



Coding Corner

FAQ

1. Can I bill a re-evaluation each time I complete a progress note or recertification?

No, a re-evaluation is not a routine, recurring service and should not be billed for routine re-evaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report. Continuous assessment of the patient's progress is a component of the ongoing therapy services, and is not payable as a reevaluation. Re-evaluations provide additional objective information not included in other documentation, such as treatment or progress notes and are focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment, or terminating services.

Consider the following points when billing for a re-evaluation:

1. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.
2. If a patient is hospitalized during the therapy interval, a re-evaluation may be medically necessary if there has been a significant change in the patient's condition which has caused a change in function, long term goals, and/or treatment plan.
3. Therapy re-evaluations should contain all the applicable components of an initial evaluation and must be completed by a clinician.

2. Please explain the difference between CPT code 97032, attended electrical stimulation, and G0283, unattended electrical stimulation.

Most non-wound care electrical stimulation treatment provided in therapy should be billed as G0283, unattended electrical stimulation, as it is often provided in a supervised manner (after skilled application by the qualified professional/auxiliary personnel) without constant, direct contact required throughout the treatment.

Most electrical stimulation conducted via the application of electrodes is considered unattended electrical stimulation. Examples of unattended electrical stimulation modalities include Interferential Current (IFC), Transcutaneous Electrical Nerve Stimulation (TENS), cyclical muscle stimulation (Russian stimulation). 97032 is a constant attendance electrical stimulation modality that requires direct (one-on-one) manual patient contact by the qualified professional/auxiliary personnel. Because the use of a constant, direct contact electrical stimulation modality is less frequent, documentation should clearly describe the type of electrical stimulation provided, as well as the medical necessity of the constant contact to justify billing 97032 versus G0283. Types of electrical stimulation that may require constant attendance and should be billed as 97032 when continuous presence by the qualified professional/auxiliary personnel is required include the following examples:

- Direct motor point stimulation delivered via a probe
- Instructing a patient in the use of a home TENS unit
- Functional Electrical Stimulation (FES) or Neuromuscular Electrical Stimulation (NMES) while performing a therapeutic exercise or functional activity may be billed as 97032. Do not bill for CPT codes 97110, 97112, 97116 or 97530 for the same time period.

3. How do I bill for time spent performing education?

A common billing mistake is to bill all education under CPT code 97535, self care/home management. However, proper coding is to use the CPT code that best describes the focus of the educational activity. For example, if the instruction given is for exercises to be done at home to improve ROM or strength use 97110; if instructing the patient in balance or coordination activities at home, use 97112; if instructing the patient on using a sock aide for dressing, use 97535; if teaching the patient aquatic exercises to use as an independent program in the community pool, use 97113; if teaching tub transfers, use 97530; and if instructing in a home electrical stimulation unit, use 97032.

4. Can I use CPT 29xxx codes from the application of cast and strapping section of the CPT books when I apply an orthotic?

According to CPT Assistant-February 2007, orthosis application differs from the purpose of an application of a cast or strapping device. Casting and strapping codes should be used when temporary immobilization/fixation is required until there is further treatment disposition and should not be reported for orthotics fitting and training. Instead, 97760 and/or 97762 should be used for orthotic fitting and training performed by therapists.

5. Is there a CPT code I can use to bill for performing a Tinetti or other balance test?

CPT code 97750, physical performance testing, may be reasonable and necessary for patients with neurological, musculoskeletal, or pulmonary conditions. Examples of physical performance tests or measurements include isokinetic testing, Functional Capacity Evaluation (FCE), 6 minute walk test, and Tinetti or other balance tests. There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. CPT code 97750 is not covered on the same day as CPT codes 97001-97004 (due to CCI edits).

Decoding CPT Codes

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

This quarter we will focus on CPT code CPT 97110 - Therapeutic exercises.

If an exercise is taught to a patient and performed for the purpose of restoring functional strength, range of motion, endurance training, and flexibility, CPT code (97110) is the appropriate code. If the focus is not strength, range of motion, endurance or flexibility then it is likely that a different CPT code is more appropriate.

Therapeutic exercises are used for the purpose of restoring strength, endurance, range of motion and flexibility where loss or restriction is a result of a specific disease or injury and has resulted in a functional limitation. Documentation should include measurable indicators to support the medical necessity of therapeutic exercise such as functional loss of joint motion or muscle strength, but also information on the impact of these limitations on the patient's life and how improvement in one or more of these measures leads to improved function.

Many therapeutic exercises require the unique skills of a therapist to evaluate the patient's abilities, design the program, and instruct the

patient or caregiver in safe completion of the special technique. However, after the teaching has been successfully completed, repetition of the exercise, and monitoring for the completion of the task, in the absence of additional skilled care, is non-covered.

