

Tips for Effective Auditing/Monitoring of Medicare Documentation for OT, PT and Speech 4/24/2013



"The wonderful thing about standards is that there are so many of them to choose from."

Grace Murray Hopper

- This presentation will include:
 - Introduction: Ambulatory Rehabilitation Documentation Requirements Within Medicare Context
 - 3 Key Medicare Coverage Requirements
 - Monitoring/Auditing Process
 - Functional Reporting

Introduction: Rehabilitation Within the Medicare Context

Covered and payable therapy services under Medicare: Services that improve and restore functions which have been impaired, lost, or reduced by illness or injury... to improve the individual's ability to perform tasks required for independent functioning.

3 Key Medicare Coverage Requirements

- Patient is Under Care of MD or Non-Physician Practitioner (NPP)
- The Right People Provide the Services
- Documentation Supports Medical Necessity and Functional Goals

- MD or NPP (DO, DPM, NP, PA) with knowledge of the patient's overall health oversees the therapy provided;
- Key evidence: MD or NPP certifies or recertifies
 Plan of Care (POC)
 - Other evidence:
 - Order or referral
 - Patient conference documentation
 - Team meeting notes
 - Documentation that MD or NPP is following patient for the referred condition

- Medicare only pays for medically necessary services delivered by staff who:
 - Meet the qualification requirements (i.e., meet state licensure requirements);
 - Work within their scope of practice (SOP)
 - Work under the correct level of supervision

- Varies from state to state
- Legally authorized parameters of the clinical function of assessment, intervention and level of care a healthcare provider can provide to a patient
- Example- Plan of Care may be performed only by a PT

- Introduction: Rehabilitation Services Within Medicare Context
- 3 Key Medicare Coverage Requirements:
 - Patient is under care of MD or NPP
 - Right people provide right services (qualified; work within SOP; correct level of supervision)
 - SLPA services not covered by Medicare
 - Documentation supports medical necessity and functional goals

General Rule: Medicare allows coverage and payment for only those services that are "reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of the malformed member." (Title XVII of SSA §1862(a)(1)(A).)

Condition #1:

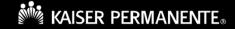
- "Plan of care must address a condition for which skilled therapy is an accepted method of treatment under accepted standards of medical practice." (MBPM Pub. 100-02 Ch. 15 §220.2A-B.)
 - "Accepted standards of medical practice"based on Medicare Manuals, Local Coverage Determinations (LCD), professional guidelines and literature.

Condition #2:

"Need for therapy determined not by diagnosis or rehabilitation potential alone, but by whether such services can only be provided by a *skilled therapist* as opposed to non-skilled personnel." (*Id*.)

Factors:

- Date of onset
- PMH & PSH (comorbidities)
- Prior vs. current level of function
- Functional impairments



Condition #3:

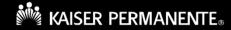
• Must have an "expectation that the patient's condition is *rehabilitative* (will improve significantly in a reasonable and generally predictable period of time), OR that the services are necessary to establish a safe and effective *maintenance* program." (*Id*.)

Condition #4:

- "The amount, frequency, and duration of services must be reasonable under accepted standards of practice." (Id.)
 - "Accepted standards of practice": MAC will consult local professionals, state and national therapy associations in developing utilization guidelines.

Condition #5:

- "Services shall be of a level of complexity and sophistication OR the condition of the patient shall be such that the services required can be safely and effectively performed only by or under the supervision of a skilled therapist." (Id.)
- "Skilled": Documents critical thinking and clinical decision-making process;
 - e.g., why intervention chosen; pre- and postintervention status; ongoing reassessment; how and why care was progressed or modified.
- "Non-skilled": Documents repetitive interventions; exercise for general health and wellness.



- Order/referral
- Evaluation
- Plan of Care (POC)
- Certification of POC
- Progress Reports
- Re-certification of POC
- Discharge Summary



Evaluation

Plan of Care (POC)

Certification of POC

Progress Reports Recertification of POC

Discharge Summary



- Diagnosis, not an order is required for PT/OT/SLP evaluation
- If verbal order → must be authenticated within 48 hours for services provided within licensed hospital space (i.e., inpatient OR hospital outpatient SLP services)



- Medical diagnosis
- Treating impairment/dysfunction
- Subjective
- Objective (e.g., identified impairments; severity or complexity of patient)
- Assessment (includes rehab potential)
- Plan (related to POC)



Minimum POC requirements under Medicare (MBPB Pub. 100-02 Ch. 15 § 220.1.2B.)

- Medical diagnosis
- Long-term functional goals
- Type of services/interventions
- Amount of services/interventions: # of times per day treatment provided (if not specified, one treatment session per day assumed)
- Frequency: # of times per week; no ranges
- Duration: # of weeks; no ranges



Minimum POC requirements under Medicare (MBPB Pub. 100-02 Ch. 15 § 220.1.2B.)

- If multiple POCs (e.g., OT, PT, Speech) →
 - Must have different POC for each discipline;
 - Each discipline must independently establish treating impairment/dysfunction and goals.



