Evergreen Rehabilitation

Clinical and Compliance Bulletin

2011 Quarter 1

Coding Corner

FAQ

1. Can speech therapy bill cognitive treatment (97532) on the same day as speech therapy treatment (92507)?

No, cognitive treatment is included in speech therapy treatment and cannot be billed separately.

New ICD-9 Codes Effective October 1, 2010

New ICD-9 codes became available October 1, 2010. The codes include a fluency disorder code and multiple codes for cognitive deficits related to traumatic brain injury or other neurological conditions. The codes are:

Codes Description

784.52 Fluency disorder in conditions classified elsewhere (MUST code underlying condition first, example: Parkinsons 332.0). This code excludes: adult onset fluency disorder (307.0), childhood onset fluency disorder (315.35), fluency disorder due to late effect CVA (438.14).

799.51 Attention or concentration deficit related to TBI or other neurological condition

799.52 Cognitive communication deficit related to TBI or other neurological condition

799.53 Visuospatial deficit related to TBI or other neurological condition

799.54 Psychomotor deficit related to TBI or other neurological condition

799.55 Frontal lobe and executive function deficit related to TBI or other neurological condition

799.59 Other signs and symptoms involving cognition related to TBI or other neurological condition
This code excludes: amnesia (780.93), amnestic syndrome (294.0), attention deficit disorder (314.00-314.01), late effects of cerebrovascular disease (438.XX), memory loss (780.93), mild cognitive impairments, so stated (331.83), transient global amnesia (437.7), visuospatial neglect (781.8).

ICD-9 Education Update

All Evergreen Rehabilitation evaluating therapists completed mandatory ICD-9 education in November. The education focused on the use of a new step-by-step coding algorithm. Keep your eyes open for a new coding handbook that will accompany the algorithm. Evergreen Rehab will be completing a QA in the month of December to ensure the new education is being implemented correctly by the therapists.

Decoding CPT Codes

Each quarter we focus on decoding the mystery of a specific CPT code.

This month we will focus on CPT code 97112, neuromuscular re-education. The official definition states "Neuromuscular Re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (one or more areas, each 15 minutes)." This therapeutic procedure is provided for the purpose of restoring balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation (PNF), BAP's boards, vestibular rehabilitation, desensitization techniques, balance and posture training). NGS' LCD 26884 Outpatient Physical and Occupational Therapy Services provided the following Supportive Documentation Recommendations for 97112:

- Objective loss of ADLs, mobility, balance, coordination deficits, hypo- and hypertonicity, posture and effect on function

- Specific exercises/activities performed (including progression of the activity), purpose of the exercises as related to function, instruction given, and/or assistance needed, to support that the skills of a therapist were required

Keeping Straight on the Regulation Road:

LCD Changes and Updates

Trailblazer's LCD Therapy Services (PT, OT, SLP) – 4Y-26AB-R5 has established new utilization guidelines effective 11/4/2010. The new utilization guidelines provide authority for automated claim denial of claims for services in excess of the following:

- Five (15 minutes each) timed PT services per patient per day.
- Five (15 minutes each) timed OT services per patient per day.
- Sixty (15 minutes each) PT services per patient per month.
- Sixty (15 minutes each) OT services per patient, per month.

Reimbursement changes in 2011

Multiple Procedure Payment Reduction (MPRR) Policy Effective 1/1/2011

The multiple procedure payment reduction (MPPR) policy is scheduled to go into effect January 1, 2011. CMS, as identified in the interim rule in July, believes that providers of services under Part B are being paid more than they should due to the methodology of valuing the CPT codes. The way that this policy will work is that on any claim submitted by a provider or supplier of therapy services, for that date of service, the contractor will pay in full the CPT code with the highest practice expense relative value (PE RV) and then every other CPT code provided that day will have the PE RV reduced by 25%. This policy is provider specific, not discipline or session specific. This means that institutional providers that provide more than one discipline per day will have all but the highest PE RV reduced by 25 %. CMS estimates that the new policy will effectively reduce payments for outpatient therapy services by 7-9% in 2011.

2011 Therapy cap limits

The therapy cap amounts for 2011 are $ 1870 annually for physical and speech therapy combined and $1870 annually for occupational therapy. The cap exceptions process through use of the KX modifier has been extended through 12/31/2011. Please remember that by assigning the KX modifier to the claim, the therapist is attesting that the services billed:

- Are reasonable and necessary services that require the skills of a therapist; (See Pub. 100-02, chapter 15, section 220.2); and
- Are justified by appropriate documentation in the medical record, (See Pub. 100-02, chapter 15, section 220.3); and
- Qualify for an exception using the automatic process exception.

