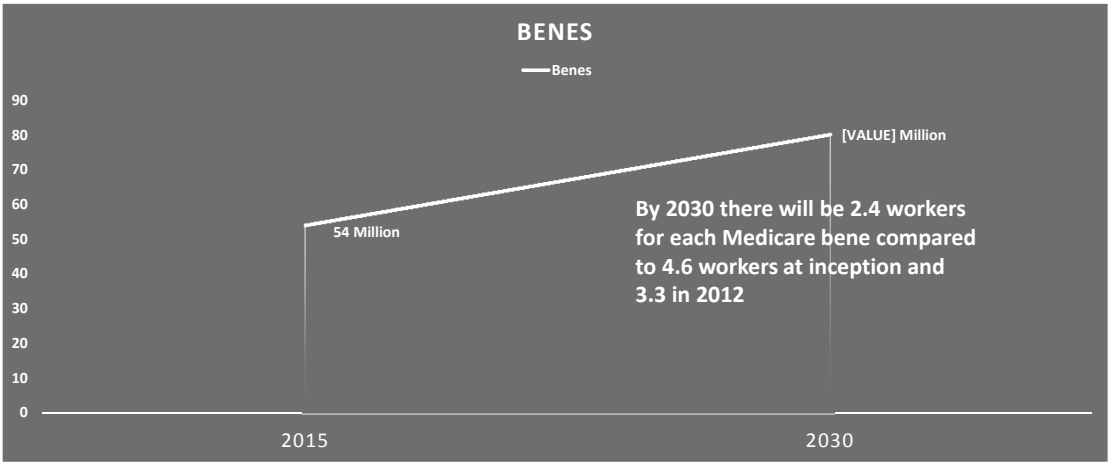
Topics for Today

- Therapy focus explained: JIMMO, Probes, Targeted Medical Reviews, Supplemental Reviews, OIG reports and findings, Investigations, Therapy Related Civil Monetary Penalties
- Understand and implement the who, what, how and why of auditing therapy Conditions for Coverage, Conditions of Participation, and Conditions of Payment
- Take away an audit tool to ensure your focus on compliance with therapy technical and medical necessity requirements for restorative and maintenance therapy (JIMMO)

2

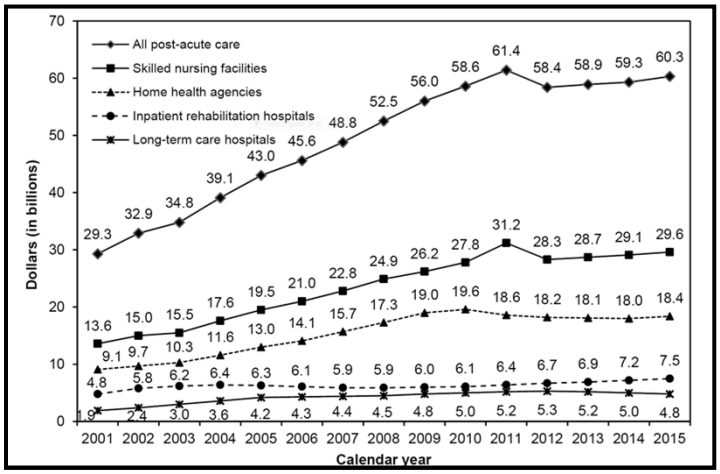
Medicare Enrollment Growth



MedPAC March 2015 Report Source: CMS 2012

3

PAC Spending – Where is the $$ Going?

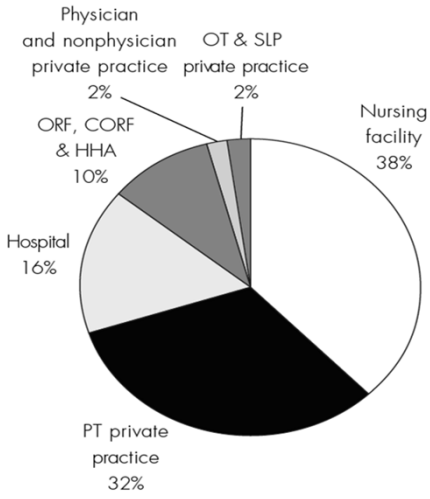


CMS Office of the Actuary 2017

4

OP Therapy – Where is the $$ Going?

Medicare spending on outpatient therapy services was $6.7 billion in 2014. PT services accounted for 71 percent of all spending on therapy services, while occupational therapy and SLP services accounted for 20 percent and 9 percent, respectively



Note: PT (physical therapist), ORF (outpatient rehabilitation facility), CORF (comprehensive outpatient rehabilitation facility), HHA (home health agency), OT (occupational therapy), SLP (speech–language pathology).

Source: MedPAC analysis of 100 percent Medicare Part B outpatient therapy claims, 2014.

5

Focus on Therapy

Cases in the News – And the News is Not Good

Why These Cases are Important

How to Incorporate into Your Risk Assessment

6

Topics

- Jimmo case back to Court
- Probes continue
- Targeted Medical Reviews
- Supplemental Reviews
- OIG reports and findings
- Investigations
- Therapy Related CMP

7

Jimmo "Maintenance"

Another round in court

Why is this important?

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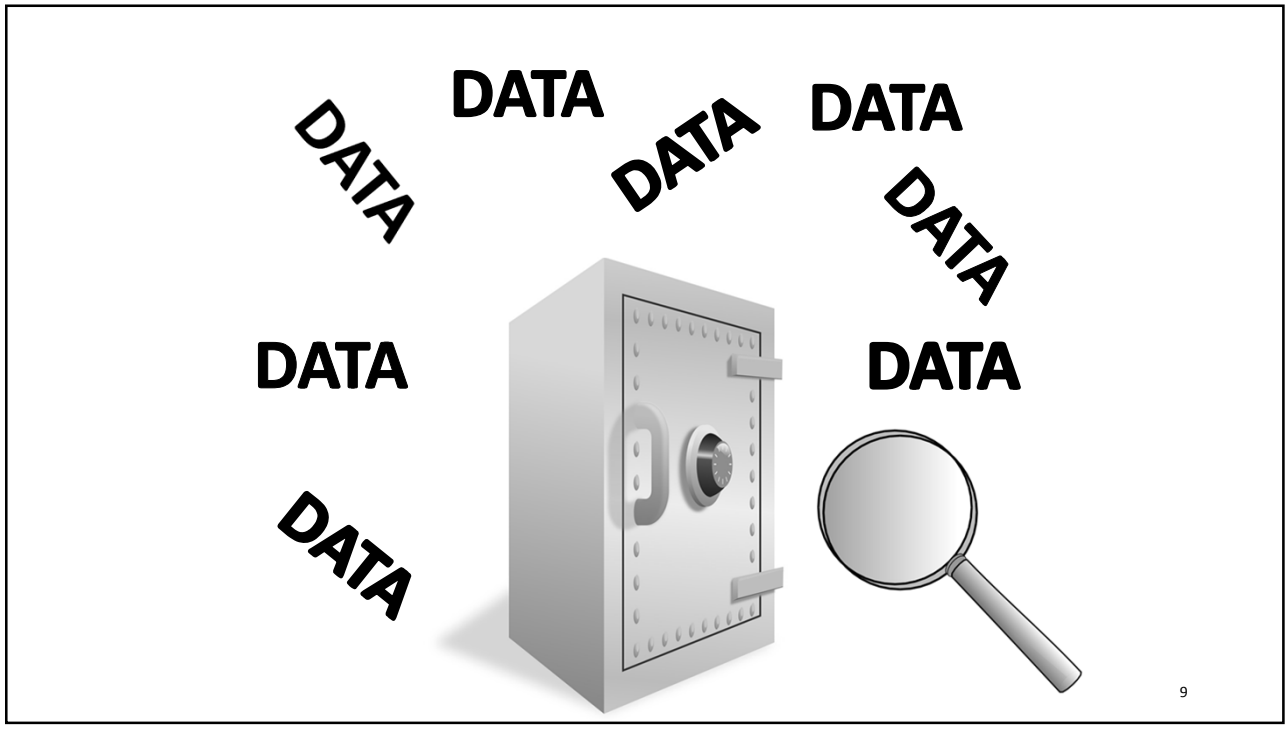

Minimum Required Components

Federal Sentencing Guidelines	**PPACA SNF**
• Standards and Procedures	• Standards and Procedures
• Oversight of Program	• Oversight of Program
• Training and Education	• Training and Education
• Auditing and Monitoring	• Auditing and Monitoring
• Reporting	• Enforcement and Discipline
• Enforcement and Discipline	• Response and Prevention
• Response and Prevention	

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Provider Self-Audit with Validation and Extrapolation (PSAVE) Pilot Program

Noridian, the Jurisdiction F Medicare Administrative Contractor (MAC), is extending the voluntary Provider Self-Audit with Validation and Extrapolation (PSAVE) pilot program. The PSAVE program allows the provider to perform a self-audit after agreeing to waive appeal rights on the universe of claims.

Noridian will provide education and validate the provider's self-audit findings on a subsample of claims. Based on the findings, we (Noridian) will extrapolate overpayments or correct underpayments. Upon completion of program requirements, the claims universe included in the PSAVE pilot receive immunity from MAC and Recovery Auditor (RA) reviews.

Program enrollment is allowed on a first come first served basis and at CMS' and Noridian's discretion. Availability is limited and registration ends March 5, 2018. If interested, would like to enroll, have questions or would like more detailed information about the PSAVE pilot, contact Part B Medical Review immediately.

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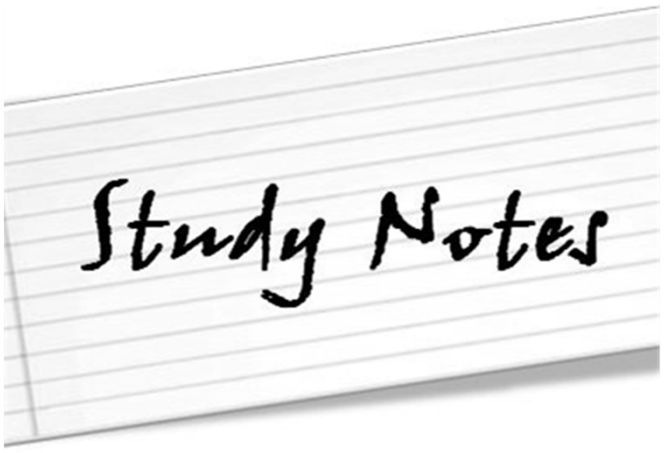
P-Save Case Study

- "Voluntary"
- 100 DOS in sample
- Provider reviews 100
- MAC selects/reviews 25
- Compare results
- What went wrong?

