The Compliance Professional’s Approach to Auditing Rehabilitation Services

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Disclosure

Yolunda Dockett: No relevant financial relationship exists

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Objectives

1. Describe regulations guiding therapy practice, documentation, and billing

2. Review the required elements of therapy documentation

3. Identify key elements of an effective auditing and monitoring program for rehabilitation services
Regulations Guiding Practice

Rehabilitation Coverage Requirements

Who makes the rules?
- State Practice Act / Administrative Code
- Payer
- Facility / Practice Policy
- National Association (APTA, AOTA, ASHA)
State Practice Act / Administrative Code

- Documentation requirements – content, timeliness
- Supervision – assistants, aides, students, temporary licensees
- Direct access
- Required competencies / certification
- Continuing education requirements
- License renewal

Payer

- Documentation requirements – content, timeliness
- Supervision – assistants, aides, students, temporary licensees
- Billing – covered vs. noncovered services, minutes vs. units
- “Medically necessary services”

And...

- Preauthorization requirements
- Benefit limitations – type or amount of service
- Authorized providers
Facility / Practice Policy

• Organizational clarity and liability
• Accreditation agency requirements (e.g., TJC, AAAASF, CARF, NCQA)
• Legal requirements
• Corporate compliance program

National Associations

• APTA, AOTA, ASHA guide best practice and service delivery in the therapy industry
• Certification
• Code of Ethics
• Professional standards
Required Elements of Therapy Documentation

- Orders
- Discharge Summary
- Medical Necessity
- Evaluation/Plan of Care
- Recert/Updated Plan of Care
- Encounter Notes
- Progress Notes
- Recert/Updated Plan of Care
Evaluation/Plan of Care

- The initial evaluation or the plan of care documents the medical necessity for a course of therapy
  - Medical and treatment diagnoses*
  - Reason for Referral demonstrates therapy evaluation medical necessity
  - Comprehensive past medical history
  - Identifies current functional impairments in comparison to prior level of function
  - **Objective and measurable long and short term goals***
  - Outlines the type, amount, and frequency of therapy services*
  - Physician or NPP certification within 30 days of the Start of Care*

* CMS minimal requirements for documentation

Identifying Objective & Measurable Goals

- Identifies the client or caregiver
- Objective and measurable
- Specific
- Functional
- Time frame
Objective and Measurable Goals

- In two weeks, patient will be able to independently complete upper body dressing while seated at edge of bed.

- Upon discharge, patient will be able to ambulate 150 ft on even surfaces with a rolling walker and contact guard assistance.

- Upon discharge, patient will increase active right shoulder flexion by 20 degrees in order to increase ability to brush and comb hair.

Poll question

Mrs. Brown was referred to occupational therapy after a recent onset of significant weakness interfering with her ability to care for her 4 month-old child and perform her daily routine.

Please choose the most appropriate objective and measurable goal from the options below:

a. Patient will improve independence in activities of daily living.

b. Patient will be able to perform upper and lower body dressing from seated position using adaptive equipment with supervision of trained caregiver in 30 days.

c. Patient to return to PLOF by discharge.
Evaluation/Plan of Care cont...

- The initial evaluation or the plan of care articulates medical necessity for a course of therapy
  - Medical and treatment diagnoses*
  - Reason for referral demonstrating medical necessity for therapy evaluation
  - Comprehensive past medical history
  - Outlines functional impairments in comparison to prior level of function
  - Objective and measurable long and short term goals*
  - *Documents the type, amount, frequency, and duration of therapy services*
  - *Physician or NPP certification within 30 days of the Start of Care*

* CMS minimal requirements for documentation

Encounter Notes

- Should be completed for every treatment visit
  - Date of treatment
  - Identify each *skilled* intervention or modality provided and billed
  - Document the patient’s response to treatment
  - Include signature and professional identify of a qualified professional
What are “skilled services?”