MDS 3.0 and RUGS IV Regulation Reminders

There were many changes that accompanied MDS 3.0 and RUGs. We would like to remind you of two significant changes that impacted therapy.

MDS 3.0 minute categories:
The MDS 3.0 changes included the new categorization of part A MDS minutes into three possible categories: individual, concurrent, and group.

Individual minutes are defined as treatment provided to one patient at a time.

Concurrent minutes are defined as treatment of two patients at the same time when the patients are performing different activities, regardless of payor source, in the line of sight of the treating therapist.

Group minutes under part A are defined as treatment of 2-4 patients, regardless of payor source, performing the same or similar activities. Examples:

1.Patients A and B are seen for 30 minutes of therapeutic exercise between 9:00 AM and 9:30 AM. At 9:30, both continue to be seen but patient A continues exercising and patient B begins to work on balance training. This continues until 10:15. At 10:15 patient A leaves and patient B continues to receive 15 minutes of transfer training. Both are part A.

Patient	Individual	Concurrent	Group
A		45	30
B	15	45	30

2.Patients A and B are seen for 30 minutes of therapeutic exercise between 9:00 AM and 9:30 AM. At 9:30, both continue to be seen but patient A continues exercising and patient B begins to work on balance training. This continues until 10:15. At 10:15 patient A leaves and patient B continues to receive 15 minutes of transfer training. Patient A is part A and patient B is part B.

Patient	Individual	Concurrent	Group
A		45	30
B	15		75

3.Patients A and B are seen for 30 minutes of therapeutic exercise between 9:00 AM and 9:30 AM. At 9:30, both continue to be seen but patient A continues exercising and patient B begins to work on balance training. This continues until 10:15. At 10:15 patient A leaves and patient B continues to receive 15 minutes of transfer training. Patient B is part A and patient A is part B.

Patient	Individual	Concurrent	Group
A			75
B	15	45	30

Part A modality MDS minutes

Only skilled therapy time (i.e., require the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met, see page O-17) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS.
--RAI Manual, Page O-21

All Eyes on Therapy

Therapy remains the focus of many Fiscal Intermediaries (FIs) as well as the Regulatory and Law Enforcement Agencies of the Federal Government as the focus on deterring fraud, waste and abuse in the Medicare and Medicaid systems has increased.

OIG workplan for 2011

The Office of Inspector General Work Plan for Fiscal Year 2011 provides brief descriptions of activities that the Office of Inspector General (OIG) plans to initiate or continue with respect to the programs and operations of the Department of Health & Human Services in fiscal year 2011. For each review, the Work Plan describes the subject, primary objective, and criteria related to the topic. In 2011, the areas of therapy services that will be a focus are:

Medicare Part A Payments to Skilled Nursing Facilities

We will review the extent to which payments to SNFs meet Medicare coverage requirements. The Social Security Act, § 1888(e), establishes the amount paid to SNFs for all covered services. Medicare pays Part A SNF stays using a system that categorizes each beneficiary into a group based on care and resource needs. The groups are referred to as Resource Utilization Groups (RUGs). In a prior report, OIG found that 26 percent of claims had RUGs that were not supported by patients' medical records. The percentage represented $542 million in potential overpayments for FY 2002. We will conduct a medical review to determine whether claims were medically necessary, sufficiently documented, and coded correctly during calendar year CY 2009.

We will review outpatient physical therapy services provided by independent therapists to determine whether they are in compliance with Medicare reimbursement regulations. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." CMS's Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 15, § 220.3, contains documentation requirements for therapy services. Previous OIG work has identified claims for therapy services provided by independent physical therapists that were not reasonable, medically necessary, or properly documented. Focusing on independent therapists who have a high utilization rate for outpatient physical therapy services, we will determine whether the services that they billed to Medicare were in accordance with Federal requirements. (OAS; W-00-11-35220; various reviews; expected issue date: FY 2011; new start)

Questionable Billing for Medicare Outpatient Therapy Services

We will review paid claims data for Medicare outpatient therapy services from 2009 and identify questionable billing patterns. We will identify counties with high utilization and compare utilization in these counties to national averages. We will also determine the extent to which billing characteristics in high-utilization counties, including questionable characteristics that may indicate fraud, differed from billing characteristics nationwide..
(OEI; 04-09-00540; expected issue date: FY 2011; work in progress)

RAC programs expand to Medicaid

(http://www.ama-assn.org/amednews/2010/12/13/gvsa1213.htm)

The Centers for Medicare & Medicaid Services issued a proposed rule last month that outlines its plan for expanding the recovery audit contractor program to Medicaid, a change required under the health system reform law.