Repetitive type exercises often can be taught to the patient or a caregiver as part of a self-management, caregiver or nursing program. For example, NGS' LCD 26884 Outpatient Physical and Occupational Therapy Services states that "for many patients a passive-only exercise program should not be used more than 2-4 visits to develop and train the patient or caregiver in performing PROM." Exercises to promote overall fitness, flexibility, endurance (in absence of a complicated patient condition), aerobic conditioning, weight reduction, and maintenance exercises to maintain range of motion and/or strength are non-covered. In addition, exercises that do not require, or no longer require, the skilled assessment and intervention of a qualified professional/auxiliary personnel are non-covered.

NGS' LCD 26884 Outpatient Physical and Occupational Therapy Services provides the following example of when a service that is initially skilled becomes non-skilled: "as part of the initial therapy program following total knee arthroplasty (TKA), a patient may start a session on the exercise bike to begin gentle range of motion activity. Initially the patient requires skilled progression in the program from pedal-rocks, building to full revolutions, perhaps assessing and varying the seat height and resistance along the way. Once the patient is able to safely exercise on the bike, no longer requiring frequent assessment and progression, even if set up is required, the bike now becomes an "independent" program and is no longer covered by Medicare. While the qualified professional/auxiliary personnel may still require the patient to "warm up" on the bike prior to other therapeutic interventions, it is considered a non-skilled, unbillable service and should not be included in the total timed code treatment minutes."

Supportive Documentation Recommendations for 97110:

- Objective measurements of loss of strength and range of motion (with comparison to the uninvolved side) and effect on function
 - > Pt will increase right ankle DF ROM from -5 degrees to 15 degrees to normalize gait terminal stance and decrease early heel off and decrease excessive hip flexion compensation during swing leg advancement
 - > Patient will increase left hip abduction strength from 2/5 to 4/5 to prevent right pelvis drop during right swing phase

- If used for pain include pain rating, location of pain, effect of pain on function
- Analysis of substitutions
 - > AROM rt. Shoulder. Verbal and manual cuing during right shoulder flexion and abduction to correct shoulder elevation/hiking substitution
- Progressions/Downgrades
 - > Progressed patient from supine hip abduction to sidelying hip abduction with knee bent to decrease lever arm. Will progress to straight knee as strength improves.
- Techniques used to ensure proper performance
 - > LE progressive resistive exercises. Focus on sidelying hip abduction performed with manual resistance to hip extension during abduction to decrease hip flexor substitution pattern and increase hip abduction strength
- Instruction in HEP or caregivers
- Emphasize why therapist was important in therapeutic exercise
 - > May include skilled cardiopulmonary monitoring including documentation of pulse oximetry, heart rate, blood pressure, perceived exertion, etc.

Keeping Straight on the Regulation Road:

CMS Continues to Release Clarifications on the Fiscal Year (FY) 2011 Final Rule for Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Changes That Were Effective October 1, 2011

Significant changes were proposed for the Skilled Nursing Facility Prospective Payment System (SNF PPS) in FY 2012 in the Proposed Rule issued by the Centers for Medicare & Medicaid Services (CMS) in April. CMS issued the Final Rule on July 29, 2011 which essentially implemented all of the significant changes that had been proposed. CMS continues to provide education and clarifications to providers on the October 1, 2011 changes. FAQs and CMS clarifications on the Fiscal Year (FY) 2012 Final Rule for Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Changes are detailed below:

General Clarifications:

FAQ:

1. Please clarify the use of the term “day of discharge”

Answer: (from CMS Follow-up information from November 3 provider training call) The term “day of discharge” can serve two

distinct purposes. The day of discharge may refer to the day the resident leaves the facility, as discussed in Chapter 2 of the MDS RAI manual and as captured within Item A2000 on the MDS. “Day of discharge” may also refer to the resident’s discharge from Medicare Part A, which is captured in Item A2400C on the MDS. As noted in Chapter 2 of the MDS RAI manual, it is possible that these two dates, that is the date of facility discharge and the date of Part A discharge, may not be the same, such as in cases where a resident uses all of his or her 100 entitled SNF benefit days but remains in the facility for some time after that point. It is also possible that the dates listed in A2000 and A2400C may be the same, such as in cases where the resident leaves the facility prior to exhausting their SNF benefit or if the resident were to expire during the course of the stay. Whether or not these two dates overlap is important to understanding the potential billing impact associated with these dates.

As noted in Chapter 3 of the Medicare Benefit Policy Manual, the date of discharge from the facility is a Medicare non-billable day. Therefore, in cases where A2000 (discharge from facility) and A2400C (last day of Medicare Part A stay) are the same, then the last day of the Medicare stay (A2400C) is a Medicare non-billable day. In cases where the resident remains in the facility after exhausting the full Medicare benefit, then the last day of the Medicare stay, which in this case would mean that A2400C would be equivalent to 100th day of the benefit, would be a Medicare billable day.

