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PREPARING FOR GOVERNMENT AUDITS: THERAPIES

INTRODUCTION

Most people would agree that the Centers for Medicare and Medicaid Services (CMS) are justified in seeking to ensure that the long-term and acute care services they pay for are appropriate and meet federal standards. After all, ours is a rapidly aging population that is increasingly reliant on the Medicare/Medicaid system. From a purely budgetary standpoint, it makes perfect sense to put checks and balances in place to make sure the dollars are spent where they should be.

In 2010, CMS launched its Medicare Recovery Audit Contractors program (RAC) to help do exactly that—primarily, to review care provider billings to identify and recover overpayments and, to a lesser extent, identify and reimburse for underpayments. CMS reports that, in fiscal year 2014 alone, the program had recouped $2.39 billion.

In the healthcare industry, new focus areas are being identified by the Office of the Inspector General (OIG) and CMS on a regular basis, and these same focus areas can easily become the subject of investigation by the Department of Justice. Among the areas of focus most on the radar of our long-term care clients are atypical antipsychotic medications, hospice services, and physical therapy services. In this three-part series of whitepapers, we'll take a look at each of these issues—examining how they came to be focus areas, what your organization needs to do to be in compliance with CMS standards, and what you can do now to prepare for, or respond to, audits.

THERAPIES GET A CLOSER LOOK

In long term care settings, physical, occupational and speech therapies are a way of life. They aid residents and patients in recovery from conditions such as stroke, rehabilitation from surgeries or joint replacements, maintaining functional status, improving functional status, and sustaining or recovering communication ability, among other uses. Perhaps because they are so common, therapies have garnered the attention of the Office of the Inspector General (OIG) and Centers for Medicare and Medicaid Services (CMS), most recently in regard to Medicare Part A coverage.

Medicare Part A Coverage: Questionable Billing Trends Emerge

Billings from skilled nursing facilities (SNFs) have been a concern of the OIG for some time, in a number of areas. In general, previous studies have shown that more than ¼ of all claims are not supported by the medical record. These unsupported claims equate to roughly $500 million in possible overpayments. More specifically, the Medicare Payment Advisory Committee (MedPAC) has raised particular concerns about billing for therapies under Medicare Part A, which has prompted further study by the OIG. MedPAC specifically raised concerns that some SNFs may be billing inappropriately for therapies in order to receive higher payments from Medicare.

Like other regulatory subjects (for example, billing for hospice services), the issue seems to stem from the way the system is designed. Medicare Part A covers skilled nursing care, rehabilitation services (including physical, occupational and speech therapy), and other services for up to 100 days during any episode of illness. To be eligible for Part A, the beneficiary must require skilled services on a daily basis; those services must be provided in an inpatient setting; and the delivery of the services must require the skills of technical or professional personnel.

If the beneficiary meets those basic criteria, the SNF then classifies the beneficiary into one of 53 groups—called resource utilization groups (RUGs)—based on his or her care/resource needs. RUGs are divided into 8 distinct categories, with 2 categories—Rehabilitation and Rehabilitation Plus Extensive Services—designated for beneficiaries who require physical therapy, speech therapy, and/or occupational therapy. SNFs further classify those who need therapy into one of 5 therapy levels, based on the number of minutes of therapy they require per week. Each of the 5 therapy levels is paid at a per diem rate, with more intensive therapy levels receiving higher payments. The 2011 therapy levels and per diem rates were as follows:

- Low therapy RUG (45 to 149 minutes of therapy per week): $430 per diem
- Medium therapy RUG (150 to 3242 minutes of therapy per week): $488 per diem
- High therapy RUG (325 to 499 minutes per week): $532 per diem
- Very high therapy RUG (500 to 719 minutes per week): $594 per diem
- Ultra high therapy RUG (720 or more minutes per week): $699 per diem

While the system is designed to provide fair payment for different degrees of medically necessary service, it is also possible that it could be misused, either intentionally or unintentionally, and higher payments may be made than are appropriate. This is the assertion of MedPAC, which prompted a formal study by the OIG.

