Session #: R12

PEPPER Report:

A Windfall of Opportunity for Improved Quality Assurance

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Objectives

- *The attendee will be able to describe cases that support or do not support the medically necessary use of Ultra High*
- *The attendee will be able to describe an IDT approach to support RUG selection*

Objectives

- *The attendee will be able to implement a successful audit procedure for review of therapy claims to support their current compliance plan*
- *The attendee will be able to describe recent OIG fraud and abuse investigation findings and will be able to implement procedures to avoid those issues*

Background

Office of Inspector General Report

- "Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More than a Billion Dollars in 2009", November 2012, OEI-02-09-00200
- Identified 25% of SNF claims billed in error
  1.5 billion in inappropriate Medicare payments
- Available at http://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf

Table 1: Percentage of SNF Claims That Were in Error, 2009

Type of Error	Percentage of SNF Claims
Inaccurate RUGs	**22.8%**
Upcoded	20.3%
Downcoded	2.5%
Did Not Meet Coverage Requirements	**2.1%**
Total error rate	**24.9%**

Source: OIG analysis of medical record review results, 2012.

Up-coded claims

- For 57% of the upcoded claims, SNFs reported providing more therapy on the MDS than was indicated in the medical record
- For 25% of the upcoded claims, reviewers determined that the amount of therapy indicated in the beneficiaries' medical records was not reasonable

OIG Examples

- SNF provided the highest level of therapy to the beneficiary even though the medical record indicated that the physician refused to sign the order for therapy
- SNF provided an excessive amount of therapy to the beneficiary given her condition

OIG Examples

- SNF reported on the MDS that speech therapy was provided even though the record contained an evaluation concluding that no speech therapy was needed and that speech therapy had not been provided.

Table 2: MDS Categories With Misreported Data Percentage of Claims

Category	% Misreported
Therapy	30.3%
Special Care (iv meds, trach care)	16.8%
Activities of Daily Living	6.5%
Oral/Nutritional (parenteral feeding)	4.8
Skin Conditions and Treatments *(e.g., ulcers, wound dressings)*	2.4%

Source: OIG medical record review, 2012.
Note: The rows do not sum to 47% because some claims had more than one problem.

OIG Recommendations

Increase and Expand Reviews of SNF Claims

- CMS should instruct its contractors to conduct more medical reviews of SNF claims.
- Expand the scope of these medical reviews to more closely scrutinize the MDS items that SNFs commonly misreport.

OIG Recommendations

Increase and Expand Reviews of SNF Claims

- Identify SNFs or SNF chains with recurring problems. Target these SNFs in their reviews and possibly refer them for further investigation, depending upon the nature of the issues.

OIG Recommendations

Use Its Fraud Prevention System To Identify SNFs That Are Billing for Higher Paying RUGs

- Report provides further evidence that some SNFs are incorrectly reporting certain MDS items, such as therapy and ADLs, to place beneficiaries into higher paying RUGs.
- CMS should use its Fraud Prevention System to identify and target these SNFs. Particularly targeting, SNFs that have a high percentage of claims for UH therapy and for High levels of assistance with ADLs.

OIG Recommendations

- Monitor compliance with the New Therapy Assessments.
  - COTs
  - EOTs

OIG Recommendations

- Closely monitor SNFs' utilization of these assessments through data analysis, which will identify SNFs that are using the assessments infrequently or not at all.
- The MACs and RACs should then target these SNFs for review to establish whether therapy assessments are being completed, as required.

OIG Recommendations

- Change the current method for determining how much therapy is needed to ensure appropriate payments.
  - CMS needs to change how it pays for therapy to reduce the incentives for SNFs to provide more therapy than necessary and to better align payments to beneficiaries' needs.

OIG Recommendations

- CMS should instruct the MACs to provide education to all SNFs, as well as specific training, to selected SNFs to improve the accuracy of their MDS reporting.
- Follow up on the SNFs that billed in error.

Therapy: CMS' #1 Target

- Development of the PEPPER report – which is heavily therapy focused
- Target areas are based upon results of the OIG report and other resources
- 6 areas measured; 5 out of 6 are focused on therapy

Outliers

- CMS sees high Medicare expenses as suggestive of over coding
- Assert that 20% highest expenses are questionable
- Identifies that expenses above the 80th percentile are outliers

Outliers

- CMS asserts that the bottom 20% of outliers are under coding
- The bottom 20th percentile are outliers—could be perceived as evidence of poor Quality of Care

PEPPER Data

- Comes from:
  - Compare Targets Report
  - Target Area Reports
  - SNF Top RUGs Reports
  - Jurisdiction-wide Top RUGs Reports

Source: SNF PEPPER User's Guide, Third Edition

PEPPER DATA

- Contains provider specific Medicare data statistics vulnerable to improper payments
- Compares against peers across state, national or MAC jurisdiction
- Shared with MACs and RACs

Target Areas

- Therapy RUG with High ADLs
- Non therapy RUG with High ADLs
- Change of Therapy Assessment
- Ultra High RUGs
- Therapy RUGs
- 90+ Day Episode of Care

Compare Targets Report

- Compares data for the most recent 3 years
- Outliers are identified as red bold for above the 80th percentile
- Green Italics for below the 20th percentile
- Not an outlier? Identified in black.