Change of Therapy (COT) OMRA

The Centers for Medicare and Medicaid Services (CMS) clarified on the November 3rd, 2011 national provider call both verbally and in their handout (slide 23) that “If the ARD of a Scheduled PPS MDS is ON or BEFORE the ARD of the COT; no COT is required but is allowed.” The RAI manual only states that the Scheduled PPS MDS ARD needs to be “before” the ARD of COT for a COT to not be required. However, CMS clarification stated “on or before.” It is important to note that the COT is “allowed” per CMS, so providers should evaluate whether or not to combine the scheduled MDS with the COT OMRA and if the RUG increases, it may prove to be beneficial to combine the scheduled MDS and COT OMRA. Here are two examples that illustrate this clarification:

1. 5 day assessment is completed on day 8 resulting in an RH. The 14 day assessment is completed on day 15 resulting in an RU. Day 7 of the COT observation period is also day 15 which falls on the ARD of the scheduled PPS assessment so the COT is not required but is allowed. In this scenario, it would benefit the facility to combine the COT with the 14 day so that the RU RUG can be billed retroactively beginning day 9.

Day	8 5 day assessment	9	10	11	12	13	14	15 14 day assessment + COT	16
PT	30	45	40			50	50	45	
OT	30	50	50			50	50	50	
ST		60	45			45	45	50	
RUG 5 day	RH	RH	RH	RH	RH	RH	RH	RU	
RUG from COT	RH	RU	RU	RU	RU	RU	RU	RU	RU

2. 5 day assessment is completed on day 6 resulting in an RU. The 14 day assessment is completed on day 13 and results in an RH for payment days 15-30. Day 7 of the COT observation period is also day 13 which falls on the ARD of the scheduled PPS assessment so the COT is not required but is allowed. In this scenario the COT is not required as the scheduled PPS assessment was completed on day 7 of the COT. The RH does not begin until day 15.

Day	6 5 day assessment	7	8	9	10	11	12	13 - 14 day assessment	14	15
PT	60	35	35			30	35	35		
OT	60	30	30			30	35	30		
RUG 5 day	RU	RU	RU	RU	RU	RU	RU	RU	RU	RH

FAQ

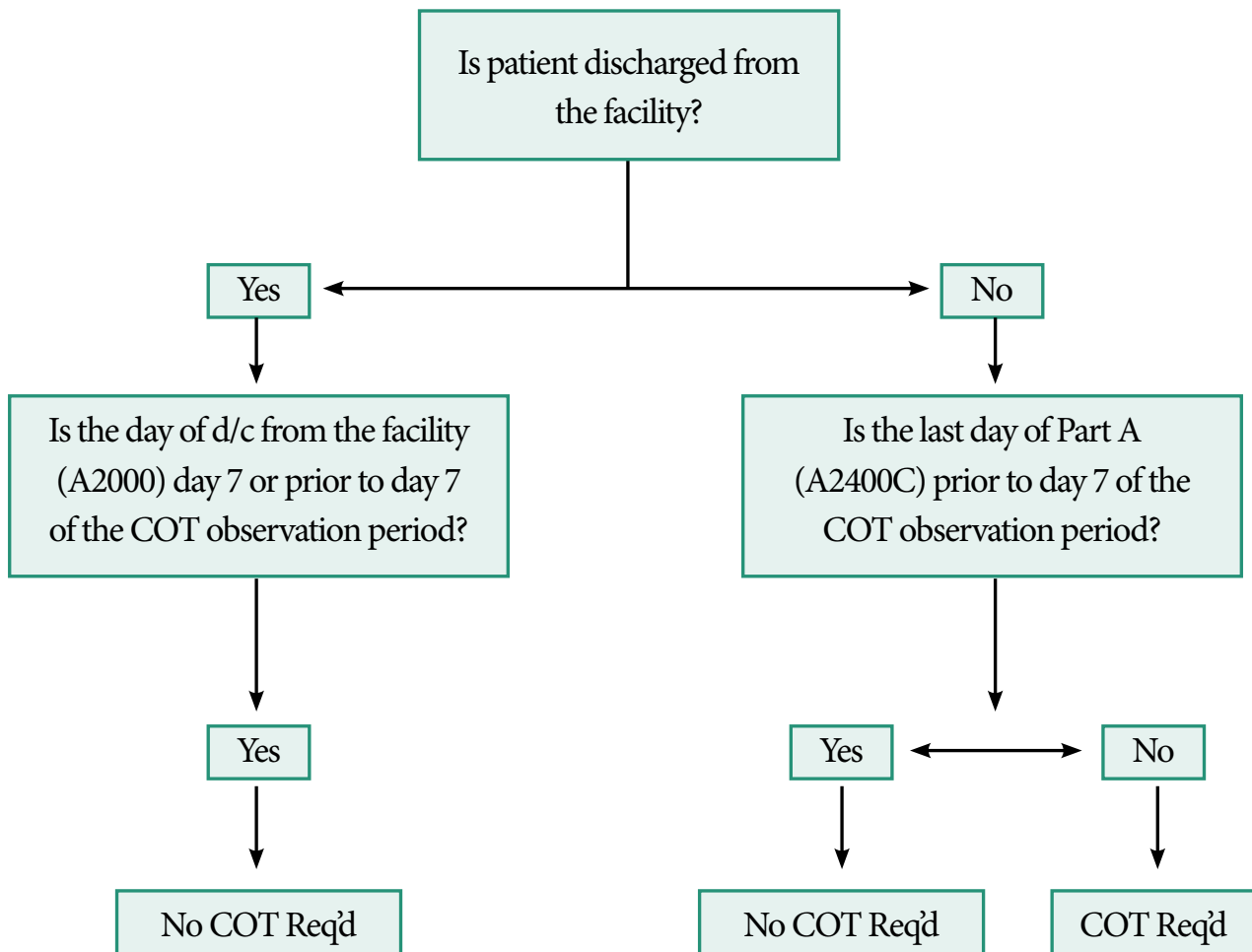
1. Please clarify the relationship between the COT OMRA and the day of discharge

