“COTs: They Are Nothing To Snooze On”

By Cheryl Babin, PT, MHA

The COT (Change of Therapy OMRA) like other OMRA (SOT, EOT, EOT-R), was introduced into the Prospective Payment System assessment schedule since the birth of MDS 3.0 in October 2010 but had it’s implementation starting with the MDS 3.0 Updates effective 10/1/2011. The rules about COTs are very complex and have significant service delivery issues along with payment challenges. Without a concerted team effort, the COT management process can leave a SNF very vulnerable to lost revenue, provider liable or default days reimbursement and the risk of future medical reviews.

A COT OMRA is required when a patient’s therapy reimbursement level changes to such a degree that it impacts the patient’s RUG – Four therapy classification and payment based on the most recent assessment completed for payment. This therapy reimbursement level can be influenced by changes in the therapy service delivery (i.e. number of days of therapy, number of disciplines of therapy, number of minutes of therapy, and the Restorative Nursing Programs for the RL categories).

The ARD for the COT is set on Day 7 of a COT observation period. The COT observation periods are successive 7 day windows (rolling) with the first observation period beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment. For example, if a team chooses day 6 as the Medicare 5-day ARD and the patient classifies into a Therapy RUG, then the COT window count starts on day 7 and ends on day 13 (continuous 7 days review). On day 13, the team must consider a COT if the patient’s rehab program has changed enough to alter the therapy RUG category, and hence reimbursement. However, if the last PPS Assessment was an End of Therapy Resumption (EOT-R), the end of the first COT observation period is day 7 after the resumption of therapy date no the EOT-R, rather than the ARD of the EOT. The resumption of therapy date is counted as day 1 when determining day 7 of the COT observation period.

If a new PPS assessment required for payment occurs with an ARD set for on or prior to the last day of a COT observation period, then a COT OMRA is not required for that observation period. For example, following the example above, if a team chooses day 6 as the Medicare 5-day ARD and the patient classifies into a Therapy RUG, then the COT window count starts on day 7 and ends on day 13 (continuous 7 days review). The next required PPS assessment for payment is a 14 day assessment. The window for ARD opens on day 13. The team can choose day 13 as the 14 day ARD. The COT observation window then “resets” for 7 rolling days and must be reviewed again on day 20. Remember, a COT is required only when there is a change in intensity of rehab services (i.e. RV to RU) and not required when there is a change within the same intensity (i.e. RVB to RVC).
The science of managing COTs continues as the team must decide if they would be a stand alone COT or combined with a scheduled PPS assessment. A few examples will illustrate this complexity.

Example 1 - A team chooses day 6 as the Medicare 5-day ARD and the patient classifies into a Therapy RUG as an RU, then the COT window count starts on day 7 and ends on day 13 (continuous 7 days review). On day 13, the team must consider a COT if the patient’s rehab program has changed enough to alter the therapy RUG category, and hence reimbursement. In this instance, the patient remains at an RU level of care, and thus the COT is not required and the team also has decided to use day 13 as the ARD for the 14 day PPS required assessment. Payment for this example would be an RU for days 1-14 based on the 5 day assessment (ARD day 6) and then an RU for days starting 15 based on the 14 day assessment (day 13) until the next COT window review date (day 20).

Example 2 - A team chooses day 6 as the Medicare 5-day ARD and the patient classifies into a Therapy RUG as an RH, then the COT window count starts on day 7 and ends on day 13 (continuous 7 days review). On day 13, the team must consider a COT if the patient’s rehab program has changed enough to alter the therapy RUG category, and hence reimbursement. In this instance, the patient receives services at an RV level of care. In this instance, it behooves the team to combine the COT and the 14 day assessment as the payment for the COT goes back 7 days. The reimbursement would be RH for days 1 – 6, RH for days 7 to the next COT review window which is day 20 in this case.

These examples demonstrate the importance of planning and communication; two basic concepts of successful PPS teams. Planning on the therapy side is vitally important. By continually monitoring the therapy that is being provided, teams can better manage any unexpected issues as they arise so that the patient can continue to receive a level of therapy service that is supported by their condition and personal needs. Additionally, since the COT observation periods are successive 7 day windows (rolling) with the first observation period beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment, teams need to plan for services on weekends and holidays. Successive 7 day (rolling) windows do not take a break and neither does the patient’s Medicare benefit regardless of the day of the week or year. Communication between team members (especially MDS and rehab) since CMS has left the choice to combine COTs with regularly scheduled assessments to the providers. Teams need to communicate the process of whether to combine or not to combine an assessment is beneficial. Generally speaking, if a patient’s rehab intensity increases, then the team would choose to combine the COT with the regularly scheduled assessment to capture the revenue increase back 7 days. If a patient’s rehab intensity decreases, then the regularly scheduled assessment would not be combined and stand alone so that the revenue is preserved until the payment kicks in from the scheduled assessment.

There are significant payment implications if a facility completes a COT early, late or misses a COT entirely so let’s consider each scenario separately. In the instance of an early COT, if the ARD for a COT is set prior to day 7 of the COT observation period, the facility must bill the default rate for the total number of days that the assessment is out of compliance. The default rate is effective from Day 1 of the COT observation period that has been reset based on the early COT ARD, and is billed for the number of days that the assessment is out of compliance. The facility may then bill the RUG from the early COT for the remainder of that COT observation period and then continue until the next scheduled or unscheduled assessment is used for payment.
This early COT also re-sets the COT review calendar so that the next COT review is 7 days from the early COT ARD. A late COT is considered when a facility fails to set the ARD for the COT within the defined ARD window for that assessment, and the resident is still on Part A, the ARD cannot be set any earlier than the day the omission was identified. To properly bill for this situation, count the number of days that the assessment is out of compliance, including the late ARD. This is the total number of days that will be billed at default beginning with the day that the assessment would have controlled payment. This late assessment changes the COT review cycle. However, the SNF must only bill the default rate until the point when an intervening assessment would control payment. In cases where an intervening assessment occurs, the intervening assessment is used to establish the COT ARD calendar, regardless of when the late assessment is completed, and the late assessment, in these cases, would not affect the COT ARD calendar. If a COT is missed (the facility does not set an ARD for an unscheduled PPS assessment within the defined window for that assessment), and the resident is discharged from Part A, the assessment is considered missed and cannot be completed. All the days that would have been paid by the missed assessment are considered provider liable. However, the provider liable period lasts only until the point when an intervening assessment controls payment.