February 2008 Vol. 13, No. 2

BRIEFINGS ON Outpatient Rehab REIMBURSEMENT AND REGULATIONS

Changes to the physician fee schedule: How it will affect your reimbursements

This year's changes to the Medicare physician fee schedule have been decided, and it could mean good things for therapists.

For starters, President Bush signed a bill to ensure the 10.1% reduction is put on hold through June 30. However, the American Occupational Therapy Association (AOTA) is gearing up to advocate for congressional action to further extend, or potentially eliminate, the reduction, says **Sharmila Sandhu,** regulatory counsel in the department of reimbursement and regulatory policy at the AOTA.

This proposed 10.1% reduction is due to the various changes in the fee schedule formula and is the direct result of a legislative requirement for budget neutrality and the system for computing the sustainable growth rate for all services provided by all therapy professions.

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Payment calculations

Reimbursement amounts for codes that OTs bill for will vary based upon the complex physician fee schedule payment calculation. Therapists will receive a 0.5% increase to the physician fee schedule conversion factor for services rendered between January 1 and June 30. However, the numbers will vary on a case-by-case basis, and in some cases they will go up, and in others they will go down, says Sandhu.

"While Congress did act and pass this 0.5% increase to the fee schedule overall, I think when therapists start to look at the fee schedule, they might be confused because they've heard there is an increase, and when they look at some of their actual codes, they've gone down," says **Chuck Willmarth,** director of reimbursement and regulatory policy at the AOTA.

> **"While Congress did act and pass this 0.5% increase to the fee schedule overall, I think when therapists start to look at the fee schedule, they might be confused because they've heard there is an increase, and when they look at some of their actual codes, they've gone down."**
>
> *—Chuck Willmarth*

The rates are the result of a complex formula, which includes relative values units (RVU) for work, practice expenses, and malpractice costs, as well as a geographic adjustment and a separate methodology for calculating a dollar conversion factor (CF). Congress addressed the major reason for the 2008 rate decrease, the formula for the CF, but other changes were not affected by the legislation. Beginning in 2007, CMS applied a budget neutrality adjustment to the work value, which effectively lowers all of the code values. Additionally, CMS introduced a new methodology for computing the practice expense (PE) RVU that affects individual codes. The new PE method will be fully implemented over a four-year period.

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Physician fee schedule

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Plan of care

The recertification of the plan of care (POC) from 30 days to 90 days permits therapy services to be covered for up to 90 days. Any therapy services provided past the 90 days will require recertification. The AOTA's members overwhelmingly supported this change, says Sandhu.

Therapists commented to the AOTA in support of moving recertification from 30 days to 90 days. "We advocated strongly in support of this change, and we believe it puts clinical decision-making back into the hands of OTs in conjunction with physicians. This is something CMS has recognized as a positive step forward that will allow for more time before having to get a physician's recertification on the plan of care," says Sandhu. "We think this is an administrative change that simplifies and benefits practice for the occupational therapist, the physician, and the patient."

Therapy cap

The AOTA advocated for an exceptions process regarding the therapy cap. There would be a financial cap on payments for therapy services under Part B for an amount of $1,810 for this year.

An exception was in place for 2007, and the AOTA requested an extension through 2008; however, this act requires congressional action.

The AOTA also commented in support of alternatives to this therapy cap, says Sandhu. It advocated to get the exceptions process of the therapy cap through legislative action so that it is currently in place through June 30, says Sandhu.

Other changes

CMS proposed new language regarding the qualifications for OTs. The AOTA submitted comments about those proposed qualifications, and they needed quite a bit of work, says Willmarth. The history of the profession and the requirements to practice are complex, so the AOTA worked with CMS to create appropriate language. The

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Illustration by David Harbaugh

"There is a bright side . . . The hospital says all overworked rehab managers are eligible for a free evaluation and plan of care."

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factors they took into consideration are ones that have changed in the therapy world over time. These include:

- Accreditation bodies
- Testing organizations
- Education levels
- State regulations

It took time to develop qualifications that work, but as a result, the final language implies the requirement for therapists to:

- Be state-regulated through licensure, certification, or registration
- Graduate from an approved school
- Pass an exam if applicable

In addition, the new language for qualifications addresses internationally trained therapists, says Willmarth. "We think CMS did a nice job of sorting through some complex issues to come up with workable qualifications," he says.

