Medicare Part B: Proactive Rehabilitation

HARMONY UNIVERSITY
The Provider Unit of
Harmony Healthcare International, Inc. (HHI)

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Housekeeping

- Sign In
- Contact Hours Certificate
- A Little About Me
- Handouts
- Contact Information for Questions

Cards are on the table: Be PROActive

- Introduction: Breakout from the same dealt hand…
Is it a Full Deck of Cards?

- Medicare Part B: Making a Decision to be Conservative or Aggressive?
- What card are you?
- The forgotten playing card...
- Potential to keeping the whole deck together and treating each card individually

Objectives

- Review of Medicare Part B Guidelines
- Medicare Part B Caps and Manual Reviews
- Documentation and Goal Writing
- Denial Management
- Proactive Program Development
- Leadership will strengthen the program

Medicare Part B: Skilled Therapy

- Entitled to Part B Beneficiaries pay additional to have Part B
- **Services must be skilled, reasonable and necessary**
- Part B reimburses 80% of fee screen. Additional insurance may cover the additional 20% (Medicaid, Medex)
Skilled Therapy Under Medicare Part B

- The Medicare cap on outpatient rehabilitation therapy services was instituted under the Balanced Budget Act of 1997 as a combined cap on speech-language pathology (SLP) and physical therapy (PT) services to Medicare beneficiaries.
- Separate cap on occupational therapy (OT).

Current therapy cap for Physical and Speech Therapy combined is $1,870 for calendar year 2012.

Current therapy cap for Occupational Therapy combined is $1,870 for calendar year 2012.

Services that meet the exceptions criteria and report the KX modifier on billing log will be paid beyond this limit with clinical justification.

Manual Medicare Reviews for Medicare Part B

- As of October 1, 2012, The phases of enacting the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 began.
- Through this new policy, any providers billing therapy services through Medicare Part B will be considered outpatient therapy services.
Manual Medicare Reviews for Medicare Part B

- **Outpatient services** includes:
  - Skilled Nursing Facilities
  - Long-term care facilities
  - Outpatient clinics
  - HOPDs (hospital-based outpatient clinics) previously exempt from the therapy caps
  - Private practices
  - Home health agencies

Manual Medicare Reviews for Medicare Part B

- Similar to the therapy cap, there is a **threshold of $3,700 for PT and SLP services combined** and another **threshold of $3,700 for OT services**. Such requests for exceptions will be manually medically reviewed.

- To ensure a timely and orderly implementation, providers within a Medicare Administrative Contractor (MAC) jurisdiction will be divided into **three Phases**. Each specific provider will be notified of their status in the phase-in process.

Skilled Therapy Under Medicare Part B

- **Treating all the patient's regardless of the medical conditions.** The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist.

- Skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic or terminal condition exists.

- The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve patient's condition. **In the case of a progressive degenerative disease, for example, service may be intermittently necessary to determine the need for assistive equipment and establish a program to maximize function.**
Skilled Therapy Under Medicare Part B

- There must be 3 days of supporting documentation reflecting an ongoing condition prior to therapy interventions?
  - While it is best practice to have an interdisciplinary team approach and have supporting documentation, if there is change in condition treatment should be provided
- Therapy cannot treat them they have exceeded the therapy cap or they just discharged from therapy?
  - If a resident present’s with a change in function and requires necessary skilled intervention, our documentation must reflect and treatment be provided
- Therapist treat Medicare Part B patient when the Medicare Part A and HMO patients census is low?
  - Treat all patients as equals regardless of payer source. Treat when necessary

Therapist treat Medicare Part B patient when the Medicare Part A and HMO patients census is low?

- Treat all patients as equals regardless of payer source. Treat when necessary
  - Despite the ever changing average daily census, best practice for any facility is to provide continue assessment and observation for changes on all residents despite the payer source

Medicare Part B Documentation Review
Rules & Regulations
Part B Service Delivery

- Local Medical Review Policy (LMRP) are published by each Intermediary
- Review to understand intermediary’s specific requirements and expectations related to Medicare B therapy billing
- Therapy documentation should reflect the wording and terminology used in the LMRP in order to support our claim

Skilled Rehabilitation MD Orders

- The service must be ordered by a physician
- Frequency and duration are required
- Must be current for entire time services are required
- “Evaluation and treatment as indicated” must be clarified

Physician Certification

- The therapy intervention must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional and must be reasonable and necessary to the treatment of the beneficiary’s illness or injury necessary to the treatment of the beneficiary’s illness or injury
Physician Certification

- Minimally required every 90 days
- Harmony recommends every 30 days.
- Continued physician oversight
- Ensure plan continues appropriate
- Summarize progress every 30 days
- 700 or 701 no longer required
- No longer a required format