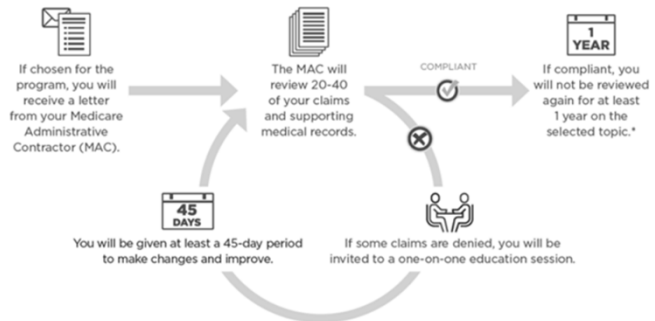


13

What are some common claim errors?

- The signature of the certifying physician was not included
- Documentation does not meet medical necessity
- Encounter notes did not support all elements of eligibility
- Missing or incomplete initial certifications or recertification

How does it work?



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Sample TPE Letter

…If there are continued high denials after three rounds, Palmetto GBA will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, ZPIC, UPIC, etc. Note: discontinuation of review may occur at any time if appropriate improvement is achieved during the review process. Appropriate improvement is determined on an individual basis for each provider based on improvement of billing and documentation errors during the review period.

This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason for Review

Your organization was selected for review based on Internal Data Analytics. A prepayment review has been initiated to probe a sample of your claims billed with the following Skilled Nursing Facility (SNF) code(s):

- RUX, RUL - Ultra High Rehabilitation Plus Extensive Services RUG Category
- RVX, RVL - Very High Rehabilitation Plus Extensive Services RUG Category
- RUA, RUB, RUC - Ultra High Rehabilitation RUG Category
- RVA, RVB, RVC - Very High Rehabilitation RUG Category

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Facility	RU	RU/V	LOS	Comm DC	RUG days
1	90.70%	97.00%	36.8	71.72%	3879
2	57.00%	93.00%	39.8	24.19%	2236
3	73.30%	86.00%	30.2	57.89%	2034
4	43.80%	91.00%	30.1	60.00%	2001
5	84.70%	98.40%	22.0	77.33%	1983
6	56.20%	95.00%	44.5	32.56%	1761
7	52.40%	94.00%	64.4	38.71%	1677
8	79.90%	96.00%	22.2	67.14%	1630
9	86.20%	98.00%	23.3	69.23%	1563
10	88.50%	94.00%	20.1	73.61%	1458
11	70.70%	94.00%	24.6	51.35%	1420
12	53.60%	67.00%	39.9	44.12%	1415
13	73.30%	95.00%	32.9	62.50%	1372
14	82.40%	92.00%	51.1	0.00%	1284
15	36.60%	77.00%	35.8	14.29%	1176
16	64.20%	97.00%	42.3	36.67%	1124
17	21.50%	78.00%	46.5	30.77%	1094
18	45.20%	86.00%	19.8	61.54%	1094
19	60.60%	85.00%	20.5	51.85%	1076
20	56.20%	90.00%	15.8	62.50%	1052

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Supplemental Medical Review Contractor: Strategic Health Solutions

- **Original therapy task orders**
  - Episode of care ends in 4th Q, resumes in 1st Q
  - Super Storm Sandy
- **Current task order**
  - 2015 MMR (manual medical review of therapy over $3700)
  - Per MACRA legislation
- **Future:**
  - Therapy threshold review at $3000?

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Table 2: Summary of Your Utilization
July 1, 2015 – June 30, 2016

CPT® / HCPCS Code	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count
97001	$10,066	124	-	114
97002	$0	0	-	0
97035	$48	4	0	2
97110	$94,927	3,442	1,550	218
97112	$37,241	1,117	941	188
97140	$34,356	1,394	1,300	209
97530	$12,554	339	312	97
G0283	$1,214	110	-	37
Total	**$190,407**	**6,530**	**1,788**	**228**

Table 3: Percentage of Beneficiaries with the KX Modifier
July 1, 2015 – June 30, 2016

	Your Percentage of Beneficiaries	Your State's Percentage of Beneficiaries	Comparison with Your State's Percentage of Beneficiaries	National Percentage of Beneficiaries	Comparison with the National Percentage of Beneficiaries
Percentage of KX	43%	37%	Higher	21%	Significantly Higher

A chi-square test was used in this analysis, alpha = 0.05.

Table 4: Average Minutes Per Visit
July 1, 2015 – June 30, 2016

	Your Average Minutes per Visit	Your State's Average Minutes per Visit	Comparison with Your State's Average	National Average Minutes per Visit	Comparison with the National Average
Minutes	52.81	44.85	Significantly Higher	45.67	Significantly Higher

A t- test was used in this analysis, alpha = 0.05.

Table 5: Average Allowed Charges per Beneficiary
July 1, 2015 – June 30, 2016

	Your Average Charges per Beneficiary	Your State's Average Charges per Beneficiary	Comparison with Your State's Average Charges per Beneficiary	National Average Charges per Beneficiary	Comparison with the National Average Charges per Beneficiary
Charges	$835.12	$908.46	Does Not Exceed	$724.03	Significantly Higher

A t-test was used in this analysis, alpha = 0.05.

Comparative Billing Reports

Source: https://www.cbrinfo.net

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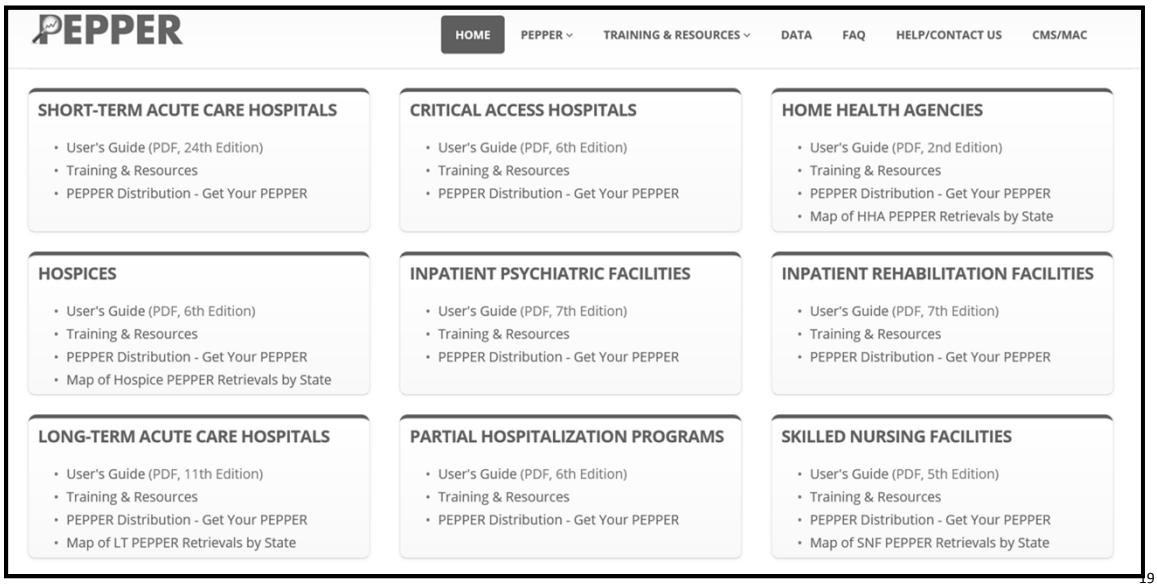
https://www.pepperresources.org/



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Why are Providers Receiving PEPPER?

CMS is tasked with protecting the Medicare Trust Fund from fraud, waste and abuse. The provision of PEPPER supports CMS' program integrity activities.

Program for **E**valuating **P**ayment **P**atterns **E**lectronic **R**eport (PEPPER) summarizes Medicare claims data statistics for one provider in areas ("target areas") that may be at risk for improper Medicare payments.

PEPPER is an educational tool that is intended to help providers assess their risk for improper Medicare payments. PEPPER cannot identify improper Medicare payments!

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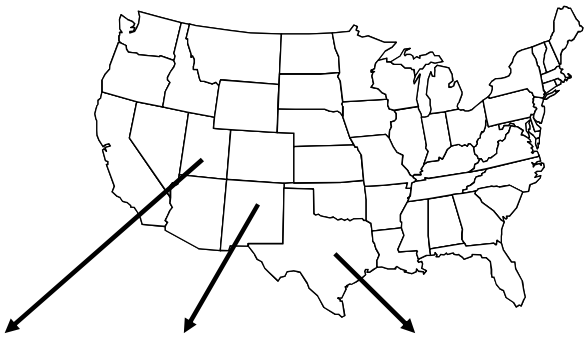
Comparisons in PEPPER

- PEPPER provides state, MAC jurisdiction and national comparisons.



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Compare Targets Report, Four Quarters Ending Q4 FY 2013

004524, Hospital G04524

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target numerator count) in the most recent time period. Percentiles indicate how a Skilled Nursing Facility's (SNF's) 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 80.0, 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, in 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 Jurisdict. %ile	SNF State %ile
Therapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB, to days billed within episodes of care ending in the report period for all therapy RUGs	399	*9.5%*	4.6	2.3	2.8
Change of Therapy Assessment	Proportion of assessments with AI second digit equal to D within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period	65	12.0%	45.4	52.6	54.0
Ultrahigh Therapy RUGs	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs	3,081	73.7%	80.9	85.3	67.6
Therapy RUGs	Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs	4,180	90.3%	36.0	51.2	48.6

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DO NOT PANIC

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Strategies….

Determine if you are an outlier

- Indication of an outlier does not necessarily mean that compliance issues exist

Do Not Panic

Determine Why You are an "Outlier"

- Sample claims/records using same inclusion criteria as target area definition
  - Review documentation in medical record - Medical Necessity Support
  - Review claim - Was it coded and billed appropriately
- Process Review

Ensure following best practices, even if not an outlier.

