Information and directions for Therapies (O0400) can be found on page O-16 of the RAI Manual and was updated October 2014.

O0400: Therapies – Special Info and Tips for Therapists

This section includes all skilled, medically necessary therapies that occurred after the resident was admitted to the SNF. In order to meet the qualifications for this section, the therapy must be ordered by a physician, based on a qualified therapy assessment and treatment plan, must be documented in the medical record, care planned, and periodically evaluated to endure that the resident receives needed therapist and that current treatment plans are effective.

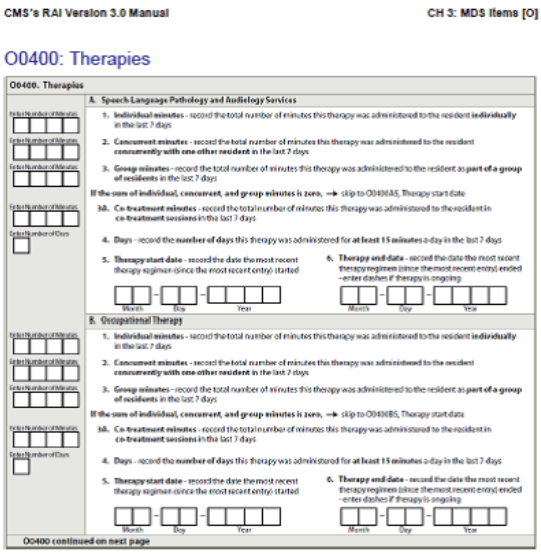
This is a very complex section when dissecting the Modes of therapy and the multiple insurance types.

Modes of Therapy Delivery – MDS Terminology:

There are 4 main categories, or modes of therapy, for documenting therapy minutes on the MDS:

1. Individual Minutes
2. Concurrent Minutes
3. Group Minutes
4. Co-treatment Minutes

Each of these categories has its own definition set by Medicare policy and is outlined


CMS's RAI Version 3.0 Manual CH 3: MDS Items [O]

O0400: Therapies

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days

2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days

3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0430A5, Therapy start date

3a. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days

4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started

6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month Day Year

B. Occupational Therapy

1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days

2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days

3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0430B5, Therapy start date

3a. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days

4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started

6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month Day Year

O0400 continued on next page

in the RAI Manual, Section O0400: Therapies.

This section explains the qualifiers for each mode of therapy and explains the differences

between residents with Medicare Part A and Part B. It is important that all therapists understand the differences between each category, including all the nuances that go with each, in order to code the MDS appropriately. The MDS, remember, is the reimbursement tool that drives the payment for each facility. Miscoding or misrepresenting minutes on the MDS can have financial consequences that *NO ONE* wants to be responsible for on an audit. This includes Medicare Part A payment *and* case mix reimbursement for states that use the MDS for determining Medicaid payment. Remember, regardless of all the other billing forms and minute logs you fill out in a given day, your entry of minutes onto the MDS….IS billing. When you fill out and sign Section O, you are saying you provided skilled care and are billing for it in the specific category you select. {You knew that, right?}

Individual Minutes:

RAI Definition: The treatment of one resident at a time. The resident is receiving the therapists' or the assistants' full attention. Individual minutes do not need to be done consecutively. The total number of individual treatment minutes should be added together for each treatment day. For example, if you saw Mrs. Smith alone for 20 minutes in the morning and went back after lunch and provided another 10 minutes one-on-one, your total individual minutes for the day would be 30.

Payer Rules: The rules are the same for this category regardless of payer type (A,B,HMO, Private Pay, Managed Part B, etc.) All the minutes listed in this category are used when determining the reimbursement and RUG score.

Comments: This may be the most straight forward mode of therapy delivery. It is the one we are most used to in many practice settings, and likely the most beneficial one for our patients. Based on all the changes Medicare has made in recent years to the reimbursement structure for the other modes, it is crystal clear that this is Medicare's preferred method of treatment for their beneficiaries.

