325 minutes of therapy per week and the Very High rehabilitation groups require 500

minutes of therapy per week. While the therapy adjustment will not significantly influence the CMIs, it will change our estimated distribution of residents by increasing the number of residents in the higher level rehabilitation RUG groups.

This adjustment methodology benefits providers that provide a substantial quantity of rehabilitation. Without taking this into consideration, we run the risk of undercounting the actual amount of therapy provided. Therefore, we propose the adjustment methodology because the RUG distribution after application of the adjustment of therapy time more closely matches the expected therapy RUGs national distribution. The adjustment methodology is described in detail in the slides presented at the March 2009 TEP posted on <http://www.qts.com/strive.html>.

We then included the adjusted therapy minutes in the STRIVE analytic database used to construct the RUG-IV classification structure and CMIs. We are confident that the STRIVE sample gave us the information we needed to evaluate changes we are proposing in this rule to the existing RUG-III model and to the therapy CMIs for RUG-IV. Still, as we discussed above, we believe that it would be premature to recommend a comprehensive restructuring of the SNF PPS therapy methodology based on a predictive model for therapy services. Thus, in this rule, we are proposing incremental, targeted changes that we believe will improve the accuracy of the existing RUG model. We plan to revisit alternatives to the current methodology used to reimburse therapy as additional information from the Post Acute Care demonstration and the analysis of IRF utilization patterns becomes available.

c. ADL Adjustments

RUG-IV, like RUG-III, uses a scale measuring Activities of Daily Living (ADLs) to identify residents with similar levels of physical function. This scale is used to sub-divide (“split”) each of the major hierarchical categories except Extensive Services. It is also used as

part of the qualification criteria for many of the RUG-IV hierarchical categories (Extensive Services, Special High, Special Low, and Cognitive Performance and Behavioral Symptoms), and is used as part of the specific criteria for classifying patients to RUGs within certain categories.

As discussed below, we are proposing revisions to the RUG-IV ADL Index that reflect both clinical and statistical considerations, with the aim of scoring similarly those residents with similar function. As discussed further below, we changed component scores to make the scale more proportional to physical function (linear). In addition, we increased the range of the RUG-IV ADL Index (17 points), as compared to the RUG-III ADL Index (15 points), to allow somewhat greater distinction in physical function. An improvement of the categorization of the RUG-IV ADL scale is suggested by the results of the regression of the ADL scale (linear) after adjusting for the RUG-IV major hierarchical categories ($R^2 = 11.1$ percent for the RUG-IV ADL Index versus $R^2 = 10.5$ percent for the RUG-III ADL Index).

In addition, as discussed further below, we made certain revisions in the eating component score to achieve better categorization of residents receiving assistance in feeding. The RUG-III ADL Index used component scores of 1, 2, and 3 with artificial feeding mechanisms; that is, Parenteral Feeding/IV Feeding or the use of feeding tubes, used to classify patients into the most dependent category. In the STRIVE analysis, we found that patients receiving One Person Physical Assist or more needed comparable staff resources to those patients who were being fed by artificial means. During RUG-IV development, we found that the inclusion of artificial feeding services in the ADL Index slightly reduced the effectiveness of the model fit. In fact, the regressions discussed immediately above dropped slightly from an R^2 of 11.1 percent to 11.0 percent for the best alternative model (with the eating