Therapy Related CMS Suggestions

- Change of Therapy
  - Indicates that the SNF is experiencing challenges with delivering services as anticipated. Look at factors that lead to the need for the COT assessment.
    - Care planning improved?
    - Issues with therapy scheduling?

Therapy Related CMS Suggestions

- Ultra High and Therapy RUGs
  - Could indicate SNF is improperly billing for therapy services.
    - Determine if therapy was reasonable and necessary.
    - Is the amount of therapy reported on the MDS supported by documentation in the medical record?

Therapy Related CMS Suggestions

- 90+ Day Episodes of Care above 80th percentile
  - Could Indicate that the SNF is continuing treatment beyond the point where those services are necessary.
    - SNF should review documentation for beneficiary episodes of care over 90 days to ensure continued care is appropriate and the treatment is skilled.

Therapy Related SMS Suggestions

- 90+ days…
  - SNF should review plans of care for appropriateness and assess appropriateness of discharge plans.

Therapy Related CMS suggestions

- Change of Therapy – below 20th percentile
  - SNFs that are using the COT assessment infrequently or not at all may be targeted by MACs or RACs for review to see if the COT is completed as required.

Percents & Percentiles

- Percents: Facilities actual % per target area
- Percentile:
  - Compares how SNF target % compare to the target % of others in specific groups

Ultra High

PEPPER

SNF PEPPER

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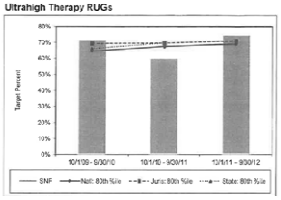
Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in outlier status
- Your Target Percent (first row in the table below) is above the national 90th percentile

Ultrahigh Therapy RUGs



Ultra High

YOUR SNF	10/1/09 - 9/30/10	10/1/10 - 9/30/11	10/1/11 – 9/30/12
Target Area Percent	72.8%	66.4%	74.7%
Target Count (Numerator: count of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL (Rehabilitation ultra high & extensive services w/ ADL 2-10 (9-15 in RUG version III)), RUC, RUB (Rehabilitation ultra high w/ ADL 3-10 (I-10 in RUG version III)), RUA (Rehabilitation ultra high w/ ADL 0-5 (4-8 in RUG version II))	2,226	1,619	1,677
Denominator Count (count of days billed within episodes of care ending in the report period for all therapy RUGs (see Appendix I in Skilled Nursing Facility PEPPER User's Guide))	3,092	2,661	2,246
Target (Numerator) Average Length of Stay	35.3	33.0	35.7
Denominator Average Length of Stay	30.6	29.8	29.9

*Data not available when target count less than 11

COMPARATIVE DATA			
	National 80th Percentile	65.1%	67.7%	69.3%
Note: State Percentiles are zero when there are fewer than 11 SNFs in the jurisdiction's state or when there are no SNFs with at least 11 target discharges.	Jurisdiction 80th Percentile	69.5%	66.7%	71.9%
	State 80th Percentile	66.6%	65.7%	71.4%

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS:
This could indicate that the SNF is improperly billing for therapy services. The SNF should determine whether therapy provided was reasonable and medically necessary, and that the amount of therapy reported on the MDS is supported by documentation in the medical record.

Compare Targets Report

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Skilled Nursing Facility PEPPER
Compare Targets Report, Four Quarters Ending 04/FY 2012