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OIG Audit Reports: California

- Northern CA case study
- Southern CA case study
- Review - ODG

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OIG Audit Report: New Jersey

- Fox Rehab case study
- Findings
- Mythical Improvement Standard
- Provider response

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Case Study

Drayer Physical Therapy Institute

United States Department of Justice

THE UNITED STATES ATTORNEY'S OFFICE
DISTRICT of SOUTH CAROLINA

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U.S. Attorney's Office
District of South Carolina

SHARE

FOR IMMEDIATE RELEASE Tuesday, July 5, 2016

Drayer Physical Therapy Institute, LLC Settle False Claims Act Case for $7,000,000

Contact Person: Jenny Aldrich (803) 929-3000

Columbia, South Carolina ---- Acting United States Attorney Beth Drake announced today that the U.S. Attorney's Office for the District of South Carolina has settled claims of health care fraud with Drayer Physical Therapy Institute, LLC ("Drayer"). Drayer has locations in South Carolina and 14 other states from Pennsylvania to Oklahoma. The United States contended that Drayer submitted claims to Medicare, TRICARE, and Federal Employee Health Benefit Programs for services being provided to multiple patients simultaneously as though the services were being provided by a physical therapist or physical therapist assistant to one patient at a time.

The investigation began with the filing of a whistleblower lawsuit called a *qui tams* lawsuit under the False Claims Act. The suit was filed by former employees of Drayer. The False Claim Act allows the government to recover actual damages and penalties of three times the actual damages and up to $11,000 per false claim. This settlement was reached based on Drayer's ability to pay.

The False Claims Act allows individuals to file lawsuits with allegations that fraud has been committed against the federal government on behalf of the government. Whistleblowers, referred to as Relators in the False Claims Act, are entitled to share in any recovery received by the government. In this case, the two relators collectively will receive 24% of the funds of the settlement or $1,680,000 plus they are

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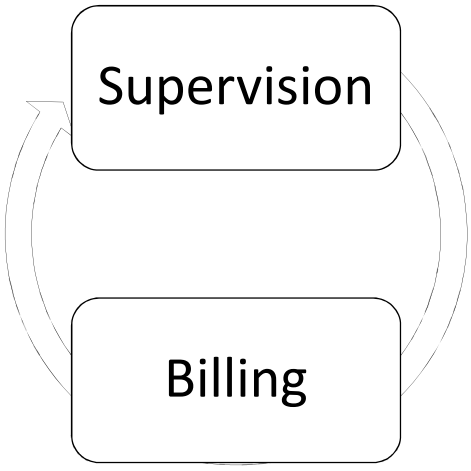
Investigations: Olde Towne Physical Therapy



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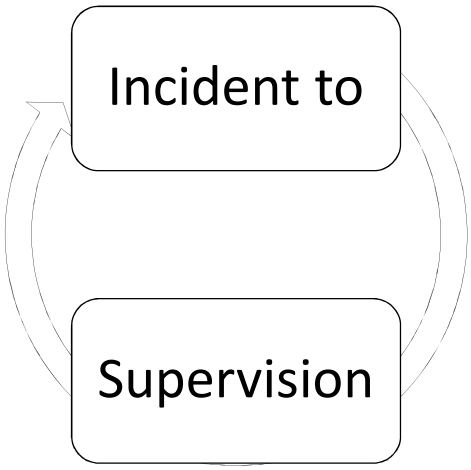
Investigations: Scripps Health Care



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SNFs in the News

Therapy upcoding case brings $347 million judgment against Consulate skilled nursing chain in a whistleblower case alleging that it routinely submitted false Medicare and Medicaid claims.

HCR Manor Care Expert Witness

1. 2015 qui tam which DOJ joined alleged ManorCare "knowingly and routinely submitted" false claims for rehabilitation services that were not necessary
   - company allegedly exerted pressure on nursing home administrators and rehabilitation therapists "to meet unrealistic financial goals," including setting prospective billing goals "designed to significantly increase revenues without regard to patients' actual clinical needs."
   - threatened to terminate skilled nursing facility managers and therapists if they did not administer the additional treatments necessary to qualify for the highest Medicare payments.
   - the provider giant increased its Medicare payments by keeping patients in its facilities even though they were medically ready to be discharged.
2. Struck a key witness
   - After ManorCare took Dr. Clearwater's deposition, it filed a motion to exclude her testimony. Also asked for sanctions because the government did not produce Dr. Clearwater's notes about patients whose records she reviewed until more than a month after her deposition ended
   - ManorCare argued that the notes were critical to its defense because they demonstrated that the nurse reviewers disagreed with each other about the care level that patients needed. ManorCare claimed that Dr. Clearwater did not reflect those differences of opinion in her report.
3. Dismissed and Ordered the U.S. Justice Department to pay legal fees to HCR ManorCare Inc

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Aegis Improvement Standard

The providers were granted summary judgment in the False Claims Act lawsuit because no specific instances of false claims were cited, and the witnesses wrongly said "significant" improvement would be needed in patients instead of "material improvement."

The suit stemmed from a complaint a former Aegis physical therapist filed in April 2010, alleging the company and Beverly Health & Rehab Center-Jesup in Georgia billed Medicare for services that were medically unnecessary. The individual also accused Aegis of providing excessive therapy services to maximize reimbursement.

A physician and nurse who testified for the government relied on a newer standard when making the determination that those services were medically unnecessary because they wouldn't be expected to result in "significant" improvement in the patients. The defendants successfully argued that "material improvement" is the correct improvement standard for therapy in a skilled nursing setting under Part A.

U.S. District Court Judge Lisa Godbey Wood said that the experts' use of "significant" instead of "material" would only serve to confuse jurors, according to Bloomberg news services, and that the government "had only unsubstantiated allegations of medically unnecessary care, and no allegations of specific false claims or those showing business practices likely to result in false claim submissions."

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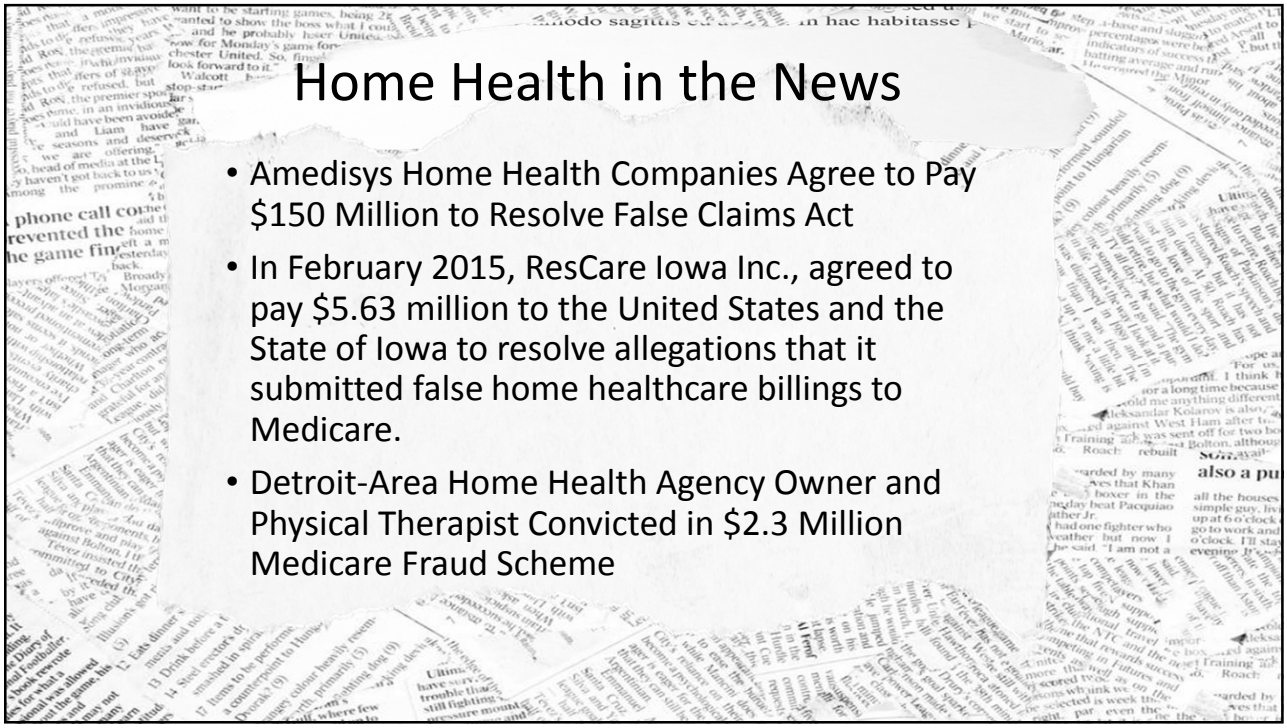

A Word About…

OIG "Rolling" Work Plan

AUSA Initiative specific to their district

The "Shapiro" template for SNF Rugs Upcoding

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The "Conditions"

Examining the Venues

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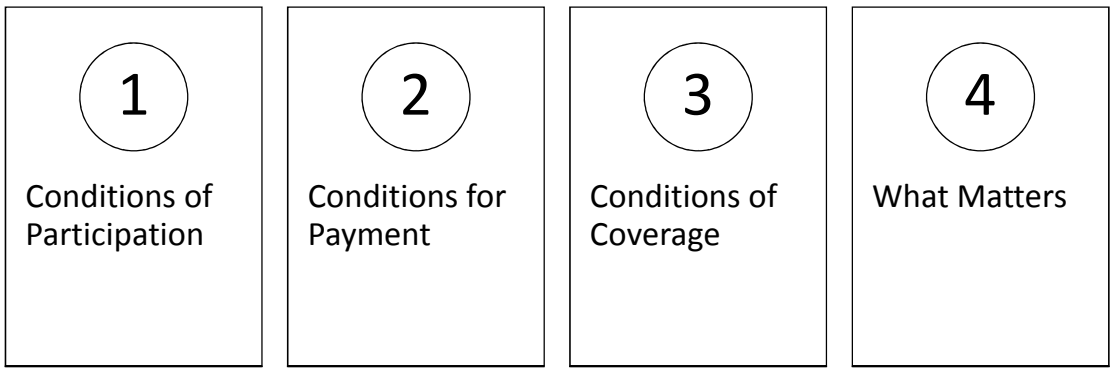
Conditions



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Conditions for Coverage (CfCs) & Conditions of Participations (CoPs)

- CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs.
  - Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - Home Health Agencies
  - Hospitals
  - Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
  - Long Term Care Facilities

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Conditions for Payment

- § 424.5 Basic conditions.
- (a) As a basis for Medicare payment, the following conditions must be met:
  - (1)Types of services. The services must be -
    - (i) Covered services, as specified in part 409 or part 410 of this chapter; or
    - (ii) Services excluded from coverage as custodial care or services not reasonable and necessary, but reimbursable in accordance with §§ 405.332 through 405.334 of this chapter, pertaining to limitation of liability.
  - (2)Sources of services. The services must have been furnished by a provider, nonparticipating hospital, or supplier that was, at the time it furnished the services, qualified to have payment made for them.
  - (3)Beneficiary of services. Except as provided in § 409.68 of this chapter, the services must have been furnished while the individual was eligible to have payment made for them. (Section 409.68 provides for payment of inpatient hospital services furnished before the hospital is notified that the beneficiary has exhausted the Medicare benefits available for the current benefit period.)
  - (4)Certification of need for services. When required, the provider must obtain certification and recertification of the need for the services in accordance with subpart B of this part.
  - (5)Claim for payment. The provider, supplier, or beneficiary, as appropriate, must file a claim that includes or makes reference to a request for payment, in accordance with subpart C of this part.
  - (6)Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.

