PROVIDING ADEQUATE OVERSIGHT OF THERAPY SERVICES AND BILLING TO MINIMIZE FACILITY RISK

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Objectives

- Identify the risks for different payor sources
- Identify areas of oversight needed
- Understand CMS documentation requirements for billing Medicare A and Medicare B
- Understand specific strategies to minimize risk on a weekly, monthly, and ongoing basis
- Establish processes for accurate billing and timely submission

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Your Medicare Number

The facility is ultimately responsible for the therapy services provided to the patients/residents.

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RUGS IV vs. PDPM

Commonalities			
Medical Necessity	Skilled Service	Documentation Requirements	Readmission

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RUGS IV vs. PDPM

Challenges		
Delivery of Therapy	Management of Staff	Restorative

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Risks Associated with Medicare Part B

Denials related to:

- Lacks medical necessity
- Coding errors
- Missed documentation Requirements
- 8-Minute Rule
  - 8 - 22 minutes = 1 Unit of billing
  - 23 - 37 minutes = 2 Units of billing
  - 38 - 52 minutes = 3 Units of billing
  - 53 - 67 minutes = 4 Units of billing
  - 68 - 82 minutes = 5 Units of billing
  - 83 minutes = 6 Units of billing

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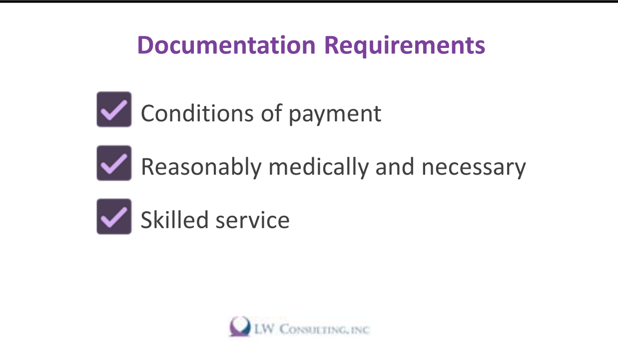

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Documentation Requirements Part A vs Part B – Reasonable and Necessary & Skilled Services

REQUIREMENT	PART A	PART B
Reasonable and Necessary	Documentation must support this requirement	Documentation must support this requirement
Skilled Services	The overall documentation must support that skilled interventions are included in the therapy plan of care	The units billed for each session must be supported by documentation of skilled services that matches the units that are billed. Every unit that is billed must have documentation to support that the billing is skilled.

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CMS Outlines Qualifications for Skilled Coverage:

- Services provided by a qualified professional
- Require the expertise, knowledge, clinical judgment, decision making abilities of a therapist

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Skilled Coverage Criteria

- Expectation of delivered services
  - Help the patient improve and attain goals
  - Prevent a worsening condition
  - In a reasonable timeline
- Must **apply** the skills of a therapist
- Actively participating in the treatment of the patient

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Skilled Coverage Criteria

If the condition has the propensity to improve on its own without therapy, skilled documentation must be clear.

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Therapy Documentation 101
for Non-Clinicians

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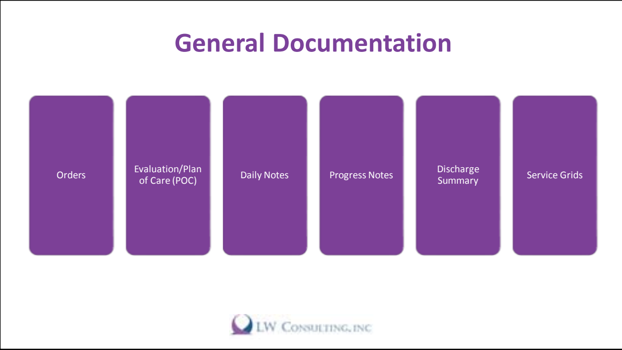

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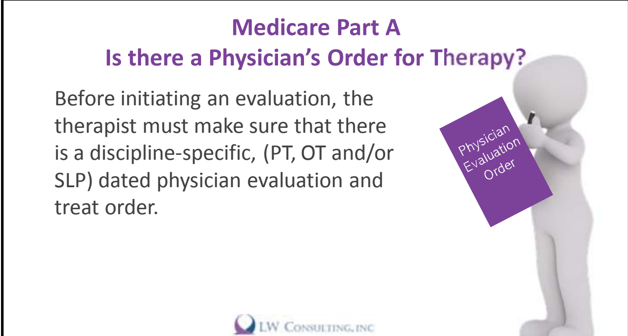