- Referring provider
- Referring medical diagnosis
- Treating impairment/dysfunction
- Long-term goals
- Rehab potential
- Type of interventions
- Frequency
- Duration
- Recertification due date



- The MD or NPP's approval of the POC; requires a dated signature on the POC or some other document that indicates approval of the POC. (MBPM Pub. 100-02 Ch. 15 § 220A.)
- Therapist must establish POC, route to MD/NPP, and have MD/NPP certify POC within 30 calendar days. (MBPM Pub. 100-02 Ch. 15 § 220.1.3B.)



- Progress report must be done every 10th visits
- There must be "active participation in treatment" by the therapist during the progress report period. (MBPM Pub. 100-02 Ch. 15 § 220.3D.)
- If therapist writes progress report earlier than required, then the next progress report period starts the next treatment visit. (*Id*.)
- NOTE: SCAL standardized documentation format: mandatory progress report with each visit.



Treatment Note Elements

(MBPM Pub. 100-02 Ch. 15 § 220.3E)

- 1. Date of treatment
- 2. Interventions/modalities
- 3. Total timed code treatment minutes
- 4. Total treatment time minutes
- 5. Signature & Title of provider

Progress Report Elements

(MBPM Pub. 100-02 Ch. 15 § 220.3D)

- Progress report interval
- 2. Date of report
- 3. Signature & Title of report writer
- 4. S: Pt's subjective report
- o. O: Objective measurements or description of changes in status relative to each goal, if they occur
- A: Assessment of improvement, extent of progress towards goals
- P: Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions (type, frequency, duration)
- 8. Changes to goals, updated POC sent for re-cert., or DC.

Order/ Referral

Evaluation

Plan of Care (POC)

Certification of POC

Progress Reports Recertification of POC

Discharge Summary



- Not a routine, recurring service, but focused on:
 - Evaluation of progress toward current goals;
 - Making a professional judgment about continued care;
 - Modifying goals and/or treatment; or
 - Terminating services.
- Indicated if:
 - New clinical findings
 - Significant change in the patient's condition; or
 - Failure to respond to current treatments. (MBPM Pub. 100-02 Ch. 15 § 220.3C.)



- As with initial certification, re-certification is a professional approval of the current POC and need for continued care. (MBPM Pub. 100-02 Ch. 15 § 220A.)
- After initial certification, recertification must occur at least every 90 days. (MBPM Pub. 100-02 Ch. 15 §220.1.3D.)
- POC must be re-certified if:
 - POC is significantly changed; OR
 - Treatment continues beyond initial certification period (max. 90 days). (*Id.*)
- Same physician/NPP not required to re-certify POC. (MBPM Pub. 100-02 Ch. 15 §220.1.3C.)



- Considered the final Progress Report;
- Covers the period from last Progress Report to date of discharge;
- Considered the last opportunity to justify the medical necessity of the entire treatment episode.
 (MBPM Pub. 100-02 Ch. 15 § 220.3D.)



- Patient is Under Care of MD or Non-Physician Practitioner (NPP)
- The Right People Provide the Services (qualified; work within SOP; correct level of supervision)
 - Note: SLPA services not covered or reimbursable by Medicare
- Documentation Supports Medical Necessity and Functional Goals

Minimum POC requirements:

- Referring medical diagnosis
- Long-term (LT) goals
- Type, amount, frequency, & duration of services.
 (MBPM Pub. 100-02 Ch. 15 § 220.1.2B.)

- "Goals should be measurable and pertain to identified functional impairments." (Id.)
 - "Functional impairments" based on:
 - Prior vs. current level of function
 - Objective findings

- Goal-Writing Framework: "In W, Mr. X will improve Y in order to perform Z."
 - W = measurable time frame (weeks)
 - X = patient-specific
 - Y = objective measurement related to impairment
 - Z = Functional activity (ADL-related, not recreational)

- Change in LT goals due to "significant change in patient's condition":
 - Considered a "significant" alteration of POC requiring re-certification;
 - "Insignificant" alterations of POC do not require recertification (e.g., modification of short-term goals to adjust for improvement made towards long-term goals; change in frequency or duration due to patient illness). (MBPM Pub. 100-02 Ch. 15 § 220.1.2C.)

- Only LT goals required in POC, but clinicians may include ST goals "in accordance with good practice";
- Progress Reports may be used to add, change or delete ST goals;
- Recommended to number LT goals (1, 2, 3);
 number and letter ST goals (1.A, 1.B, etc.).
 (MBPM Pub. 100-02 Ch. 15 §§ 220.1.2B, 220.3D.)