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42 CFR 424.24 - Requirements for medical and other health services furnished by providers under Medicare Part B. Outpatient physical therapy and speech-language pathology services -

- (1)Content of certification.
  - (i) The individual needs, or needed, physical therapy or speech pathology services.
  - (ii) The services were furnished while the individual was under the care of a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
  - (iii) The services were furnished under a plan of treatment that meets the requirements of § 410.61 of this chapter.
- (2)Timing. The initial certification must be obtained as soon as possible after the plan is established.
- (3)Signature.
  - (i) If the plan of treatment is established by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, the certification must be signed by that physician or nonphysician practitioner.
  - (ii) If the plan of treatment is established by a physical therapist or speech-language pathologist, the certification must be signed by a physician or by a nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case.
- (4)Recertification -
  - (i)Timing. Recertification is required at least every 90 days.
  - (ii)Content. When it is recertified, the plan or other documentation in the patient's record must indicate the continuing need for physical therapy, occupational therapy or speech-language pathology services.
  - (iii)Signature. The physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan must recertify the plan by signing the medical record.

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Chart Review Conditions of Payment

- Certification: Timely
- Delayed Certification (30, 60) w/ Reason
- Patient under Care of Physician
- Treatment Plan: LTG
- Treatment Plan: Type, Amount, Frequency, Duration
- Recertification: Timely
- Recertification: Delayed
- Qualified Clinicians (Definitions)
- Supervision (Direct v. General)

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NancyBeckley & Associates
Rehab Compliance Resources

Patient ID _____ Date POC _____ Date POC Signed _____ Clinic _____

Dates: _____ to _____ # Visits _____ Review Date _____ Reviewer _____

Therapist _____ ☐PT ☐PTA ☐OT ☐COTA ☐SLP

Therapist _____ ☐PT ☐PTA ☐OT ☐COTA ☐SLP

Patient Evaluation & Plan of Care	YES	NO	N/A or Comments
Physician POC/Referral? Is there a script in the chart?			
Date of MD referral on Script			
Was **diagnosis** stated? ICD-10 Medical Diagnosis (comes from MD)			
Was **rehab diagnosis** stated? ICD-10 Reason for Rehab (therapist)			
Is date of **injury/onset** noted? What prompt referral? **CHRONIC**			
STG with time frames? (not required by Medicare)			
LTG with time frames? (entire episode of care)			
FLR - Functional Limitation Category/Impairment Rating/Rationale?			
Treatment **frequency & duration** recommended? e.g. 3x w/4 weeks			
Modalities/Exercises: "TE to increase UE ROM + TA to restore dressing"			
Is a **PROTOCOL** Mentioned – **is it in chart?**			
Objective tests & measurements? From PT eval of patient			
PLOF stated? Related to ADL activities, "Prior to injury patient could…"			
Previous medical/rehab history? Pertinent medical & rehab when, why?			
CLOF stated – deficits? Results of eval – "following injury patient can't"			
Was the initial treatment plan explained to the patient? Input solicited?			
Rehab potential ☐Excellent ☐Good ☐Fair ☐Poor note this			
Certification - Plan of Care? Certified period for up to 90 days			
Late certification? Reason? Documentation of attempts			
Daily TREATMENT Notes	**YES**	**NO**	**N/A**
Patient subjective trend noted: better, same worse – TREND?			
Necessary treatment received?			
Patient reaction and tolerance to treatment noted?			
Note signed by the treating staff member?			
Documentation note **co-signed** by the PT/OT if provided by PTA/COTA			

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§ 424.27 Requirements for comprehensive outpatient rehabilitation facility (CORF) services.

- Medicare Part B pays for CORF services only if a physician certifies, and the facility physician recertifies, the content specified in paragraphs (a) and (b)(2) of this section, as appropriate.
  - (a)Certification: Content.
    - (1) The services were required because the individual needed skilled rehabilitation services;
    - (2) The services were furnished while the individual was under the care of a physician; and
    - (3) A written plan of treatment has been established and is reviewed periodically by a physician.
  - (b)Recertification -
    - (1)Timing. Recertification is required at least every 60 days for respiratory therapy services and every 90 days for physical therapy, occupational therapy, and speech-language pathology services based on review by a facility physician or the referring physician who, when appropriate, consults with the professional personnel who furnish the services.
    - (2)Content.
      - (i) The plan is being followed;
      - (ii) The patient is making progress in attaining the rehabilitation goals; and,
      - (iii) The treatment is not having any harmful effect on the patient.

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IRF (Manual Requirements)

- Requirements: Pre-Admission Screen, Post Admission Physician Evaluation, Individualized Overall Plan of Care and IRF-PAI assessment. IDT conferences once/week
- Meet Medical Necessity Criteria:
  - Active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must by PT or OT
  - Must generally require an intensive therapy program (15 hours in 7 days)
  - Physician supervision by a rehabilitation physician req'g face to face visits at least 3x/week
- Therapy must begin within 36 hours. Standard of care is individual (one on one). Group may serve as an adjunct to individual

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§ 424.22 Requirements for home health services.

- Medicare Part A or Part B pays for home health services only if a physician certifies and recertifies the content specified in paragraphs (a)(1) and (b)(2) of this section, as appropriate.
- (a)Certification -
  - (1)Content of certification. As a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician must certify the patient's eligibility for the home health benefit, as outlined in sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, as follows in paragraphs (a)(1)(i) through (v) of this section. The patient's medical record, as specified in paragraph (c) of this section, must support the certification of eligibility as outlined in paragraph (a)(1)(i) through (v) of this section.
    - (i) The individual needs or needed intermittent skilled nursing care, or physical therapy or speech-language pathology services as defined in § 409.42(c) of this chapter. If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need. If the narrative is part of the certification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.
    - (ii) Home health services are or were required because the individual is or was confined to the home, as defined in sections 1835(a) and 1814(a) of the Act, except when receiving outpatient services.
    - (iii) A plan for furnishing the services has been established and will be or was periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function under paragraph (d) of this section. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)
    - (iv) The services will be or were furnished while the individual was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

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§ 424.22 Requirements for home health services.

- (v) A face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by a physician or allowed non-physician practitioner as defined in paragraph (a)(1)(v)(A) of this section. The certifying physician must also document the date of the encounter as part of the certification.
  - (A) The face-to-face encounter must be performed by one of the following:
    - (1) The certifying physician himself or herself.
    - (2) A physician, with privileges, who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.
    - (3) A nurse practitioner or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Act) who is working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.
    - (4) A certified nurse midwife (as defined in section 1861(gg) of the Act) as authorized by State law, under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.
    - (5) A physician assistant (as defined in section 1861(aa)(5) of the Act) under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.
    - (B) The face-to-face patient encounter may occur through telehealth, in compliance with section 1834(m) of the Act and subject to the list of payable Medicare telehealth services established by the applicable physician fee schedule regulation.
- (2)Timing and signature. The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan.

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§ 424.22 Requirements for home health services.

- (b)Recertification -
  - (1)Timing and signature of recertification. Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Recertification should occur at the time the plan of care is reviewed, and must be signed and dated by the physician who reviews the plan of care. Recertification is required at least every 60 days unless there is a -
    - (i) Beneficiary elected transfer; or
    - (ii) Discharge with goals met and/or no expectation of a return to home health care.
  - (2)Content and basis of recertification. The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need. If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

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§ 424.22 Requirements for home health services.

- (c)Determining patient eligibility for Medicare home health services. Documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. This documentation shall be provided upon request to the home health agency, review entities, and/or CMS. Criteria for patient eligibility are described in paragraphs (a)(1) and (b) of this section. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.
- (d)Limitation of the performance of physician certification and plan of care functions. The need for home health services to be provided by an HHA may not be certified or recertified, and a plan of care may not be established and reviewed, by any physician who has a financial relationship as defined in § 411.354 of this chapter, with that HHA, unless the physician's relationship meets one of the exceptions in section 1877 of the Act, which sets forth general exceptions to the referral prohibition related to both ownership/investment and compensation; exceptions to the referral prohibition related to ownership or investment interests; and exceptions to the referral prohibition related to compensation arrangements.
  - (1) If a physician has a financial relationship as defined in § 411.354 of this chapter, with an HHA, the physician may not certify or recertify need for home health services provided by that HHA, establish or review a plan of treatment for such services, or conduct the face-to-face encounter required under sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act unless the financial relationship meets one of the exceptions set forth in § 411.355 through § 411.357 of this chapter.
  - (2) A Nonphysician practitioner may not perform the face-to-face encounter required under sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act if such encounter would be prohibited under paragraph (d)(1) if the nonphysician practitioner were a physician.

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SNF PPS Admission Requirements

- Must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive days
- Must admit to the SNF within 30 days of discharge from the hospital
- Must require SNF care for a condition that was treated during the qualifying hospital stay, or for a condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in the hospital.
- Waivers – bundled payments
- Retroactive denial of 3 day hospital stay

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§ 424.20 Requirements for posthospital SNF care.

- Medicare Part A pays for posthospital SNF care furnished by an SNF, or a hospital or CAH with a swing-bed approval, only if the certification and recertification for services are consistent with the content of paragraph (a) or (c) of this section, as appropriate.
- (a)Content of certification -
  - (1)General requirements. Posthospital SNF care is or was required because -
    - (i) The individual needs or needed on a daily basis skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in an SNF or a swing-bed hospital on an inpatient basis, and the SNF care is or was needed for a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter; or
    - (ii) The individual has been correctly assigned one of the case-mix classifiers that CMS designates as representing the required level of care, as provided in § 409.30 of this chapter.
  - (2)Special requirement for certifications performed prior to July 1, 2002: A swing-bed hospital with more than 49 beds (but fewer than 100) that does not transfer a swing-bed patient to a SNF within 5 days of the availability date. Transfer of the extended care patient to the SNF is not medically appropriate.
- (b)Timing of certification -
  - (1)General rule. The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.
  - (2)Special rules for certain swing-bed hospitals. For swing-bed hospitals with more than 49 beds that are approved after March 31, 1988, the extended care patient's physician has 5 days (excluding weekends and holidays) beginning on the availability date as defined in § 413.114(b), to certify that the transfer of the extended care patient is not medically appropriate.

