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Medicare Muscle: Creating Defensible Documentation

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Medicare Muscle

Creating Defensible Documentation

A Changing Climate

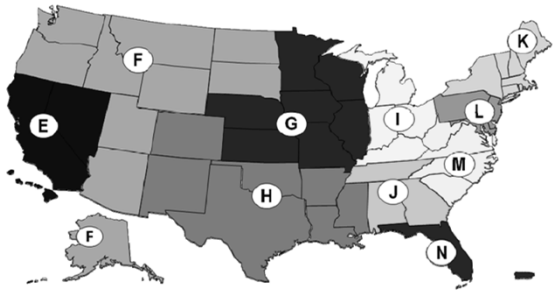
- Therapy professionals are educated and trained in an environment of evidence, research and accountability. Yet identified waste and abuse in the Medicare and Medicaid systems as well as a general increase in benefit use have resulted in a sea change in the scope and intensity of oversight to our practices and service delivery. Despite an internal compass that requires integrity in the services we provide, it is not uncommon that our documentation does not always convey that which we think to be inherently true about the therapy we provide.
- Understanding the coverage requirements and the proper language to convey how we have met them will result in documentation that can withstand the scrutiny of an audit, or can be successfully defended in an appeal situation.

CMS and MACs

- CMS = Center for Medicare and Medicaid Services. The federal body, overseen by the Department of Health and Human services, that administers several federal health programs, including Medicare and Medicaid.
- While CMS is responsible for the legislative oversight of Medicare, the actual administration of the benefit – disbursements, claims review and implementation of policy – is the responsibility of Medicare Administrative Contractors, or MACs. (These entities used to be called "Fiscal Intermediaries" before a jurisdiction and policy realignment that was rolled out over several years .)

MAC Jurisdiction

Consolidated A/B MAC Jurisdictions



Note: Chain providers or interstate acquisitions can result in your MAC being "out of jurisdiction," but knowing your MAC is important!

Where to Find the Rules

- Both CMS and the MAC can issue direction regarding specific coverage guidelines for therapy services.
  - Guidelines issued directly by CMS are called "National Coverage Determinations."
  - Guidelines issued by the MAC are called "Local Coverage Determinations."
- The CMS website has a searchable database of LCDs and NCDs.
- Not all MACs have LCDs about all practice areas. In the absence of an LCD, the NCD applies. In the absence of an LCD or NCD, the "acceptable professional standards" directive applies.

Where to Find the Rules

Medicare Benefit Policy Manual

- Chapter 8 Details the guidelines for meeting the Inpatient/Part A Benefit requirements.
- Chapter 15 Details the guidelines of the Outpatient/Part B delivery and documentation requirements.
- The two chapters often cross-reference each other.
- Chapter 6 is not specific coverage guidelines, but does detail the PPS requirements, including how to count delivery minutes (individual vs. concurrent vs. group, and co-treatments.)

Auditor Programs

Congress has enacted multiple pieces of legislation designed to identify overpayments in the Medicare and Medicaid system, and has implemented several programs and retained multiple contractors to carry out reviews and audits.

- Recovery Auditor Programs
- Zone Program Integrity Contractors
- Comprehensive Error Rate Testing agencies
- Supplemental Medical Review Contractors
- MAC's can also audit directly

Jimmo vs. Sibelius

"On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*, in which the plaintiffs alleged that Medicare contractors were inappropriately applying an "Improvement Standard" in making claims determinations for Medicare coverage involving skilled care." (From the *Jimmo vs. Sibelius Settlement Agreement Fact Sheet.*)

- What does this mean for therapists?
  - There has never been an "improvement standard" in the CMS guidelines, and the settlement was specifically in response to Contractors denying payment for services over the imposing of one.
  - ***However***, all other CMS standards still apply. Services must be reasonable, necessary and require the skills of a therapist.
  - The only clarification is that there is no requirement that progress be made or expected in order for therapy services to be considered covered by Medicare.

Medicare Part A vs Part B

- In both cases, service must be reasonable, necessary and require the skills of a therapist.
- Part A has specific requirements related to sustaining the benefit.
- Part B has specific requirements in coding and benefit availability.