These qualifications won't be implemented until January 1, 2010, to provide time for OTs and OT assistants to come into compliance with these standards, says Sandhu.

Language prior to the rulemaking was outdated, and most people weren't in compliance, says Willmarth. For example, the old requirements recognized an accreditation body that no longer exists, so recent graduates were clearly not in compliance. The new requirements reference the appropriate updated bodies. There isn't a substantial change in the OT profession that wouldn't have already been covered in order to practice by either a state law or a Medicare requirement, he says.

Many of these changes are updates to ensure that standards are consistent and no longer as confusing as they previously were, says Sandhu.

Physician Quality Reporting Initiative

The AOTA is working with a Medicare contractor called Quality Insights, which is based in Pennsylvania and deals with developing nonphysician practitioner quality measures.

The AOTA advocated for the expansion of quality measures that OTs may report. Several other measures were also advocated for by the AOTA, and it was successful in adding the following initiatives:

- Documentation of current medication in the medical record
- Patient codevelopment of the POC
- Pain assessment prior to initiating patient treatment
- Universal weight screen
- Screening for cognitive impairment
- Screening for clinical depression
- Adoption of health IT

"We continue to work on those initiatives, and there are measures that are currently being developed with Quality Insights that will be proposed in the future," says Sandhu. ■

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Taking a stand

AOTA and APTA work to eliminate CMS' additional certification requirements

In December 2007, after more than two years of efforts by the American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA), the additional requirement for OTs and PTs to perform wheelchair evaluations under Medicare was eliminated.

The AOTA reimbursement and regulatory policy staff and the APTA had made an ongoing effort to convince CMS to eliminate this requirement. If the requirement had passed, OTs and PTs performing wheelchair evaluations for higher-end power devices would have been required to attain additional certification.

This requirement, released in 2006, was included in the Medicare durable medical equipment (DME) contractor's Local Coverage Determination (LCD) policy for power mobility devices.

The original LCD specifically required OTs and PTs to attain certification as Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioners before they could perform the specialty evaluations necessary for patients receiving Group 2, Group 3, or Group 4 power wheelchairs.

In response, the AOTA began to draft comments to send in to CMS. The fact that the different regions of DME contractors all adopted this particular LCD made it unique in that, as a result, it became a national policy instead of a regional policy, says **Sharmila Sandhu,** regulatory counsel in the department of reimbursement and regulatory policy at the AOTA.

"When that LCD went out for comment, it came to our attention that the regions were looking at how wheelchair evaluations should be conducted and performed," she says.

Rectifying the situation

The AOTA has been involved in several meetings with different Medicare leaders, says Sandhu.

The initial meeting began with the CMS office of program integrity to generate awareness about this issue. Then the AOTA arranged a meeting with Herb Kuhn, the acting administrator of CMS, to explain the issue to him. "We've worked closely with the APTA; they've also been a part of the meetings," says Sandhu.

A series of letters were then sent by the AOTA to the many parties involved. Finally, a reconsideration request was sent to the medical directors, asking them revise the LCD.

A meeting between the AOTA and the medical directors was granted to discuss the issue prior to a decision

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about revising the LCD to remove the RESNA Assistive Technology Practitioners certification from the language, says Sandhu.

The logic behind the proceedings of the AOTA include the fact that:

- OTs and PTs are competent by virtue of their education and their licensure
- The additional certification requirement was burdensome and unnecessary given the existing standards OTs and PTs are already held to
- OTs and PTs are held to ethical requirements that ensure that they only practice in areas of competency

With this requirement, there would also be an access issue for Medicare beneficiaries who need to get a wheelchair evaluation beginning April 1, because there wouldn't be enough OTs or PTs with the certification to actually serve them, says Sandhu.

"We were able to make these arguments to the medical directors through the meeting, and ultimately, they came out with the decision and agreed to remove the requirement," she said.