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§ 424.20 Requirements for posthospital SNF care.

- (c)Content of recertifications.
  - (1) The reasons for the continued need for posthopsital SNF care:
  - (2) The estimated time the individual will need to remain in the SNF;
  - (3) Plans for home care, if any; and
  - (4) If appropriate, the fact that continued services are needed for a condition that arose after admission to the SNF and while the individual was still under treatment for the condition for which he or she had received inpatient hospital services.
- (d)Timing of recertifications.
  - (1) The first recertification is required no later than the 14th day of posthospital SNF care.
  - (2) Subsequent recertifications are required at least every 30 days after the first recertification.
- (e)Signature. Certification and recertification statements may be signed by -
  - (1) The physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of an emergency and has knowledge of the case; or
  - (2) A physician extender (that is, a nurse practitioner, a clinical nurse specialist, or a physician assistant as those terms are defined in section 1861(aa)(5) of the Act) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section -

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When Do You Pay Back?

01	02	03	04
When do you pay back?	Audits under privilege?	Refunds?	SDP?

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What Would You Do?

Lack of Physician/NPP Certification Medicare Part B POC
Late documentation
Missing documentation
Medical necessity
Excluded employee
Expired license

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Where is Therapy Provided

- Hospitals
  - Acute
  - Critical Access Hospitals
  - Inpatient Rehab Facilities (IRF)
- Nursing Facilities
  - Part A
  - Part B
- Home Health Agencies
  - Part A
  - Part B

- Rehab Agencies (ORF)
- Comprehensive Outpatient Rehabilitation Facility (CORF)

- Therapists in Independent Practice
  - PTPP, OTPP, SLPPP
- Physician Offices

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Different Rules

Rules That Differ

Rules That Remain the Same

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Rules That Differ

- Supervision
- Group
- Cotreatment
- Emergency Preparedness
- Direct Access
- Therapy Evaluation
- Certification
- Documentation
- Evaluation
- Consolidated Billing
- Repetitive Billing
- ABN Requirements
- Expedited Review
- POC Certification – Part B
- CORF – PT
- CORF – Respiratory
- Length of Certification
- CORF
- Therapy “incident to” ≠ NP/PA rules

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Supervision Definitions

General supervision means the procedure is furnished under the clinician's overall direction and control, but the clinician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the clinician.

Direct supervision in the office setting means the clinician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the clinician must be present in the room when the procedure is performed.

Personal supervision means a clinician must be in attendance in the room during the performance of the procedure.

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Therapy Supervision

Direct	General

• Private Practice
  • PTPP
  • OTPP
  • STPP
• Physician Office*
	• Acute
	• Home Health
	• IRF
	• SNF
	• Rehab Agency (ORF)
	• CORF

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State Practice Act – Supervision Variances

Georgia Physical Therapy

- "Licensed physical therapist shall be present in the same institutional setting, 25 percent of any work week, Monday through Friday, and shall be readily available to the assistant at all other times, including weekend coverage, for advice, assistance and instruction"

Nevada Physical Therapy

- "Nevada Administrative Code 640.596(1)(c) provides that "A physical therapist's assistant shall not have less than 2000 hours of experience as a physical therapist's assistant during which the supervising physical therapist is on the premises when any procedures or activities of physical therapy are performed by the physical therapist's assistant, before working in any setting without such supervision." Pursuant to these provisions, each physical therapist's assistant must submit a completed affidavit to the Nevada State Board of Physical Therapy Examiners attesting that the physical therapist's assistant has been supervised on-site in excess of 2000 hours by the supervising physical therapist, before working in any setting without on-site supervision."

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Group

Medicare Part A SNF PPS	**Medicare Part B**
• Group: • Planned treatment for **four** patients performing same/similar activity	• Group: • CPT codes 97150 (PT, OT and ST) **two or more** individuals • CPT 92508 (ST), **two or more** individuals

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Cotreatment

Medicare Part A SNF PPS	Medicare Part B
• When two clinicians, each from a different discipline, treat one resident at the same time (with different treatments), both disciplines may code the treatment session in full. • Therapists should only provide co-treatment if the purpose for such treatment is to enhance the quality of care the patient receives. • Practitioners should never co-treat simply because it is logistically more convenient to do so. • If the therapists believe co-treatment is the best way to help the patient progress toward his or her goals, they must clearly document that rationale within each daily note.	• When two clinicians, each from a different discipline, treat one resident at the same time. • The clinicians must split the time between the two disciplines as they deem appropriate. • Each discipline may not count the treatment session in full, and the time that was split between the two disciplines, when added together, may not exceed the actual total amount of the treatment session.

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Student Supervision

Medicare Part A SNF PPS	Medicare Part B
• Supervision to be determined by clinical instructor based on student abilities. • Under Medicare Part A the student is an extension of the therapist meaning that the definitions of group, individual and concurrent are applied as if the student and therapist are one in the same.	• Therapy student must be in line-of-site supervision of the supervising therapist who is making the skilled judgment and is responsible for the assessment and treatment. • The supervising therapist is not engaged in treating another patient or doing other tasks. • The supervising therapist is responsible for signing all documentation. A student may also sign the documents, but it is not necessary.

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01	02	03	04
Qualified Therapist 42 CFR 484.4 - Personnel qualifications • License Verification • Exclusion	Practice (Act)	Therapy Thresholds (Part B)*	Active Participation (Part B)

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Cap & Threshold Medicare Part B

- Permanent Fix (“Repeal”) to the Therapy Cap.
  - Continues to require the KX modifier on claims exceeding the cap amount. ($2010 in 2018 per 2018 MPFS FR)
  - Continues targeted medical review but decreased the threshold from $3700 to $3000.
- Reduces payment for outpatient therapy provided by a PTA or COTA in 2022. Requires a modifier be developed by January 1, 2019 to indicate outpatient therapy was provided by a COTA or PTA. The modifier will be applied to the claim for all PTA and COTA outpatient therapy services beginning January 1, 2020. A 15% reduction in fee schedule payment for outpatient therapy provided by a COTA or PTA will begin for service provided on or after January 1, 2022.

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Medicare Part B Clinician Active Participation

1

The minimum progress report period shall be at least once every 10 treatment days. The progress report period requirements are complete when both the elements of the progress report and the clinician's active participation in treatment have been documented.

2

Verification of the clinician's required participation in treatment during the progress report period shall be documented by the clinician's signature on the treatment note and/or on the progress report.

3

ACTIVE PARTICIPATION of the clinician in treatment means that the clinician personally furnishes in its entirety at least 1 billable service on at least 1 day of treatment.

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Active Participation

- Washington Physical Therapy
  - Supervision requires that the patient reevaluation is performed: Every fifth visit, or if treatment is performed more than five times per week, reevaluation must be performed at least once a week

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Complicating Risk & Factors

- EMR not specific to therapy venue
- Therapist float
  - Within systems
  - Contract therapists

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High Risk Areas

Therapy Eval Codes	RUGs Levels	Home Health
Specific Codes • 97112	CCI Edits • 97530/97140	Private Insurance • Humana

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Audit Plan

Internal & External Audits

Auditing & Monitoring Calendar

Audit Tools

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Compliance Program Effectiveness

HCCA – OIG Compliance Program Effectiveness Tool

Case Study – Encore Rehabilitation

AUSA

Targeted Issues: Illinois: Home Health

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Tools

- Monitoring & Auditing Calendar
- Chart Audit Tool for Part B
- Therapy Eval Codes Audit Tool
- Risk Assessment Check List

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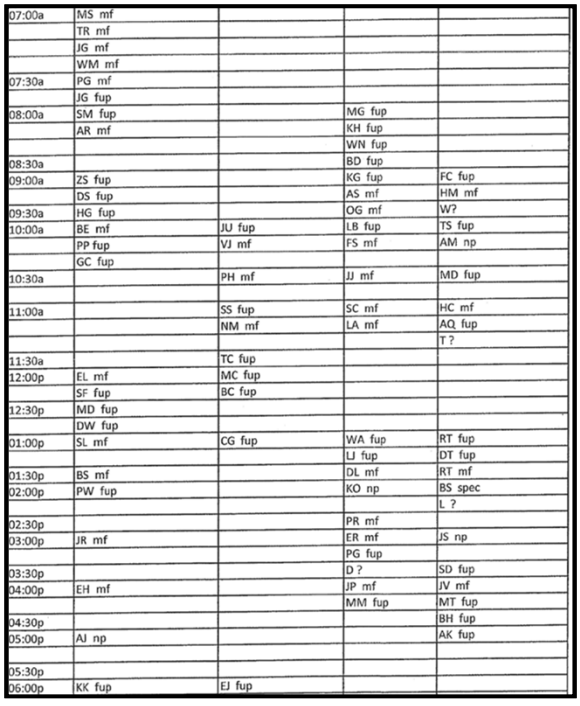
Clinic Calendar

- Are all treatments feasible?
- Are all treatments billable?
- Support personnel?
- Qualified support personnel?
- Supervision?
- Time apportioned for 1:1
- Group therapy?
- Chart notes?