Medicare Part A Benefit

Four criteria (taken from the Medicare Benefit Policy Manual, Chapter 8):

• 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; 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 (5x/week meets the requirement when the skilled service is physical, occupational or speech therapy.)

• As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.

• 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.

Can Speech alone skill a patient for Part A services?

Medicare Part B Benefit

- Subject to cap and threshold limits:
  - $1920 annual cap shared between Physical Therapy and Speech Therapy.
  - All claims are subject to Manual Medical Review after exceeding the threshold of $3700, shared between PT and ST.
- Use of specialized modifiers
  - KX Modifier:
    - Used to communicate the existence of Medical Necessity for services after the $1920 cap.
  - 59 Modifier:
    - Used to communicate that services were distinct in nature when use of two partnered CPT codes suggests the possibility of overlap. This is applicable across disciplines.
- Requires outcome reporting

Critical Content

What do you need to say in order to show that your services meet the CMS requirements of being reasonable, necessary and requiring the skills of a therapist?

Dialing in the Diagnosis

- Ensure that there is a meaningful relationship between the medical and treatment diagnosis. For example, a medical diagnosis of Dysphagia does not have a clear link to Symbolic Language Dysfunction. Likewise, a medical diagnosis of hip fracture has no clear relationship to dysphagia.
- In a Part A course of treatment, the medical diagnosis for SLP services does *not* need to be the same as the medical diagnosis PT and OT are using. However, if skilled therapy services are the driver of the part A benefit, then at least *one* discipline must be in compliance with the diagnosis criteria for the Part A benefit. Speech can only be the sole therapy skilling a patient if the diagnosis criteria is met.

Dialing in the Diagnois, (cont.)

- In the presence of a new and persistent condition that does not clearly correlate to an existing medical diagnosis, communicate directly with the physician to establish the underlying condition and have the diagnosis added to the patient's medical record.
- ICD-9 Coding guidelines require the highest degree of specificity possible. The 787.20 ICD-9 code, Dysphagia NOS may be used as a "rule out" diagnosis for evaluation purposes. However, the diagnostic skills of the clinician are expected to be utilized in the presence of actual pathology.
- Refer to your MAC's LCD to identify if certain medical diagnoses are disallowed for the delivery of speech therapy services. A diagnosis violation, unless submitted due to a coding error, is a difficult error to later defend if the claim is rejected.

Is it Necessary?

- An easy way to explain the necessity of your services:
  - What good thing will happen if you give the services?
  - What bad thing will happen if you *don't* give the services?
- Benefits to Receiving Services: Improved nutrition and hydration, decreased risk of aspiration and related medical complications, ability to communicate wants and needs to caregivers, ability to analyze safe activity in an independent environment, increased ability to engage with family and medical practitioners, improved ability to follow instructions for safety

Is it Necessary? (cont.)

- Risks in the Absence of Services: Weight loss, dehydration, aspiration and respiratory infection, isolation, excess dependence, failure to achieve community discharge, failure to succeed with rehabilitation program, permanent institutionalization, risk for harm or injury.
- The analysis can be based in health (maintaining weight, respiratory status, ability to communicate pain) or function (ability to follow directions to participate in daily care, ability to use microwave for meals when home alone).

Is it Reasonable?

Do the services show a meaningful relationship to the nature and severity of the condition?

- Can be demonstrated by thoroughly documenting severity, change from prior functional levels, rehabilitation potential and/or need for complex services.
  - General rehabilitation principles support that a new, severe condition in a patient with good rehabilitation potential and a high prior level of functioning responds well to more intense and more frequent services. Additionally, conditions with a high degree of inherent complexity or medical risk may also require more intense and more frequent services.

Is it Reasonable? (cont.)

- There are no fixed guidelines for intensity or duration in any CMS publication. The burden is on the professional to able to clearly demonstrate the link between the condition presented, the frequency of the services provided and the length of the course of care.
- At the end of each reporting period (certification period or weekly progress note) ask yourself, “Why does the patient need more?” and be able to make your case in your documentation.

Is it Skilled?

