Regulatory Updates for Outpatient Rehab
+ Documentation Audit - Next Steps

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Objectives

• Discuss changes in regulation for outpatient therapy delivery
• Future payment reform proposals
• Summarize key documentation audit focus areas
• Review of documentation audit tools / tips for successful use
March 2014 Regulatory Update

In the absence of any legislation by March 31, 2014, all rules come to an end meaning:

• Therapy cap will not apply to ANY hospital outpatient therapy departments (all other providers will be held to the cap $’s)
• The scheduled 20.1% cut in CPT rates will be implemented
• There will be no extension of the therapy cap (New Cap Amount: $1920.00 for OT, $1920.00 for PT/ST combined) that requires KX modifiers be added to all claims exceeding the cap amount detailed above to indicate the medical necessity of the services being provided. This will mean the cap is a hard cap.
• There will be no requirement of the Manual Medical Review process that states Medicare must perform medical review of all claims that meet/exceed the threshold amount of $3700.00 for OT, $3700.00 for PT/ST combined in a calendar year.

**all claims > $3700.00 threshold currently in cue this year waiting for RAC reassignments will not be reviewed**

April 2014 Regulatory Updates

• Doc Fix (Sustained Growth Rate) Bill was passed by Congress on 3/31/14. The bill, Protecting Access to Medicare Act of 2014 states:
  ➢ Physician Fee Schedule cut of 24% is delayed till March 31, 2015 (replace it with a 0.5% conversion factor through December 31, 2014 and a 0.0% update from January 1, 2015 through March 31, 2015)
  ➢ Therapy Cap Exceptions Process (KX modifier) would be extended through March 31, 2015 (including manual medical review)
  ➢ Caps and exception process includes hospital outpatient departments through March 31, 2015.
  ➢ ICD-10 delayed till October 1, 2015
  ➢ Delayed enforcement of the “two-midnight” rule for hospital inpatients by RACs until March 31, 2015.
  ➢ CMS will not need to hold claims effective with dates of service April 1, 2014
What's Up with the RACs???

- CMS has "paused" additional documentation requests from Medicare recovery audit contractors as the agency procures the next round of RAC contracts.
- The pause in operations will allow auditors to complete all outstanding claims reviews and other processes before the current contracts expire, as well as allowing CMS to refine and improve the RAC program.
  - Feb. 21 will be the last day RACs can send a post-payment additional documentation request.
  - Feb. 28 will be the last day Medicare administrative contractors can send additional documentation requests for the Recovery Auditor Prepayment Review Demonstration.
  - June 1 is the last day RACs can send improper payment files to the MACs for adjustment.

CMS has not yet specified when regular operations will resume.

RAC Improvements for the Future

CMS will make 5 adjustments to the RAC program in response to industry feedback which will take place with new contract awards:

1) RACs will have to wait 30 days to allow for discussion before sending claims to MACs for adjustment. Providers will no longer have to choose between initiating a discussion and an appeal (Discussion periods were not allowed for pre-payment manual medical review demonstration states).
2) RACs will have to confirm receipt of a discussion request within three days.
3) RACs must wait until the second level of appeal is exhausted before collecting their contingency fee. (fees were collected after recovering improper payments even if the provider decided to appeal)
4) CMS is establishing revised additional documentation request limits diversified across different claim types (for example, inpatient and outpatient). Previously these were based on the entire facility.
5) CMS will require auditors to adjust the ADR limits based on providers' denial rates so that those with low rates will have correspondingly low request limits to reward compliance with Medicare rules.
Other Regulatory Odds and Ends

- G-code claim rejection issues
- Translation services focus (surveyors, lawyers)
  - Therapists
  - Students
  - Over the phone translator (family, friend, paid entity)
  - Smart phone apps (Google translates)
- RAC reviews – all 2014 claims > $3700 PT/ST or OT will be subject to review

Audience Poll #1

How many of you have seen claims rejected for functional limitation coding errors (check all that apply)