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Medicare Part B Initiation of Care

- Order or referral not required
- The plan of treatment must be **CERTIFIED** by a physician

** Payment is dependent on the certification of the plan of care rather than the order*

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CERTIFICATION – Part B

- Certification is a physician's approval of a plan of care
- Timely signature
- Delayed Certification required after 60 days
- System to track for signatures, dated upon arrival, and delayed certifications

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Evaluation and Plan of Care (POC)

- Medical and Treatment diagnoses
- Reason for the therapy referral
- Prior level of function/Patient's goal or plan/Discharge destination
- Current level of functions/identify the functional limitations
- Use of Standardized Test(s)
- LTG and STG Goals
- Treatment interventions
- Frequency and Duration
- Rehabilitation potential
- For PT and OT: justification of the evaluation complexity
- Date/Therapist's signature with professional credentials

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Which Medical and Treatment Diagnoses Should be Used?

Medical	Treatment
Medicare Part A: The primary reason for the SNF admission **Medicare Part B:** The condition for which the patient is receiving skilled therapy **Example:** Encounter for other orthopedic aftercare	**Medicare Part A and B:** The condition that reflects why the patient is being treated by therapy **Example**: Muscle wasting and atrophy, not elsewhere classified, right lower leg

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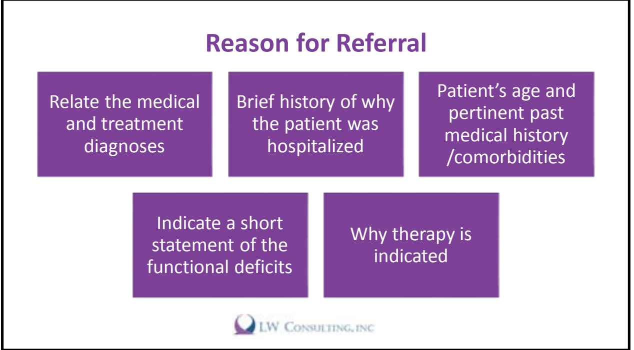
Reason for Referral



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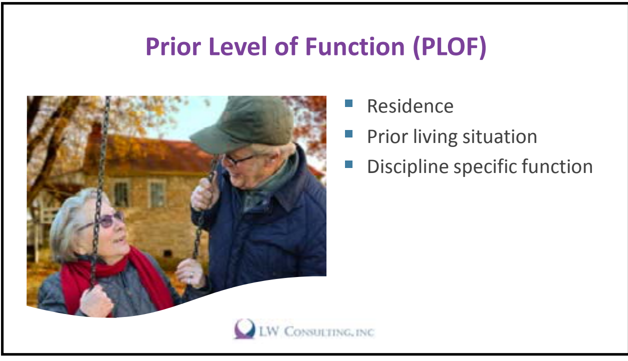
Prior Level of Function (PLOF)



- Residence
- Prior living situation
- Discipline specific function

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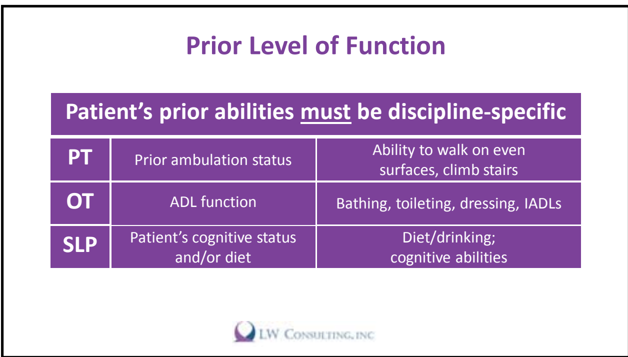

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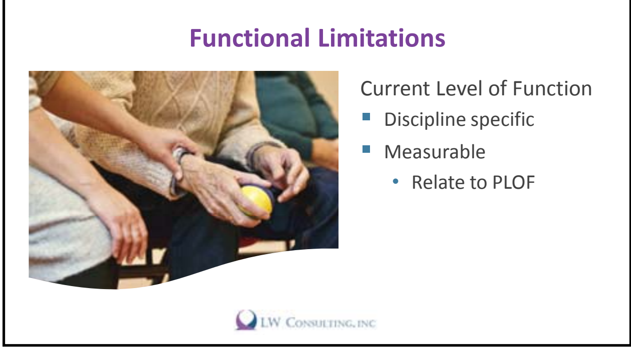