The Compare Targets Report displays statistics for target areas that were equivalent data (11+ target numerator counts) in the most recent three periods. Percentiles indicate how a Skilled Nursing Facility's (SNFs') target area percent compares to the target area percents for all SNFs in the respective comparison group. For example, if a SNF's national percentile (see below) is 800, 80% of the SNFs in the nation have a lower percent value than that SNF. The SNF's state percentile (if displayed) and the Medicare Administrative Contractor (MAC) jurisdiction percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas, or at or below the 20th percentile for areas at risk for undercoding, indicate that the SNF may be at a higher risk for improper Medicare payments. The greater (or smaller, for areas at risk for undercoding) the percentile value, the particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target:	Description	Target Count	Percent	SNF National %ile	SNF State %ile	SNF Jurisdict. %ile
Therapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equaled RUX, RUL, RUC, RUB, RUA; days billed within episodes of care ending in the report period for all therapy RUGs	1,954	61.4%	85.0	88.8	91.3
Nontherapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equaled SSC, CC2, CC1, BB2, BB1, PE2, PE1, BB, B1 in RUG-IV, HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PDE/PDE1 in RUG-IV; days billed within episodes of care ending in the report period for all nontherapy RUGs	27	39.7%	80.0	90.0	90.0
Ultrahigh Therapy RUGs	Proportion of days billed within episodes of care ending in the report period were RUG equaled RUX, RUL, RUC, RUB, RUA; 10 days billed within episodes of care ending in the report period for all therapy RUGs	1,677	74.7%	85.8	84.6	85.0
Therapy RUGs	Proportion of days billed within episodes of care ending in the report period for therapy RUGs; 10 days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs	2,246	98.9%	83.5	83.7	90.4

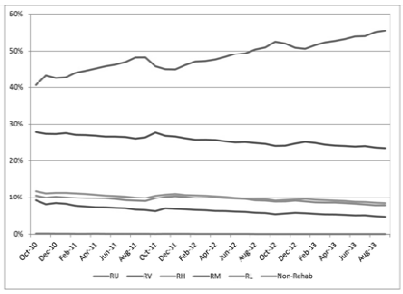
SNF PPS Final Rule 2015

- CMS released the Final Rule which, among other things, highlighted two "notable trends" in therapy service delivery

Trend #1
Resident Classification

- The percentage of billed service days in the RU RUG groups has increased from 44.8% (2011) - 46.8%(2012). – estimated 55%(2013)
- They noted that this is a steady increase.

Figure 1: SNF Case-Mix Distributions by Major RUG-IV Category



Trend #2
Therapy Utilization

- 75% of the total billed days in FY 2013 were in Very High and Ultra High.
- The amount of therapy reported is just enough to surpass the relevant therapy minute threshold for a given category.

Figure 2: Allocated Therapy Minutes per Beneficiary, All Intervals

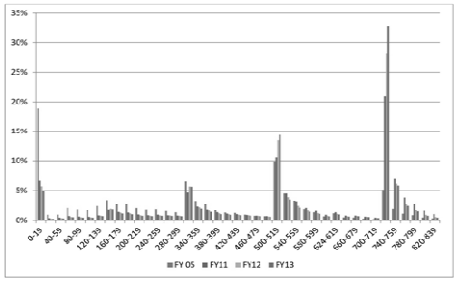
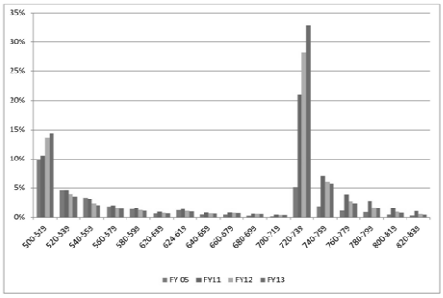


Figure 3: Allocated Therapy Minutes per Beneficiary, RU and RV RUG Intervals



CMS Comments Trends

- "Given the comments highlighting the lack of medical evidence related to the appropriate amount of therapy in a given situation, it is all the more concerning that practice patterns would appear to be as homogenized as the data would suggest…"

CMS Comments on Trends

- "…which highlighted potential explanatory factors for the observed trends, such as internal pressure within SNFs that would override clinical judgment, we find these potential explanatory factors troubling and entirely inconsistent with…"

CMS Comments on Trends

- "...intended use for the SNF benefit. Specifically, the minimum thresholds for each therapy RUG category are certainly not intended as ceilings or targets for therapy provision."

CMS Comments on Trends

- "Therefore services which are not specifically tailored to meet the individualized needs and goals of the resident, based on the resident's condition and the evaluation and judgment of the resident's clinicians, may not meet this aspect of the …"

CMS Comments on Trends

- …definition for covered SNF care, and we believe that internal provider rules should not seek to circumvent the Medicare statute, regulations and policies or the professional judgment of the clinicians."

Intense Therapy Focus

- Roughly 90% or more of all Medicare Part A claims have therapy driven RUG scores
- A fairly proportionate amount needs to be the focus of compliance efforts

Compliance Program

- Mandatory since 2013
  - Contains a system of policies and procedures
  - Monitor and audit; address issues
  - Reporting method
  - Need a compliance manager/officer

OIG Guidance

- http://oig/hhs/gov/compliance/complianceguidance/index.asp

Points to Consider

- How much is therapy a part of your current plan?
- Is there a special focus for outlier areas?
- Do they know what the plan entails?
- Are they active participants?
- Do they have a separate compliance plan?