Skilled Rehabilitation/MD Involvement

- MD involvement to prevent injuries
- Medicare allows the professional therapist to develop a suggested plan of treatment and to begin providing services based on the plan prior to MD signature
- MD signature required before facility bills Medicare
  - Timely considered less than 30 days
  - Recommend at time therapy initiates
- MD Faxed signatures acceptable

Prior Level of Function

- It has been determined that the prior level of function is one area reviewers are using to generate denials
- Prior level of function must be highly detailed and paint a picture of what the patient was doing at home
- Address problems identified on evaluation
- Discipline specific
Prior Level of Function

- A thorough prior level of function is the basis for the patient's long term goals
- Harmony recommends interviewing the patient as well as family or staff caregivers
- If info is not obtained at the time of evaluation, document in an addendum as soon as it is obtained

Evaluation

- Potential is good or excellent
  - For stated goals
  - Goals should be appropriate so they can be achieved
  - Not related to medical status
- Reason for Referral

Evaluation

- Previous Therapy
  - Reflects recent therapy related to this problem only
  - State previous therapy and reason (gait, ADL)
  - Documentation must support reason why seen again after a recent discharge (6 months)
Evaluation

- Narrative should summarize patient need, potential and reason a skilled therapist is needed.
  - Focus on functional status verses medical
  - Avoid negative statements

Onset Date

- Date of the medical or treatment diagnosis for which therapy services are being rendered Must be of a recent onset. Chronic conditions greater than 3 months are at risk for denial
- Emergency matters: choking, falling, etc. Require immediate attention and there is no need to “wait” for documentation
- For chronic diagnoses, indicate the date of the change or deterioration in the patient’s condition that now necessitates therapy services (acute exacerbation date)

Diagnosis

- Medical diagnosis supports deficits identified on evaluation being treated
- Be reported on the UB-04. What is the process between therapy and billing?
- Ensure chronic codes that are not related are not used
  - Dementia
  - UTI
Diagnosis

- Indicate the **Medical diagnosis** that has resulted in the **therapy disorder**
- Relate to the current plan of care for therapy
- Represent the most intensive services (over 50% of the revenue code billed)
- Relevant to the problem to be treated; e.g. O.A. with treatment diagnosis of “pain in the joint” or “difficulty walking”

Onset Date/Reason for Referral

- State specific decline or problem
- Not “admission”
- Nursing notes should support a change in condition requiring a skilled therapy services
- Nursing needs to clearly outline the precipitating event(s) to Rehab referral
- There is no federal requirement for 3 days of nursing documentation to initiate Part B services
- Rehab needs to work with nursing as a team

Reason for Referral

- Avoid statement such as “to purchase private wheelchair” or “New admission”
- Provide the reason for the referral as it relates to the primary or treating diagnosis or condition and the mechanism of injury
- For chronic conditions, an objective description of the changes in function (acute exacerbation) that now necessitate skilled therapy should be indicated
Writing Goals

- **Treatment goals** are of two types, separate or in combination
  - The functional outcome goal identifies the desired client performance resulting from therapy (dress, ambulate, articulate)
  - The enabling goal identifies the method by which a therapist enables a client to accomplish the goal (increase ROM, improve memory, increase activity tolerance)

Writing Goals

- Treatment goals should:
  - Be realistic
  - Have a positive effect on the quality of the patient's life
  - Be measurable and quantifiable
  - Be related to function
  - Appropriately reflect the patient's needs

Writing Goals

- Treatment goals consist of:
  - **Short-term goals** are interim targets; steps to achieve the long-term goals. Achieved in 2 weeks.
  - **Long-term goals** are what the client will have achieved at the time of discharge
Writing Goals

- Treatment Goal Components
  - **Functional Outcome** – (required) the desired result
  - **Qualifier** – (required) objective measure
  - **Techniques or Strategies** – verbal cues, energy conservation techniques
  - **Condition** – requirements necessary for correct performance; description of the environment, adaptive equipment

Duplication of Services

- Rehab goals can appear to be demonstrating a duplication of services. High risk of denial
- Commonly seen goal areas:
  - Independence with bed mobility
  - Transfers
  - Ambulation

Duplication of Services

- The goals must be written to differentiate the skilled area to be addressed by each discipline
- Careful review of what the patient must be able to do to return home safely to formulate goals
- Goals can then be broken down into subsets of what tasks the patient must complete on a daily basis to be successful at home
Daily Notes

- Treatment encounter notes is required for every treatment day, and every therapy service
- The treatment encounter note must record:
  - The name of the treatment, intervention or activity
  - The time spent in services represented by timed codes
  - The total treatment time
  - The identity of the individual providing the intervention

