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WHITE PAPER

Preparing For Government Audits: Therapies

INTRODUCTION

There is little argument that the Centers for Medicare & Medicaid Services (CMS) are justified in seeking to ensure that the long-term and post-acute care services they pay for are appropriate and meet federal standards. And 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.

Between the Medicare Recovery Audit Contractors (RAC) program and the Office of Inspector General (OIG), the use of physical, occupational, and speech therapies are under constant scrutiny when it comes to over-billings, overpayments and, to a lesser extent, even underpayments.

In this white paper, we will take a look at therapies within the context of what providers need to do to be in compliance with CMS standards and what they can do now to prepare for potential audits.

THERAPIES GET A CLOSER LOOK

In long-term and post-acute care settings, physical, occupational, and speech therapies are a way of life. They aid residents and patients in recovering 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 OIG and 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 OIG for some time in a number of areas. In general, previous studies have shown that more than one-quarter 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.

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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 eight distinct categories, with two 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 five therapy levels, based on the number of minutes of therapy they require per week. Each of the five 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 324 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 services, 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 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, as follows:

- 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 a 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 three-fourths 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 have not changed. Between 2006 and 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 for the OIG. In September of 2015, the OIG released a report, "The Medicare Payment for Skilled Nursing Facilities Needs to be Reevaluated." The report noted the discrepancy between SNFs' costs for therapy and Medicare payments, combined with the payment method currently in place created an incentive for SNFs to bill for higher than necessary therapy. As a result of the evaluation, the OIG recommended a change in the method of paying for therapy that relies on characteristics of the beneficiary and care needs. The CMS is proposing replacement of the SNF PPS' existing case-mix classification model, the Resource Utilization Groups, Version 4 (RUG-IV) with a new model, the Resident Classification System, Version I (RCS-I).

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DOCUMENT, DOCUMENT, DOCUMENT

The importance of appropriate documentation when it comes to therapies is probably repetitive for most of your clinicians but it's worth mentioning here. Develop a set of protocols around documentation now to ensure compliance with CMS requirements.

In addition, since auditors generally look back at least three years, that's another reason to adopt strict requirements around proper documentation. Some things to consider with regard to a documentation strategy: Ensure the completion of initial screenings and evaluations, record care plans consistently, enter progress notes on time, and make sure continued therapy is supported appropriately.

Auditors expect to see a full and detailed picture of a 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).

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; and
- 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

If you hire an outside service to review your documentation, it should be customized to examine almost any criteria you specify, but a good starting point should include some or all of the following items:

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?
- *Comorbidities:* 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 dentified? Is his or her current level of function also clearly identified? Are both levels of function described using objective measurements and specific information with 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 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, are the following items 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 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 informatio 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?

RECORD RELEASES

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.

CONCLUSION

Compliance audits are not going away, which is why it is so important to 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 successfully support your claims.

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When you need objective assistance to conduct an internal audit, prepare records for release, or respond to adverse decisions, Excelas can help.

RESOURCES

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Reilly M. Is your documentation ready for an ADR? Post Acute Consulting webinar.

"Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-Mix Methodology." Proposed Rule by the Centers for Medicare and Medicaid Services.