Points to Consider

- Do you know what the results of their compliance audits systems found?
- How are issues being resolved?

Therapy Compliance

- Education
- Documentation and Billing Auditing
- Follow-up
- Reporting Systems–Compliance Hotline

Therapy Education

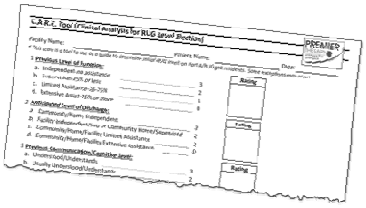
- Clinical Decision Making–Education for RUG level Election
- Patient RUG levels based upon clinical need—not predetermined level based upon staffing, reimbursement, other onside influences.

Clinical Justification

- Documentation must include clinical justification for the intensity and duration a patient is seen in therapy
- Surveyors and auditors are looking for this justification especially when initially choosing a RUG level

Clinical Justification

- C.A.R.E. Tool: *Clinical Analysis for RUG level Election*


C.A.R.E. Tool (Clinical Analysis for RUG level Election)

PREMIER

Clinical Justification

- C.A.R.E. Tool
  - It is a clinical decision scoring tool to help guide therapist for the best RUG level for patient
    - "Brain on Paper"
    - Scoring Areas:
      - PLOF: The more independent a person was prior to episode may require more intensity to gain back their prior level of function

Clinical Justification

- C.A.R.E. Tool- Con't.
  - Scoring Areas:
    - Anticipated Discharge Destination: If the resident is returning home with assistance or alone may require a higher intensity initially to achieve a functional level to discharge there

Clinical Justification

- C.A.R.E. Tool-Con't.
  - Scoring Areas
    - Previous Cognitive/Communication Level: A resident who was independent prior to episode may require a higher intensity of therapy initially to regain PLOF

Clinical Justification

- C.A.R.E. Tool-Con't.
  - Scoring Areas
    - Admitting Dx: Typically a Neuro-diagnosis such as CVA requires a higher intensity of therapy compared to Ortho-diagnosis such as Shoulder surgery
    - Co-morbidities play a role too, if coupled with admitting dx, that may require higher intensity therapy Ex: ankle fx with previous CVA

Clinical Justification

- C.A.R.E. Tool- Con't
  - Scoring Areas
    - Number of Goals for All Disciplines
      - If you look at goals as a 15 minute tx per goal, the more goals you have, the higher intensity of therapy may result.
      - Ex. OT: 3 goals; PT: 4 goals; ST:4 goals- Could mean 165 mins/day which is easily an UH

Clinical Justification

- C.A.R.E. Tool- con't.
  - Scoring Areas:
    - Limitations of Resident: These issues could limit the intensity of therapy and subtract from total score Ex: Non-weight bearing, poor motivation
    - Current ADL Status: Usually the more dependent a resident may be, the more intense treatment may be to achieve an improved level

Nursing Education

- Because ADL scoring reflects the services needed to care for a patient and patient's participation level which is then tied to reimbursement, you must train your nursing staff, including aides, to understand and accurately score ADLs.

Nursing Education

- Teach and Train nursing staff on policy of scoring ADLs
- Make sure they know what is extensive assist vs. limited assist
- Make sure they understand all the subsets of tasks that make up an activity
  - Ex. Bed mobility consists of supine to sit, sit to supine, rolling/turning, scooting and positioning self in bed

Nursing Education

- ADL Scoring
  - Nursing must document self-performance and assist needed per resident and it should reflect consistently with ADL score
  - ADL status should improve with therapy intervention and thus the improvement should be seen on the nursing unit and in the documentation of nursing

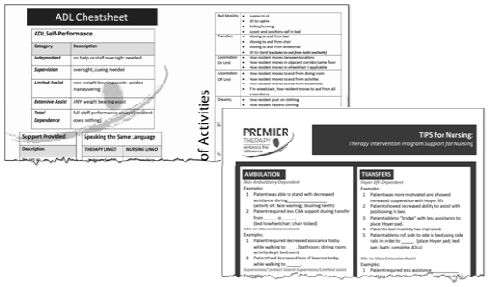
Nursing Education

- Documentation
  - Many NF's are electronic for documentation but it still must have the medical necessity and progress reflected to support need for therapy
  - Improvement in function of the resident should be in documentation and reflected on scoring on the MDS assessments