Progress Notes

- **Progress Reports**: Progress reports should be completed every 10 treatment days or 30 calendar days whichever is less. These will include components required in the weekly progress summary while also requiring:
  - Updated goals and treatment plan with identification of significant improvement in functional skills
  - Weekly recommended
  - 10th visit must be by PT or OTR and documented

Progress Notes

- **Progress Report Content**
  - Assessment of the **patient's response** to the services
  - **Progress** towards each of the treatment goals
  - Documentation of any **treatment variations** with the associated rationale
  - Progress within levels of care
  - Re-assessment and establish new goals
Progress Notes

- Document the need for **continued services by a skilled therapist** versus the use of restorative nursing
  - Non-skilled services include: Observing or monitoring, general practice techniques, and reviewing previously learned material
  - Skilled services include: Educating the patient, assessing mobility skills, evaluating the effectiveness of, instructing the patient in a progressive exercise program, or modifying the treatment program

Progress Notes

- Identify the **expectation for further progress**
- Identify the resident’s **risk factors** that may be eliminated by receiving the therapy services

**Examples:** The resident is at a high risk to fall due to balance deficits, the resident is at high risk for aspiration due to delayed swallowing response, or the resident is at high risk for burns due to problems spilling while attempting to drink from a cup

Progress Notes

- Justify the **frequency, duration and intensity** of the treatment
  - **Example:** The resident would benefit from one more week of treatment at five times per week to provide reinforcement and carryover of the functional tasks. The program will continue with a progression of the exercise program, modifications to the functional maintenance program and completion of staff education with the functional maintenance program
Progress Notes

- Any change in the treatment plan would require physician clarification orders.
- The completion of clarification orders in the physician order’s (telephone orders) section of the medical record to communicate the expected treatment plan with the physician and receive verbal approval for the treatment to continue. The physician will still need to sign the written treatment plan prior to billing Medicare for the therapy services.

Re-Evaluation

- Re-evaluations are appropriate when a significant change occurs or there is a need for formal re-evaluation to establish initial baseline data not previously recorded. The billing codes for re-evaluation should be used in these instances only as a one-time charge. The re-evaluation codes should not be billed for completion of the monthly summaries, discharge summaries or when sending general information into the physician.

Denial Reasons: Audit Focus
Reasons for Denials

- Services related to activities for the **general good** and welfare of patients (e.g., general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation), do not constitute physical therapy services for Medicare purposes
- **Diathermy** and **Ultrasound** heat treatments for the treatment of asthma, bronchitis, or any other pulmonary condition are considered not reasonable and necessary, and therefore, non-covered.
- **Electrical Stimulation** used to treat motor function disorders, such as multiple sclerosis, is considered investigational and therefore, non-covered.
- **Electrical Stimulation** used in the treatment of facial nerve paralysis, commonly known as Bell’s Palsy, is considered investigational and therefore, non-covered.
- **Home health** physical therapy is not covered to treat Skilled Nursing Facility patients.
- **Work hardening/conditioning** is a non-covered service. These services relate solely to specific work skills and do not provide any diagnostic or therapeutic benefit for the patient that requires physical rehabilitation.
- Failure to document a complete treatment plan as outlined in Documentation Required section.
- Services determined not to require the skills of a therapist.
Reasons for Denials

- **Lack** of documentation relating to the patient having the potential to show significant progress
- **Goals are not functional** (i.e., patient will perform 10 repetitions of upper extremity exercises with the yellow theraband)
- **The amount, frequency and duration of services were not reasonable, given the patient’s current status**

Reasons for Denials

- **Gains were not significant** and there was no indication of carryover of the functional task
- The outcome of therapy treatment was not documented
- Duplication of services between physical therapy and occupational therapy
- Skilled therapy was provided when non-skilled maintenance services would have been more appropriate
- The therapist ignored the patient’s prior level of function and set unrealistic goals

Patient Identification and PROACTIVE Program Development
Program Development

- Successful development and implementation of a Part B therapy program
  - Identify all patients in-house who have access to Part B benefits. Consider co-payment source as well
  - Implement process to get patient/family approval for Part B therapy services prior to delivery
  - Educate nursing on appropriate patient referrals for Part B therapy services
  - Therapy to initiate routine review of key facility reports to address resident needs in a timely fashion (e.g., falls, weight loss, skin, etc.)

