Compliance
a shared commitment

Rehabilitation
Regulatory Compliance Risks

September 2009
Agenda - Rehabilitation Compliance Risks

• Understand the basic requirements for Inpatient Rehabilitation Facilities (IRFs) and Outpatient Rehabilitation Facilities (ORFs) – Conditions of participation, payment system
• Understand the risks for outpatient therapy, both in the hospital and ORF settings, including rounding, medical necessity
• Understand the risks for IRFs, including intensity of service, co-morbidities
• Auditing and Monitoring rehabilitation risks for IRFs and ORFs
IRF Conditions of Participation

• IRFs must meet general hospital requirements and then additional requirements to be exempted from the regular acute care Inpatient Prospective Payment System (IPPS)
• See 42CFR §412.33
• Provider agreement to participate as a hospital PLUS:
  • Free-standing facility or distinct unit of hospital
    – Beds cannot be co-mingled with acute care patients
• Serve an inpatient population with 60% requiring intensive rehabilitation services for treatment of at least one of 13 specified conditions (60% Rule)
• Medical Director who
  – Provides services to the hospital and its patients on a full-time basis (20 hours if unit)
  – Medical Doctor (MD) or Doctor of Osteopathy (DO)
  – minimum two years training in rehabilitation services
IRF Conditions of Participation (cont.)

• Develop a Plan of Care that is reviewed by a multidisciplinary team at least every two weeks to assess progress and further need for services

• Failure to meet any of the Conditions of Exclusion will result in loss of IPPS exempt status, and reimbursement will default to Diagnostic Related Groups (DRGs)
  – Significant financial impact as average length of stay for IRFs is 16 days; for general inpatient it is 6 days
Inpatient Hospital Stays for Rehabilitation

• See Medicare Benefit Policy Manual – Chapter 1 §110
  – Concepts originally from Health Care Financing Administration (HCFA) ruling 85-2. HCFA was the predecessor to Centers for Medicare and Medicaid Services (CMS)

• Two basic requirements
  – The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient’s condition; and
  – It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a Skilled Nursing Facility (SNF), or on an outpatient basis.

• Also recognizes that hospital stays for rehabilitation services are based upon an assessment of each patient and indicates that denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule," or any other "rules of thumb," are not appropriate.
Inpatient Hospital Stays for Rehabilitation (cont.)

• Preadmission screening
  – Preliminary review of patient condition and previous medical record to assess if patient likely to benefit
  – Normal but not required
• Admission orders – must have physician orders
• Inpatient assessment – admission and discharge
  – Patient assessment instrument (IRF-PAI) – nine categories evaluated based on observation during first three days and final day
  – Interrupted stays of less than 3 calendar days affect dates
• Coverage
  – full assessment may take between 3 and 10 calendar days (or more if medically necessary)
  – Inpatient stay may be covered even if assessment determines patient is not suitable for rehabilitation
Inpatient Hospital Stays for Rehabilitation (cont.)

- Screening criteria (medical necessity)
  - Close medical supervision by a physician with specialized training or experience in rehabilitation
  - 24 hour rehabilitation nursing
  - Relatively intense level of rehabilitation services – generally at least 3 hours of therapy services 5 days per week (“3 hour rule”)
  - Multi-disciplinary team approach to delivery of program
  - Coordinated program of care – team conference at a minimum every two weeks
  - Significant practical improvement
  - Realistic goals
  - Length of rehabilitation program – coverage stops when further progress is unlikely or can be achieved in a less intensive setting
Proposed Changes to Medicare Benefit Policy Manual

• IRF care is reasonable and necessary if patient meets all requirements of revised §110
• Preadmission Screening – Required, Licensed clinician
• Post-Admission Physician Evaluation within 24 hours – if not appropriately discharged within 3 days
• Medical Necessity Criteria met at time of admission
  – Require intensive rehabilitation – 3 hours per day, 5 days per week starting within 36 hours of admission
  – Require an intensive and interdisciplinary approach
  – Expectation of measurable improvement of a practical value
The IRF Prospective Payment System (IRF-PPS)

• Implemented October 2001
  – Effective first cost reporting period on or after that date
  – For new units, first cost reporting period after full year as distinct unit
• Applies to Medicare Part A patients only
• Single payment for entire admission
The IRF Prospective Payment System (cont.)

