“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**
HCCA's 17th Compliance Institute

- 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.

Scope of Practice Definition:
- 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 post-intervention 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
- 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)
1. Progress report interval
2. Date of report
3. Signature & Title of report writer
4. S: Pt’s subjective report
5. O: Objective measurements or description of changes in status relative to each goal, if they occur
6. A: Assessment of improvement, extent of progress towards goals
7. 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.
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 re-certification (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
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)
Functional limitation G-codes with severity modifier C-codes 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

<table>
<thead>
<tr>
<th>C-Hule</th>
<th>0 percent impaired, limited or restricted</th>
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<tbody>
<tr>
<td>CI</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CJ</td>
<td>At least 20 percent but less than 40 percent impaired, limited or restricted</td>
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<tr>
<td>CK</td>
<td>At least 40 percent but less than 60 percent impaired, limited or restricted</td>
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<tr>
<td>CL</td>
<td>At least 60 percent but less than 80 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CM</td>
<td>At least 80 percent but less than 100 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CN</td>
<td>100 percent impaired, limited or restricted</td>
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</table>
### G-Code and C-Code Reporting Frequency

<table>
<thead>
<tr>
<th>Outset</th>
<th>At least every 10th visit</th>
<th>Re-evaluation</th>
<th>Discharge / End reporting</th>
<th>Reporting of subsequent limitation</th>
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<tbody>
<tr>
<td>Projected goal functional status</td>
<td>Projected goal functional status</td>
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<td>Discharge functional status</td>
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*(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.)*

**Questions?**