Answer: (from CMS Follow-up information from November 3 provider training call) The term “day of discharge” can serve two distinct purposes. The day of discharge may refer to the day the resident leaves the facility, as discussed in Chapter 2 of the MDS RAI manual and as captured within Item A2000 on the MDS. “Day of discharge” may also refer to the resident’s discharge from Medicare Part A, which is captured in Item A2400C on the MDS. As noted in Chapter 2 of the MDS RAI manual, it is possible that these two dates, that is the date of facility discharge and the date of Part A discharge, may not be the same, such as in cases where a resident uses all of his or her 100 entitled SNF benefit days but

remains in the facility for some time after that point. It is also possible that the dates listed in A2000 and A2400C may be the same, such as in cases where the resident leaves the facility prior to exhausting their SNF benefit or if the resident were to expire during the course of the stay. Whether or not these two dates overlap is important to understanding the potential billing impact associated with these dates. In cases where the resident is discharged from the facility on or prior to Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.

In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met.

Finally, in cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility and this date is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.



2. When does the first COT observation period begin?

Answer: (from CMS Follow-up information from November 3 provider training call) As noted in the FY 2012 SNF PPS proposed and final rules, the ARD for a COT OMRA is to be set 7 days following the ARD set for the most recent PPS assessment used for payment. Additionally, as noted in Section 2.9 of the MDS RAI manual, the ARD for a COT OMRA may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's current RUG-IV therapy classification. As such, if an assessment does not yet exist for a resident which includes sufficient therapy to classify the resident for a therapy RUG, regardless of the RUG used for billing in the case of index maximization, then facilities may not complete a COT OMRA for this resident. The practical implication of this is that a COT OMRA may not be used as the first assessment that would classify a resident into a RUG-IV therapy group. This initial classification must be done using one of the regularly scheduled assessments or by completing a Start of Therapy OMRA.

3. Is a COT OMRA necessary when a resident misses 3 consecutive days of therapy and Day 7 of the COT observation period falls on one of the 3 missed days. For example, a resident misses therapy Days 36-38 and Day 7 of the COT observation period is Day 37.

Answer: (From CMS Follow-up information from August 23 provider training call and September 1 Open Door Forum) In cases as described above, the necessity of a COT OMRA will depend on what day is used for the ARD of the EOT OMRA. In this example, if the ARD of the EOT OMRA is set for either Day 36 or Day 37, then a COT OMRA would not be necessary. If the ARD of the EOT OMRA is set for Day 38, then, in addition to the EOT OMRA, the COT OMRA would need to be completed, assuming there has been a sufficient change in the intensity of therapy.

End-of-Therapy (EOT) OMRA

FAQ

1. If a patient does not receive therapy for three consecutive days during the ARD window for the 5 day scheduled PPS assessment is an EOT OMRA required?

Answer: (from CMS Follow-up information from November 3 provider training call) For residents who do not receive therapy for three consecutive calendar days during the allowable ARD window for the 5-day scheduled PPS assessment, facilities are not required to adjust the date of the ARD for the 5-day assessment or to combine the 5-day assessment with an EOT OMRA.

2. Is the EOT OMRA necessary for patients who miss three days consecutive days of therapy who are not classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category?