Without the agreement

"Technically, looking at the LCD, beginning April 1, 2008, Medicare would have put in place the requirement that all OTs and PTs obtain certification as RESNA Assistive Technology Practitioners in order to perform a specialty seating evaluation that's required for patients to receive certain high-level power devices," says Sandhu.

With this LCD in place, all OTs who work in the area of power mobility device evaluations would be required to have this additional certification in order to bill for their services. If they did not have the certification, they would not receive payments from Medicare for their work, says Sandhu.

Effect on patients

Now that the requirement has been removed, beneficiaries will have greater access to OTs to perform the specialty evaluations for wheelchairs. The number of OTs who would have been available to perform these evaluations with the requirement in place would have been much lower. "Our concern was that beneficiaries would have an access issue and be left without wheelchairs they desperately need," says Sandhu. ■

Time to analyze your contracts

Now that you have contracts—or will soon—there is an opportunity to grow into a mutually acceptable and valuable relationship with your contracted managed care plans.

At this point during the contract's life cycle, constant performance monitoring, relationship management, and issue resolution must be in place.

Performance monitoring is carried out through financial analysis using custom and standardized reporting. Considerations should be given to financial outcomes, marketing outcomes, and administrative overhead in managing the contract.

Each contract's performance is evaluated via monthly, quarterly, and annual reports. Any areas of concern are further analyzed with custom reporting from an internal or external source, such as a referring physician or the managed care plan.

Managing your relationship with the managed care plan entails regular communication with the managed care plan's staff and management. That way, operational issues can be resolved to enhance referrals through marketing efforts, unless, of course, it is a capitation plan.

The owner or manager of the therapy clinics and the provider organization's marketing or contracting staff need to be involved.

During this process, you can bring problems to light and look for resolution.

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Contracts

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In addition to creating a monthly or quarterly report, evaluate the contract each year on its renewal date. A contract-specific renewal analysis should be performed, and information is gathered from the staff to form a response to the managed care plan if any action is needed to modify the existing contract.

If no changes are to be made, and the contract is designed to automatically renew, no further action is required, and the life of the contract continues. Renewal also may undertake any changes required by proposing an amendment to the contract.

Potential changes generally involve reimbursement rates or operational clauses related to utilization review or mandatory regulatory clauses that the managed care plan will require.

There are also several points that need to be discussed relative to contract and rates review and recommended policies for successful contracting.

For example, to administer an effective managed care contracting program, the facility, practice, or therapy center must have:

- Timely, accurate, and necessary data with respect to actual service performance—both clinical and financial
- Referral patterns
- External market data in light of the program's contracts

Take the following steps to address the data analysis needs of successful contacting:

- Evaluate existing data within the facility, practice, or therapy center by determining the availability and accuracy of data. This can come from your billing system, a practice management system, or an additional database that has been implemented to collect patient information.
- Evaluate how the managed care financial information will be disseminated to those that can make financial and clinical decisions.
- Determine what is necessary to consider all elements of the business end of the practice so that managed care contracting strategy can be refined, tuned, and implemented.

The following are sample reports for routine reporting on a monthly and annual basis, as well as a contract renewal analysis:

- Routine monthly and annual reports
  - Monthly total performance
  - Managed care effect on total business
  - Year to date by program or service
- Contract renewal analysis
  - Financial performance statement
  - Overview of statistics
  - Statistics by service
  - Statistics by month ■

Source: Managed Care for Rehab Providers Made Easy: Mastering Contracts and Obtaining Reimbursement, *by Nancy J. Beckley, MS, MBA, CHC. Published by HCPro, Inc.*

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Questions? Comments? Ideas?