Concurrent Minutes:

RAI Definition: The treatment of 2 residents at the same time. These residents are not performing the same or similar activities. Both of these residents are in line of sight of the treating therapist or assistant. The 2 residents do not need to have the same insurance.

Payer Rules:

Medicare Part A: This definition above applies to Medicare Part A only.

Medicare Part B: Medicare Part B does not include concurrent therapy in its billing set up. Medicare Part B treatments are either individual, when the session is one on one, or group, when more than 1 resident is being treated at the same time. As you will see in the next category, the RAI Manual definition of Group and the Part B definition of Group are different.

Comments: This category can get a little tricky since the definition of concurrent does not apply to Medicare Part B, but if a therapist is treating a Medicare Part A and a Medicare Part B resident together, the rule applies for the Medicare Part A resident. To further clarify, the following are 2 examples right out of the RAI Manual (Page O-25):

1. PT provides therapy that is not the same or similar to Mrs. Q and Mrs. R at the same time, for a total of 30 minutes. Mrs. Q's stay is covered under the Medicare SNF PPS Part A benefit. Mrs. R is paying privately for therapy. Based on the information above, the therapist would code each MDS for this day as follows: Mrs. Q= 30 Concurrent Minutes; Mrs. R=30 Concurrent Minutes.

Simple, right? Now let's see what happens when 1 of the residents in the pair has Medicare Part B.

2. PT provides therapy that is not the same or similar to Mrs. S and Mrs. T at the same time, for a total of 30 minutes. Mrs. S's stay is covered under the Medicare SNF PPS Part A benefit. Mr. T's therapy is covered under Medicare Part B. Based on the information above, therapy would be coded as follows: Mrs. S=30 Concurrent Minutes; Mrs. T=30 Group Minutes. (This is based on the Medicare Part B definition of Group Therapy, as you will see in the next section. Remember, concurrent therapy cannot be coded on the MDS for a resident receiving therapy under Medicare Part B.)

When entering concurrent therapy minutes onto the MDS, the total number of minutes is entered. However, the resident does not get full credit for minutes in this category. The software grouper will take the concurrent minutes entered and divide them in half, only actually counting

1/2 of the total concurrent minutes toward the billable minutes and RUG score for this resident. Are you starting to see why it does not pay to provide concurrent minutes? The minutes are reduced down to individual minutes anyway for both residents.

Group Minutes:

RAI Definition: The treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or assistant who is not supervising any other individuals.

Payer Rules:

Medicare Part A: The definition above pertains to Medicare Part A. Group therapy should be a "planned event" and requires a total of 4 residents to qualify as a group treatment under Part A. (2,3 or 5 do not constitute a group for Medicare A)

Medicare Part B: Group therapy as defined by Medicare Part B, is the treatment of 2 or more individuals simultaneously, regardless of payer recourse, who may or may not be doing the same activities. (2,3,4,10…any more than 2 is a group for Medicare B)

Comments: This category can get a little tricky as well, since the definition of group is different for Part A and Part B. To further clarify, the following examples are right out of the RAI Manual (Page O-26,27):

OT provides similar treatment to Mr. W, Mr. X, Mrs. Y and Mr. Z at the same time for 30 minutes. Mr. W and Mr. X are covered under Medicare Part A, Mrs. Y is covered under Medicare Part B and Mr. Z is private pay for therapy. Based on the information above, the MDS entries for this day would be coded as follows: Mr. W= 30 Group Minutes; Mr. X=30 Group Minutes; *Mrs. Y=30 Group Minutes; Mr. Z=30 Group Minutes.

*Please note that Mrs.Y would have 30 Group Minutes listed on the MDS for this session in accordance with the MDS rule for group therapy, but her billing log information for that day, the log that will be used to submit a claim to Medicare Part B by the facility, should reflect 30 minutes under the CPT Code 97150–Group Therapeutic Procedures. This is the appropriate

CPT code when two or more individuals are treated at once for Part B. If you are billing ADL's, exercise, or any other codes for this session, you are not following CPT guidelines and are over-billing Medicare Part B. Does your flow sheet or software have 97150 as an option for your Part B residents?