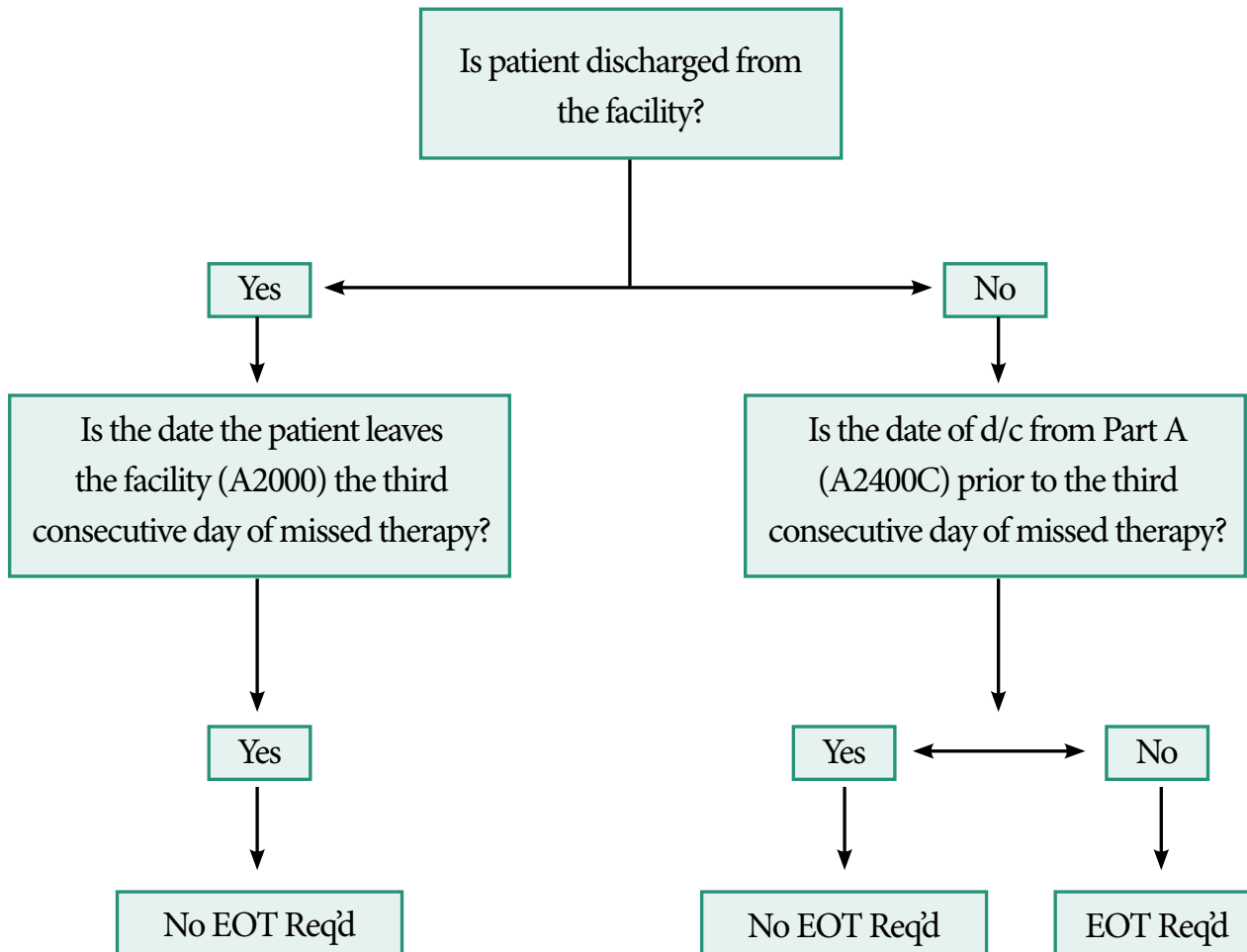
Answer: (from CMS Follow-up information from November 3 provider training call) In accordance with the MDS RAI manual, an EOT OMRA is necessary in cases where a resident classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and does not receive any therapy services for three or more consecutive calendar days. As such, an EOT OMRA is not necessary for residents who have not yet been classified into such a RUG category on a scheduled or unscheduled PPS assessment

3. Please clarify the relationship between the End of Therapy OMRA and the Day of Discharge

Answer: (from CMS Follow-up information from November 3 provider training call) In cases where a resident classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and does not receive any therapy services for three or more consecutive calendar days and the resident is discharged from the facility on the third day of missed therapy services, then no EOT OMRA is required. More precisely, in cases where the date coded for Item A2000 is the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.

In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.

Finally, in cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual.



Leave of Absence

FAQ:

1. Please clarify the effect of Leave of Absence (LOA) days on scheduled PPS assessments.

Answer: (From CMS Follow-up information from August 23 provider training call and September 1 Open Door Forum)
For scheduled assessments, pursuant to the policy outlined in Chapter 2, page 2-64, of the MDS 3.0 RAI Manual, the Medicare assessment schedule is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment. For example, if a resident leaves a SNF at 6:00pm on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00am, then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay. Therefore, a facility that would choose Day 27 for the ARD of their 30-day assessment would select Thursday as the ARD date rather than Wednesday, as Wednesday is no longer a billable Medicare Part A day.

