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# With Payment Changes and Medicare Audits, Therapy Services Are Ripe for Monitoring

By Nina Youngstrom

Because Medicare significantly increased payment for CPT code 97530 (therapeutic activity) in January, it's ripe for monitoring as part of an internal audit plan at organizations that provide rehabilitation. Therapists tend to bill CPT 97530 and 97110 (therapeutic exercises) incorrectly or are confused about how to bill them, and auditors have taken notice. The codes are the focus of at least one Medicare administrative contractor (MAC) under Targeted Probe and Educate (TPE), and they're an example of why rehab providers should track utilization, experts say.

It's hard for therapists to demonstrate their clinical judgment and support the medical necessity of CPT 97110 visit after visit because the patient performs therapeutic exercises every time and it can become repetitive, said Holly Hester, senior vice president of compliance and quality at Casamba. "If all your treatments look the same from a billing perspective, it could be a little red flag you're waving to your MAC, saying 'I am doing something out of the ordinary,'" she said. "CMS has told us over and over, shame on you if you change your practice based on reimbursement."

Monitoring utilization trends in rehab is an important part of compliance oversight, especially with auditors looking over their shoulder and new therapies gaining currency and codes, Hester said at the Health Care Compliance Association's Compliance Institute in April. Because of the potential for errors with the billing and documentation of physical, occupational and speech therapy—and the licensure and credentialing of therapists—organizations may want to include them in their annual Work Plans, said Yolunda Dockett, corporate compliance officer at Lorien Health Services, who also spoke at the conference.

External auditors certainly have their eye on rehab. Part B therapies in a hospital setting are on the list of approved issues in all states for recovery audit contractors (RACs), and they're a focus of TPE. For example, Novitas added physical therapy to TPE reviews in May. Inpatient rehabilitation facilities and skilled nursing facilities also are on TPE and RAC audit lists, and therapy drives a lot of their reimbursement. Auditors may zero in on suspiciously consistent billing for units of therapy, which are 15 minutes each, and rounding of therapy minutes. "Medicare expects the actual treatment time to be delivered, not to the nearest rounded minutes," Hester said. "If every treatment is 45 minutes on the dot, it's a problem. Therapists are good, but they are not that good at starting and stopping treatment. If every treatment is 38 minutes so you have just enough minutes to bill a third 15-minutes unit of therapy, that's a problem."

The documentation also has to be consistent with the codes. "When every single occupational therapy patient has M62.81, generalized muscle weakness, as the treatment diagnosis, that's a problem," Hester said. "It's even more of a problem if their evaluation says WFL—within functional limits—or maybe 'we forgot to look.' If you say in the evaluation the patient is functional with strength, but then you're saying you're treating muscle weakness, you are not," she said.

Hester advised rehab providers to keep an eye on recent developments, which may lead to more Medicare

coverage but could cause billing errors. For example, all 50 states now allow direct access to outpatient physical therapy, which means in some shape or form, physical therapists, like chiropractors, are allowed to treat patients for musculoskeletal conditions without a physician referral, she explained. But Medicare Part B and some commercial payers still require physician certification of the plan of care. "Now that every state has some form of direct access, there's talk about making that less restrictive," Hester said. "From a compliance perspective, knowing the state regulations and payer regulations around that is critical for setting up a practice for direct access."

## Codes Are Coming for Dry Needling

Another development is the growing use of dry needling, an intervention to manage musculoskeletal pain used in physical therapy. Hester said the American Medical Association is expected to establish level one codes for dry needling in the next update to its CPT book, which will take effect in January. For now, the American Physical Therapy Association recommends using unlisted codes, such as 97799, to report dry needling. "The first step is to have a code. Then the question becomes, is anyone going to pay for it?" she said. From a compliance perspective, if practices are delivering dry needling, they have to watch coding carefully and probably will have to collect payments directly from patients until payers cover the service.

Because the fate of therapy claims depends heavily on the medical necessity of rehab, compliance departments may want to include documentation reviews in their annual work plans (see chart below), Dockett said. "The Medicare manual is key," she noted. All physical, occupational and speech therapy guidelines are in Chapter 15 of the *Medicare Benefit Policy Manual* (section 220 and 230), which is followed by other payers.

Therapy begins with an order or referral, Dockett said. The rest of the documentation is about supporting medical necessity:

- **Evaluation/plan of care:** Documentation must include the medical diagnosis and the treatment diagnosis, which is determined by therapists according to the patient's functional deficits and comorbidities that they will address in the plan of care, Dockett said. "It's important to ensure our evaluations are patient specific," she explained. It's a red flag if a sample of 10 charts shows all patients have therapy five times a week for 30 days. "There should be variation consistent with what is documented in the functional assessment and documented goals."

- **Medical history:** "This should be comprehensive and describe all relevant conditions and comorbid conditions affecting the treatment and the patient's functional performance," she said. For example, if patients are evaluated for a decline in their activities of daily living (ADL), the therapist should consider whether they have a comorbidity of dementia. Dockett suggested looking for comparisons of past to current levels of functioning. "If the patient was independent at home and is at maximum assistance for ADL on evaluation, that supports the need for the evaluation."