2010: SNF BILLING FOR THERAPY SERVICES

The 2010 OIG research study appears to bear out the concerns expressed by MedPAC. The study looked back at SNF therapy billings from 2006 to 2008, and questionable billing trends began to emerge.

- From 2006 to 2008, billings for ultra high therapy RUGs increased from **17% to 28%**. Over the two years included in the study, payments for high paying RUGs increased by $5 billion. In comparison, other lower paying therapy RUGs saw a decrease of $0.25 billion, and non-therapy RUGs saw decrease of $0.46 billion.
- For-profit SNFs were more likely to bill for high paying RUGs than non-profit or government RUGs: **32%** of RUGs from for-profit SNFs were ultra high therapy, compared to just 18% from non-profit and 13% from government.
- Some SNFs exhibited questionable billing practices in 2008 by using ultra high therapy RUGs much more frequently than other SNFs: For 3/4 of all SNFs, ultra high therapy billings accounted for up to 39% of RUG billings. However, for some SNFs (about 1%), **77%** of RUG billings were for ultra high therapy.

Notably, although increases in the use of ultra high therapy RUGs are evident in the studies, the characteristics of the Medicare beneficiary population has not changed. Over the time period from 2006 to 2008, the average age of beneficiaries decreased from 79.9 to 79.8 years of age, and the top 20 admitting diagnoses were identical and accounted for over 50% of all admissions in both years.

The study shows that billing practices have certainly changed. But, because the admitting diagnoses and demographics of patients have not changed accordingly, the increase in ultra high therapy RUGs likely cannot be attributed to the health of the patient population. Thus, it seems possible that some SNFs may not be billing appropriately for therapy services. As a result of this study, in 2012 SNFs became a focus of increased monitoring by CMS, and SNF billing for therapies under Medicare Part A remains a priority item on OIG's 2014 work plan.

BECOME PROACTIVE WITH YOUR DOCUMENTATION

To be in compliance, your clinical documentation must meet strict criteria, every time. It's true that auditors are looking at cases from at least 3 years past, and there is no realistic way to go back in time to ensure that proper documentation happened. So, the best option is to take a proactive approach: get a handle on what you're doing (or not doing) now, and make sure it's right going forward. The earlier you can get your own practices into alignment with compliance criteria, the better off you'll be in the long run.

Start with an objective assessment of a sample of your records that provides a look at how well you're doing overall with CMS requirements. Are initial screens and evaluations present and fully completed? Are care plans consistently recorded? Are progress notes entered on time and do they support the case for continued therapy?

If it sounds like a monumental task to assess a sample of your records, it doesn't have to be. Excelas has solutions available to help you take an honest and objective assessment of what you're doing. We dedicate time and human resources to complete an analysis of your documentation practices, so your staff can remain focused on more immediate tasks. In the event that you are audited, we can also help you prepare records for release or help you respond to audit findings.

EXCELAS SOLUTIONS: PROACTIVE DOCUMENTATION REVIEWS

Like any compliance issue, auditors are looking for specific information in the medical record to assess eligibility of therapy claims. In this case, auditors expect to see a full and detailed picture of the resident's therapy experience. A lack of pertinent detail, or missing types of documentation, could be the difference between receiving payment or being denied (or worse, being accused of fraud or abuse). More than ever, your clinical documentation plays a crucial role in the auditor's decision making.

When assessing the appropriateness of therapies, auditors are generally assessing whether:

- The patient can reasonably be expected to improve (i.e., achieve the highest practical level of function) or return to his or her prior level of function in a reasonable amount of time,
- The therapy is necessary to safely and effectively establish a maintenance program
- Therapies are consistent with accepted standards and specific to the condition of the patient
- The intensity, frequency and duration of therapy are appropriate for the specific patient, given his or her current status
- Therapy services are at a level of complexity that they can only be safely and effectively conducted by a licensed therapist or therapy assistant

Review of CMS-required Documentation

Excelas will review a sample of your records and provide a summary report describing whether the records contain all the specific documentation types and information required by CMS. Reviews can be customized to examine almost any criteria you specify, but a good starting point includes some or all of the following:

- *Initial Therapy Screen / Evaluation:*
  - **Reason for Referral:** Does the therapy evaluation focus on a specific problem or identified issue such as a recent fall, change in status, or decline in function? Is the issue specific and does it clarify what, exactly, therapy should address.
  - **Co-morbidities:** Does the evaluation document any and all co-morbidities that may impact therapy progress?
  - **Prior Level of Function and Current Level of Function:** Is the resident's prior level of function (just before their change in status or decline in function) clearly identified? Is his or her current level of function also clearly identified? Are both levels of function described using objective measurements and specific information in regard to abilities, level of assist, and activity tolerance, for example?
  - **Supporting Documentation:** Is information in the evaluation supported by nursing notes (e.g., notes on change in status or function)?

- *Plan of Care*
  - **Relevant Diagnoses:** Are the diagnosis/diagnoses for which therapy services are required as treatment included?
  - **Long-term Therapy Goals:** Are therapy goals objective, specific, measurable, time-bound, patient-centered and functional? Do goals specify the level of function to be achieved and a time-bound target for achieving the level of function?
  - **Therapy Type(s):** Are the types of therapy required by the resident indicated (i.e. PT, OT, ST, or a combination)?
  - **Amount of Therapy:** Does the plan indicate how many times per day the resident will require therapy?
  - **Frequency of Therapy:** Does the plan indicate the number of sessions to be completed per week?
  - **Duration:** Does the plan indicate the number of weeks that will be needed to achieve therapy goals?
  - **Procedures/Modalities:** Does the plan describe all procedures/modalities to be performed, e.g., gait training, therapeutic exercise, ADL training, etc.?

- *Daily Progress Notes / Treatment Notes:*
  For each therapy session, is the following information documented by the therapist?:
  - Treatment Date
  - Every Procedure/Modality Performed
  - Total Treatment Time in Minutes
  - Signature and Credentials of Therapist

- *Weekly Progress Notes*
  - **Medical Necessity:** Is justification for ongoing treatment provided?
  - **Skills of a Therapist:** Is the complexity of treatment and service provided described, and does it indicate the ongoing need for a licensed therapist?
  - **Progress:** Is significant progress, or barriers to progress, outlined?

- *Nursing Notes*
  Has nursing documented the following as a complement to the therapy notes?:
  - **Therapy Attendance:** Has it been noted when the resident attends therapy sessions? If a session is missed, is the reason why documented?
  - **Pain:** Did nursing document any pain or discomfort that manifests following therapy sessions?
  - **Compliance:** Did nursing indicate any refusals or other non-compliance regarding therapy sessions?
  - **Safety Factors:** Did nursing document any safety issues that result from or impact therapy?
  - **Self-care:** Did nursing document all self-care by the resident both in and out of his or her room? Similarly, did nursing document any problems the resident is having in performing self-care?

- *Updated Treatment Plan / Recertifications*
  - **Progress:** Is demonstrated progress outlined since treatment began?
  - **Functional Status:** Is the impact of therapy on the resident's functional status described?
  - **Goals:** Are the reasons why therapy should be continued outlined? For example, which long term goals have yet to be achieved?

- *Discharge Summary*
  - **Criteria to Discontinue Treatment:** For what reasons has treatment has been suspended, and what criteria were met?
  - **Current Functional Status:** What is the resident's current functional status? Is it described using objective measurements and specific information in regard to abilities, level of assist, activity tolerance, etc.?
  - **Goals Achieved:** Does the discharge summary outline all goals and milestones achieved?
  - **Unmet Goals:** Does the summary provide reasons for any goals not achieved?
  - **Continuing Care:** Does the summary describe plans for the resident's ongoing care?
  - **Referrals:** Does it list all referrals for additional services?
  - **Equipment:** Does it list any equipment provided or ordered?

We'll provide insight into where your documentation is sufficient and where it is not meeting CMS requirements. Summary reports can be provided for individual facilities, across all facilities, or both. Like all of our work products, an internal audit for therapies can be customized to suit your needs—get the information you need in the way that works

best for you. With actionable information at your fingertips, you'll be on the path to compliance in no time.