2. Please clarify the effect of Leave of Absence (LOA) days on unscheduled PPS assessments.

Answer: (From CMS Follow-up information from August 23 provider training call and September 1 Open Door Forum) **For unscheduled PPS assessments, the ARD of the relevant assessment is not affected by the LOA because the ARDs for unscheduled assessments are not tied directly to the Medicare assessment calendar or to a particular day of the resident's stay.**

EOT example:

An EOT OMRA must be performed if a resident does not receive therapy for three consecutive calendar days, which may include days during which the resident experienced a LOA. For example, if a resident were to miss therapy on Monday and Tuesday, go to the emergency room at 9:00pm on Wednesday, return to the facility on Thursday at 10:00am and receive therapy on Thursday, then an EOT OMRA would be required with an ARD set for Monday, Tuesday, or Wednesday.

With regard to payment, the EOT OMRA would control payment for those Medicare-billable days during which the resident did not receive therapy while those non-Medicare billable days would remain non-billable to Medicare. We would note that, in the example above, the provider could complete the Resumption of Therapy items to resume therapy after the patient's return, assuming the resumption was completed consistent with existing policies governing the definition of a resumption of therapy.

COT example:

In the case of a COT OMRA, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. For example, if the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 9, returning at 2:00pm on November 10, Day 7 of the COT observation period would remain November 14.

With regard to payment, consistent with current policies related to the COT OMRA, the COT OMRA would set payment for those Medicare billable days beginning on Day 1 of the COT observation period and forward until the next scheduled or unscheduled assessment. Any days during which the resident was out on the LOA would remain non-billable to Medicare.

CMS released Calendar Year 2012 Final Rule for the Physician Fee Schedule on November 1, 2011

On November 1st, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update payment policies and rates for physicians and nonphysician practitioners (NPPs) for services paid under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2012. This is the same fee schedule used to pay for Part B therapies in outpatient and nursing facilities. Highlights of provisions in the final rule for the physician fee schedule that will impact therapy are discussed below.

CY 2012 payment rates face a 27.4% reduction

CMS announced in the final rule the physician fee schedule update for CY 2012 is projected to be negative 27.4 percent. This is slightly less than the 29.5 percent cut that CMS estimated in the proposed rule because the Medicare cost growth has been lower than expected. Over the last few years Congress has taken action to avert these cuts prior to their effective date. On December 23, 2011, HR 3765 The Temporary Payroll Tax Cut Continuation Act of 2011

was signed into law which averts the 27.4% cut to the physician fee schedule until February 29, 2012. If Congress does not intervene prior to February 29, 2012, the Medicare payment rates will be reduced 27.4 percent beginning March 1, 2012.

Therapy Cap Limitations

The dollar amount of the therapy cap in CY 2012 will be \$1880. Congressional action is necessary to extend the exceptions process. On December 23, 2011, HR 3765 The Temporary Payroll Tax Cut Continuation Act of 2011 was signed into law which extends the exception process until February 29, 2012. If Congress does not intervene prior to February 29, 2012, the cap exception process will no longer be in effect beginning March 1, 2012.

Multiple Procedure Payment Reduction (MPPR)

No revisions were made to CMS's policy regarding application of the MPPR to outpatient therapy services. MPPR is a reduction to the practice expense portion of the payment for a therapy procedure when more than one unit or procedure is provided to the same patient on the same date of service. The MPPR of 25% for services furnished in an institutional setting and 20% for services furnished in a non-institutional setting remains unchanged.

CGS J15 MAC LCDs Issued

Effective October 17, 2011 Medicare Part A Ohio and Kentucky workloads transitioned from NGS to CGS, the J15 MAC (Medicare Administrative Contractor). CGS has issued Local Coverage Determinations (LCDs) that impact the delivery of therapy services. Listed below is the information on the LCDs that contain detail on the diagnosis (ICD-9) codes that support medical necessity:

LCD	Codes that Support Medical Necessity
Local Coverage Determination (LCD) for Swallow Evaluation and Dysphagia Treatment (L31905)	438.82, 464.01, 464.51, 478.30-478.34, 478.6, 507.0, 787.20-787.24, 787.29
Local Coverage Determination (LCD) for Speech-Language Pathology (L31899)	307.0, 315.00-315.02, 315.09, 315.1, 315.2, 315.31, 315.32, 315.34, 315.35, 315.39, 315.5, 315.8, 352.1-352.6, 356.8, 389.00, 389.01-389.06, 389.08, 389.10-389.18, 389.20-389.22, 438.0, 438.10-438.14, 438.19, 438.6, 438.83, 478.30-478.34, 478.5, 784.3, 784.40-784.42, 784.51, 784.52, 784.59, 784.61, 784.69, 996.79, V40.1, V41.2, V41.3, V41.4, V43.81, V52.8, V72.83

2012 Therapy Cap Limitations

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare therapy patients. These limits change annually. Therapy caps for 2012 will be \$1880 for physical therapy and speech therapy combined and \$1880 for occupational therapy.

Therapy Cap Exceptions Process Expires Feb. 29, 2012 Unless Congress Acts

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Act, required payment under a prospective payment system (PPS) for outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). Section 4541(c) of the BBA required application of financial limitations to all outpatient rehabilitation services (except those furnished by or under arrangements with a hospital).