07:00a	MS mf			
	TR mf			
	JG mf			
	WM mf			
07:30a	PG mf			
	JG fup			
08:00a	SM fup		MG fup	
	AR mf		KH fup	
			WN fup	
08:30a			BD fup	
09:00a	ZS fup		KG fup	FC fup
	DS fup		AS mf	HM mf
09:30a	HG fup		OG mf	W?
10:00a	BE mf	JU fup	LB fup	TS fup
	PP fup	VJ mf	FS mf	AM np
	GC fup			
10:30a		PH mf	JJ mf	MD fup
11:00a		SS fup	SC mf	HC mf
		NM mf	LA mf	AQ fup
				T?
11:30a		TC fup		
12:00p	EL mf	MC fup		
	SF fup	BC fup		
12:30p	MD fup			
	DW fup			
01:00p	SL mf	CG fup	WA fup	RT fup
			LJ fup	DT fup
01:30p	BS mf		DL mf	RT mf
02:00p	PW fup		KO np	BS spec
				L ?
02:30p			PR mf	
03:00p	JR mf		ER mf	JS np
			PG fup	
03:30p			D ?	SD fup
04:00p	EH mf		JP mf	JV mf
			MM fup	MT fup
04:30p				BH fup
05:00p	AJ np			AK fup
05:30p				
06:00p	KK fup	EJ fup		

Chart Audit

NancyBeckley & Associates
Rehab Compliance Resources

Patient ID _____ Date POC _____ Date POC Signed _____ Clinic _____

Dates: _____ to _____ # Visits _____ Review Date _____ Reviewer _____

Therapist _____ ☐PT ☐PTA ☐OT ☐COTA ☐SLP

Therapist _____ ☐PT ☐PTA ☐OT ☐COTA ☐SLP

Patient Evaluation & Plan of Care	YES	NO	N/A or Commer
hysician POC/Referral? Is there a script in the chart?			
ate of MD referral on Script			
s diagnosis stated? ICD-10 Medical Diagnosis (comes from MD)			
s rehab diagnosis stated? ICD-10 Reason for Rehab (therapist)			
te of injury/onset noted? What prompt referral? CHRONIC			
ith time frames? (not required by Medicare)			
h time frames? (entire episode of care)			
nctional Limitation Category/Impairment Rating/Rationale?			
t frequency & duration recommended? e.g. 3x w/4 weeks			
Exercises: "TE to increase UE ROM + TA to restore dressing"			
OL Mentioned – is it in chart?			
& measurements? From PT eval of patient			
lated to ADL activities, "Prior to injury patient could..."			
ehab history? Pertinent medical & rehab when, why?			
s? Results of eval – "following injury patient can't"			
nt plan explained to the patient? Input solicited?			
lent ☐Good ☐Fair ☐Poor note this			
Certified period for up to 90 days			
cumentation of attempts			
	YES	NO	N/A
r, same worse – TREND?			
noted?			
ed by PTA/COTA			

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Location: Patient Name: DOS: Therapist:

Occupational Profile & History		☐ **Brief** History Including Review of Records Relating to Presenting Problem	☐ **Expanded** Review of Records & **add'l review** of physical, cognitive, psychosocial hx related to current func. performance	☐ Review of Records and **Extensive Add'l review** of physical, cognitive, psychosocial hx related to current func. performance
Assessment (performance deficits)	Total # of Checks	Body Structure/Function/Physical Skills: ☐ Balance ☐ Mobility ☐ Strength ☐ Endurance ☐ FMC ☐ GMC ☐ Sensation ☐ Dexterity ☐ Vision ☐ Hearing ☐ Vestibular ☐ Proprioception ☐ Pain ☐ ROM ☐ Tone ☐ Continence ☐ Wound Cognitive Skills: ☐ Attention ☐ Perception ☐ Thought ☐ Understand ☐ Problem Solve ☐ Sequencing ☐ Learn ☐ Memory ☐ Emotional ☐ Consciousness ☐ Orientation ☐ Temperment/Personality ☐ Energy/Drive Psychosocial Skills: ☐ Interpersonal Interaction ☐ Habits ☐ Routines & Behaviors ☐ Coping Strategies ☐ Environmental Adaptations		
Clinical Decision Making		☐ Low	☐ Moderate	☐ High
		☐ Problem Focused Assessment	☐ Detailed Assessment	☐ Comprehensive Assessment
		☐ Limited # of Treatment Options	☐ Several Treatment Options	☐ Multiple Treatment Options
		☐ No Comorbidities	☐ May have comorbidities impacting occupational performance	☐ Presence of comorbidities impacting occupational performance
		☐ No Modification of Tasks or assist necessary to complete evaluation	☐ Min-Mod Modification of Tasks or assist with assess necessary to complete eval	☐ Significant Modification of Tasks or assist with assess is necessary to complete eval
Code:		Occupational Profile & History	Performance Deficits	Clinical Decision Making
Low Complexity -- 97165		☐ Brief	☐ 1-3	☐ Low
Moderate Complexity--97166		☐ Expanded	☐ 3-5	☐ Moderate
High Complexity--97167		☐ Extensive	☐ 5+	☐ High
OT EVAL CPT CODE SUPPORTED: ☐ 97165 (Low) ☐ 97166 (Moderate) ☐ 97167 (High)				

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LOCATION: PATIENT NAME: DOS: THERAPIST:

History	Total # Checks	Check all IMPACTING POC, if not impacting POC then do not check: ☐Comorbidity 1 ☐Comorbidity 2 ☐Comorbidity 3 ☐Sex ☐Age ☐Coping Style ☐Social Background ☐Education ☐Profession ☐Past / Current Experience ☐Behavior Pattern ☐Character		
Examination	Total # Checks	Body Systems: Musculoskeletal (Symmetry, ROM, Strength, Height, Weight, Pain, Posture): ☐Head ☐Neck ☐Back ☐LE ☐UE ☐Trunk Neuromuscular: ☐Balance ☐Gait/Locomotion ☐Transfers ☐Bed Mobility ☐Motor Control/Learning ☐ Cardiovascular/Pulmonary (HR, RR, BP, Edema) ☐ Integumentary (Pliability (texture), scar formation, color, integrity, wound) ☐ Other (Ability to Make Needs Known; Consciousness; Orientation; Learning Preference; Expected Behavioral/Emotional Response) Activity Limitation: ☐Bed Mobility ☐Transfers ☐Locomotion Level ☐Stairs ☐Bathing ☐Dressing ☐Toileting ☐Self Feeding ☐Hygiene/Grooming ☐Reaching Overhead ☐Bend ☐Squat ☐Lift ☐Carry ☐Stand ☐Sleep ☐Sit ☐ Continence ☐ Other Participation Restriction: ☐Work ☐School ☐ Church ☐Community Activity ☐Drive ☐ Volunteer ☐Interpersonal Rel'ship ☐Meal Prep ☐Cleaning ☐Shop ☐Laundry ☐Medication Mgmt ☐Personal Finances ☐ School ☐ Other		
Clinical Presentation		☐ Stable &/or Uncomplicated	☐ Evolving with Changing Characteristics	☐ Unstable & Unpredictable Char.
Code:	**History**	**Examination**	**Clinical Presentation**	**Clinical Decision Making**
Low Complexity -- 97161	☐ None	☐ 1-2	☐ Stable/Uncomplicated	☐ Low
Moderate Complexity--97162	☐ 1-2	☐ 3+	☐ Evolving with Changing Characteristics	☐ Moderate
High Complexity--97163	☐ 3+	☐ 4+	☐ Unstable/Unpredict.	☐ High
PT EVAL CPT CODE SUPPORTED:		**☐ 97161 (Low) ☐ 97162 (Moderate) ☐ 97163 (High)**		

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Risk Assessment Checklist - Customize

- Certification
- Service Code Usage
- Length of Stay
- Intensity per visit/episode
- License
- Exclusion/Sanction
- Code of Conduct/Compliance training
- P&P
- Denial Trends
- NCD
- LCD
- OIG Reports
- MedPAC Reports
- State Practice Act
- Conditions of Participation
  - Emergency Preparedness
- Section 1557
- HIPAA
- Pepper/CBR

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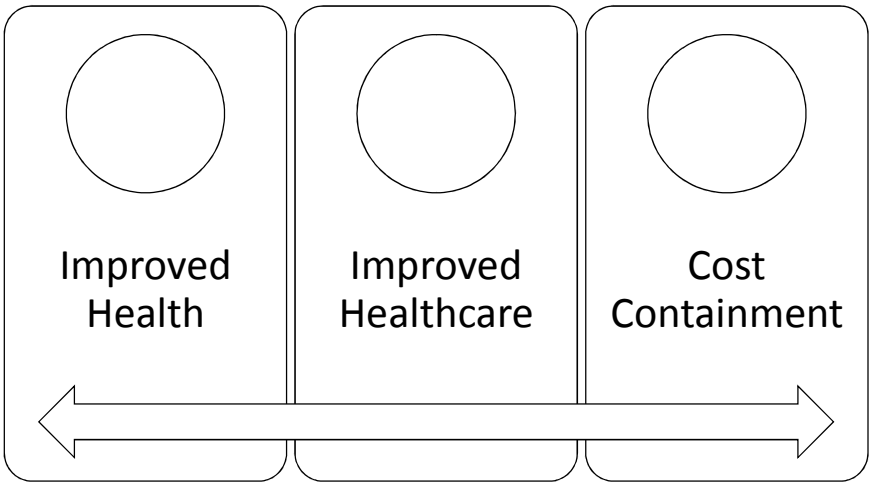
Health Care Reform



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Health Care Paradigm Shift

Historical

- Provider centric
- **Incentives for volume**
- Siloed care
- Fee for service

Reforming

- Patient centric
- Incentives for outcomes
- Coordinated care
- **Value based**/ alternative payment

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Resident Classification System-Version I Overview

- RCS-I is a PPS reform model aimed at revising payment methodology from **volume** to **value,** basing reimbursement on patient characteristics and not the amount of the services provided.
- RCS-I was published in April of 2017 as an Advanced Notice of Proposed Rule Making (ANPRM), https://www.regulations.gov/document?D=CMS-2017-0061-0002
- This model follows recommendations from the Office of the Inspector General (OIG) and MedPAC, a group that advises Congress.