- Introduction: Speech-Language Pathology Within Medicare Context
- 3 Key Medicare Coverage Requirements:
 - Patient is Under Care of MD or Non-Physician Practitioner (NPP)
 - The Right People Provide the Services (qualified; work within SOP; correct level of supervision)
 - Documentation Supports Medical Necessity and Functional Goals

Monitoring/ Auditing

Compliance Monitoring and Auditing

- Sample
 - Representative of staff members and types of patients
 - Monthly
- Medicare Coverage Requirements and State Scope of Practice regulations

	Physical Therapy Outpatient Compliance Monitoring	Site A	Site B	Site C	Site D	SiteE	Site F	
	%	JAN	JAN	JAN	JAN	JAN	JAN	
1	Prescribed care is 'reasonable & necessary' as documented in the MR:							
	Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch.15 220.2A							
a	c) Ongoing PT treatment meet medical necessity guidelines	*	94	100	100	100	100	
	Plan of Care:							
2	Plan of care established timely: 42 CFR Ch IV 410.61(b)	*	100	100	100	100	100	
3	Diagnosis							
b	b) Treating impairment or dysfunction	*	94	100	100	100	100	
3	Functional ADL Goals (Medicare only)	*	96	100	100	100	100	
	Initial Certification (Medicare Only)							
4	Evidence Plan of Care sent to qualified treating Provider for Certification: 42 CFR	*	100	100	100	100	100	
	Ch IV. 410.61.(e)			.00	100			
5	Plan of Care is certified by the provider, (requires authentication) 42 CFR Ch IV.	*	100	100	100	100	100	
	410.61.(e)							
	Recertification							
6	Duration of Treatment not greater than 90 days or prior to the end of the	*	100	na	na	100	100	
_	treatment plan							
7	Evidence POC sent to qualified treating provider for recertification,	*	100	na	na	100	100	
8	Recertification verified: authenticated by the provider: 42 CFR part 482.56. (b)	*	100	na	na	100	100	
	Progress Report							
	The minimum PT progress report period is every 10 treatment sessions.		100	100	100	100	100	
	Medicare Benefits Policy Manual 220.3. (D)		100	100	100	100	100	
	Discharge Summary:							
11	Discharge Summary present	*	100	100	100	100	100	

Legend
Scope of Practice Element
Payor Coverage Requirement Element
Below Target 95%-100%
* Quarterly Monitoring

CMS Functional Reporting

- Middle Class Tax Relief Act of 2012 mandated CMS to collect information on beneficiary's claim form regarding:
 - Function and condition
 - Therapy services provided
 - Outcomes achieved on patient function

- Applies to all outpatient PT, OT, and SLP services furnished in:
 - Hospitals
 - CAHs
 - SNFs
 - CORFs
 - Rehabilitation agencies
 - Home health agencies
 - Private offices of therapists, physicians, and NPPs



- Outpatient therapy providers must submit non-billable:
 - Functional limitation codes (G-codes)
 - Severity modifier codes (C-codes)

Example of Charge Form for Initial Evaluation Visit

	. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 342 92 3,								+	22. MEDICAID RESUBMISSION ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER											
2. L 24. A	Fro	m	(S) 0	F SER	VICE To DD	YY	B. PLACE OF SERVICE	C. EMG	4. L D. PROCEDUR (Explain Ur CPT/HCPCS			ımstano		0	E. DIAGNOSIS POINTER	F. S CHAF		G. DAY: OR UNIT	Famil	IL ID. OUAL	J. RENDERING PROVIDER ID. #
01	10	1	3	01	10	13	11		97001		GP				1		83 0	0 1		NPI	987654321
01	10	1	3	01	10	13	11		97110	(GP				1		34 0	0 1		NPI	987654321
01	10	1	3	01	10	13	11		G8978	L	GP	CL					0 0	0		NPI	987654321
01	10	1	3	01	10	13	11		G8979	1	GP	CI					0 0	0	I	NPI	987654321
01	10	1	3	01	10	13	11		G8427								0 0	0		NPI	987654321
01	10) 1	3	01	10	13	11		3288F	L							0 0	0	Ţ	NPI	987654321

- Functional limitation G-codes with severity modifier Ccodes based on ICF
 - "Functional limitation": combines ICF "activity limitation" and "participation restriction" categories

- To determine severity of functional limitation, therapist must use a *valid and reliable* functional outcome tool (e.g., FCMs), objective test, or objective measure
 - May use multiple tools, tests, or measures to determine severity
 - Therapist judgment combined with objective data gathered may be used to determine severity modifier

- Therapist *must document* G-codes and the rationale for selection of severity modifier C-codes in the *medical* record
 - Document the tool, test, or measure used
 - If more than one tool, test, or measure used to calculate severity, therapist must document how he or she arrived at the final calculation
 - E.g., smart phrase indicating tool, test, or measure used and how functional limitation severity was calculated

CHule	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
СК	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
СМ	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

Outset	At least every 10 th visit	Re-evaluation	Discharge / End reporting	Reporting of subsequent limitation
Current functional status	Current functional status	Current functional status		Current functional status
Projected goal functional status	Projected goal functional status	Projected goal functional status	Projected goal functional status	Projected goal functional status
			Discharge functional status	
				(NOTE: Reporting of a subsequent functional limitation only occurs when the primary functional limitation resolves and patient continues care for treatment of subsequent functional limitation.)