Since the creation of therapy caps, Congress has enacted several moratoria. The Deficit Reduction Act of 2005 directed CMS to develop exceptions to therapy caps for calendar year 2006 and the exceptions have been extended periodically. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions. In 2006, the Exception Processes fell into two categories, Automatic Process Exceptions, and Manual Process Exceptions. Beginning January 1, 2007, there is no manual process for exceptions. All services that require exceptions to caps shall be processed using the automatic process. All requests for exception are in the form of a KX modifier added to claim lines. The KX modifier is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

On December 23, 2011, HR 3765 The Temporary Payroll Tax Cut Continuation Act of 2011 was signed into law which extends the exception process until February 29, 2012. The automatic process for exceptions will expire on February 29, 2012 if congress does not act to extend the exception process. This will result in Medicare Part B therapy patients being limited to a cap of \$1880 for physical therapy and speech therapy combined and \$1880 for occupational therapy in 2012.

2012 Medicare Copays and Deductibles

CMS released information on the copays and deductibles for Medicare Part A and Part B services in 2012. The Part A deductible paid by a beneficiary when admitted as a hospital inpatient will be \$1,156 in 2011, an increase of \$24 from this year's \$1,132 deductible. The Part A deductible is the beneficiary's cost for up to 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay an additional \$289 per day for days 61 through 90 in 2012, and \$578 per day for hospital stays beyond the 90th day in a benefit period. For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 in a benefit period will be \$144.50 in 2012, compared to \$141.50 in 2011. In 2012, the Part B deductible will be \$140, a decrease of \$22 from 2011 and the Part B copay will remain 20%.

Wisconsin Physicians Service Insurance Corporation (WPS) Awarded the Jurisdiction 8 A/B MAC Contract

On September 30, 2011 CMS announced that Wisconsin Physicians Service Insurance Corporation (WPS) was awarded the Jurisdiction 8 A/B MAC contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states of Indiana and Michigan. WPS is the incumbent for the Part B Carrier contracts in Michigan. Over the next several months, CMS will oversee the transfer of the Part A workload for Indiana and Michigan and Part B workload for Indiana from the incumbent contractor, National Government Services Inc. (NGS), to WPS.

National Government Services Inc. (NGS) Awarded the Jurisdiction 6 A/B MAC Contract

On September 30, 2011 CMS announced that National Government Services, Inc. (NGS) was awarded the Jurisdiction 6 A/B MAC contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states of Illinois, Minnesota, and Wisconsin. NGS is the incumbent for the Part A Fiscal Intermediary contracts in Illinois and Wisconsin. Over the next several months, CMS will oversee the transfer of the Part B workload for Illinois, Minnesota, and Wisconsin from the incumbent, Wisconsin Physicians Service Insurance Corporation (WPS), and the part A workload for Minnesota from the incumbent, Noridian Administrative Services (NAS), to NGS.

Zone Program Integrity Contractor (ZPIC) Zones 3 and 6 Awarded to Cahaba Safeguard Administrators

The Medicare Prescription Drug Improvement and Modernization Act of 2003 called for CMS to realign the Program Safeguard Contractors (PSCs) into seven jurisdictions and be renamed Zone Program Integrity Contractors (ZPICs). The intent of these alignments is to have each ZPIC be responsible for the detection, deterrence and prevention of fraud, waste, and abuse across all claim types in their jurisdiction. ZPICs detect, investigate and gather evidence of suspected fraud and abuse to be turned over to the Office of Inspector General (OIG) for criminal or civil prosecution. These cases may result in prison sentences, monetary penalties, or certain forms of administrative sanction.

CMS announced that the remaining two ZPICs (#3 and #6) have been awarded to Cahaba Safeguard Administrators, LLC. Zone 3 consists of the states of Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio and Kentucky. Zone 6 consists of the states of Pennsylvania, New York, Maryland, District of Columbia, Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, and Vermont.

Recovery Audit Contractor (RAC) Program Demand Letters to be Issued by Medicare Administrative Contractor (MAC) Beginning January 3, 2012

As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing Recovery Audit Contractor (RAC) demand letters to providers from its Recovery Auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a RAC finds that improper payments have been made to a provider, they will submit claim adjustments to the provider's Medicare (claims processing) contractor. The Medicare contractor will then establish receivables and issue automated demand letters for any RAC identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from providers.

The Medicare contractor will then be responsible for fielding any administrative concerns providers may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating RAC and his/her contact information in the related demand letter. Providers should continue to contact the RAC for any audit specific questions, such as their rationale for identifying the potential improper payment.