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Under RCS-I Skilled Nursing Facility Level of Care Definition Will NOT Change

- Care in a SNF is covered if all of the following four factors are met:
  - The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
  - The patient requires these skilled services on a daily basis (see §30.6); and
  - As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
  - The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

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Under RCS-I Quality and Survey Expectations Will NOT Change

- New Survey Process secondary to Phase II Requirements of Participation went into effect 11.28.2017
- Short and Long Stay Quality Measures are still in place
- Quality Reporting Program
- Value Based Purchasing
- 5 Star Rating System

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RCS-I Structure

Looking at Therapy Implications

ADR/Denial Process (Reason) Changes from MDS

Contracting for Therapy Services

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Resident Classification System, Version I (RCS-I)

Current

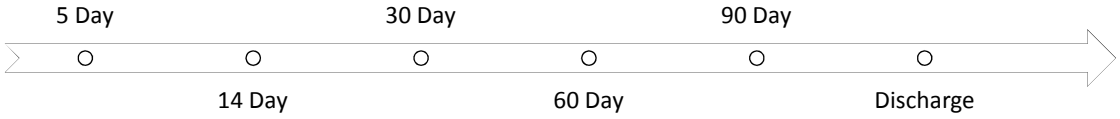
Length Of Stay Impact
None
Modes of Treatment Allowed
Individual
Concurrent
Group capped at 25%
MDS Assessment to Determine RUG
RUG level based on: Scheduled assessments: 5, 14, 30, 60 and 90 day Rolling 7 day checkpoint to determine any increase or decrease in total therapy minutes

Proposed

Length Of Stay Impact
PT/OT incremental payment decrease after day 14 NTA adjustment factor for days 1 to 3 at 3.00 and then setting it at 1.00
Modes of Treatment Allowed
Individual
Concurrent capped at 25% (this may be made discipline specific)
Group capped at 25% (this may be made discipline specific)
MDS Assessment to Determine RCS
5-day SNF PPS scheduled assessment to classify into RCS level. No additional assessments/change to RCS level unless criteria for a significant change are met 84

Proposed

Current



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5- day assessment

- RCS-I considers the possibility of reducing the administrative burden on providers by concurrently revising the assessments that would be required under the RCS-I model.
- Specifically, they are considering the possibility of using the 5-day SNF PPS scheduled assessment to classify a resident under the RCS-I model under consideration for payment purposes for the entirety of his or her Part A SNF stay, except as described below (SCSA, interrupted stay).

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Significant Change Assessment Importance

1

RCS- I also considers permitting providers to reclassify residents from the initial 5-day classification using the **Significant Change in Status Assessment (SCSA),** which is a Comprehensive assessment (that is, an MDS assessment which includes both the completion of the MDS, as well as completion of the Care Area Assessment (CAA) process and care planning).

2

This would only be used in cases where the criteria for a significant change are met in cases where an SCSA is completed, considering an approach in which this assessment could reclassify the resident for payment purposes, but the resident's variable per diem adjustment schedule would continue rather than being reset on the basis of completing the SCSA.

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MDS Key Areas for Assessment Accuracy

- Section B
- Section C
- Section D
- Section E
- Section G
- Section H
- Section I
- Section J
- Section K
- Section M
- Section N
- Section O

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Resident Classification System, Version I (RCS-I)

Current

RUG Component	Determining Factors
Therapy (23 RUG levels)	Total Therapy Minutes & Functional (ADL) Score/Extensive Services
VERSUS	
Nursing (43 RUG levels)	Diagnosis; ADL Score; Clinical Care; Behavioral or cognitive performance symptoms; Depression
PLUS	
Non Case Mix	

Proposed

RUG Component	Determining Factors
PT/OT (30 levels with Case Mix-CMI range .8 to 1.82)	Clinical Category (5); Functional Level (ADL); Cognition
PLUS	
ST (18 levels with Case Mix-CMI range .61 to 4.91)	Clinical Category (2); Swallow; Cognition/Comorbidity
PLUS	
Nursing (Case Mix 43 levels)	Diagnosis; ADL Score; Clinical Care; Behavioral or Cognitive Performance Symptoms; Depression
PLUS	
Non Therapy Ancillary (NTA) (6 Case Mix levels)	Comorbidities and Services
PLUS	
Non Case Mix	

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RCS-1 Unadjusted Federal Rate Per Diem

* Note this does not include geographic wage index*

Rates below are multiplied times the Case Mix Indexes for each component area and then added together to determine daily rate

- **Urban**

Rate Component	Nursing	NTA	PT/OT	SLP	Non-Case-Mix
Per Diem Amount	$100.91	$76.12	$126.76	$24.14	$90.35

- **Rural**

Rate Component	Nursing	NTA	PT/OT	SLP	Non-Case-Mix
Per Diem Amount	$96.40	$72.72	$141.47	$31.06	$92.02

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RCS-I Case Mix Example

Mr. Brown was admitted following acute onset of cerebrovascular accident

Case Mix- (1.47 x 126.76)+ (4.19 x 24.14)+(1.64 x 100.91)+ (2.02 X 76.12)+Non-Case Mix ($90.35)= 697.09 (daily for day 1-3)

- Physical and Occupational Therapy
  - TQ (1.47) Acute- Neurologic; Transfer TD (+2); Eating TD (+2); Toileting TD(+2)= Functional score of 6; No Moderate to Severe Cognitive Impairment
- Speech Language Pathology
  - SA (4.19) Acute Neurologic; Both Presence of a Swallowing Disorder and Mechanically Altered Diet; Both SLP Co-Morbidity and Mild to Severe Cognitive Impairment
- Nursing
  - LD1 (1.64)
- Non-Therapy Ancillary
  - NC Group- DM (2) and Parenteral Feedings Low Intensity (5)= Score of 7, Case Mix= 2.02

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Therapy (PT-OT) Component

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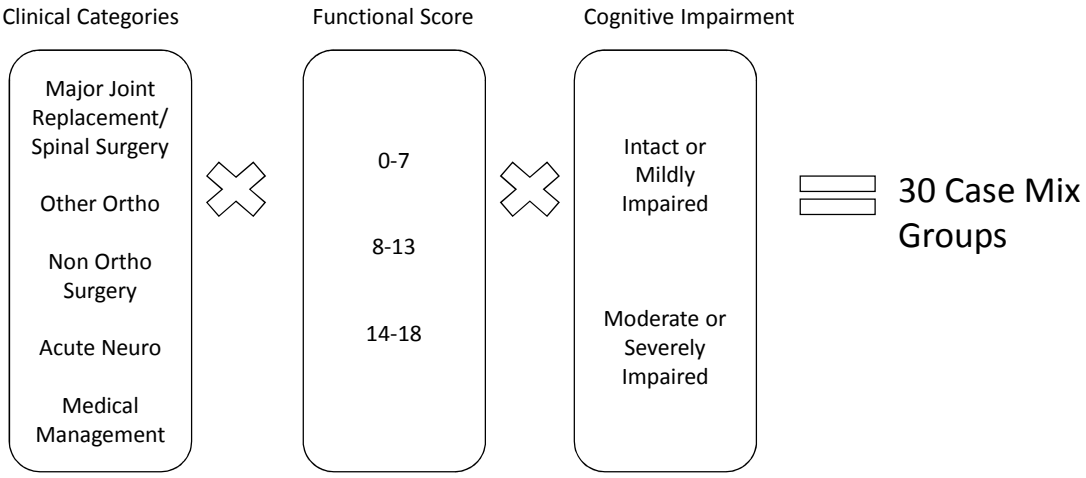
PT/OT Component Case Mix Groups are defined based on the clinical category, functional score (eating, transfers, and toileting) & level of cognitive impairment



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KEY MDS Areas PT/OT Component

- I8000 Clinical Category
- G0110B Transfers
- G0110H Eating
- G0110I Toileting
- BIMS or CPS
  - BIMS
    - C0200 Repetition of three words
    - C0300 Temporal orientation
    - C0400 Recall
  - CPS
    - B0100 Coma and completely dependent or ADL did not occur
    - C1000 Severely impaired cognitive skills (C1000 = 3)
    - B0700, C0700, C1000 Two or more of the following: B0700 >0 Problem being understood; C0700 =1 STM problem; C1000>0 Cognitive skills problem AND one or more of the following: B0700 >=2 severe problem being understood; C1000 >=2 severe cognitive skills problem

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PT/OT Functional Level Scoring Scale

Different scale from what is currently used in Section G
Note the difference in eating scale

ADL Self Performance Score	Transfer	Toileting	Eating
Independent	+3	+3	+6
Supervision	+4	+4	+5
Limited Assistance	+6	+6	+4
Extensive Assistance	+5	+5	+3
Total Dependence	+2	+2	+2
Activity Occurred Only Once or Twice	+1	+1	+1
Activity Did Not Occur	+0	+0	+0

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CFS Cognitive Scale Classification

The CFS combines the Section C: BIMS and CPS scores to account for the 12% of residents who are non-interviewable.

CFS Cognitive Scale	BIMS Score	CPS Score
Intact	13-15	--
Mildly Impaired	8-12	0-2
Moderately Impaired	0-7	3-4
Severely Impaired	--	5-6

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Major Joint Replacement or Spinal Surgery PT/OT

Clinical Category	Function Score	Moderate/Severe Cognitive Impairment	Case Mix Group	Case Mix Index
Major Joint Replacement or Spinal Surgery	14-18	No	TA	1.82
	14-18	Yes	TB	1.59
	8-13	No	TC	1.73
	8-13	Yes	TD	1.45
	0-7	No	TE	1.68
	0-7	Yes	TF	1.36

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Other Orthopedic PT/OT

Clinical Category	Function Score	Moderate/Severe Cognitive Impairment	Case Mix Group	Case Mix Index
Other Orthopedic	14-18	No	TG	1.70
	14-18	Yes	TH	1.55
	8-13	No	TI	1.58
	8-13	Yes	TJ	1.39
	0-7	No	TK	1.38
	0-7	Yes	TL	1.14

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Acute Neurologic PT/OT

Clinical Category	Function Score	Moderate/Severe Cognitive Impairment	Case Mix Group	Case Mix Index
Acute Neurologic	14-18	No	TM	1.61
	14-18	Yes	TN	1.48
	8-13	No	TO	1.52
	8-13	Yes	TP	1.36
	0-7	No	TQ	1.47
	0-7	Yes	TR	1.17

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Non-Orthopedic Surgery PT/OT

Clinical Category	Function Score	Moderate/Severe Cognitive Impairment	Case Mix Group	Case Mix Index
Non-Orthopedic Surgery	14-18	No	TS	1.57
	14-18	Yes	TT	1.43
	8-13	No	TU	1.38
	8-13	Yes	TV	1.17
	0-7	No	TW	1.11
	0-7	Yes	TX	.80

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Medical Management PT/OT

Clinical Category	Function Score	Moderate/Severe Cognitive Impairment	Case Mix Group	Case Mix Index
Medical Management	14-18	No	T1	1.55
	14-18	Yes	T2	1.39
	8-13	No	T3	1.36
	8-13	Yes	T4	1.17
	0-7	No	T5	1.10
	0-7	Yes	T6	.82