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Managed care contract renewal analysis for Insurance Company A: Contract year ending June 30, 2006, and June 30, 2007

Financial performance statement—Report 1			
	Inpatient	Outpatient	Total
Year ending June 30, 2007			
Total charges			
Contractual allowance			
Bad debt			
Direct costs			
Contribution margin			
Indirect costs			
Total profit/(loss)			
P/(L) as % of total charges			
Year ending June 30, 2006			
Total charges			
Contractual allowance			
Bad debt			
Direct costs			
Contribution margin			
Indirect costs			
Total profit/(loss)			
P/(L) as % of total charges			

Source: Managed Care for Rehab Providers Made Easy: Mastering Contracts and Obtaining Reimbursement, *by Nancy J. Beckley, MS, MBA, CHC. Published by HCPro, Inc.*

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Managed care contract renewal analysis for Insurance Company A: Contract year ending June 30, 2006, and June 30, 2007 *(cont.)*

Overview of statistics—Report 2			
	2006	2007	% change
Outpatient			
Visits			
Total charges			
Reimbursement			
Reimbursement %			
Charges per visit			
Reimbursement per visit			
Grand totals			
Total charges			
Reimbursement			
Reimbursement %			
Charges per patient			
Reimbursement per patient			

Outpatient statistics by service—Report 3					
	2007 visits	2006 visits	% change	2007 changes	% reimbursement
Service					
Physical therapy					
Speech therapy					
Occupational therapy					
Cardiac					
Orthopaedic					
Other					
Totals					

Source: Managed Care for Rehab Providers Made Easy: Mastering Contracts and Obtaining Reimbursement, *Nancy J. Beckley, MS, MBA, CHC. Published by HCPro, Inc.*

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Successfully handle patient complaints

How to deal with Health and Human Services

A disgruntled patient accuses you of failing to protect her protected health information (PHI), thereby violating her rights under the HIPAA privacy rule. But rather than complaining directly to you, the patient goes straight to the U.S. Department of Health and Human Services' Office for Civil Rights (OCR) to air her grievances.

Soon, you receive a letter from OCR outlining the complaint and demanding that you explain your actions and what you plan to do to resolve the situation.

"There are times when healthcare providers are blindsided by these complaints," says **Mary D. Brandt, MBA, RHIA, CHE,** of Brandt & Associates in Bellaire, TX.

Brandt says your first priority when you receive notification from OCR should be to recognize the seriousness of the complaint and launch an internal investigation.

Regardless of whether the patient went straight to OCR or complained to facility staff members before contacting the federal government, the facility should assign the complaint to an appropriate staff member, such as a compliance or privacy officer, she says.

Gathering information

If you receive a complaint from OCR, you may need to contact the patient to obtain more information. This situation requires tact and diplomacy. Be sure to approach the patient in a nonconfrontational manner. Nurse managers should contact the patient by telephone and discuss the alleged breach of privacy in a friendly, empathetic manner.

Although OCR provides a copy of the actual patient complaint, the amount of information in the complaint varies based on the patient's ability to effectively communicate the circumstances. All staff members involved with customer service must know who is in charge of handling complaints and should immediately forward any complaints received to that individual.

Prompt response

"The last thing you want is for an OCR notification to sit on the desk in a busy clinic. A quick response is essential," says Brandt.

Respond swiftly and document your response, including any action taken. If you fail to respond within the specified time, OCR will contact you again. Brandt reminds facilities that OCR can impose financial penalties of $100 per violation and up to $25,000 per year.

Brandt recognizes that it is unrealistic to think that you will make every patient happy. However, if you do your best to rectify problems in a timely manner, OCR will take that into consideration.

Be proactive about complaints

The best way to avoid an OCR notification or patient complaint is to "create an environment that is not going to give patients a reason to complain," says **Kate Borten, CISSP, CISM,** president of The Marblehead Group in Marblehead, MA. Borten acknowledges that complaints often are a direct result of staff members' behavior. She advises facilities to constantly remind staff members about privacy requirements.

Borten says nurse managers must teach staff members how to handle complaints in an appropriate manner. Most staff members can handle simple, minor complaints. However, more controversial complaints should be referred to the person who is in charge of these matters. ■

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BRRR coding corner

Editor's note: This column appears monthly in **BRRR** *to help answer subscribers' coding questions.* ***Rick Gawenda, PT,*** *director of rehabilitation for Detroit Receiving Hospital and owner of Gawenda Seminars (*www.gawendaseminars.com*) in Ypsilanti, MI, answered the coding question below. Submit questions to Editorial Assistant Kerry Vegliando at* kvegliando@hcpro.com.

Q Can you please clarify the 90-day certification interval?