Nursing Education

- Documentation
  - Example: Mrs. Smith moved from walker to cane this week. She is now able to transfer to toilet with supervision. She has improved from limited assist to supervision. Therapy planning home assessment next week.
- Write weekly update note during UR meeting

Nursing Education



Therapist Education

- Track topic, participants, date
- All therapy basics should be reviewed
  - LCD
  - Program Integrity Manual
  - PPS – RAI Manual Specifics

LCD

- Local Coverage Determination
  - o Speech, Swallowing, PT/OT
  - o Reviews medical necessity
  - o Documentation requirements
  - o CPT coding and use
    - Suggested visit limitations
    - Documentation to support coding

- Coverage Limitations

LCD Cheat Sheet

CPT CODES	CODE DESCRIPTION	VISIT LIMITATIONS	DESCRIPTION	APPROPRIATE USAGE SUGGESTED
97032	ELECTRICAL STIMULATION Direct Motor Joint Delivery via Probe, 1:1 Supervision	12 1-2	Muscle Re-training TENS Instruction	MUSCLE WEAKNESS AND LOCALIZED PAIN Only non-neurological causes of weakness, pathway to muscle must be intact(eg. Contractures, post-splint or post-weakness) *Not appropriate for muscle strength grade of FAIR or above*
G0283	ELECTRICAL STIMULATION Transcutaneous, Supervised (may be unskilled)	6 12	No Improvement Improvement Demonstrated	CONTROL OF SWELLING AND PAIN Must show improvement on swelling and pain by 6 visits or alternate treatment methods should be included in plan of care. Performed simultaneously with US, then bill as 97035 US
97035	ULTRASOUND (one or more areas)	6 12	No Improvement Improvement Demonstrated	IMPROVED MOBILITY IN JOINT, LIGAMENTS AND TENDONS 6 visits without report of progress requires initiation of alternate treatment in P.O.C. Include pain ratings, location and effect on function *Bill only this code if concurrent use of US and E-stim Phonophoresis bill under US code*
97110	THERAPEUTIC EXERCISES Develop strength, endurance, ROM and flexibility 15 minutes per unit	12-18 1-2	Joint Mobility and Muscle Strength PROM Instruction for Caregiver	FUNCTIONAL DEFICITS RESULTING FROM INJURY OR DISEASE Note new exercises and updates to program to demonstrate transition toward an independent or caregiver assisted H.E.P.
97112	NEUROMUSCULAR RE-EDUCATION 15 minutes per unit	12-18	Functional Balance, Motor Coordination, Postural, Kinesthetic Sense, and Proprioception for Sit/Stand Activities	FUNCTIONAL NEUROLOGICAL DEFICITS FROM CEREBRAL DYSFUNCTION, NEUROLOGICAL DISEASE OR TRAUMA (eg.: Paresthesia or peripheral diffuse pain in LE, loss of deep tendon reflexes, nerve palsy such as foot drop; gross and fine motor deficits; hypo/hypertonicity; poor sit/stand balance)
97116	GAIT TRAINING 15 minutes per unit	12-18	Pt/Caregiver Training for Ambulation (Includes Stair Climbing and Uneven Surfaces)	IMPAIRED WALKING ABILITY FROM NEUROLOGICAL, MUSCULAR, AND SKELETAL DYSFUNCTION OR TRAUMA (eg.: Progressive debilitative disease with recent decline in safe ambulation; instruction in use of assistive devices; instruction in LE prosthetic, orthotic or bracing; retraining in stairs or uneven surfaces for home and community; instruction for caregiver in appropriate guarding and assistive techniques.)
97150	GROUP THERAPY 1 unit per service add group code for dysphagia	N/A	Simultaneous Treatment of Two or More Patients	INSTRUCTION ON PROPER FORM AND TECHNIQUE, UPGRADING OF DIFFICULTY LEVEL OF ACTIVITY BEING PERFORMED Must document in treatment note if billed for that day the purpose and number of participants and description of skilled activity
97530	THERAPEUTIC ACTIVITIES 15 minutes per unit	10-12	Use of Dynamic Activities in a Progressive Manner to Improve Functional Performance	FUNCTIONAL MOVEMENT ACTIVITIES DIRECTED AT IMPAIRMENT OF MOBILITY, STRENGTH, BALANCE AND COORDINATION. (eg. Bending, lifting carrying, reaching, catching, pushing, pinching, grasping, transfers, bed mobility and overhead activities.)

