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Why compliance matters to the enforcement community

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by Nancy J. Beckley

Rehab risks in a RAC world

» Manual medical review of outpatient therapy claims exceeding $3,700 was mandated by the American Taxpayer Relief Act of 2012.
» Recovery Auditors conduct manual medical review on prepayment and post-payment basis.
» Providers must assess beneficiary utilization and medical necessity in planning for effective use of ABN.
» Therapy documentation best practice takes into account local coverage determinations.
» A tracking system is critical for the $1,900 cap and $3,700 threshold and RAC processing.

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The world of outpatient therapy, including physical therapy, occupational therapy, and speech language pathology has seen risk grow exponentially over the past year, while at the same time suffering reimbursement hits from governmental programs, most notably Medicare, and commercial payers as well.

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New rules for all providers, and old rules for new providers

All outpatient therapy providers are now subject to the new manual medical review as of January 1, 2013 and functional limitation reporting requirements that began on July 1, 2013. On January 1, 2013, hospital providers (with the exception of critical access hospitals), came under the therapy caps that the rest of the outpatient world has experienced since 2006.

Rule #1 — Therapy caps

Financial limitations on outpatient therapy have been in place permanently since 2006. Although instituted as part of the Balanced Budget Act of 1997, the therapy industry was successful in lobbying efforts to achieve a moratorium on implementation of the financial limitations, known as therapy caps, until 2006. Hospitals were exempt from the therapy caps, giving Medicare beneficiaries a place of last resort for therapy, if they exceeded the caps and were not eligible for an automatic exception. The hospital therapy cap exemption was eliminated for the fourth quarter of 2012, and in 2013, hospitals are also under the therapy caps.[1] Only critical access hospitals (CAHs) remain exempt from the therapy caps, because they are paid on cost rather than the Medicare Physician Fee Schedule (MPFS). However, therapy services received at CAHs count toward a beneficiary's therapy cap utilization, with the amount being computed as if services were paid on the MPFS.

The amount calculated toward the utilization cap is based upon the MFPS after the multiple procedure payment reduction (MPPR) is calculated at 50% of the practice expense of the second highest code and subsequent codes. The MPPR was increased for all outpatient therapy providers, from 20% for private practice/physicians and 25% for institutional providers to 50% for all providers, effective April 1, 2013. The MPPR cuts apply for services provided across all disciplines under a therapy plan of care on the same day. While in place, the 2% sequestration Medicare cuts apply to the portion that Medicare pays, not the entire MPFS amount. Depending on the mix of therapy services and the procedures billed, providers are reporting anywhere from an additional 7%–15% reduction in revenue from March 31 to April 1, 2013.

Rule # 2 — Therapy threshold and manual medical review

In its November 2012 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended a continuation of manual medical review of therapy claims over the $3,700 threshold in 2013.[2] This was incorporated into the American Taxpayer Relief Act of 2012 (ATRA), with implementation effective January 1, 2013. The Medicare Administrative Contractors (MACs) were initially charged with prepayment review of all therapy claims over the $3,700 thresholds ($3,700 for physical therapy and speech language pathology combined, and a separate $3,700 threshold for occupational therapy). CMS identified a permanent solution with the Recovery Auditors (RACs) effective on April 1, 2013. Claims by providers in the Recovery Auditor Prepayment Demonstration states would be under prepayment review with a 10-day mandated review period. Providers in the remaining states would have therapy claims over the $3,700 thresholds reviewed on a post-payment basis.

Rule #3 — Functional limitation reporting

All therapy providers, including CAHs, must provide functional limitation reporting in 2013. A testing period was in place through June 30, 2013, and full implementation commenced on July 1, 2013. Seen as a way to provide CMS with information about beneficiary functional impairment and therapy outcomes, the implementation by the therapy community is with mixed emotion. Few disagree with the need to collect outcome data on outpatient therapy service, but question if the system will deliver the information that CMS needs in their quest to develop an outpatient therapy payment system. Additionally many providers, particularly hospitals, find the implementation of the claims based functional reporting coding to be cumbersome and costly, both in terms of technology application and implementation.[3,4] Functional limitation reporting for hospitals includes inpatients with Medicare Part B benefits only, as well as observation patients.

Recovery auditors — an outpatient therapy tipping point

Inpatient rehab facilities have known both controversy and success in the RAC demonstration program and the permanent program, but there has been little to rock the boat in outpatient therapy. As the RAC program got underway with automated reviews, a CMS-approved issue of billing of untimed codes in units greater than one was posted in all four RAC regions. The only therapy providers reporting problems were those where the application of the edit was programmed in error to deny any claim where more than one untimed code appeared on a date of service.

The 2013 RAC review of outpatient therapy will take place in a new world of provider—rather than beneficiary—liability for therapy claims over the therapy caps that have been denied. Prior to 2013, therapy over the therapy caps was statutorily excluded as a benefit if it was not medically necessary. ATRA changed the liability to provider liability in 2013, requiring providers to issue a mandatory Advance Benefits Notice (ABN) before therapy services are delivered. The ABN indicates that the services are not medically necessary, and transfers the liability to the beneficiary. In 2013, a provider cannot hedge their bets by billing therapy with the KX modifier (attesting to medical necessity), and simultaneously pass the liability to the beneficiary if the therapy services are denied.