A There have been a lot of questions regarding the 90-day certification for Medicare patients. First of all, the 90-day certification period is for all outpatient therapy settings, including comprehensive outpatient rehabilitation facilities. The rule does not apply to services provided to Medicare patients in a skilled nursing facility under Part A reimbursed via the prospective payment system.

The 90-day certification period is effective January 1. As of **BRRR**'s print date, CMS has not notified the Medicare contractors of this change. CMS must do so via a Change Request release. The agency is currently working on this Change Request and says it hopes to have it out soon. Once out, and after the Medicare contractors have been notified, it will be retroactive to January 1.

Keep in mind that the certification period is up to 90 days. If the therapist develops the plan of care (POC) as three times per week for six weeks, and the physician or nonphysician practitioner signs that POC, therapy can be provided for up to six weeks. If the patient requires skilled therapy services beyond the six weeks, the therapist would have to update the POC, including the frequency and duration of therapy services, and send that updated POC to the patient's physician for recertification (i.e., signature and date of the physician or nonphysician practitioner).

The initial POC should be developed based upon the results of the initial evaluation and the therapist's professional assessment to determine the appropriate duration of therapy services. Very few POCs would need to be initially developed for 13 weeks.

The benefit of extending the certification period to 90 days is to allow the therapist to treat those patients that need therapy beyond 30 days without the added burden of obtaining a recertification. It will also allow the therapist to taper the frequency of therapy services based on the needs of the patient. For example, a therapist may initially see a patient three times per week for three weeks and then decrease the frequency to twice per week for two weeks and then once per week for two weeks and then discharge the patient.

CMS is concerned that this change will significantly increase the utilization of therapy services. Regardless of the length of the certification interval, the amount of visits that the patient requires is based on the needs of the patient and the professional assessment of the therapist. The patient should be discharged when all function-based goals have been achieved or when he or she has stopped making progress in therapy. The utilization of therapy services will be monitored by CMS. ■

Put documentation tips in the palm of your hand

Proper documentation is vital to reimbursement and patient care in the therapy setting. Improper documentation can lead to a host of problems, including denials, decreased reimbursement, and lawsuits.

Unfortunately, therapists don't receive formal training about documentation and are often left alone to decipher the confusing requirements set forth by Medicare, Medicaid, and managed care companies.

The *Pocket Guide to Therapy Documentation* offers documentation tips and advice in a convenient and handy format.

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BRRR Q&A

Editor's note: ***Nancy J. Beckley, MS, MBA, CHC,*** *president of Bloomingdale Consulting Group in Brandon, FL, answered the questions below. Please submit questions to Editorial Assistant Kerry Vegliando at* kvegliando@hcpro.com.

Q Is it legal for an insurance company or managed care plan to pay different rates for the same service? For example, is it legal to pay different rates for PT to different providers in our area? Shouldn't all providers be paid the same for the service that is provided?

A Prior to the rise and predominance of managed care, health insurance reimbursed providers based on 80% of charges or the usual, customary, and reasonable fee, known as the UCR.

Insurance companies establish these fees based upon data they collect for a specific marketplace. The UCR fee is the charge for healthcare that is consistent with the average rate or charge for identical or similar services in a certain geographical area. To determine the UCR for therapy procedures in a given geographic area, insurers will analyze statistics either from national studies of fees charged by medical providers maintained by the Health Insurance Association of America or other data aggregators, as well as their own claims history database.

Under various types of managed care arrangements, it is possible for therapy providers in a given community to have rates that vary for the same visit or procedure. For example, one provider may have signed a contract for a specific rate that is guaranteed for two years, whereas a newer provider may be offered a different rate for their contract period that is either higher or lower based not only upon market forces but also on the financial contracting strategies of the managed care company.

A therapy provider that offers specialized services may be able to negotiate for a higher level of reimbursement. Providers that have multiple locations in the marketplace may have more negotiating power than a single therapy clinic, and hospital and health system providers may be able to leverage their contracting savvy to provide favorable rates for outpatient rehab services.