Medicare Part B Proactive Rehab

- Routinely perform 30-day window of wellness, quarterly, annual, and significant change in status screens
  - Review previous therapy service dates or documentation for most recent services or reviews
  - Review ADL flow sheets for previous three months and current month’s notes for any dramatic changes in coding
  - Review nursing documentation for one to identify any red flag areas (falls, skin issues, positioning issues, incontinence, pain, feeding issues)

Program Development Systems for Resident Identification

- 24 Hour Report review daily
  - Facility knowledgeable on how to identify declines in functions
  - Effective Communication at Daily Stand-Up and Weekly Medicare Meeting
  - Develop Specialty Programs and perform monthly or quarterly rounds
**Patient Identification**

- Review MD orders for 1-2 months for med/diet change orders, equipment orders, and recent acute diagnosis that may indicate a therapy screen is needed
- Interview direct care staff for patient's with a functional decline in mobility, ADLs or communicating
- Review patients at RISK for skin issues, weight, pain, behavior, restraint, incontinence and fall risks
- Review MDS data for changes from prior assessments focus on ADLs, mobility, ROM, pain, and cognition

**Progress Notes**

- Progress reports written by assistants supplement the reports of the clinicians (between 10 visits)
- These notes need to consist of:
  - Date of the beginning of the interval the report refers to
  - Date that the report was written (within the interval)
  - Objective reports of the patient's subjective statements
  - Objective measurements or description of changes in status relative to each goal being addressed
  - Signature of the professional and the date it was written

**Program Development**

- Create a Clinical Leader Program partnering Rehab and Nursing staff for program development
- **Lunch and Learn** Program In-Servicing
- Create STOP Program: See, Tell, Observe and Referral Program
Program Development

Specialty Programs

- Pain Management
- Seating and Positioning
- Contracture Management
- Wound Care
- Dementia Rounds
- Dementia Intervention (mobility, communication, safety and behavior)
- Dining Rounds
- Activity Rounds
- Therapy Integration with RNA
- Continence Program
- Rehab Dining
- Dysphagia Management (Altered consistencies)
- Fall and Balance Program
- Comprehensive use of modalities and other treatment areas

Pain Management Program Development

- Clinical Partnership:
  - Nurse Clinical Leader: Pain Management Specialist
  - Rehab Clinic Leader: Modalities and Manual Therapy

Strategies for Identify patients with pain:
- Review patients weekly during RISK meeting to identify current pain management program and review pain assessment to identify changes
- Review MD orders of scheduled versus PRN pain medication
- Talk with team regarding patients stating they have pain while completing ADL care, transfers during activity programs
- Monitor patients with decline in ability to move joints or increase difficulty with range of motion. Also monitor increase behaviors such as increase yelling, combative ness, change in moods or sleep pattern may be caused by pain symptoms
Pain Management Program Development

Examples of Reason for Referral:

- Patient has had increase pain which prevents patient from performing functional tasks
- Patient requires more assistance from caregivers due to pain
- Patient referred by Nursing to OT services due to patient has increase pain in R shoulder causing patient to have moderate assist with toileting skills and transfer

Examples Prior Level of Function:

- Patient was able to put on shirt with minimal assistance. Patient had little to nor pain in shoulder while getting dressed
- Patient required increase time due to joint stiffness; however, reports no prior pain hindering functional performance

Assessment Tools: Numerical pain scale, Facial pain scale, Goniometry and Manual Muscle Testing and Sensory testing kits

Examples of Goals:

- Patient will have decrease R shoulder pain 3/10 pain with use of diathermy and gentle stretch to increase ROM in prep for combing back of hair
- Patient will have 1 complaint of pain to R shoulder while stretching arm up to put on pull over shirt with minimal assistance
Pain Management Program Development

- Treatment activities:
  - Patient tolerate modalities: Estim, diathermy, ultrasound, hot pack, etc. to decrease pain and increase joint flexibility
  - Soft tissues massage, joint mobilization, relaxation techniques

Seating and Positioning Program Development

- Clinical Partnership:
  - Clinical Nurse Leader: Skin integrity specialist
  - Clinical Rehab Leader: Positioning Specialist
  - Equipment Leader: Safety Specialist to check equipment

- Strategies for Identifying positioning problems:
  - Positioning Rounds performed routinely to inspect proper use of seating system and identify change in condition
  -Examples: Falls forward, leans to one side, feet dangle in chair, new pressure ulcer or edema, slides out of chair, reduce restraints, head and neck pain or abnormal position or needs more assistance with propelling wheelchair
Examples of Reason for Referral:
- Patient sliding from wheelchair and requires frequent repositioning
- Patient having difficulty propelling wheelchair and maneuvering around obstacles
- Patient has increased leaning and pain in side or patient has increased coughing during meal due to head flexed forward

Prior Level of Function:
- Patient seated in 16” hemi height wheelchair with pressure reducing seat cushion
- Patient able to propel wheelchair 50 feet with verbal cues for safety