When entering group minutes on the MDS, the total number of minutes are entered. However, just like with concurrent minutes, the resident does not get full credit for minutes in this category. The software grouper will take the group minutes entered and divide by 4, only actually counting 1/4 of the total minutes toward the billable minutes and RUG score for this resident. Group treatment does have its place in the clinic depending on the resident situation. However, after providing 60 minutes of group treatment to 4 individuals and only being able to apply 15 minutes of credit to each resident, clinicians should question if group is the way to go.

Co-Treatment:

RAI Definition: When 2 clinicians (therapists or assistants), each from a *different discipline,* treat one resident at the same time with *different treatments*. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited. *(This is a direct quote from the Manual.)*

Payer Rules:

Part A: Both disciplines providing a co-treatment may code the treatment session minutes in full, as long as all policies regarding the modes of therapy were followed. The total number of minutes allocated under co-treatment on the MDS should be the same for the 2 disciplines that provided it. For example, if PT and OT provided a co-treatment for the same resident, the length of time they spent together co-treating must be equal. The co-treatment boxes on the MDS must match for both disciplines.

Part B: Therapists or assistants working together as a team to treat one or more patients cannot each bill separately for the services provided at the same time to the same patient. Medicare Part B is not compatible with the term co-treatment because CPT codes dictate billing. The

therapist cannot bill for his/her services and those of another therapist when both provided services at the same time to the same patient. When a PT and OT both provide services to the same patient at the same time, only one therapist can bill for the entire service, or the PT and OT can divide the service units in half. ….So would a Med B resident ever have co-treatment minutes listed on the MDS? Nope.

Comments: This category is often confused with concurrent, though they are very different. It was so confusing that APTA, AOTA and ASHA published a joint document explaining co-treatment and provided example scenarios. APTA also put out a handy document defining co-treatment across all practice settings (a great tool if you travel between different settings.)

Co-treatment minutes on the MDS are currently NOT used by Medicare for reimbursement purposes….YET. For now, the data from this category is being collected and the future use of this category will be determined.

A Few Words About The Modes Of Therapy…

- The modes of therapy can be confusing, especially when the rules are different depending on the resident's payer source. Therapists need to know the resident's insurance when documenting and billing minutes.
- There are many rules and many payer types. The RAI Manual states that if the resident's therapy is not being provided under Medicare Part B, then the rules for Part A should be followed when determining modes and minutes.
- A resident may have more than 1 type of mode in a given day or multiple modes when reviewing the 7 day look back period. It is essential that therapist documentation be organized and detailed. Each daily treatment provided should include the mode or modes of therapy that was provided. This is a requirement.
- A reviewer should be able to look at what you entered on the MDS and then look at your daily notes and logs, and come up with the same calculation of modes and minutes.
- The modes of therapy were established to be utilized as a "planned therapy event." The RAI Manual specifically states that the therapist plan of care must incorporate the modes of therapy that the resident will participate in and the reason for each mode. So for example, if you are providing group or concurrent therapy sessions, those residents should have these mode types listed in the plan of care and the reason it is needed.

- Concurrent and Group therapy modes should not be provided unless the resident will benefit from it in some manner. Medicare continues to reduce the reimbursement for these 2 categories as they were heavily abused in the past. Be on the lookout for situations that may occur where group and concurrent sessions are provided for the wrong reasons (ie: staff shortages, staff convenience, boosting productivity) or are provided to only one payer type (ie: HMO's).
- If you are providing treatment in any other mode other than individual, you must code the appropriate mode on the MDS and on the billing log.
- Most software systems have the mode of therapy rules incorporated into their design and even auto-populate the MDS. That is both good and bad. Good, because we don't have to worry about it–everything will end up as it should be. Bad, because we never learn the rules and we are still responsible for knowing them.