Insurance regulations are individual to each state, so it is important to check with your state insurance commissioner office to determine the regulations that govern reimbursement of providers for insured services. When you are considering the type of managed care contracts to enter into, it is important to set a financial strategy for your facility. If a particular managed care contract or reimbursement rate does not fit with that strategy, it is probably better to walk away than accept a rate that does not provide reimbursement consistent with your financial strategy.

Q Are we required to provide Medicare training to our employees starting in January? We have a new therapist who indicated that this is a Medicare requirement, according to his previous hospital employer. Can you provide me with the specific Medicare requirement?

A Medicare does not require that providers offer annual training. Most Medicare providers, particularly large providers such as hospitals, have voluntarily developed a compliance program consistent with a provider-specific *Compliance Program Guidance* developed by the Office of Inspector General.

Facilities and providers that have developed a compliance program establish a training and education component to ensure that their employees, contractors, and vendors receive appropriate training and education about practice standards and procedures. Compliance annual training and updates may take place at the beginning of the year or on the employee's employment anniversary date.

There is not a specific guidance for rehab, but outpatient providers may use the guidance issued in 2000 for individual and small group physician practices. The guidance can be accessed at *http://oig.hhs.gov/authorities/docs/physician.pdf*. ■

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News in brief

New rehabilitation system unveiled

Doctors and robotics engineers that joined together two years ago to develop a computer-based patient rehabilitation system will finally unveil their project, reported the *Hindustan Times*.

Engineers from Rice University in Houston, and doctors from Memorial Hermann, also located in Houston, completed the study after 16 patients used a prototype rehabilitation system with a joystick to help with eye-to-hand coordination. The purpose of the computer program is to measure how a patient responds to every exercise, and the therapist can learn where the patient needs more work, according to the *Hindustan Times.*

Treatment sought through specialized treadmill

Patients at a therapy clinic in Phoenix who are suffering from orthopedic and athletic injuries receive treatment on a treadmill that reduces the user's overall body weight while exercising, according to *www.businesswire.com.* The treadmill, G-Trainer Anti-Gravity Treadmill, helps patients with lower extremity injuries or surgeries and improves athletic performance. Previous ways of helping these types of patients include aquatic therapy and the use of a harness, according to the Web site.

Potential for educational loan relief for PTs

Some PTs may see a relief in student loan payments in the future. Therapists who practice in areas with a shortage of healthcare providers are eligible for the Physical Therapist Student Loan Repayment Eligibility Act (S 2485). Senator Jon Tester (D-MT) introduced the bill in December 2007, according to an American Physical Therapy Association (APTA) press release. "As a result of the extensive education and clinical training required to become a physical therapist, students often begin their careers with significant levels of debt," said APTA President R. Scott Ward, PT, PhD.

Therapists prescribe video games to assist recovery

Therapists are turning to the Nintendo Wii to rehabilitate stroke victims, according to Reuters. OTs at Ohio State University Medical Center's Dodd Hall Rehabilitation Hospital in Columbus state that patients who use the video game system build balance, coordination, endurance, and upper and lower body strength. Patients recovering from spinal cord or traumatic brain injuries also benefit from the Wii. Patients use the video game system 30 minutes per day, two to three times per week, in addition to their three hours of daily therapy, according to Reuters.

New ASHA president elected

The American Speech-Language-Hearing Association (ASHA) has elected a new president, according to an ASHA press release. In January, Catherine H. Gottfred, PhD, began her one-year presidency term.

According to Gottfred, her primary goal is to make ASHA's new governance model what it is meant to be, which is a voice for ASHA's members. Gottfred has 26 years of volunteer experience with ASHA and is the founder of the nonprofit Leap Learning Systems in Chicago, according to the release.

ASHA educates consumers about volume safety

The American Speech-Language-Hearing Association (ASHA) was spreading the word of volume safety and noise-induced hearing loss at this year's Consumer Electronic Show in Las Vegas, according to an ASHA press release.

ASHA was urging consumers to use electronic devices, such as MP3 players, at safe listening levels. Loud volumes increase the risk of hearing loss, which can be permanent. "Sales figures from the holidays underscore the popularity of MP3 players and similar devices," ASHA President Catherine H. Gottfred, PhD, says. "If the technology is misused for too long, over time, noise-induced hearing loss can result." ■

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