Assessment Tools: Comprehensive seating assessment include mat assessment including supine, unsupported seating and supporting seated positions. Goniometry measurement, manual muscle and coordination testing
**Program Development**
*Seating and Positioning Program*

**Goals:**
- Patients will require mod A to anterior weight shift and rise sit-to-stand due to poor muscle contractile strength
- Patient will tolerate seating system with use of lateral support cushion to increase trunk control to good sitting balance and promote safe swallow during meals with s/sx of discomfort or skin integrity issues

**Program Development**
*Seating and Positioning Program*

**Treatment activities:**
- Supine and unsupported sitting exercise to increase trunk control, use of modalities to decrease joint stiffness and pain, wheelchair mobility training

**Program Development**
*Wound Management Program*

**Clinical Partnership**
- Clinical Nurse Leader: Skin Integrity Specialist and Dietician
- Clinical Rehab Leader: Wound Specialist include Modality use
Program Development
Wound Management Program

Strategies for identifying skin integrity issues:
- Identify RISK meeting active skin integrity issues, nutritional decline, impaired sensation, incontinence, prior wound history
- During Positioning Rounds discuss potential skin issues and Wound Care rounds discuss current treatments for skin integrity issues
- Regular Communication and Educate Rehab’s Roles with Wound Care Specialty team
- Review Norton Pressure ulcer risk or Braden Scale for change and risks

Example of Reason for Referral:
- Patient has had a Stage III coccyx wound treated by skilled nursing for past 35 days and presents with increase pain and inability to remain OOB
- Patient has increase complaints of pain to left heel which nursing reports is red, boggy, and difficulty for patient to transfer from bed to wheelchair

Prior Level of Function:
- Patient has been followed by Wound Team and continues to present with State III coccyx wound with daily dressing changes and using ROH0 seat cushion while OOB
- Patient with history of peripheral vascular disease presents with skin breakdown to heels, has been min A with stand-pivot transfers during care
Program Development
Wound Management Program

Evaluations should portray clinical necessity for skilled therapy intervention:
- Etiology and duration of wound, type of prior treatment by medical team, stage of wound, description of wound including length, width, depth, grid drawing are a few examples

Example of Goals:
- Patient will decrease size of wound by .1cm with increase in granulation tissue to promote healing to coccyx area
- Patient will be able to reposition self in wheelchair with min assist to provide pressure relief and increase circulation to promote wound healing to coccyx

Treatment Activities:
- Reflect the skilled plan of treatment, including specific frequent of the modality. For example: Electrical Stimulation for a chronic state III and IV pressure ulcer, arterial ulcer, diabetic ulcer and venous stasis ulcer not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care.
- Positioning program, use of modalities including diathermy and ultrasound
- Educating patient on monitoring skin integrity, ability to reposition self and treat limitation in transfer and mobility
Program Development
Contracture Management Program

Clinical Partnership:
- Clinical Nurse Leader: Restorative Nurse Programmer
- Clinical Rehab Leader: Contracture Management Specialist

Strategies for identifying contracture risk:
- Daily stand up, 24 hours report regarding increase pain, joint stiffness, muscle spasms, tonal changes for example
- Patient currently on splinting program, regularly assess appropriate use and necessity for splint
- Interview staff to identify patients who have new or increase limitations of movement that are affecting function
- Review MDS (Section G04000) to identify change in range of motion

Reason for Referral:
- Patient refusing to wear resting hand splint, reports pain with wear and redness noted after 2 hours of wear time
- Patient has increase tone to left elbow and direct care staff report patient has increase pain and difficulty with donning shirts
Program Development
Contracture Management Program

Prior Level of Function:
- Patient was issued R resting hand splint on May 2011 and was wearing splint up to 8 hrs a night
- Patient had full functional range of motion to R hand and was able to grasp and hold utensil to self feed with independence

Examples of Goals:
- Patient will increase left elbow extension by 10 degrees and have min complaints of pain in prep for orthotic fit and prevent further contracture
- Patient will tolerate R resting hand splint x 4 hours with signs or symptoms of pain or irritation in order to have increase ability to grasp and hold object during meals

Treatment Activities:
- Use of modalities to cause vasodilatation and relieve pain from muscle spasm. As well as to increase mobility in the tissues.
- Passive, Active assisted, Active range of motion exercises
- Splint fabrication and trial use and training to prevent further contracture and increase joint flexibility
Program Development
Cognitive Dementia Program

- Clinical Partnership:
  - Clinical Nurse and Therapist: Dementia Specialist, Activities Department, Dementia Programmer
- Strategies for Identifying Cognitive Program:
  - Interview staff and families to identify change in resident's condition such as: Answers questions inappropriately. Needs assistance finding room (was able to find previously). Forgets eating meals / refuses stating they have already eaten. Taking food from others tray. Disoriented – needs constant reminders about person, place, time. Difficulty communicating needs and wants