- **Goals:** They should be objective and measurable, with goals that relate the patient's activity to his or her deficits, as identified in the plan of care. For example, therapists should include the amount of assistance or type of device used in the therapeutic activity. "If clinicians are working on transfers with patients, make sure they're documenting what they're using to perform the transfer," Dockett said. Is it a bed to wheelchair transfer with minimal assistance or with an adaptive device, such as a rolling walker? "Make sure you're specifying that," she suggested, along with the time frame for attaining the goal.

- **Encounter notes/daily notes:** They should be completed for every visit, Dockett said. "Therapists use encounter notes to demonstrate the continued need for the therapy services delivered, what was delivered and what the patient's response was," she said. They support the need for skilled services.

- **Skilled services:** "They require expertise, knowledge, clinical judgment and decision making that can only be delivered safely and effectively by or under the supervision of a licensed therapist," Dockett said. For example, caregiver education is a skilled service. "Did the client or caregiver demonstrate a transfer that you educated them on? Did they report an understanding of hip precautions that were provided to the client?" she said. Clinicians also have to document the patient's response to the treatment. Skilled services are documented in progress notes.

- **Recertification/updated plan of care:** Medicare requires physicians to recertify the plan of care every 90 days. Other payers are different, and there may be requirements under state practice acts.

- **Discharge summaries:** "This is the last opportunity for the clinician to document why services are needed and the individual's response to therapy," she said. "When I review documentation, a lot of times weekly notes and daily documentation [are] pretty weak. I rely heavily on discharge summaries to summarize therapy and services delivered as well as the patient's progress and performance." If patients are not meeting goals, clinicians should explain in the discharge summary why not (e.g., difficulty with lower body dressing) and articulate the goals and the patient's limitations (e.g., cognitive deficits).

Dockett said documentation may get "shakier" with longer lengths of stay. "I find over time that documentation tends to be weaker if patients are on a case load for more than 30 days," she explained. "I review documentation at 29 days and have calls with rehab leadership to ensure documentation supports required services."

State practice acts also are an important part of compliance reviews. Hester said therapists' licenses should be verified annually with the state, using primary source verification on state board websites. Also, therapists can't supervise a service performed by a therapy assistant unless they're both certified in the service if certification or credentialing is required by law. For example, if occupational therapy assistants are certified in physical agent modality (PAM), their supervising occupational therapists have to be PAM certified, she explained. And while most states grant temporary licenses to therapists while they await licensure exams, "Medicare is strict about what students can and can't do," Hester said.

Contact Dockett at ydockett@lorienhealth.com and Hester at holly.hester@casamba.net. ✧

## Audit Tool to Help Evaluate Compliance With Therapy Documentation Requirements

With physical, occupational and speech therapy under review by Medicare auditors, it's important to ensure the medical necessity of your services (see story above). This audit tool was developed by Holly Hester, senior vice president of compliance and quality at Casamba, and Yolunda Dockett, corporate compliance officer at Lorien Health Services. Contact Dockett at ydockett@lorienhealth.com and Hester at holly.hester@casamba.net.

### Rehabilitation Documentation Review

| | | |
|---|---|---|
| Facility: | Reviewer: | Date of Review: |
| Patient: | Discipline: | Therapist: |

| Areas to Review | Meets Expectations:<br><br>Y/N/NA | Comments |
|---|---|---|
| Physician Order/Referral | | |
| Referral/order is current? | | |
| Referral/order signed & dated by the physician? | | |
| Extension or other required order is in the chart? | | |
| Evaluation/Plan of Care | | |
| Evaluation is complete and documented timely? | | |
| Plan of Care signed and dated by physician/NPP within 30 days of Start of Care? | | |
| Reason for referral is clearly stated and supports therapy intervention? | | |
| Medical & treatment diagnoses are clearly stated and support Plan of Care? | | |
| Prior level of function supports treatment? | | |
| Medical history is comprehensive and relates to reason for treatment? | | |
| Functional testing completed and limitations clearly stated? | | |
| Therapist's clinical assessment/impression documented? | | |
| Goals are specific, measurable, functional, and have time frames? | | |
| Plan of Care includes interventions/procedures related to the goals? | | |
| Frequency and duration are appropriate and specific? | | |
| Progress Notes | | |
| Daily/treatment encounter notes present for all dates of therapy delivered, including treatment rendered on day of evaluation? | | |
| Progress reports completed by therapist as required by payer and applicable state practice acts? | | |

| | | |
|---|---|---|
| Number of treatments is supported by the frequency/duration? | | |
| Goals are addressed in encounter notes and progress reports? | | |
| Encounter notes reflect skilled interventions and time billed? | | |
| Patient's response to treatment is documented? | | |
| Education of patient, staff, caregiver, or family is clearly documented? | | |
| Progress reports support need to continue treatment? | | |
| Active participation by therapist at least every 10 visits for Med B? | | |
| Co-signatures are recorded as required by practice act? | | |
| Updated POC/DC Summary | | |
| Updated Plan of Care/Recertification signed and dated timely by the physician/NPP? | | |
| Discharge summaries are filed in the medical record and completed by clinician timely? | | |
| Discharge recommendations & referrals are made as appropriate? | | |
| Progress clearly documented? Comparison made from initial status? | | |
| Goals are addressed with explanations for goal(s) not attained? | | |
| Need for medically necessary, skilled service is documented? | | |

**Compliance Percentage:**

**Action Plan Recommended? Y / N**