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an interview with Professor Paul Fiorelli

Director, Cintas Institute
for Business Ethics
Xavier University
Cincinnati, OH

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> "I ask companies the question, "If the CEO of the company tapped the average employee on the shoulder, asking her or him to explain what the mission statement means to them, would they be able to do it?"

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by Nancy J. Beckley

Rehab under review: The devil is in the details

» The Office of Inspector General (OIG) continues to identify physical therapists in private practice in its annual Work Plans and the resulting audit reports have been published.

» Medicare Administrative Contractors (MACs) are conducting probes and targeted medical reviews on outpatient therapy claims; reports are that error rates are high.

» Therapy over the $3,700 threshold is subject to "manual medical review" based upon criteria mandated in MACRA.

» Therapy providers should carefully review Additional Document Requests (ADRs) and prepare a well-organized response.

» Therapy documentation best practice is always the best defense, and therapy practices should pre-emptively audit to ensure response readiness.

Nancy J. Beckley *(nancy@nancybeckley.com) is President of Nancy Beckley & Associates LLC, a rehab compliance consulting firm in Milwaukee, WI.*

/in/nancybeckley @nancybeckley +NancyBeckley

The risk in outpatient therapy, including physical therapy and occupational therapy, seems to grow exponentially each year, but at the same time these services continue to suffer reimbursement hits from governmental programs, most notably Medicare, but commercial payers as well. Providers report concern over the lack of subject matter expertise by the various review entities and reviewers.

Beckley

OIG Work Plan: Physical therapists in private practice

The Office of Inspector General (OIG) has continued to identify physical therapists in private practice in its annual Work Plan.[1] As a result, related OIG audit reports have been published in the past several years. The 2017 Work Plan provides the background and context for continued reviews of "Physical Therapists – High Use of Outpatient Physical Therapy Services":

> Previous OIG work found that claims for therapy services provided by independent physical therapists were not reasonable, were not properly documented, or the therapy services were not medically necessary. Medicare will not pay for items or services that are not "reasonable and necessary" (SSA § 1862(a)(1)(A)). We will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations. Our focus is on independent therapists who have a high utilization rate for outpatient physical therapy services. Documentation requirements for therapy services can be found in CMS's Medicare Benefit Policy Manual, Pub. No. 100-01, Ch. 15 § 220.3.

The OIG audit reports provide informed insight as well as excellent tools for risk assessment. The context for therapy review

selection appears to be based upon therapists that are among the highest therapy billers for a specified year in that provider's state. Perhaps the most interesting section of these audit reports are the auditees' responses, which are contained in an appendix to the report.

A therapist is at risk for the "review pool" based upon high utilization—but the utilization marker is based upon the high-water mark in each state. For instance, a Missouri physical therapist with $290,000 in reimbursement in 2014 is identified as a high utilizer, but the threshold in California for a high utilizer was closer to the $500,000 mark in 2014. It is essential to know the numbers for your peer group comparison, as well as to incorporate this information into your compliance risk assessment. Providers should not fear providing services, but rather understand the risk of audit probability and ensure policies and procedures are in place that support documentation, coding, and billing of therapy services consistent with Medicare policy and commercial payer contracts. Private practice providers can begin to assess their risk for audit by accessing the CMS files that are readily available in *The Wall Street Journal (WSJ)* database lookup tool. Alternatively, the *WSJ* has created a database lookup tool.

MACs target medical reviews

Outpatient therapy is under review across the Part A and Part B Medicare Administrative Contractors (MACs) because of consistently high errors in therapy. The Comprehensive Error Rate Testing Program (CERT) Medicare A-B CERT Task Force developed the "Task Force Scenario: Documenting Therapy and Rehabilitation Services for Outpatient Therapy Services" as their first joint effort.[2] The Task Force identified the key reason for the high rate of therapy denials as "insufficient" documentation in the medical records. According to the Task Force, this not only includes lack of compliance with document requirements identified in the *Medicare Benefits Policy Manual*,[3] but also includes: (1) Missing or illegible signature on the Plan of Care (POC); (2) Missing or illegible signature for physician's certification; and (3) Missing or illegible signature and required treatment minutes in narrative or on the flow sheet.

Specific reviews underway by each MAC can be found at their respective websites. For example, one MAC reports on the results of a widespread prepayment review on the whirlpool code. Therapy providers using the whirlpool code for fluidotherapy (i.e., generally hand therapists) are getting caught up with all provider types using this code for traditional whirlpool treatments. The error rates are at 100%, with the reason being that documentation was missing to establish complicating factors for the procedure, or lack of rationale for why the presence of a therapist was required. Another MAC review targets cognitive skills with error rates greater than 80%, largely attributed to documentation lacking the identification of a cognitive deficit. In general, more than one error is noted by the MAC, and many denied claims lack a certified POC and/or the documentation of timed code treatment minutes to support the number of units billed.