Program Development
Cognitive Dementia Program

- Reason for Referral:
  - Patient has had decrease attention span and causing difficult to redirect to attend to self feeding
  - Patient unable to complete self care task as is demonstrating frustration when present with multiple step task of washing, grooming and dressing

Program Development
Cognitive Dementia Program

- Prior Level of Function:
  - Patient was able to self feeding in supervised dining room with occasional verbal cues for 100% of meal
  - Patient was able to gather clothes from closest and perform sponge bath at sink level with standby assistance with min verbal cues
Program Development
Cognitive Dementia Program

- Evaluation to include formalized assessment to identify patient’s cognitive ability. Testing will capture patients ability to follow simple commands, attend to task, problem solve or remember task for example
- Examples of Goals:
  - Patient will complete upper body dressing with visual cue card to instruct one step at a time with min assistance
  - Patient will complete table top activity with 5/8 items and demonstrates a 5 minute attention span with 2 verbal cues to redirect

Program Development
Cognitive Dementia Program

- Treatment Activities:
  - Orient patient to treatment area to increase awareness with use of visual memory aides
  - Focus on attention span and ability to concentrate on task with low stimulus to heavy stimulus environment

Program Development
Dining Rounds

- Clinical Partnership:
  - Clinical Nurse Leader: Hands on Deck nursing staff
  - Dietary Specialist: dietician and Dietary Manager
  - Clinical Therapist Leader: SLP or OT with interest in feeding and Dysphagia treatment
Program Development
Dining Rounds

- Strategies to Identify Dining Program:
  - Perform regularly scheduled Dining Rounds to identify patient's who are at risk for weight loss, has difficulty feeding self, abnormal positioning at meals.
  - Pt who have difficulty swallowing, signs and symptoms of Dysphagia including: food pocketing, choking/coughing, drooling taking longer time to finish meals, recurrent or slow resolving respiratory issues.
  - Increased visibility of the therapy professionals during meal times.
  - Screen those with alerted diet and use of adaptive equipment to identify if still relevant for current use.

Program Development
Dining Rounds

- Assessment Tools to consider:

Program Development
Dining Rounds

- Reason for Referral:
  - Patient has had 10-pound weight loss in the past 3 month and has little interest in eating.
  - Patient noted to have increase drooling and storing food in cheeks while eating regular diet with think liquids.
  - Patient has increase spillage of food and beverages while self feeding.
Program Development
Dining Rounds

Prior Level of Function:
- Patient was independent feeding self in independent dining room with use of one-handed feeding equipment
- Patient tolerated mechanical soft diet with nectar thick liquids. Patient requires minimal verbal cues for 100% intake

Examples of Goals:
- Patient with use rocker knife with non-affective hand to cut up meat with stand by assistance
- Patient will alternate solid and liquids to promote safe swallow with 75% of meal with min verbal cues
- Patient will establish good carryover of clock method to identify food items on table top to increase self feeding skills with minimal assist

Treatment Activities:
- Visual and perceptual retraining exercises to determine ability to identify objects during meal
- Use of adaptive equipment to decrease spillage and increase ability to self feed
Program Development
Incontinence Management

- Clinical Partnership:
  - Clinical Nurse Leader: direct Care Nursing Staff
  - Clinical Rehab Leader: Continence Management Specialist

- Strategies to Identify Continence Management Program:
  - Review the MDS (section H)
  - Assess current caseload for incontinence, ensure it is part of the plan of care. Observe for signs of incontinence example patient having increase need to use toilet, has increase wetness, using incontinence products.
  - Interview direct care staff to see whom they toilet often or find wet
  - Review facility reports and quality indicator reports

- Assessment tools to consider:
  - Comprehensive Incontinence Assessment
  - Reason for Referral:
    - Patient is noted to have increase wetness during day and increase frequency using toilet as compared to 2 weeks ago
    - Patient has urinary leakage while coughing or laughing
    - Patient reports increase urgency to urinate
Program Development
Incontinence Management

- Prior Level of Function:
  - Patient is independent toileting self and able to anticipate need to urinate and no leakage noted

Program Development
Incontinence Management

- Examples of Goals:
  - Patient will decrease urinary incontinence to 3 incontinence products
  - Patient will decrease from 6 cups to 4 cups of bladder irritants per day
  - Patient will increase time between voiding episodes from 1 hour to 2 hours