- The simple question:
  - Is the activity provided something that only a therapist would know how to do, or know how to do safely? Does this activity require the education and training only a therapist would have?
  - If you can articulate exactly what you are doing that is *qualitatively different* than something a nurse, a CNA or a family member would do, then your documentation will support the skilled nature of the service.

Unskilled vs. Skilled

- Unskilled:
  - Fed noon meal
  - Offered fluids
  - Performed oral care
  - Had patient name objects
  - Talked to family
  - Did exercises
  - Used flash cards

- Skilled:
  - Analyzed texture response
  - Evaluated oral transport
  - Assessed airway protection with challenge bolus
  - Delivered progressive-sized bolus
  - Performed progressive resistive lingual strengthening exercises
  - Facilitated word retrieval with phonemic cue fading
  - Trained family in effective yes/no question technique
  - Identified improved airway protection technique.

Unskilled vs Skilled (cont.)

- **Poor**: "Saw patient at lunch. Gave ½ c. applesauce and ½ banana. Patient pleased with snack items."
- **Better**: "Treatment at lunch, patient in wheelchair in dining room. Offered puree and soft textures. Patient cooperative and with fair mastication effort. Not ready for texture upgrade yet."
- **Best**: "Treatment during meal, assessed posture and educated dining room staff in postural support for upright seating for improved airway protection. Analyzed functional activity tolerance for mastication on soft solids, patient able to sustain 3-6 second mastication independently, but able to facilitate 10 seconds sustained with verbal-tactile cueing. Showing positive benefit to progressive challenge and progression to textured solids is expected."

Avoid the Traps

- Don't rely on progress to make your case for you; explain why the progress wouldn't have happened without you. Progress alone doesn't show how something is reasonable, necessary or skilled.
- In your documentation, focus on the skilled things that *you* did more than you focus on what the patient did. Medicare is paying for you, not the patient.
- Take a progressive defense approach: The longer a patient is receiving services, the greater the therapist's burden to show how the services continue to meet CMS criteria.
- Ensure your documentation is legible! Illegible documentation or use of nonstandard terms or abbreviations can be cited as a reason to deny a claim.

Can Speech Alone Skill a Part A Patient?

- Can you show how it required a skilled professional?
- Can you show why it needs to be 5 days a week?
- Can you show why it had to be in an inpatient setting?
- Can you show the manner in which it was reasonable and necessary?

YES! Here is one of countless examples:

A 70 year-old woman who previously lived independently in her home without assistance and with no close family has a stroke and develops moderate expressive aphasia. Due to her high prior level of function and her recent onset, she has excellent rehabilitation potential for functional recovery and she is very motivated to return home. Physical and occupational therapy services improve her abilities to a level where she would only need 2-3 hours of caregiver assistance per day, but her residual aphasia has resulted in her inability to reliably summon assistance in an emergency. Because of the compromise to her safety, she cannot reside in her community living situation. The services she has received have resulted in measurable improvement in word finding and intentional communication, but she does not yet have mastery in answering the phone and word retrieval decompensates when she is anxious. Despite no further need for physical or occupational therapy, an additional course of 1-2 weeks of intensive speech therapy services with treatment emphasis on telephone use and the reliable use of a Life-Alert device is anticipated to increase functional communication for safety which would allow a successful transition to a community setting with the support that the patient has available. Treatment activities will include intentional communication training, development of a cue-card system for phone use, cause and effect training for use of Life-Alert device, training verbal response in stress environments, training in use of adapted phone, and caregiver training in use of scripts for effective multi-day phone checks.

Summary

- More beneficiaries. More services billed.
- This means more auditing and more scrutiny.
- The burden is on the professional to know the requirements and be able to show how he or she met them.
- Knowing the guidelines and building up your library of what to say that shows you met them will allow your documentation to do its job for you.
- Make your time spent documenting worth its investment.

Resources

- CMS.GOV:
  - Medicare Benefit Policy Manual: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html
  - Interactive MAC Map: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html
  - LCD/NCD Search Page: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx
- ASHA: Medicare Coverage Policies, Speech-Language Pathology:
  - http://www.asha.org/practice/reimbursement/medicare/McareCoverageSLP/