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SLP Component

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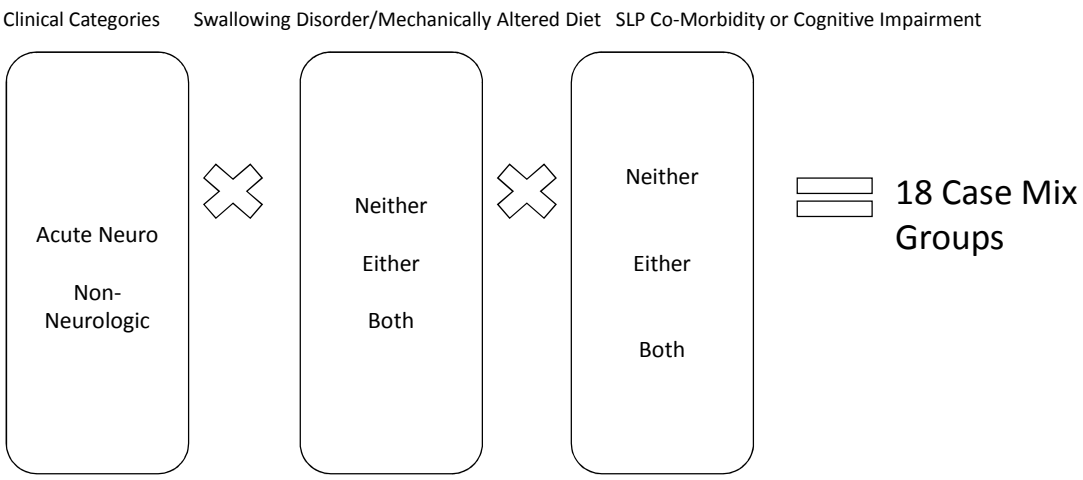
SLP Bucket Case Mix Groups



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Key MDS Areas ST Component

- I8000 Clinical Category
  - Aphasia; CVA, TIA or Stroke; Hemiplegia or Hemiparesis; TBI; Tracheostomy (while resident); Ventilator (while resident); Laryngeal Cancer; Apraxia; Dysphagia; ALS; Oral Cancers; Speech and Language Deficits
- Section K: Swallowing and Nutritional Status
- BIMS or CFS
  - BIMS
    - C0200 Repetition of three words
    - C0300 Temporal orientation
    - C0400 Recall
  - CFS
    - B0100 Coma and completely dependent or ADL did not occur
    - C1000 Severely impaired cognitive skills (C1000 = 3)
    - B0700, C0700, C1000 Two or more of the following: B0700 >0 Problem being understood; C0700 =1 STM problem; C1000>0 Cognitive skills problem AND one or more of the following: B0700 >=2 severe problem being understood; C1000 >=2 severe cognitive skills problem

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CFS Cognitive Scale Classification

The CFS combines the Section C: BIMS and CPS scores to account for the 12% of residents who are non-interviewable.

CFS Cognitive Scale	BIMS Score	CPS Score
Intact	13-15	--
Mildly Impaired	8-12	0-2
Moderately Impaired	0-7	3-4
Severely Impaired	--	5-6

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SLP: Clinical Categories

Clinical Category	**Description**
Acute Neurologic	Received treatment for acute neurologic condition (e.g. stroke) in prior inpatient stay
Non Neurologic	Did not receive treatment for acute neurologic condition (e.g. stroke) in prior inpatient stay

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ST Example- Acute Neurologic Case Mix

Clinical Category	Presence of Swallowing Disorder or Mechanically Altered Diet	SLP Related Comorbidity or Mild to Severe Cognitive Impairment	Case Mix Group	Case Mix Index
Acute Neurologic	Both	Both	SA	4.19
	Both	Either	SB	3.71
	Both	Neither	SC	3.37
	Either	Both	SD	3.67
	Either	Either	SE	3.12
	Either	Neither	SF	2.54
	Neither	Both	SG	2.97
	Neither	Either	SH	2.06
	Neither	Neither	SI	1.28

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ST Example- Acute Neurologic Case Mix

Clinical Category	Presence of Swallowing Disorder or Mechanically Altered Diet	SLP Related Comorbidity or Mild to Severe Cognitive Impairment	Case Mix Group	Case Mix Index
Non-Neurologic	Both	Both	SJ	3.21
	Both	Either	SK	2.96
	Both	Neither	SL	2.63
	Either	Both	SM	2.62
	Either	Either	SN	2.22
	Either	Neither	SO	1.70
	Neither	Both	SP	1.91
	Neither	Either	SQ	1.38
	Neither	Neither	SR	.61

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Nursing Component

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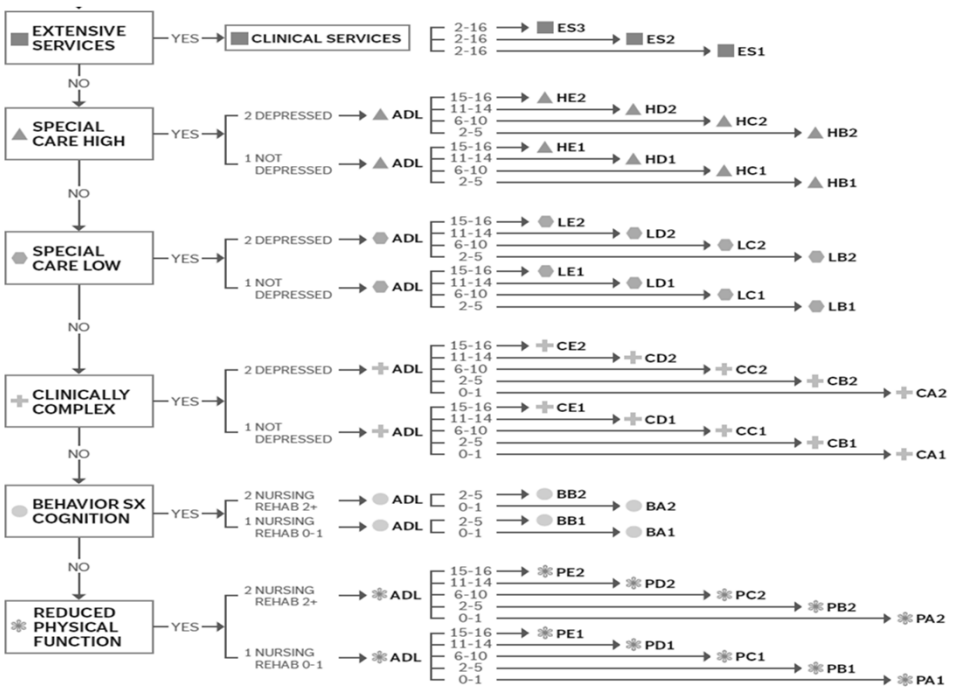

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Non Therapy Ancillary (NTA) Component

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Non Therapy Ancillary

NTA SCORE RANGE	NTA GROUP	CASE MIX
11+	NA	3.33
8-10	NB	2.59
6-7	NC	2.02
3-5	ND	1.52
1-2	NE	1.16
0	NF	0.83

- **HIV/AIDS**
- **Parenteral / IV feeding high intensity K0510A2**
- **IV medication O0100H2**
- **Parenteral / IV feeding low intensity K0710A2; K0710B2**
- **Vent/Respirator O0100F2**
- **Transfusion O0100I2**
- **Kidney Transplant Status I8000**
- **Opportunistic Infections I8000**
- **Infection with multi resistant organisms I1700**
- **CF I8000**
- **MS I5200**
- **Major organ transplant status I8000**
- **Trach O0100E2**
- **asthma, COPD, chronic lung disease I6200**
- **Chemo O0100A2**
- **DM I2900**
- **ESLD I8000**
- **wound infection (other than foot) I2500**
- **Transplant I8000**
- **infection isolation O0100M2**
- **MRSA I8000**
- **Radiation O0100B2**
- **diabetic foot ulcer M1040B**
- **bone/joint/muscle infection/necrosis I8000**
- **highest ulcer is stage 4 M300D1**
- **osteomyelitis and endocarditis I8000**
- **Suctioning O0100D2**
- **DVT/PE I8000**

	8 points
	7 points
	5 points
	2 points
	1 point

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What is the HHGM

- Removes use of therapy visits to determine payment/eliminates thresholds
- 144 different episode payment groups
- Groupings based upon:
  - Admission Source: Institutional Vs. Community
  - Timing
  - Clinical Groupings (6)
  - Functional Level
  - Comorbidity Adjustment
- Resource Use (Case-mix weight for each group)
  - Cost per minute + non-routine supplies
- 30-Day Episode
  - Early—First 30 day episode
  - Late

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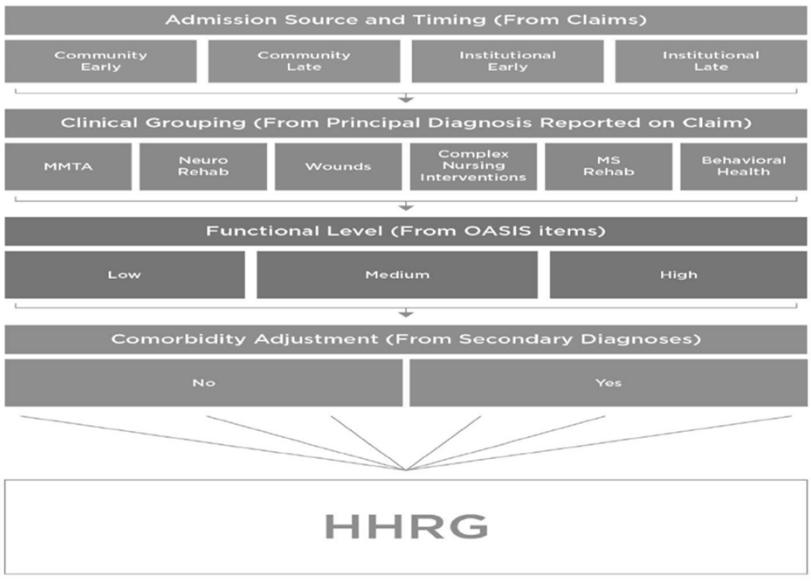
Structure of Proposed HHGM



Under the Home Health Groupings Model, an episode is grouped into one (and only one) subcategory under each larger colored category. An episode's combination of subcategories groups the episode into one of 144 different payment groups.

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Topics for Today

- Therapy focus explained: JIMMO, Probes, Targeted Medical Reviews, Supplemental Reviews, OIG reports and findings, Investigations, Therapy Related Civil Monetary Penalties
- Understand and implement the who, what, how and why of auditing therapy Conditions for Coverage, Conditions of Participation, and Conditions of Payment
- Take away an audit tool to ensure your focus on compliance with therapy technical and medical necessity requirements for restorative and maintenance therapy (JIMMO)

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Q & A

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