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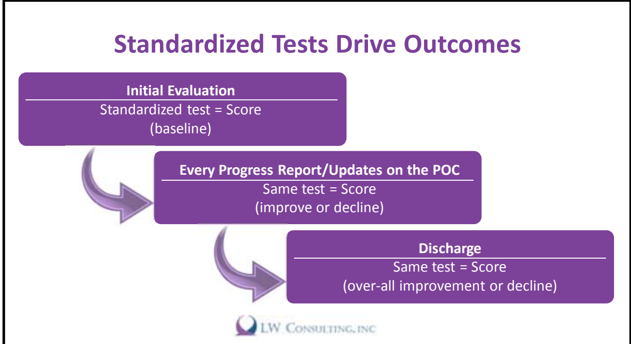

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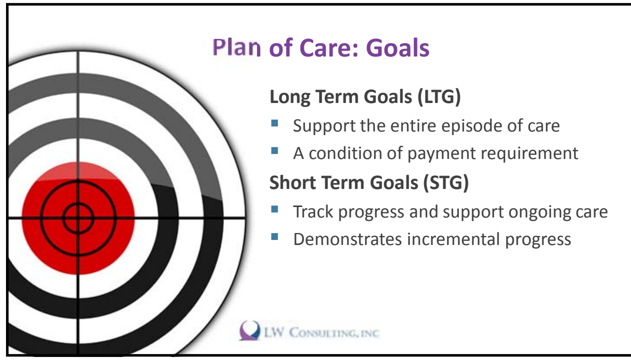

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BEST PRACTICE = SMART GOALS

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Goal Requirements

- **LTG** and **STG** must be detailed, measurable and relate to function
- **Goals** should be written for the patient and not for the therapist

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Plan of Care: Treatment Interventions

- Appropriate for the nature and severity of the patient's condition
- Individualized
- Scope of practice

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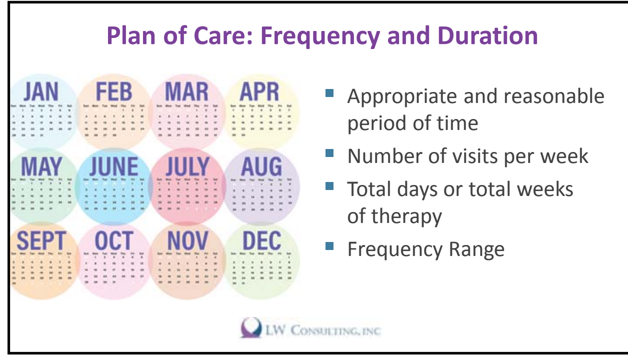

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Signature Requirements

- Must be legible if it is handwritten
- Signature and date correlate with start of care
- Credentials (PT, OTR/L, SLP-CCC)

SIGN HERE

Robert Smith, OTR/L

Date: 2/15/2018

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Documentation Requirements Part A vs Part B - Daily Notes

REQUIREMENT	PART A	PART B
Daily Notes	There is no CMS requirement for daily notes. Many State Practice Acts and/or companies require a daily note to support the overall need for therapy; however, it is not required by CMS. NOTE: if something is documented that is NOT skilled, those minutes might not be support as MDS minutes. An example might be "patient refused to participate in treatment today" and 15 minutes are recorded.	There must be a daily note to create a record of all treatments and skilled interventions that are provided and to record the time of the services to justify the use of billing codes on the claim. Documentation is required for every treatment day, and every therapy service. This is found in the CMS MBPM Chapter 15, 220.3, E. Treatment Note. If 3 units of therapeutic exercise are billed, documentation must support the time for 3 unites to be billed (8-Minute Rule)

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Documentation Requirements Part A vs Part B - Weekly Notes

REQUIREMENT	PART A	PART B
Weekly Notes	There is no requirement for a set weekly note; documentation just must support that the care is skilled, reasonable and necessary. Most choose to provide a regular progress note either weekly or biweekly to meet this requirement	The minimum progress report period should be at least one progress note every 10 treatment days. This is found in the CMS Medicare Benefit Policy Manual Chapter 15, 220.3, D. Progress Report.

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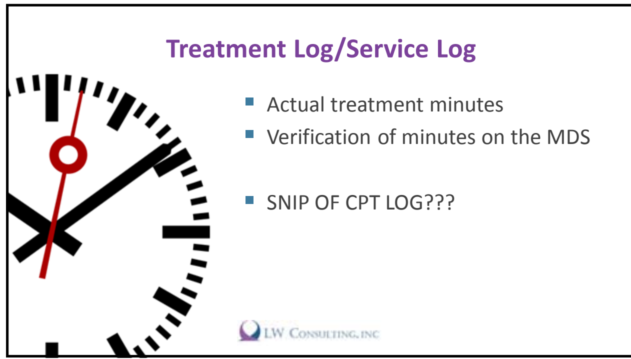

Treatment Log/Service Log

- Actual treatment minutes
- Verification of minutes on the MDS
- SNIP OF CPT LOG???