EXCELAS SOLUTIONS: RECORD RELEASE SERVICES

In the event that you are audited and faced with preparing dozens of records for release, your first instinct may be to gather and send them as quickly as possible. While it's true that deadlines are tight, releasing disorganized, incomplete or inaccurate medical records can shed a negative light on the facility and disrupt the efficient evaluation of records by auditors.

Save your team the stress of preparing records by using Excelas' record release services. We can organize the medical record, assess its completeness, notify you of any missing record types or gaps in documentation, and ensure all pages of the record belong to the correct person—we can even extract records from your EMR system. Within a matter of days, you can be sure that the records you release are orderly, complete and free of any "wrong patient" records.

Electronic Record Retrieval

Our medical record professionals will work remotely to extract all available portions of the record directly from your EMR system, as well as any supplemental systems you may use. We will efficiently locate and compile all the documentation needed to produce a complete medical record, saving you valuable time and resources. If your organization uses paper records in addition to your EMR, we can identify the portions of the record absent from the EMR system that are needed to compile the full record, and we can coordinate and track their retrieval.

Record Organization

Nothing can be more damaging to an audit than releasing incomplete records. Excelas' Record Organization service provides a responsive, incredibly fast overview of the medical record to ensure all key documentation types have been included. You will be alerted to any critical missing records before the chart leaves your facility. We will also organize your records so that they are chronological, indexed and easy to review—for the auditor, and for you.

Ensuring a Clean Record

Besides ensuring that you're releasing a complete record, our team can also ensure that the record is clean, free of any "wrong patient" records (e.g., records belonging to another patient/resident). You know the implications of releasing an incomplete record. But think about the additional implications of releasing records with another patient's information. Not only might that information contradict what is in your claims, but more importantly, it may raise HIPAA compliance and quality concerns.

Wrong-patient information is a common problem in records we see. Among our claims and litigation projects, 34% of records we receive for review include at least one page of "stranger" records. But when it comes to regulatory projects—the kind of projects that put a "rush to respond" burden on providers—the percentage of records released

with wrong-patient information increases to nearly 43%, on average. The more records that need to be released, the higher the incidence of error becomes.

EXCELAS SOLUTIONS: RESPONDING TO ADVERSE DECISIONS

Sometimes, no matter how complete your records are, you might still receive an adverse decision or face regulatory allegations. If the best defense strategy requires an expert review, Excelas can help you keep costs under control and minimize the time expert reviews can take. Our medical analysts perform high-level data abstraction on the documents in question, providing your experts with an organized electronic record and data points already extracted for their review. Each data point is hyperlinked to the page of the record where the pertinent information was found. Your experts can spend their time efficiently assessing the medical situation and developing their opinion, instead of sorting through extraneous information and shuffling through hundreds or thousands of pages of records.

If your team needs to understand the particulars of each patient's situation to form a response to a regulatory action, Excelas can review the records in question, pull out critical information for each patient/resident and provide unbiased summary reports outlining the medical decisions that were made.

CONCLUSION

A few things seem certain. First, compliance audits are here to stay. They will come, and so will the incumbent stress of answering them. Second, appropriate medical decision-making and the proper documentation thereof is what will decide the outcome of your audit.

Assess your procedures now, whether or not you've been audited on this issue. Engage appropriate, dedicated and knowledgeable consultants and partners who can help you identify what you're doing right and where you need improvement. If you're appealing adverse decisions or answering allegations, the same holds true: work with an independent partner who can help you draw out the information that will succesfully support your claims.

Take the information your consultants provide and use it to your overall advantage, facility-wide. Educate nurses, physicians, case managers, medical record personnel and billers on what they're doing well and where they need to improve. Then, inspire your teams to follow through on it—every resident, every time.

When you need objective assistance to conduct an internal audit, prepare records for release, or respond to adverse decisions, we're just a phone call away. We've helped a growing list of clients manage their regulatory challenges. We can help you, too. *A quick, no-obligation conversation will show you the valuable difference we can make for your organization. Contact us today!*

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