Manual medical review of therapy over the $3,700 threshold

Review of therapy over the $3,700 threshold has migrated from the MACs to the Recovery Audit Contractors (RACs) and now to Medicare's Supplemental Medical Review Contractor (SMRC).[4] MACRA eliminated the requirement for manual medical review of all claims exceeding the thresholds and instead allows a targeted review process. CMS has tasked Strategic Health Solutions (SHS), as the SMRC, to perform reviews of therapy over the $3,700 threshold on a post-payment basis.

CMS has directed SHS to select claims based on: (1) Providers with a high percentage of patients receiving therapy beyond the threshold as compared to their peers during the first year of The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); and (2) Evaluation of the number of units/hours of therapy provided in a day.

Therapy providers should review and prepare an organized response to all items requested in an Additional Document Request (ADR). Preparation of an ADR cover letter should clarify and provide reference to Medicare regulations and policy, even when the ADR does not accurately reflect these regulations and policy. Several "waves" of catch-up post-payment reviews for therapy over the $3,700 thresholds in 2015 have been conducted over the past year. Many therapy providers are reporting success in these reviews, but others have expressed concern that the review contractor is missing items, perhaps in part due to the ADR list. Specifically, providers are concerned that the items requested are not in the same format and familiar language of the documentation requirements in the *Medicare Benefits Policy Manual*. For example, a valid delayed certification is included in the records, but the SMRC denies the claim stating "certification not present." Therapy providers are right to be concerned when the record content submitted is overlooked because format and language are inconsistent.

Reviewing and indexing the record request — Don't assume anything

Providers are given deadlines for submission, and often valuable response days are lost in the mail. Contractors, including the SMRC, will require a response in a specified number of days from the date of the letter. Even under the best circumstances, providers often lose more than five days in this process. Providers may assign the task of responding to a clerical or administrative staff member whom they feel is best suited to assemble and organize the documents, but the oversight of a therapist (and particularly the therapist of record) is necessary to do a quality check of the record and to identify where in the medical record each requested item is located. A best practice approach is for the provider to identify and highlight all the required elements in the submitted record as well as to provide a crosswalk from the ADR request list to the location in the submitted record.

The devil is in the details. Given the small reimbursement for a single therapy date of service, the provider's expense associated with requesting a discussion period and/or proceeding to the first level of appeals can be mitigated up front. Mitigation can be achieved through organization and attention to detail when assembling the initial response to the record request. For many providers, the problematic issues are the certification of the POC and the signature attestations. To that end, the provider should seek to obtain the certification, or a delayed certification, for any POC wherein the certification is missing or the date of certification is missing. The delayed certification should be submitted along with a reason for the delay, and this should be pointed out in the cover letter with the response. Signature logs and attestations for signatures that are not legible or consistent with CMS signature requirements should be obtained, and also identified in the cover letter. Providers who pre-emptively obtain delayed certifications and signature attestations can mitigate routine (and unnecessary) reasons for denial of therapy claims. See Table 1 for tips in responding to the ADR. For the examples in this table, we identified the ADR letter for therapy over the $3,700 threshold posted on the SMRC's website.[5]