A. No activity/rejections in past 3 months
B. A few rejections of claims that WERE inaccurately completed
C. Several rejected claims –all WERE inaccurately completed
D. Few rejected claims for errors that did not exist
E. Several rejected claims for errors that did not exist
Physical Therapy Classification and Payment System (PTCPS)

- would consist of 3 evaluation codes and 9 examination and intervention codes for a total of 12 codes. (A therapist could conduct an evaluation and an examination and intervention service in the same day)
- Affects practitioners who utilize the 97000 code series (PT/OT/ATC)
- Pilot studies to be implemented end of 2014 into 2015

Eval Codes:
1. Problem Focused – Limited Complexity
2. Detailed – Moderate Complexity
3. Comprehensive – Significant Complexity

Refer to “Criteria to Determine Severity” handout

Payment Reform Continued

Examination and Intervention Codes:
4. Limited Patient Severity – Limited Therapy Intervention
5. Moderate Patient Severity – Limited Therapy Intervention
6. High Patient Severity- Limited Therapy Intervention
7. Limited patient Severity-Moderate Therapy Intervention
8. Moderate Patient Severity – Moderate Therapy Intervention
9. High Patient Severity – Moderate Therapy Intervention
10. Limited Patient Severity – Significant Therapy Intervention
11. Moderate Patient Severity – Significant Therapy Intervention
12. High Patient Severity – Significant Therapy Intervention
Payment Reform Continued

The following codes would be reported separately from the evaluation and intervention coding system:

• **Active Wound Care Management (97597 - 97606):**
  Rationale: Multiple other qualified health care professionals perform these interventions and report these codes, often delivered outside a physical therapist plan of care.

• **Physical Performance, Test and Measurement (97750):**
  Rationale: This code reflects intermittent testing throughout an episode of care and could be reported outside of an episode of care as well, in order to determine specific impairments or functional deficits to inform a potential need for an individual to be evaluated and treated. This service could require multiple hours (eg, FCE).

• **Assistive Technology Assessment (97755):**
  Rationale: This service typically requires multiple hours, is accessed by other qualified health care professionals and is poorly described by "more than 45 minutes."
  • All other codes outside 97000 series (physical medicine and rehabilitation codes) would be reported separately.

DOCUMENTATION AUDIT
NEXT STEPS
Through the Eyes of the Medical Reviewer – Initial Eval

- Reason for Eval
- Other medical conditions
- Residence and Responsibilities
- DC Plan
- Functional Status (CLOF / PLOF)
- Underlying Impairments
- LTG’s
- STG’s
- Interventions
- Frequency / Intensity / Duration
- Rehab Prognosis / Prognostic Indicators

Refer to “Through the Eyes of a Medical Reviewer” handout

Through the Eyes of a Medical Reviewer – Progress Report

- Patient status (functional deficits and underlying impairments)
- Patient’s response to treatment
- Progress or lack of progress
- Skilled intervention documentation for EVERY CPT billed
- Impact on daily life / burden of care
- Justification for continued therapy
  - Remaining impairments needing focus / risk that still exists
  - Focus of upcoming tx sessions
  - Why are continued interventions still necessary?
- Rehab prognosis – changed?
Documentation Audits – Why Take the Time?

Protection

➢ Of the program
  • Accuracy of coding, billing and documentation ensures accurate payment; prevents focused medical review/overpayments

➢ Of the patient
  • Accurate and high quality documentation promotes pt safety and quality of care

➢ Of you, the provider
  • Accurate coding, billing and documentation will ensure you avoid liability; stay away from fraud and abuse issues

MINIMIZE RISK / MAXIMIZE PAYMENT

ReDoc Initial Evaluation Chart Audit Form - Page 1
### ReDoc Initial Evaluation Chart Audit Form-page 2

**Physical Findings:**
- Cause(s) of the functional deficits listed, measurable, standardized tests used as appropriate: **YES** ✗ **NO** ☐
- Related to the intervention: **YES** ✗ **NO** ☐
- Impairment goals (ISO 10002):
  - Includes underlying impairments and related functional deficit; is measurable: **YES** ✗ **NO** ☐
  - Do all components of each ISO 10002 have a corresponding baseline objective measure under the functional deficit and/or the underlying impairments section? **YES** ✗ **NO** ☐
- Comments: ________________________________