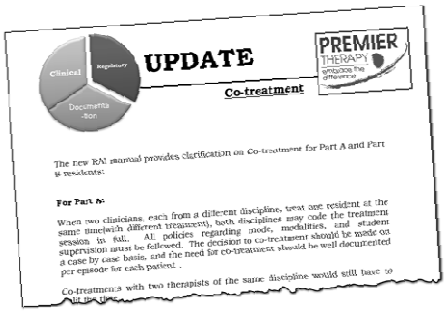
LCD Cheat Sheet

CPT CODES	CODE DESCRIPTION	VISIT LIMITATIONS	DESCRIPTION	APPROPRIATE USAGE SUGGESTED
97532	COGNITIVE SKILLS DEVELOPMENT 15 minutes per unit	N/A	Activities to Improve Attention, Memory, Sequencing and Problem Solving. Instruction in Compensatory Techniques.	COGNITIVE DEFICITS RESULTING FROM HEAD TRAUMA OR CEREBROVASCULAR ACCIDENTS (Acute Only) *Note: Use Restricted to the following three medical diagnoses below* 310.1 Personality Change due to Conditions Classified Elsewhere 310.8 Other Non-psychotic Mental Disorders following Organic Brain Damage 310.9 Unspecified Non-psychotic Mental Disorder following Organic Brain Damage. Can use 97530 code to bill for functional activities with concentration on cognitive abilities to perform them
97535	SELF-CARE, HOME MANAGEMENT TRAINING 15 minutes per unit	N/A	Training in ADL Compensatory Strategies, Safety, Use of Adaptive Equipment and Assistive Technology in Home Environment	DIAGNOSIS WHERE SELF-CARE TRAINING IS REASONABLE. Patient/Caregiver must be willing and have the capacity to learn.
97542	WHEELCHAIR MANAGEMENT 15 minutes per unit	3-4	Assessment, Fitting and Training, and Transfers to/from Wheelchair	PREVENTION OF CONTRACTURES AND PRESSURE POINTS, PROMOTE INDEPENDENCE, IMPROVE LIVING CONDITIONS *Note: Restraint reduction and the application of non-specialized equipment to a wheelchair is not considered a skilled service.*
97760	ORTHOTIC MANAGEMENT and TRAINING 15 minutes per unit	1-4	Assessment and fitting of upper or lower extremity orthotic or trunk orthotic	Do not bill with 97116 code with 97760 promotion of immobilization or to assist patient to function at a higher level once the management of the orthotic can be turned over to the patient, staff or caregiver it will no longer be covered by Medicare. Increasing wearing time is not billable
97762	CHECKOUT FOR ORTHOTIC/ PROSTHETIC USE ESTABLISHED PATIENT 15 minutes per unit	N/A	Patient's response to wearing devices, if patient is able to don/doff device and need for padding. Patient tolerance to any dynamic activity with orthotic	Billed once initial fit is established. Further visits for modifications and monitoring should be billed under 97762 Document tolerance and any complications (i.e. pain, skin breakdown and falls) directly related to device
97761	PROSTHETIC TRAINING UPPER OR LOWER 15 minutes per unit	N/A	Training of prosthetic device	Gait training with prosthesis should be billed under 97116. Use for prep of stump, skin care modifications, initial mobility and functional activity training.
92526	TREATMENT OF SWALLOWING DYSFUNCTION AND OR ORAL FUNCTION FOR FEEDING untimed code use once per day	N/A - not limited if restoring function	Treatment of swallowing disorder; must be an acceptable method, reasonable expectation for improvement	92526 is a comprehensive code that includes most aspects of dysphagia treatment. Do not use additional codes in combination with 92526 when the focus is on swallowing. If purpose of the dysphagia treatment is the development of a maintenance program to delay or minimize muscular and functional deterioration, 2-4 visits may be covered.
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMM. AND/OR AUDITORY PROCESSING DISORDER - Untimed code use once per day	N/A	Treatment of speech, language, cognitive linguistic disorder; must be an acceptable method, reasonable expectation for improvement	Speech language pathology services provided for chronic disorders of memory and orientation are covered services when significant functional progress is demonstrated at early stages of the disorder. Preparation of memory aids such as memory books, memory boards, or communication books may be covered. Supervision of use is not skilled procedures also covered: design of a treatment program addressing the patient's disorder, assessment and analysis is expected; establishment and training of compensatory strategy use; establishment of a hierarchy of speech-language tasks and cueing that directs a patient towards goals; analysis of progress; selection and training of a device for augmentative communication; patient/family caregiver education

Education

Medicare Benefit Policy Manual Chapter 1

- Contains 4 points for Reasonable and Necessary
  - Provided under a plan of care designed to treat the patient's specific symptoms;
  - Doctor must order therapy services and approve the plan of care;
  - Services must need to be performed or supervised by a licensed therapist;
  - Must be a reasonable expectation of measurable improvement within a predictable period of time.