As therapy providers respond to the Additional Documentation Requests (ADRs) for review by the RACs, there is a great deal of apprehension, not only about potential denials for therapy that the provider and referring physician feel is medically necessary, but

apprehension about continuing therapy for patients during a prepayment review process. For the mandatory 10-day review, the clock starts ticking when the claim arrives at the reviewer's desk. Those experienced in the RAC or medical review process know that 10 days is likely to mean close to 30 days when taking into account processing time for the provider in submission of the ADR, and processing time in and out at the RAC.

Not many outpatient therapy providers, including hospitals, can afford to provide a month of free therapy while awaiting a RAC decision. Henceforth, there is a large provider dilemma with respect to beneficiary therapy. If a provider attests to medical necessity, and appends the KX modifier to all claim lines, there is no fail safe option by issuing an ABN, as there was in 2012 when CMS recommended use of the voluntary ABN as a courtesy. The mandatory use of the ABN for therapy over the cap must be accompanied by the GA modifier, indicating that care is not medically necessary. That is the only way that liability for therapy over the caps can be transferred to the beneficiary in 2013. A provider cannot hedge their bets in 2013, looking to the beneficiary for payment if therapy services over the caps are denied.

Mitigating risk: Documentation best practices

Therapy that is medically necessary is likely to be denied if the therapist does not comply with therapy documentation rules or Local Coverage Determinations (LCDs).[5] A therapist may be able to verbally express the need for therapy in a case presentation, but unless it can be represented as medically necessary in the medical record, a denial is likely if the documentation is reviewed. In 2013, therapy providers have the highest likelihood of their documentation being reviewed than ever before, with a guaranteed 100% documentation review when beneficiaries exceed one of the $3,700 therapy caps. Implementing a "best practice" documentation program, subject to internal monitoring and auditing compliance activities, is the first step in moving forward with confidence in determining if therapy is medically necessary, including recommendations for continued skilled therapy.

In a number of scenarios, a beneficiary will exceed the therapy cap where it is medically necessary, such as:

- receiving both physical therapy and speech language pathology services, because both are included in the $1,900 cap and $3,700 threshold;
- a single complicated episode of therapy, such as a brain injury with multiple orthopedic trauma;
- a single episode of therapy for a patient with multiple comorbidities and complexities that directly impact the course of therapy; or
- multiple single, unrelated episodes of therapy (e.g., therapy post-knee replacement, followed in several months by therapy following a stroke).

The initial therapy evaluation, as noted in Table 1 (on page 74), is the place to firmly establish medical necessity through normal therapy tests and measurements, in addition to clinical impressions of the interactive effect of comorbidities on the recommended frequency and duration of therapy and patient prognosis. For example, a patient who comes in for shoulder-joint replacement therapy and also has an accompanying vestibular disorder is likely to require additional therapy to address the balance issues, because it relates to the safe course of therapy for the shoulder.

The CMS-required therapy Plan of Care (PoC) establishes the course of therapy, which is certified by the referring physician or non-physician practitioner. The PoC must address

Table 1: Summary of best practices for documentation of therapy

Rehab Documentation Best Practice	Where
Test, measure, and document functional scores, performance tests, and clinical findings indicating the impact of any complexities and comorbidities on the course of therapy, including prognosis	Initial Therapy Evaluation
Relate clinical findings and short-term goals to functional deficits, impairment ratings, and long-term goals	Therapy Plan of Care
Identify skilled intervention demonstrated through ongoing patient assessment, exercise, and functional progression, including techniques and parameters utilized	Therapy Daily Note
Serially track and update important clinical and functional findings related to goals	Therapy Progress Report
Summarize entire episode of care to include patient progress, goal/functional achievement, and reason for discharge	Therapy Discharge Report

the patient's clinical findings and short-term goals (short term goals are optional), and relate them to functional deficits, impairment ratings, and long-term goals. The gap between the current level of function (CLOF) and prior level of function (PLOF) establishes the reason for therapy and should be evident to anyone reviewing the PoC.

The therapy daily note, including flow sheets that contain exercise techniques and parameters, should show skilled intervention. A progression of daily notes should show patient progression and ongoing therapist assessment of the patient. If the daily note is particularly good at accomplishing this, a progress report (due every 10 therapy visits) will easily update the clinical findings and patient progression to goals. The first therapy progress report should be a routine compliance monitoring activity. If the medical necessity for continued skilled care is not demonstrated at the first progress report, it is not likely that a case for the medical necessity of continued therapy can take place at a latter point in time. Each successive progress report should be subject to the same monitoring activities, and answer the question: "Is continued care medically necessary?

The therapy discharge report, which is another updated progress report, should summarize the entire episode of care, rather than progress from the last report to discharge. This may be the best defense document for a RAC post-payment review.

Conclusion

Outpatient therapy services have undergone tremendous financial and policy changes from CMS in the past year. Therapy providers must not only apply operational efficiencies to their practice or department, but they must increasing rely on compliance-related monitoring and auditing activities to ensure that the therapy provided is medically necessary and supported by best practice documentation.

1. See American Taxpayer Relief Act of 2012. Available at http://bit.ly/15OOasV
2. See MedPAC November 2012 Report. Available at http://1.usa.gov/15hPQie
3. CMS FAQ Recovery Auditor – Outpatient Therapy Claims. Available at http://go.cms.gov/17WMPjq
4. CMS Slide Show on Manual Medical Review. Available at http://go.cms.gov/15PHuAJ
5. Therapy documentation rules are found in CMS IOM 100-02, Medicare Benefits Policy Manual, Chapter 15, beginning at Section 220. Providers should reference MAC Local Coverage Determinations for additional requirements.