• Requires completion of the Patient Assessment Instrument (PAI)
• Assignment to a case mix group (CMG) based on:
  – Etiologic diagnosis
  – Motor score and in some cases Cognitive score from PAI
  – Comorbidities
  – Age (in some cases)
• Certain comorbidities may increase reimbursement
The Patient Assessment Instrument (PAI)

• 3 page form
  – Demographic information
  – Function Modifiers
  – Functional Independence Measure (FIM) Instrument

• Initial assessment completed by day 4 of admission
  – Covers first 3 days of admission (except bowel/bladder accidents—go back 7 days)

• Discharge assessment required within 5 days of discharge
  – No penalty for late assessment; 25% penalty for late submission
The Patient Assessment Instrument (PAI) (cont.)

- Measures patient’s ability at admission and discharge in specific areas, divided into Motor and Cognitive functions on FIM
- FIM items are weighted
- Each area of assessment is assigned a score of 1 to 7 (1 = most dependent, 7 = most independent)
- Total score for motor and for cognition affects the Case Mix Group (CMG)
Outpatient Therapy Payment System

• Same payments across settings – hospital outpatient, private practice, physician office, nursing home, outpatient rehabilitation facility
• Fees established in the physician fee schedule
• Reported using Current Procedural Terminology (CPT) codes
• Performed by licensed personnel
  – Physical Therapist (PT), Occupational Therapist (OT), Speech Language Pathologist (SLP)
  – Also physicians, Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialist (CNS) if allowed by state
  – PT and OT Assistants if supervised
• Therapy caps of $1810 for 2008 (for PT/SLP and separately for OT) applicable in all settings except hospital outpatient
  – Exemption from therapy caps if medically necessary
  – Automatic process for patients with qualifying conditions – use of KX modifier to indicate exemption
# Inpatient Rehabilitation Risks

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Sub-sub Category</th>
<th>Risk</th>
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<tbody>
<tr>
<td>Hospital Billing Integrity</td>
<td>Medical Necessity</td>
<td>Medicare Admissions Criteria</td>
<td>Failure to document medical necessity for admission</td>
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<td>Failure to document need for 24 hour/day nursing care</td>
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<td>3-hour “Rule”/Guideline (Therapy services)</td>
<td>Failure to furnish intensive therapy services during IRF stay</td>
</tr>
<tr>
<td>Services Performed within Scope of Practice</td>
<td>Licensed Personnel</td>
<td>Unlicensed personnel (e.g. Rehab Techs) furnishes treatment not permitted by state rules</td>
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<tr>
<td></td>
<td></td>
<td>Licensed personnel (e.g. Physical Therapy Assistant (PTA) / Athletic Trainer Certified (ATC)) furnishes treatment not permitted by state scope of practice rules</td>
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</tr>
<tr>
<td></td>
<td>Unlicensed Personnel</td>
<td>PTA/ATC (licensed personnel) treats patient when payor does not allow treatment</td>
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<tr>
<td>Hospital Billing</td>
<td>Case-Level Payment Adjustments</td>
<td>Early Transfers</td>
<td>Delaying discharge dates in order to avoid early transfer payments for Medicare patients</td>
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<tr>
<td></td>
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<td>Interrupted Stays</td>
<td>Improperly billing for two separate and distinct stays when a Medicare patient is discharged and re-admitted within 3 days</td>
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<tr>
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<td>Short Stays</td>
<td>Delaying discharge dates in order to avoid short stay payments for Medicare patients</td>
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<tr>
<td>Coding</td>
<td>IRF - CMGs, FIM, PAI,</td>
<td>Late submission/filing of PAI</td>
<td>Inaccurate diagnosis codes placed on PAI leading to incorrect comorbidity tier</td>
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<td>Inaccurate FIM score placed on PAI</td>
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<td>Integration of codes into Case Mix Group is inaccurate</td>
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<td>IRF- Discharge Disposition</td>
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<td>Incorrect assignment of discharge disposition</td>
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<tr>
<td>Professional Billing Integrity</td>
<td>Billing for non-employed providers</td>
<td>Inappropriately billing for inpatient services performed by non-employed providers (e.g., nurse practitioners, radiologists, etc.)</td>
</tr>
<tr>
<td>Conditions of Participation</td>
<td>Classification of IRF - 60% Rule</td>
<td>Facility does not meet required threshold for CMS-13 qualifying diagnosis as a percentage of all discharges</td>
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<tr>
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<td>Inaccurate assignment of impairment or qualifying diagnosis code</td>
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<tr>
<td>Vendor Relationships</td>
<td>Orthotics and Prosthetics (O&amp;P)</td>
<td>Substantial price concessions offered by a vendor for PPS-covered O&amp;P items in exchange for referrals of items that a vendor may bill directly to Medicare</td>
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<td>Failing to pay an outside vendor for an O&amp;P item that is necessary during the inpatient stay for which hospital is responsible</td>
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<tr>
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<td>Ambulance/Transportation</td>
<td>Failing to pay an outside vendor for transportation that is necessary during the inpatient stay for which hospital is responsible</td>
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# Outpatient Therapy Risks