UPDATE

PREMIER THERAPY

Co-treatment

The new RAI manual provides clarification on Co-treatment for Part A and Part B residents:

For Part A:

When two clinicians, each from a different discipline, treat one resident at the same time(with different treatment), both disciplines may code the treatment session in full. All policies regarding mode, modalities, and student supervision must be followed. The decision to co-treatment should be made on a case by case basis, and the need for co-treatment should be well documented per episode for each patient .

Co-treatment with two therapists of the same discipline would still have to

Education

- Staff signature on all items
- Keep posted–cross reference against audit findings
- Make sure PRN and new staff are in-serviced,
  - Historically, they cause a large portion of reasons for denial.

Therapy Auditing

- 3 Suggested levels
  - Self Audit
  - Therapy Director Audit
  - Compliance or Outside Auditor
- Audits should consist of:
  - Documentation content/technical
  - PPS Management
  - Supportive IDT documentation review

Most Common Reasons for Denials

- Issues with prior level of function
- Lack of medical complexity – Primary DX
- No qualifying hospital stay (observation issues)
- Lack of consistency between therapy and nursing documentation to support decline
- Lack of significant progress
- Lack of medical necessity - decline

Most Common Reasons for Denials

- Duplication of services
- Technical issues
- Therapy repetitive, lacks complexity requiring the skills of a therapist
- Notice: ALJ payment much more difficult to achieve

Most Common Reasons for Denials

- Lack of carryover to nursing unit
- No nursing documentation to support ADL portion of RUG score
- Therapy does not support RUG through treatment minutes present in documentation

Content/Technical Audit

- 3 or more per week by therapy manager
- Random chart selection
- Focused reviewed based upon outlier status

Weekly Audit Form

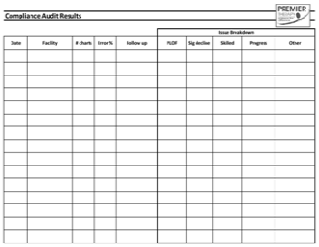
Documentation Audit: Basic Review

Patient: Click here to enter text. Clinician: Click here to enter text. Discipline: Choose an item.

	Review For…	Yes	Missing data/comments
Evaluation	DX support tx		
	PLOF complete/specific		
	Reason for referral/neg dec to support decline present		
	Standardized test given		
	Objective/measures used		
	Significant decline noted		
	Cognitive status		
POC	ST/LT Goals measurable/timeframe		
	Baseline present		
	Freq/Dur appropriate		
	Signed/Dated by Ther/Doc		
Orders	All present/signed by Doc		
Daily Notes	Tx dates correspond w/billing		
	Entries: complete/skilled		
	Signatures/Cosigns: Complete		
Progress Notes	Status: All columns complete		
	Progress significant		
	Assessment complete thorough		
	Plan: Specific-appropriate		
UPOC	Timely/Signed by physician		
	Status per goal		
	Progress significant		
	Assessment/Plan complete - specific		
	Complex issue to cont tx		
Discharge	Complete summarization [illegible]		
10th visits	[illegible]		
CPT visits	Met or below sugg #s		
G Codes	Present in billing, documentation, and clinical reasoning present for selection		
Doc. legible			
Notes:			
Res/ Follow-up:			

Audited by: Click here to enter text. Date: Click here to enter a date.

Content/Technical Audit Summary & Follow up


Compliance Audit Results

PDE/MEP

Date	Facility	# charts	Error %	follow up	Issue Breakdown				
					FLOF	Sig decline	Skilled	Progress	Other

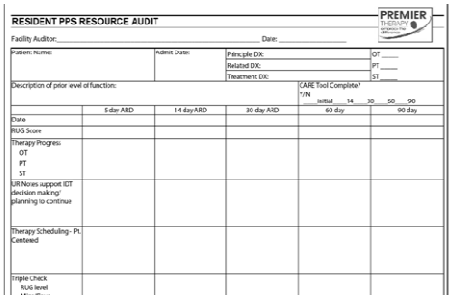
PPS Management Audit

- Review all data related items associated with the claim including:
  - RUG score at each assessment
  - Method of RUG choice
  - Current stay count
  - Progress in content audit supports ongoing treatment for each discipline

PPS Management Audit

(cont'd)

- UR Notes–show IDT agreement
- Discharge Planning–started day one
- Therapy Scheduling–patient centered not schedule centered



RESIDENT PPS RESOURCE AUDIT

PREMIER

Facility Auditor: _____ Date: _____

Patient Name:	Admit Date:	Principle DX:	OT _____
		Related DX:	PT _____
		Treatment DX:	ST _____
Description of prior level of function:		CARE Tool Complete? Y/N Initial 14 30 50 90	

