



**HCCA's 12<sup>TH</sup> ANNUAL COMPLIANCE INSTITUTE**

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## Rehabilitation Compliance Risks

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### Agenda - Rehabilitation Compliance Risks

- Understand the risks for outpatient therapy, both in the hospital and Outpatient Rehabilitation Facility (ORF) settings, including rounding, medical necessity
- Understand the risks for Inpatient Rehabilitation Facilities (IRFs), including intensity of service, co-morbidities
- Monitoring rehabilitation risks for IRFs and ORFs



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## IRF Conditions of Participation

- Free-standing facility or distinct unit of hospital
  - Beds cannot be co-mingled with acute care patients
- Medical Director who is MD or DO with minimum two years training in rehabilitation services
- 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
- Provide patients a minimum 3 hours/day or 15 hours/week of rehabilitation services (“3 hour rule”)
- Inform patients of five specific rights
- Comply with compliance threshold (“75% Rule”)
- **Failure to meet any of the major Conditions of Participation will result in loss of IPPS exempt status, and reimbursement will default to DRGs**
  - Significant financial impact as average length of stay for IRFs is 16 days; for general inpatient it is 6 days



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## The IRF Prospective Payment System

- 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
- 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
  - Comorbidities
  - Age (in some cases)
- Certain comorbidities may increase reimbursement



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## 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
- Measures patient's ability at admission and discharge in specific areas, divided into Motor and Cognitive functions on FIM
- FIM items are weighted, effective October 2005
- 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)



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## Outpatient Therapy

Category	Sub-Category	Risk
Billing Integrity	Services Performed within Proper Scope	Unlicensed personnel (e.g. Rehab Techs) furnishes treatment not permitted by state rules
		Licensed personnel (PTA/ATC) furnishes treatment not permitted by state scope of practice rules
		PTA/ATC (licensed personnel) treats patient when payor does not allow treatment
	Coding - CPT	Incorrect rounding of minutes for therapy units
		Incorrect modifier usage (Specifically the review of the use of the KX modifier in the ORF setting)



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## Outpatient Therapy

Category	Sub-Category	Risk
Billing Integrity	Individual vs. Group Therapy	Billing Medicare for individual therapy when group therapy was performed
	Medical Necessity	Treatment cannot be medically supported
	Plan of Care	Services performed fail to conform to POC
		Physician signature not received timely on initial POC
		POC does not meet technical standards for payment (e.g. goals, frequency, etc.)
		Re-evaluation billed without appropriate documentation regarding medical necessity
		POC extension not developed and signed by physician in a timely manner



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## Inpatient Therapy

Category	Sub-Category	Sub-sub Category	Risk	
Hospital Billing Integrity	Medical Necessity	Medicare Admissions Criteria	Failure to document medical necessity for admission	
			Failure to document need for 24 hour/day nursing care	
		3-hour "Rule"/ Guideline (Therapy services)	Failure to furnish intensive therapy services during IRF stay	
	Services Performed within Scope of Practice	Licensed Personnel		Unlicensed personnel (e.g. Rehab Techs) furnishes treatment not permitted by state rules
				Licensed personnel (PTA/ATC) furnishes treatment not permitted by state scope of practice rules
		Unlicensed Personnel	PTA/ATC (licensed personnel) treats patient when payor does not allow treatment	



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## Inpatient Therapy

Category	Sub-Category	Sub-sub Category	Risk	
Hospital Billing Integrity	Case-Level Payment Adjustments	Early Transfers	Delaying discharge dates in order to avoid early transfer payments for Medicare patients	
		Interrupted Stays	Improperly billing for two separate and distinct stays when a Medicare patient is discharged and re-admitted within 3 days	
		Short Stays	Delaying discharge dates in order to avoid short stay payments for Medicare patients	
	Coding	IRF - CMGs, ICD-9, HIPPS, FIM, PAI, IGCs	Late submission/filing of PAI	
			Inaccurate diagnosis coding placed on PAI leading to incorrect co-morbidity tier	
			Inaccurate FIM score placed on PAI	
			Integration of codes into Case Mix Group is inaccurate	
IRF- Discharge Disposition	Incorrect assignment of discharge disposition			



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## Inpatient Therapy

Category	Sub-Category	Risk
Professional Billing Integrity	Billing for non-employed providers	Inappropriately billing for inpatient services performed by non-employed providers (e.g., nurse practitioners, radiologists, etc.)
Conditions of Participation	Classification of IRF - 75% Rule	Facility does not meet required threshold for CMS-13 qualifying diagnosis as a percentage of all discharges
		Inaccurate assignment of impairment or qualifying diagnosis code
Vendor Relationships	Orthotics and Prosthetics (O&P)	Substantial price concessions offered by a vendor for PPS-covered O&P items in exchange for referrals of items that a vendor may bill directly to Medicare
		Failing to pay an outside vendor for an O&P item that is necessary during the IP stay for which hospital is responsible
	Ambulance/Transportation	Failing to pay an outside vendor for transportation that is necessary during the IP stay for which hospital is responsible