**Functional Measures:**
- Current level of function listed for each functional area addressed in “prior functional status” section and long term goals: **YES** ✗ **NO** ☐
- Is there a clear difference between IFAC and CGOF; or, if not, is sufficient rationale given for why therapy needs to evaluate? **YES** ✗ **NO** ☐
- Functional Goals (ISO 10002):
  - Does the ISO present objective functional criteria and make sense for DC environment? **YES** ✗ **NO** ☐
  - Is clinical justification for treatment evident; if further therapy is recommended? (functional characteristics and analysis) **YES** ✗ **NO** ☐
- Comments: ________________________________

**Functional Limitation Reporting:**
- Category chosen is related to LTO: **YES** ✗ **NO** ☐
- Modifier is supported by tests/measures: **YES** ✗ **NO** ☐
- Clinical reasoning for choice of modifier is provided in documentation: **YES** ✗ **NO** ☐
- Comments: ________________________________

### ReDoc Reeval / Progress Report Chart Audit Form

#### General Information
- Patient Name: ________________________________
- Time of Day: ________________________________
- Discipline: PT ☐ OT ☐ SLP ☐
- Reviewer: ________________________________
- Therapist: ________________________________

**Physical Findings:**
- Updated status of all underlying impairments listed as objective, measurable terms: **YES** ✗ **NO** ☐
- All new underlying impairments have measurable baselines: **YES** ✗ **NO** ☐
- Impairment goals (ISO 10002):
  - Are all ISOs related to interventions provided? **YES** ✗ **NO** ☐
  - Demonstration of progression and focus of treatment evidenced by updating/upgrading ISOs? **YES** ✗ **NO** ☐
- Comments: ________________________________

**Functional Measures:**
- Functional gains are readily apparent when comparing CGOF to IFAC; or, if not, explanation as to why the lack of progress and modifications being made to address: **YES** ✗ **NO** ☐
- Rationale for construct measurements clearly documented including remaining impairments and functional deficits to be addressed? **YES** ✗ **NO** ☐
- Functional improvement: description of gains, adjustments, progressions, and/or special techniques, and justification all CGOF codes applied? **YES** ✗ **NO** ☐
- Functional level (ISO): Changed from eval, recert completed, and explanation why changed: **YES** ✗ **NO** ☐
- Comments: ________________________________

**Functional Limitation Reporting:**
- Functional limitation coding performed per required intervals: **YES** ✗ **NO** ☐
- Modifier chosen match underlying impairment functional deficit’s objective data: **YES** ✗ **NO** ☐
- Clinical reasoning for choice of modifier is provided in documentation: **YES** ✗ **NO** ☐
- Comments: ________________________________

**Interventions / Frequency/Intensity/Duration:**
- Are all treatment approaches (ISO) supported by SIAs or LGTs? **YES** ✗ **NO** ☐
- If frequency/intensity/duration changed, documentation of reason for change is clear: **YES** ✗ **NO** ☐
- Comments: ________________________________
## Chart Audit Tips

- New Hires (within first three months)
- Each therapist reviewed quarterly at a minimum thereafter
- Ongoing Process Improvement (if areas of opportunity identified)
- To ensure behavior change has occurred following education
- To address trends noted in denials
- Peer Review
- Train / Review / Delegate
Creative Rehab Strategies

CRS ensures that rehab providers maximize reimbursement and are protected from financial and legal liabilities. Working with facility staff, we provide risk assessment to identify risk (industry risk, Medicare or other third party reimbursement risks, practice risk) and prioritize for establishing plans of corrections and ongoing monitoring.

- Internal monitoring and auditing
- Training and education
- Medical record audits
- Monitoring of OIG, ZPIC, RAC, CERT, MAC, NCD/LCD activity
- Denials management
- Documentation quality education and training resources

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