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<tbody>
<tr>
<td>Billing</td>
<td>Services Performed within Proper Scope</td>
<td>Unlicensed personnel (e.g. Rehab Techs) furnishes treatment not permitted by state rules</td>
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<td>Licensed personnel (PTA/ATC) furnishes treatment not permitted by state scope of practice rules</td>
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<td>PTA/ATC (licensed personnel) treats patient when payor does not allow treatment</td>
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<tr>
<td>Coding - CPT</td>
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<td>Incorrect rounding of minutes for therapy units</td>
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<td>Incorrect modifier usage (Specifically the review of the use of the KX modifier in the ORF setting)</td>
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<tr>
<td>Billing Integrity</td>
<td>Individual vs. Group Therapy</td>
<td>Billing Medicare for individual therapy when group therapy was performed</td>
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<tr>
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<td>Medical Necessity</td>
<td>Treatment cannot be medically supported</td>
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<td>Plan of Care (POC)</td>
<td>Services performed fail to conform to POC</td>
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<td>Physician signature not received timely on initial POC</td>
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<td>POC does not meet technical standards for payment (e.g. goals, frequency, etc.)</td>
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<td>Re-evaluation billed without appropriate documentation regarding medical necessity</td>
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<td>POC extension not developed and signed by physician in a timely manner</td>
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Types of Controls

• Preventive
  – Education / Training
    ✓ Example – All administrators and sales personnel complete sales & marketing training annually
  – Approvals
    ✓ Contracts Example – Legal does not draft / approve any contracts with referral sources unless appropriate Compliance approvals are present
    ✓ Chargemaster Example – Information Services does not make requested change without VP Business Operations approval
  – Pre-Billing Edits
    ✓ Example – All therapy claims that do not meet Coverage Determinations (Local or National) are suspended and must be manually reviewed before billing
Types of Controls

• Detective
  – Audits
    ✓ Outpatient Example – 100% automated review of coded versus billed CPTs
    ✓ Outpatient Example – Random sample of Medicare Plans of Care reviewed each quarter
  – Outlier Analysis
    ✓ IRF Comorbidity Code Usage – Hospital usage compared to benchmarks (similar to PEPPER reports of complex v. simple DRG usage in acute care)
Control Questions

• For All Control Types:
  – What is the control action?
  – Who is involved?
  – How is the action carried out?
  – Where is the action carried out (i.e. facility, division, corporate)?
  – How often is the action carried out?

• For Detective Controls (other than outliers) also add these:
  – What is the audit or monitoring activity?
  – How many files, claims, etc. reviewed?
  – Are there error/compliance thresholds associated with the audit/review?
  – When are corrective action plans (CAPs) initiated?
  – Who follows-up on the action plans?
  – Where is the CAP remediation information reported once completed?

• For Outlier Controls add these:
  – What is being measured?
  – How often should it be measured?
  – Are there error/compliance thresholds associated with the analysis?
  – When are corrective action plans (CAPs) initiated?
  – Who follows-up on the action plans?
  – Where is the CAP remediation information reported once completed?
Monitoring

• Compliance with the 60% rule
  – Presumptive
  – Actual

• Self-audits
  – Coding accuracy
  – Therapy hours
Monitoring Questions

• What risk areas are monitored?
• How often is the monitoring?
• What changes have been made if any issues have been identified?
• Are all parties involved in the self-audits- nursing, therapy, physician, coding and billing?
Rehabilitation Risks Potential Audits