Services or interventions which require the “skills of a therapist”
- What therapists went to school to learn how to do
- What therapists do that no one else can do

**What did the clinician do during treatment?**

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<tr>
<th>Assess</th>
<th>Analyze</th>
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<tr>
<td>Progress</td>
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Poll question

Mrs. Brown received 32 minutes of physical therapy treatment to address lower extremity weakness impacting her ability to walk and move around her environment as identified during the evaluation.

Which of the following statements reflect the skilled physical therapy services Mrs. Brown received?

- a. Therapeutic exercises per flow sheet to improve strength for gait.
- b. Instructed in LE strengthening per flow sheet with progression to gravity-resisted exercise for hip abduction and extension to decrease pelvic drop during gait. Patient able to perform sidelying, prone, and standing hip abduction and extension with verbal and visual cues to avoid compensation with trunk.
- c. Patient performed bed mobility tasks with minimal assistance and performed LE therapeutic exercise while seated on mat with supervision. Patient ambulated 25 feet with supervision using a rolling walker.
Poll question

Mrs. Brown also received 48 minutes of speech therapy treatment to address the moderate cognitive deficits observed by the physical therapist and validated during the speech therapy evaluation.

Which of the following statements reflect the skilled speech therapy services Mrs. Brown received?

a. Patient completed task comparing similarities and differences.
b. Introduced verbal reasoning tasks including identification of similarities and differences given 2 words.
c. Patient received skilled speech therapy services to provide cognitive retraining.

Progress Reports

- Progress reports provide justification for continued medical necessity and should be routine and completed at least every 10 visits*
- Outlines objective performance and functional status changes
  - Includes changes to short-term goals or treatment approach
  - Documents patient, family, or caregiver education and response to training
  - Provides an assessment of progress towards short-term goals or limitations
  - Articulates professional judgment of the therapist for continued treatment or discharge planning

* Medicare Part B requirement
Re-Certification/Updated Plan of Care

- Provides evidence of physician/NPP approval for continued therapy services
- Must be completed at least 90 days after initial certification*
- Required when:
  - Significant changes to the Plan of Care exist (i.e., long-term goals, medical status, etc.)
  - Treatment continues beyond the initial certification period

* Medicare Part B requirement

Discharge Summary

- Provides an overview of progress/limitations since last reporting period
  - Summarizes the skilled services and education provided
  - Documents current functional level in comparison to initial level and outlined goals
  - Articulates assessment of patient’s progress and limitations
  - Outlines discharge recommendations and referrals as appropriate
Establishing an Auditing & Monitoring Program

Auditing and Monitoring Therapy Services

• First things first!
  • Familiarize yourself with applicable policies and regulations
  • Get to know your Company’s leaders
  • Use your risk assessment to establish the frequency of your auditing and monitoring process
  • Use your resources — Involve the therapy department leadership and staff in monitoring program
  • Set benchmarks / thresholds for compliance
Auditing and Monitoring Therapy Services

Documentation

- Technical requirements; key clinical content areas; timely completion
- Billing supported by documentation; correct coding; aberrant billing patterns & “red flags”
- Licensure, certification, & credentialing requirements are current. Supervision requirements are followed.

Documentation

TECHNICAL
- Referral / Order
- Certified POC
- Progress Reports / UPOCs completed timely

CLINICAL
- Reason for Referral
- Prior vs. Current Level of Function
- Therapist’s Clinical Assessment
- Goals
- Skilled Interventions
- Justification for Continued Treatment
Billing

- Documentation supports services billed
- Correct coding
- Rounded minutes
- Billing thresholds (e.g., 8-minute rule)
- Pre-authorization requirements
- Utilization trends

Licensure / Supervision

- Screening
  - Exclusions
  - Licensure - Limited/temporary license/probation/sanction
- Certification/credentialing
  - Physical Agent Modalities (OT)
  - Dry needling (PT)
- Supervision requirements
  - Practice Act
  - Payer
  - Students, assistants, aides/techs
References

- www.aota.org
- www.apta.org
- www.asha.org