Table 1: Best practices for dealing with document requests

Requested Item	Translation	Response Best Practice Tips
1. Copy of the claim bill	Copy of CMS 1500 or UB04 form	Don't wait until last minute if you need to request this from your biller
2. Physician order/referral for therapy services	MD/NPP referral (order) not needed if the Plan of Care (POC) is certified	Submit the MD/NPP referral; it may save an appeal. If a direct access patient, identify that the certified POC fulfills "order" requirement
3. Physician initial certification/ recertification(s) for services signed and dated	#3, #5 and #6 are all related. Typically, the certification is on the POC, and re-certification is on the progress note or re-evaluation	Identify your documents by title, number pages in each ADR, and identify the location. Describe initial evaluation/re-evaluation and rationale with diagnosis and prior level of function > POC > certification/re-certification
4. Clinical documentation including progress notes, rationale, and pertinent diagnosis to support the need for therapy services	The rationale and diagnosis to support therapy is typically contained in the evaluation/POC. The request may appear to be for a separate document (it is not)	Show where the rationale and diagnosis to support therapy service is found in your documentation response (e.g., initial evaluation, POC)
5. Initial therapy evaluation and subsequent therapy re-evaluations; that must include prior level of function	Prior level of function (PLOF) is a required element of a therapy evaluation, if you submit a single POC/evaluation document make sure to identify the location of PLOF	See #3 Identify your documents by title, number pages in each ADR, and identify the location. Describe initial evaluation/re-evaluation and rationale with diagnosis and prior level of function > POC > certification/re-certification
6. Individualized plan of care for therapy services	POC that is tied to #5 and certified in #3	See #3 – *AND* include type of therapy, frequency, and duration. Hedge your bets by including the specific exercises, activities, and modalities in the POC
7. Individualized treatment records (encounter notes) that include: modalities, goals, frequency, duration of services, and outcomes for each discipline	Goals, frequency, and duration are items required in the POC, not the daily encounter notes. Typically, outcomes are reported in progress notes and include goal achievement and functional limitation reporting. This request is mixing apples and oranges	Identify that your "individual treatment records" (daily notes) include the required elements: • Date of treatment • Identification of each specific intervention/ modality provided and billed (timed and untimed codes) • Total timed code treatment minutes and total treatment time in minutes • Signature and professional identification of the qualified professional who furnished the services
8. Documentation and/or logs that include supporting treatment minutes and units for all services rendered on the date(s) of service billed	Daily documentation must include supporting treatment minutes: total timed code treatment minutes and total treatment time in minutes	Describe use of "flow sheets" and reference if you use EMR embedded flow sheets in the daily notes, or paper flow sheets containing a range of dates. Identify how the timed code minutes are identified and tallied per code
9. Discharge summary for all therapy disciplines	A discharge note is required for every therapy episode, even if the patient abandoned care. The note is required for the therapy discipline in question	Identify that you are providing a therapy discharge note for the therapy discipline that is under review
10. Copies of any patient notices given (e.g., Advance Beneficiary Notice of Noncoverage)	Properly signed Advance Beneficiary Notice of Noncoverage (ABN) that has been coded to the claim with the proper modifier, indicating services were not covered or not medically necessary	The request may be confusing, as a Notice of Privacy Practice is also a "notice," but it is not required for medical review. The kind of notice is stated in the review contractor's letter
11. Any abbreviation keys or acronym keys used	A rehab data dictionary. Reviewers are not subject matter experts and may not know what SLS (single leg stand), clams, (hip external rotation exercise), or YTB (yellow Theraband) means	Prepare this in advance so it is ready to go. Different abbreviations are used across the country; match to your therapy notes
12. Any and all other documentation to support the therapy services billed	Include items scanned to your electronic medical record (EMR), or filed outside the therapy notes, most importantly documentation of attempts to certify the POC	At the top of the list should be a cover letter identifying, by number and in order, the items being submitted in support of the claim date. Point out any discrepancies in delayed certification

Mitigating risk: Documentation best practice

The saying, "The best defense is a good offense" holds true for therapy providers who can anticipate reviews to continue. As noted in OIG audit reports and in the education provided by the CERT Task Force, therapy errors continue because providers do not have policies and procedures, or education in place related to the documentation, coding, and billing for therapy services. To be more specific, providers should heed the following advice of the CERT Task Force:[6]

- Ensure the medical records submitted provide proof the service(s) was certified and rendered.
- Ensure the medical records provide justification supporting medical necessity and that skilled services were needed.
- Create a complete POC, making certain to include your legible signature, professional identification (e.g., physical therapist [PT], occupational therapist [OTR/L]) and date the POC was established.
- Document when the POC is modified, including how it has been modified and why the previous goals were not met or could not be met.
- Confirm the POC is certified (or recertified when appropriate) with the physician's/non-physician provider's (MD/NPP) legible signature and date.
- Clearly document, in minutes, the total time spent on timed-code treatment only and the total treatment time (including timed and untimed codes) in the patient's record.

Therapy providers, no matter the site of service, will continue to remain under review, not only because of mandates, but because of sustained high error rates. When responding to an ADR request, therapy providers should carefully review the request and index their response to each requested item.

1. HHS OIG Work Plan archive available at http://1.usa.gov/1g9X7oi
2. Medicare A-B CERT Task Force: "Task Force Scenario: Documenting Therapy and Rehabilitation Services for Outpatient Therapy Services" Comments on therapy available at http://bit.ly/2sUMJgr
3. Medicare Benefits Policy Manual, IOM 100-02; Ch. 15, §§220-230.
4. CMS: Therapy cap: Manual Medical Review of Therapy Claims Above the $3,700 Threshold. February 9, 2016. Available at http://go.cms.gov/2sKnP4l
5. CMS: SMRC Additional Document Request letter. Available at http://bit.ly/2uaZvqy
6. Cahaba: Task Force Scenario: Documenting Therapy and Rehabilitation Services. March 2014. Available at http://bit.ly/2sfPR4l