Program Development
Incontinence Management

- Treatment Activities
  - Scheduled voiding or habit training
  - Bladder retraining for stress, urge or mixed incontinence
  - Pelvic muscle exercises
  - Electrical stimulation
  - Environmental changes for easier access to bathroom
Falls and Balance

Assessment Tools to consider:
- Tinetti’s Test, Berg Test, Functional Reach test, chair stand test, and 6-minute walk test

Reason for Referral:
- Patient has unsteady gait while ambulating from room to dining room and has had 2 episodes of loss of balance in the past week
- Patient able to ambulate 35 feet with rolling walker with min assist x 1 however requiring increase verbal cues for safety
- Patient requires verbal cues for hand placement to push up to stand and unable to bear weight onto left leg due to sore on heel

Prior Level of Function:
- Patient was able to ambulate 100 feet with rolling walker with supervision for safety
- Patient required mod A x 1 to roll to left side to get from side-lying to edge of bed

Clinical Partnership:
- Clinical Nurse Leader: Risk Manager, Safety/Quality assurance Nurse
- Clinical Rehab Leader: Falls and balance specialist
Program Development
Falls and Balance

- Strategies to Implement a Falls and Balance Program:
  - Review Risk Meeting note and review falls reports and data
  - Daily Risk Meeting note and review falls reports and data
  - Interview staff to identify who requires more assistance, who requires frequent redirecting on transfer and mobility. Identify patients have increase difficulty with bearing weight, transferring, ambulating, has changes in vision, or altered muscle tone.

Program Development
Falls and Balance

- Examples of Goals:
  - Patient will decrease left knee pain to 2/10 and build gross LE strength to 4/5 to focus on stand pivot transfers
  - Patient will increase static standing to fair + with ability to right self with min assist for 1 minute in order to perform standing ADL tasks
  - Patient will ambulate 75 feet with CTG A with rolling walker with slight SOB on exertion and <90% O2 saturation on 1L NC

Program Development
Falls and Balance

- Treatment Activities:
  - PREs, Strengthening and balance programming, analyze gait patterns over various surfaces, ongoing graded cueing to improve deviation in weight shift during swing phase of gait. Functional reach activities and obstacle course or walk test programming
Skilled Therapy
Under Medicare Part B

- **Maintenance Program**: During the last visits for rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized skill, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

Billing: Correct Coding Initiative (CCI) Edits

CPT Coding

- Proper rehabilitation coding is required to obtain reimbursement for Medicare part B services
  - Reflect established goals and treatment plan
  - Be an accurate description of services provided
  - Be specifically supported in daily documentation
  - Demonstrate the complexity of treatment provided
Service based codes are codes which indicate that a treatment modality or procedure occurred on a specific date. These codes are billed for 1 unit and are not related to the time it took to deliver the service.

Timed codes are based on 15 minute units of time. The number of units is based on the total time for treatment delivery. The number of units of billed codes is based on an 8 minute rounding rule.

- 8 - 22 minutes = 1 unit
- 23 - 37 minutes = 2 units
- 38 - 52 minutes = 3 units
- 53 - 67 minutes = 4 units
- 68 - 82 minutes = 5 units
CPT Coding

- 8 - 22 minutes = 1 unit
- 23 - 37 minutes = 2 units
- 38 - 52 minutes = 3 units
- 53 - 67 minutes = 4 units
- 68 - 82 minutes = 5 units

8 Minute Rule

- Increase in denials related to not applying the 8 minute rule
- Can bill for each HCPC based on 8 minute rule however total time must also equal total units billed under 8 minute rule

Example:
Physical Therapy works with a patient for 24 minutes (2 units) on neuromuscular re-education (97112) and 23 minutes (2 units) of therapeutic exercise (97110)

Since the total treatment time was 47 minutes, there should be a total of 3 units billed (not 2 units for each code)
Method of Service Delivery

- Individual therapy – one on one intervention
- Group therapy (97150)
- Concurrent therapy should be billed as group treatment under Med B
- Co-treatment time needs to be split between the therapists

Students and Rehab Aides

- Services provided by rehabilitation aides cannot be billed to Medicare B (they may be billed to Medicare A and other payors when properly supervised)
- Services performed by therapy students are not reimbursed by Medicare B

Correct Coding Initiative (CCI) edits

- National guidelines developed to limit fraud and abuse in billing practices
- Edits include mutually exclusive codes and bundled codes
- Mutually exclusive codes are those that cannot be billed together on the same day. They are considered to be procedures that would not reasonably be performed at the same patient encounter
- Component codes identify those codes that are considered bundled together into a more comprehensive code. All time spent on these codes in one session would be added together and billed under the comprehensive code
Correct Coding Initiative (CCI) edits