• Services Performed within Proper Scope – Licensing
  – Preventive Control: Each new licensed employee has primary source verification of active license in good standing verified before first day of employment.
  – Preventive Control: Each new non-licensed employee (i.e. aides, rehab techs, exercise physiologists, athletic trainers, massage therapists) is required to sign a copy of their job description within the first 3 days of employment, which includes information from the state practice act regarding scope of practice, to be kept in their personnel file.
  – Audit: Review of personnel files to determine if
    ✓ Licensed - dates of licensure verification before first day of employment
    ✓ Non-licensed – personnel file contains signed copy of job description dated within first 3 days of employment
Rehabilitation Risks Potential Audits

• Outpatient Therapy Coding
  – Potential Surveillance Claims Audit - random sample of at least 30 Medicare claims is selected from the universe of all outpatient Medicare therapy claims for services provided during the review period. Reviewer uses a template(s) to review the medical and billing records for each claim to verify that Medicare billing and coding requirements are met, including
    ✓ Outpatient Plan of Care (i.e., timely physician signatures, completion of required elements, and timely physician signatures on re-certifications);
    ✓ Licensed staff provided all services rendered; and
    ✓ the services that were billed are adequately supported in the medical records
    ✓ the applicable CPT codes and units were billed correctly (e.g., the correct CPT codes were billed, the minutes of service were rounded correctly into billable units).
Rehabilitation Risks Potential Audits

• Outpatient Therapy Coding
  – Group Therapy. A sub-sample of claims is selected to assess the accuracy of group versus individual therapy billing. All Medicare services furnished by the therapist for the date of the claim are reviewed for compliance with Medicare group therapy rules in accordance with a template.
Rehabilitation Risks Potential Audits

• Inpatient Coding
  – Preventive Control: Each new coder receives training. All coding reviewed 100% until training is completed.
  – Audit:
    ✓ Review of personnel files / training records to determine if / when coder received training
    ✓ Review of documentation of 100% review by another coder until date of training
Rehabilitation Risks Potential Audits

• Inpatient Coding
  – Potential Surveillance Audit: ICD-9-CM and CMG Coding. Random sample of at least 30 Medicare claims is selected from the universe of all IRF Medicare discharges during the period for review. Medical records are reviewed to determine
    ✓ Accuracy of the Impairment Group Codes
    ✓ Accuracy of case-mix group (CMG)
    ✓ Accuracy of the tier billed based on the ICD-9-CM
    ✓ Correct Functional Impairment Measure (FIM) scores contained in the medical record (i.e., the FIM score in the medical record was transcribed correctly)
Rehabilitation Risks Potential Audits

- Inpatient Coding
  - Potential surveillance audit: Timely submission of PAIs to CMS. For each claim selected for surveillance review, the reviewer also verifies that the Patient Assessment Instrument (PAI) was submitted to the CMS national database in a timely manner.
Rehabilitation Risks Potential Audits

• Inpatient Coding - Outlier
  – Potential data analysis: Information from IRF PAI repository vendor is used to benchmark utilization of ICD-9-CM comorbid codes (excluding primary etiological codes) that effect Medicare tier assignments. Hospitals with utilization for any of the selected codes during the review period above a designated threshold level are designated as “outliers” and subject to further review.
  – Potential Audit: For each comorbid code that is determined to be an outlier, a file is obtained of Medicare discharges during the review period for that code (i.e., the universe). From each of the universes, a random sample is selected for review. These records are reviewed to determine whether the comorbid condition is supported in the record.
Rehabilitation Risks Potential Monitoring

- Inpatient Interrupted Stays
  - Analysis of the claims data semiannually, using the previous 6 months data to identify claims with potential errors (i.e., two admission dates within 3 days for same patient or an actual interrupted stay code is used) for an interrupted stay. Follow-up is performed for each potential error.
Rehabilitation Risks Potential Audits

• Outside Services
  – All outside service agreements with suppliers include an attachment which includes the guidelines that all invoices/bills for Medicare inpatients must be submitted to hospital and not to third party payors.
  – Potential Audit – review of any outside services provided to patients. Review of documentation to determine:
    ✓ Contract in place for services
    ✓ Invoice received by hospital
    ✓ Invoice/bill charges match contract terms
    ✓ Invoice paid by hospital
Contact Information

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