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## Monitoring Issues

- Is your organization compliant with the present 75% rule?
  - Is your organization monitoring this? How often?
  - What steps are being taken to assure compliance?
- Is there communication on a regular basis between the physician, PPS Coordinator and the Coder?
  - Are all documented comorbidities captured on the IRF PAI?
  - Are comorbidities on the IRF PAI appropriately documented in the medical record?
  - Are correct coding guidelines followed?
  - What changes have been made if any issues have been identified?
- Are self-audits being done on a regular basis?
  - What IRF risk areas are being monitored?
  - Are all parties involved in the self-audits- nursing, therapy, physician, coding and billing?
  - What process changes have been made if any issues have been identified?



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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 claims that do not meet Coverage Determinations (Local or National) are suspended and must be manually reviewed before billing**



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## 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 complex v. simple DRG usage in acute care)
    - IDTF Example – Volume of MRIs and CTs with/without contrast compared to total MRI/CT volume



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## 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 are you trying to measure?**
  - **How often do measure?**
  - **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?**



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## Monitoring Rehabilitation Risks Examples

- Services Performed within Proper Scope – Licensing
  - Preventive Control: Each new employee (i.e. aides, rehab techs, exercise physiologists, athletic trainers, massage therapists) is required to sign a copy of their job description, which includes information from the state practice act regarding scope of practice, to be kept in their personnel file.
  - Preventive Control: Before tasks may be delegated to a non-licensed person, a competency evaluation must be completed, documentation to be kept in personnel file.
  - Preventive Control: Before scheduling an appointment with a Physical Therapy Assistant, personnel consult spreadsheet of payor rules to review if PTA may treat
  - Detective Control: During surveillance audits, licenses of personnel who treated patient are confirmed.



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## Monitoring Rehabilitation Risks Examples

- Outpatient Therapy Coding (Rounding, Group v. Individual, Plan of Care)
  - Detective Control: Claims Audits. 30 days following the close of each calendar quarter, a random sample of xx Medicare claims is selected from the universe of all outpatient Medicare therapy claims for services provided during the quarter for review. 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 and 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).
  - Group Therapy. A sub-sample of xx 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.



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## Monitoring Rehabilitation Risks Examples

- Inpatient Coding
  - Preventive Control: Each new coder receives training. All coding reviewed 100% until training is completed.
  - Detective Control: ICD-9-CM and CMG Coding. About 30 days following the close of each calendar quarter, a random sample of xx Medicare claims is selected from the universe of all IRF Medicare discharges during the quarter for review. Copies of the medical files for each sample claim are reviewed to determine the appropriateness of case-mix group (CMG) and tier billed based on the ICD-9-CM and associated Impairment Group Codes assigned to the claim. The reviewer also evaluates whether the CMG assigned to the claim is supported by Functional Impairment Measure (FIM) scores contained in the medical record (i.e., the FIM score in the medical record was transcribed correctly). A written report of the results is prepared for review by the Compliance Committee.
  - Detective Control: Timely submission of PAIs to CMS. For each claim selected for review above, the reviewer also verifies that the Patient Assessment Instrument (PAI) was submitted to the CMS national database in a timely manner. Any exceptions are included in the report to the Compliance Committee.



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## Monitoring Rehabilitation Risks Examples

- Inpatient Coding -Outlier
  - Information from the Uniform Data System for Medical Rehabilitation (UDSMR) 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 12-month period ending on June 30 of each year above a designated threshold level are designated as "outliers" and subject to further review. For each comorbid code that is determined to be an outlier, a file is obtained of Medicare discharges during the audit period for that hospital/code (i.e., the universe). From each of the universes, a random sample of five discharges is selected for review. These records are reviewed to determine whether the comorbid condition is supported in the record. An error is defined as any comorbid condition included in the original claim paid by Medicare that was determined by the audit team not to be supported by the medical record and resulted in a payment error (i.e., either an over or underpayment). Each code outlier with more than one claim error or a net payment error rate of 10 percent or more (regardless of the number of errors) is subject to extrapolation of the sample results. Audit findings and recommendations for additional training or other remedial action are reported to the Compliance Committee and the Controller.



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## Monitoring Rehabilitation Risks Examples

- Inpatient Interrupted Stays
  - Compliance analyzes 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. A written report of the summary of findings is presented to the Compliance and Internal Controls Committee.



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## Monitoring Rehabilitation Risks Examples

- Outside Services
  - All outside service agreements with suppliers include an attachment which includes the guidelines that all bills for HealthSouth Medicare inpatients must be submitted to HealthSouth and not to third party payors. All agreements are processed via the term sheet process, which includes review and signature approval by Compliance. Legal does not draft/approve contract without all approvals in the file.



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