	5 day ARD	14 day ARD	30 day ARD	60 day	90 day
Date					
RUG Score					
Therapy Progress: OT PT ST					
UR Notes support IDT decision making/ planning to continue					
Therapy Scheduling - Pt. Centered					
Triple Check RUG level					

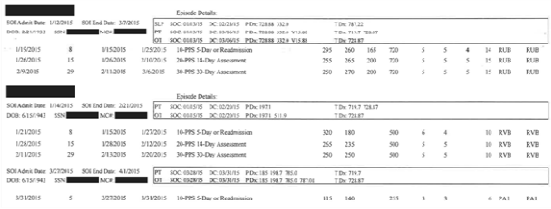
Billing Audit

- Focus on all areas where data mining may indicate outlier status
- Ultra High % vs. national average–can be determined on a monthly basis–why wait for PEPPER?
- Section O–Triple Check
- Primary Medical Diagnosis

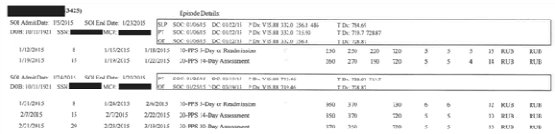
Billing Audit

- Length of stay vs. Changes in RUG
  - Use already available billing resources to audit
    - PPS RUG report from either facility or therapy software

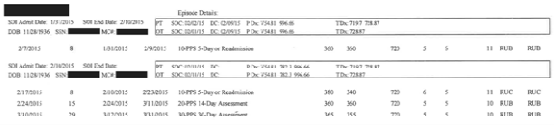
MDS Audit Report



MDS Audit Report

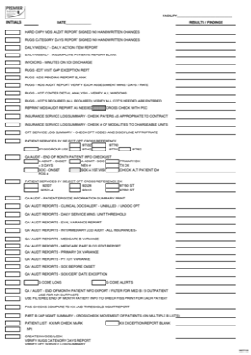


MDS Audit Report



Billing Audit

- Check CPTs for duplication services
- Secondary 3 day break audit for EOT purposes
- Secondary COT alert
- 3 day qualifying stay double check



Things to Avoid

- OIG Findings:
  "provided medically unreasonable and unnecessary rehabilitation therapy services to its Medicare Part A beneficiaries, particularly during the patients' assessment reference periods, so that it could bill Medicare for those patients at the highest per diem rate possible"

OIG Findings/Comments

- Nursing home residents should not be subject to unreasonable or unnecessary rehabilitation therapy that is dictated by a company's profits rather than patient needs.

Source: www.mcknights.com

OIG Findings/Comments

- …failed to prevent from engaging in a pattern and practice of providing high levels of therapy that were not reasonable or necessary during so-called "assessment reference periods." EMA billed Medicare patients at the highest therapy reimbursement level, and then provided less therapy to those same patients outside the assessment reference periods.

OIG Findings/Comments

- designed to inflate Medicare reimbursement, including:
  (1) presumptively placing patients in the highest reimbursement level unless it was shown that the patients could not tolerate that amount of therapy rather than using individualized evaluations to determine the level of care most suitable for each patient's clinical needs;

OIG Findings/Comments

(2)providing the minimum number of minutes of therapy required to bill at the highest reimbursement level while discouraging the provision of therapy in amounts beyond that minimum threshold, despite the Medicare requirement that the amount of care provided be determined by patients' clinical needs;

OIG Findings/Comments

(3)arbitrarily shifting the number of minutes of planned therapy between different therapy disciplines to ensure targeted reimbursement levels were achieved;

OIG Findings/Comments

(4) providing significantly higher amounts of therapy on the final day of an assessment reference period in order to achieve the minimum level of therapy necessary to achieve the highest RUG level;

OIG Findings/Comments

(5)reporting estimated or rounded minutes instead of reporting the actual minutes of therapy provided

- "Patient need must dictate the provision of Medicare benefits rather than the fiscal interests of providers

Source: FBI Press Release September 15, 2014

Suggestions

- Use C.A.R.E. Tool or some other tool that uses patient's medical condition to select RUG
- All conversations should be about medical necessity not reimbursement with clinicians
- Consistent planning of minutes

Suggestions

- For resident's who are sick, making up day's minutes not always possible, expect COTs
- Stop watch, clock, phone–something must be present to note start and stop time
- 7 day a week therapy

Suggestions

- Use the UR process to draw all members of the IDT in on RUG levels
- Being an outlier for UH may be clinically possible depending on the type of patient and rehab to home percentage, but all levels of compliance reviews must be completed

Questions?

Thank you!