RACs are third-party auditors CMS hires to comb through Medicare claims from hospitals, physicians and others to identify improper payments. A permanent, nationwide RAC program now operates under fee-for-service Medicare. Provisions in the Patient Protection and Affordable Care Act mandate an expansion to Medicaid by Dec. 31. The health reform law also directs CMS to expand RACs to Medicare Advantage and the Medicare prescription drug program by year's end.

Under the proposed Medicaid rule, published Nov. 10 in the Federal Register, states must establish Medicaid RAC programs by submitting state plan amendments to CMS by Dec. 31. However, states are not required to have the program fully implemented until April 1, 2011.

Contractors working for states will audit payments made to physicians and hospitals, looking for Medicaid payments that may have been underpaid or overpaid. The program is part of the health reform law's larger strategy of cracking down on waste, fraud and abuse in the system.

"Tools provided by the Affordable Care Act will help us achieve that goal," said CMS Administrator Donald M. Berwick, MD. "We are using many of the lessons that we learned from the Medicare RAC program in the development and implementation of the Medicaid RACs, including a far-reaching education effort for health care providers and state managers."

In October, CMS sent state Medicaid directors a letter that provided initial guidance on the RAC program. It hosted an education forum on the topic Nov. 4.
Comments on the proposed rule are due by Jan. 10, 2011.

Senator favors program

RACs will review Medicaid physician claims and identify and recover overpayments made for services provided under Medicaid's state plans and waivers. The proposed regulation gives states the option to pay their Medicaid RACs on a contingency basis or under some other fee structure for identifying and recovering overpayments.

Under the regulation, as proposed, a state may use its current administrative appeals process or modify its process for Medicaid RAC-related appeals. All fees paid to the Medicaid RACs must come from amounts recovered after all available appeals have been exhausted, CMS has proposed.

A 3-year Medicare RAC demo program identified almost $1 billion in Medicare overpayments.

Sen. Tom Carper (D, Del.) has been a leading proponent of expanding the RAC program. During a hearing on Capitol Hill this year, he highlighted progress made under a three-year Medicare RAC demonstration program that launched in several states in 2005 and identified about $1 billion in Medicare overpayments.
But Carper is still waiting for CMS to issue proposed rules on how RACs would work in Medicare Advantage plans and Medicare Part D, something the agency is mandated to do by the end of the year.
Nonetheless, he is pleased to see the expansion of RACs to Medicaid under way and the progress made in the Medicare program.
"CMS learned a lot from the recovery audit contractor pilot program, including the importance of working closely with the provider community," Carper told American Medical News. "Along with many other lessons learned, good two-way communications between CMS and providers must be maintained as the RAC program expands to all of Medicare and Medicaid. Ultimately, this program is an important tool as we work to save taxpayer dollars and strengthen Medicare and Medicaid for years to come."

AMA critical of RACs

However, a report released by the Government Accountability Office in March criticized CMS' efforts with the Medicare RAC program.

The report concluded that though the agency used auditors to identify payment system vulnerabilities that lead to overpayments, it had not implemented corrective actions for 60% of the most significant vulnerabilities. Those systemic problems represented $231 million of the roughly $1 billion in improper payments discovered by the contractors, GAO concluded.

CMS said in response to the report that it was taking steps to resolve coordination issues and address payment system vulnerabilities through the national, permanent RAC program.

Physicians also raised concerns during the Medicare RAC demonstration. As a result, CMS said it has made some changes to the program. For example, every audit firm is required to hire a physician medical director to assist nurses, therapists and certified coders upon request, manage quality assurance procedures, and maintain relationships with physician associations.

The American Medical Association has disapproved of the RAC program, saying it has proved burdensome for physician practices to comply with the audits even when the reviews turn up little or no evidence of Medicare overpayments. Some physicians who were audited during the Medicare demonstration project said some reviews appeared to be fishing expeditions to find overpayments, demanding scores of medical records that went back several years.

Tabulating the savings

The recovery audit contractor program could save the federal government more than $1 billion in Medicaid spending during the next five years, according to the Office of the Actuary at the Centers for Medicare & Medicaid Services. Auditors used historical experience from the Medicare program to estimate the potential savings.

Potential net savings to federal Medicaid from RAC expansion, in millions:

Fiscal year	Estimated savings
2011	$80
2012	$170
2013	$250
2014	$310
2015	$330

Source: "Medicaid Program; Recovery Audit Contractors," Federal Register, Nov. 10 (federalregister.gov/a/2010-28390)