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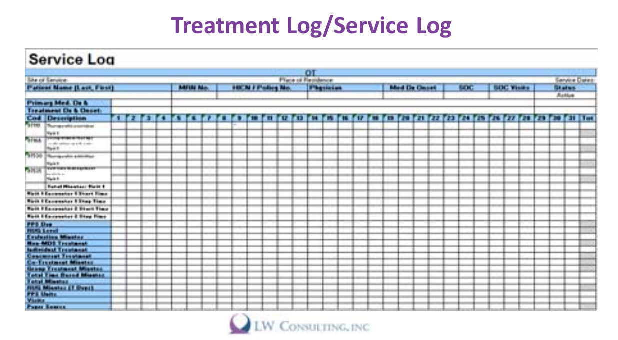

Treatment Log/Service Log

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Discharge Summary

- Clinical assessment of overall skilled care
- Overall improvement toward each established STG/LTG
- May be incorporated with the progress note
- Barriers encountered during the episode of care
- Standardized tests
- Discharge destination and recommendation
- Timely completion

Discharge Summary

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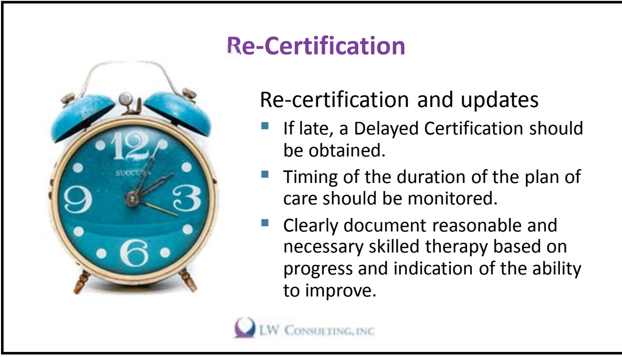

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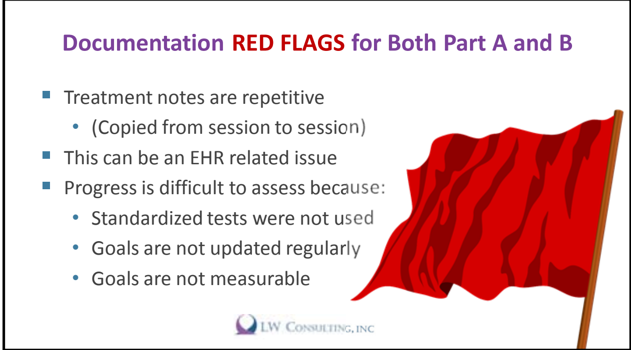

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Best Practice

- Specific codes and minutes of skilled therapy, by mode of treatment
- Missed treatments and reason
- Co-treatments
- Modalities
- Group treatment
- Any significant change should be documented to provide information to support skilled care delivery

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Other Rehab Areas of Oversight

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Other Rehab Areas of Oversight Needed

- Current licenses
- Staff competency
- Patient safety
- Infection control
- HIPAA
- Equipment maintenance
- Staff training
- Supervision compliance

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Oversight Strategies

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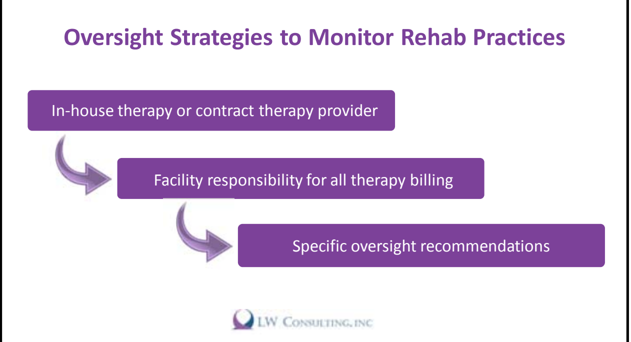

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An Effective Compliance Plan

- The foundation to support your billing practices
- Demonstrates that the provider is taking steps to ensure compliance
- Policy and Procedures outline expectations

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Policy Suggestions Related To Documentation

- Tracking of therapy documentation in the medical record
- How is documentation in the EHR maintained (especially if the therapy provider uses a different system)?