- In order to bill comprehensive and component codes together on the same service day a modifier (-59) must be added to the UB-04
- Documentation must indicate that these services were delivered separately (different time frame, different session/visit/encounter, different body part addressed, different discipline)
- Failure to follow these edits will result in line item denial (denial of a specific code)

Comprehensive Codes Examples

- The group code (97150) is either mutually exclusive or comprehensive and encompasses all of the therapeutic procedure codes (97110, 97750). You must identify that the group intervention occurred at a different time than individual treatment when performed on the same day
- Therapeutic activities (97530), orthotic training (97504), and prosthetic training (97520) are codes which encompass many of the commonly used therapeutic procedure codes

Example for orthotic training (97504) and gait (97116):
- If the orthotic intervention is for the UE, bill both codes
- If the orthotic is for the LE and gait training was related to use of the orthotic bill all time under 97504
- If the orthotic is for the LE but it was not utilized or addressed during gait training, bill both codes. Orthotic placed after gait, orthotic education of patient or caregivers on placement and fit, gait training with focus on facilitation of trunk control, correction of gait deviations, etc. Documentation must identify separate services
Speech Therapy

- Average SLP caseload consists of 70% Dysphagia cases
- Reimbursement for almost all speech codes are in service codes and not timed
- Treatments primarily consist of 92526 (dysphagia) 92507 (speech)
- Most intermediaries will not allow use of 97000 codes (exercise)

Occupational Therapy

- Average OT caseload consists of 80% ADL Retraining cases
- Reimbursement for almost all care is in timed codes that can be billed multiple times in a single day
- Sessions 30 to 45 minutes in length most commonly
- Treatments primarily consist of 97110, 97535 and 97530

Physical Therapy

- 90% of caseload is Gait Training
- Most frequently billed codes are 97116, 97112 and 97110
- Modalities are reimbursed at a lesser rate
- Sessions 30 to 45 minutes in length most commonly
Code Selection

- Codes are not specific and treatment provided may meet the criteria for multiple codes.
- 97110 is a relatively low reimbursing code. When dealing with any neurological component therapist should consider using 97112 (Neuro-Muscular Re-ed).
- Therapist should use 97542 if the exercises are specifically designed to enhance WC use and progress is tested on WC use then exercises can be considered as a part of that code.

CPT Codes Management

**Example (accurate coding)**

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT Code</th>
<th>PT # 1 Fee ($)</th>
<th>PT # 2 Fee ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ther. ex.</td>
<td>97110</td>
<td>7 min.</td>
<td>23 min.</td>
</tr>
<tr>
<td>ther. activ.</td>
<td>97530</td>
<td>23 min.</td>
<td>2 x 27.77</td>
</tr>
<tr>
<td>neuro re-ed.</td>
<td>97112</td>
<td>25 min.</td>
<td>2 x 28.41</td>
</tr>
<tr>
<td>gait</td>
<td>97116</td>
<td>5 min.</td>
<td>25 min.</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td></td>
<td>60 min.</td>
<td>112.36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60 min.</td>
<td>103.09</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rev./min. 1.87</td>
<td>Rev./min. 1.68</td>
</tr>
</tbody>
</table>

CPT Codes Management

**Example (minutes management)**

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT Code</th>
<th>Fee ($)</th>
<th>Scenario #1</th>
<th>Scenario #2</th>
<th>Scenario #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ther. ex.</td>
<td>97110</td>
<td>26.93</td>
<td>15 min.</td>
<td>15 min.</td>
<td>15 min.</td>
</tr>
<tr>
<td>ther. activ.</td>
<td>97530</td>
<td>27.77</td>
<td>10 min.</td>
<td>15 min.</td>
<td>10 min.</td>
</tr>
<tr>
<td>neuro re-ed.</td>
<td>97112</td>
<td>28.41</td>
<td>15 min.</td>
<td>15 min.</td>
<td>20 min.</td>
</tr>
<tr>
<td>gait</td>
<td>97116</td>
<td>23.62</td>
<td>13 min.</td>
<td>15 min.</td>
<td>15 min.</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td></td>
<td>106.73</td>
<td>53 min.</td>
<td>60 min.</td>
<td>97 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rev./min. 2.01</td>
<td>1.77</td>
<td>1.59</td>
<td></td>
</tr>
</tbody>
</table>
Billing Logs

- Match notes for days billed
- Match minutes billed (only required on log)
- Match record for intervention
- Signature and professional identification of the qualified professional who provided or supervised the treatment
- List each person who contributed to the treatment during that encounter (i.e. OTR, COTA)

Questions/Answers

- Harmony Healthcare International
- 1 (800) 530 – 4413
- Mfox@harmony-healthcare.com

Harmony Healthcare International
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Analysis is cost & obligation free