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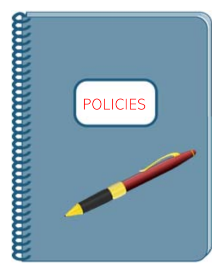
Policy Suggestions Related To Documentation

- Who holds the license for the EHR that therapy uses?
- What if the relationship ends; who owns the documentation?
- How is documentation reviewed for completeness?



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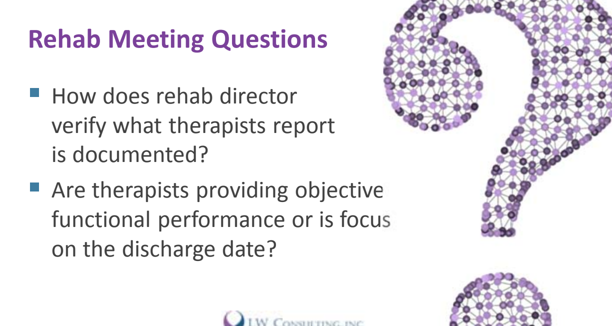

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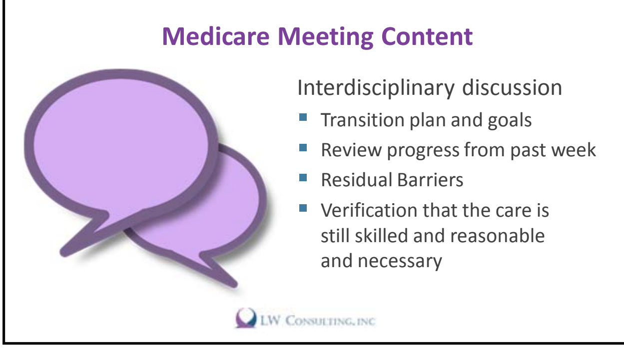

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Medicare Meeting Format

- Interdisciplinary discussion of barriers, transition plan and goals, with some verification that the care is still skilled and reasonable and necessary
- Monitor standardized tests
- Are progress and the need for skilled care demonstrated?

Medicare Meeting Agenda

1. Barriers
2. Transition plan
3. Goals

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Triple Check

- Formal meeting
- Written Policy and Procedure
- Monitoring of all Technical Requirements
- Verification of all dates, signatures, codes, and minutes

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Focus Areas for Monthly Review

- Critical Performance Indicators
  - Metrics
  - Trends
  - Outliers
- Chart Audit Results (depending on circumstances)
- Reports

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Quarterly Therapy Oversight Recommendations

Quarterly meeting with a Rehab Focus

- If in-house, review metrics with the Rehab Director
- If contract: request a formal report
- Set goals for the next quarter

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Diagnosis Coding Under PDPM

- Diagnosis coding will be the most critical element of CMI scoring
  - This relates directly to the financial reimbursement
  - The code will be entered into the MDS in a New Item called “I0020B”
- This is a NEW mindset because the IDT will have to think about the reason for the SNF admission…

The reason for the hospitalization
may not be the reason for the SNF admission any longer

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Systems changes to support PDPM diagnosis coding preparation

- Monitor physician documentation
- Set up systems to secure hospital information
- Ensure communication and training with physicians
- Verify all codes through the CMS Clinical Mapping Tool for RTP codes
- Run analysis on comparison of current diagnosis coding to PDPM projections using a Grouper Tool
- Audit diagnosis coding for accuracy

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System Changes

- Tracking of therapy utilization under PDPM compared to current/historical RUGs IV PPS

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System Changes

- Critical performance indicator changes
  - Therapy outcomes
  - Length of stay correlated to outcomes
  - Reimbursement under PDPM
  - Concurrent and Group limits under PDPM
- Ongoing monitoring of metrics
  - Readmission tracking correlated to therapy
  - Diagnosis coding supported by protocols and clinical pathways

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CHANGES TO THE CAP

- No longer a cap on Part B
- The KX modifier is still required for claims above $2,040
- Documentation must support the use of the KX modifier as a medically necessary skilled service
- APTA highlights specifics regarding the legislation for the exceptions process:
  - Threshold $3,700 to $3,000 for targeted medical review through 2027
  - Claims > above $3,000 not automatically be subject to medical review

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KX Modifiers, If Applicable

- Only required for Medicare Part B patients
- Supports medical necessity
- The KX modifier shall not be added to any line of service that is **not a medically necessary service** (and that would become non-billable)

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Questions?

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Thank You for joining us today!

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