All Eyes on Therapy

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

Obama Administration Announced Recovery of Over \$5.6 billion in Fraudulent Payments in Fiscal Year 2011

On December 13, 2011, the Obama Administration announced recovery of over \$5.6 billion in fraudulent payments in fiscal year 2011, a 167 percent increase from 2008. Of the \$5.6 billion recovered by DOJ in 2011, over \$2.9 billion was in health care fraud alone. This was driven in part by expansion of the Medicare Fraud Strike Forces, specialized teams of agents and prosecutors who focus on catching health care fraud. At the start of the Administration, there were two Strike Force teams. Now, there are Strike Force teams in nine different cities. In 2008, they brought cases involving \$384 million in fraudulent claims. This year, they brought cases involving over \$1 billion in fraudulent claims. For every dollar spent on this effort, the Administration has recovered seven dollars.

RAC Programs Expand to Medicaid January 1, 2012

CMS has issued a final rule implementing the Medicaid Recovery Audit Contractor program effective January 1, 2012. CMS published the proposed rule last November, and set April 1, 2011, as the date by which states had to implement their Medicaid RAC programs. However, in February CMS delayed the implementation date to allow states more time to set up their programs. The Medicaid RAC program beginning January 1, 2012 is based on the Medicare Recovery Audit Contractor program, which has recovered nearly \$670 million and counting in 2011 – increasing the taxpayer dollars recovered by nearly 800 percent compared to 2010. The Medicaid RAC program is intended to identify overpayments and underpayments within each state's Medicaid program, and to recover all overpayments. CMS expects to see savings of \$2.1 billion during the next five years, of which \$900 million will be returned to states. Provisions in the final rule include the following:



- States must refer any suspected fraud or abuse to local law enforcement or the appropriate Medicaid Fraud Control Unit (MFCU).
- Require states to coordinate Medicaid RAC operations with other auditing organizations operating within the state.
- Require the Medicaid RAC to hire at least one full-time medical director.
- Set limits on the number of medical records a Medicaid RAC can review.
- Require Medicaid RACs to work with the state to create education and outreach programs.
- Prohibit Medicaid RACs from reviewing claims older than three years, unless granted an exemption from the state.
- Require Medicaid RACs to return their contingency fee if any overpayment determination is reversed during the appeals process.
- Ensure that Medicaid RACs do not audit claims that have already been audited, or are currently being audited by another organization.

CMS Announces New Demonstrations to Help Curb Improper Medicare, Medicaid Payments

In 2010, the President announced three goals for cutting improper payments by 2012: reducing overall payment errors by \$50 billion, cutting the Medicare fee-for-service error rate in half, and recovering \$2 billion in improper payments. To help achieve these goals, the Centers for Medicare & Medicaid Services (CMS) has announced it will launch demonstration programs beginning in January 2012 targeting some of the most common factors that lead to improper payments.

Recovery Audit Prepayment Review January 1, 2012-
December 31, 2014

The Recovery Audit Prepayment Review demonstration will allow Medicare Recovery Auditors (RACs) to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The RACs will conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews will focus on seven HEAT states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. This demonstration will also help lower the error

rate by preventing improper payments rather than the traditional “pay and chase” methods of looking for improper payments after they have been made.

Reviews will begin with reviews of short inpatient hospital stays (two days or less) and the planned MS-DRGs for review are:

January 1	MS-DRG 312 SYNCOPE & COLLAPSE
March 1	MS-DRG 069 TRANSIENT ISCHEMIA MS-DRG 377 G.I. HEMORRHAGE W MCC
May 1	MS-DRG 378 G.I. HEMORRHAGE W CC MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
July 1	MS-DRG 637 DIABETES W MCC MS-DRG 638 DIABETES W CC MS-DRG 639 DIABETES W/O CC/MCC

Prior Authorization for Certain Medical Equipment

The second demonstration will require Prior Authorization for certain medical equipment for all people with Medicare who reside in seven HEAT states with high populations of fraud- and error-prone providers (CA, FL, IL, MI, NY, NC and TX). It is felt that this is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary’s medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary’s right to receive quality products from accredited suppliers.

The Prior Authorization demonstration will be implemented in two phases. During the first phase (the first three to nine months), the Medicare Administrative Contractors will conduct prepayment reviews on certain medical equipment claims. The second phase, for the remainder of this three-year demonstration, will implement prior authorization, a tool utilized by private-sector health care payers to prevent improper payments and deter the fraudulent provision of items or services.

Part A to Part B Rebilling

The third initiative will allow hospitals to rebill for 90 percent of the Part B payment when a Medicare contractor denies a Part A inpatient short stay claim as not reasonable and necessary due to the hospital billing for the wrong setting. Currently, when outpatient services are billed as inpatient services, the entire claim is denied in full.

This demonstration will be limited to a representative sample of 380 hospitals nationwide that volunteer to be part of the program. This demonstration will allow hospitals to resubmit claims for 90 percent of the allowable Part B payment when a Medicare Administrative Contractor, Recovery Auditor, or the Comprehensive Error Rate Testing Contractor finds that a Medicare patient met the requirements for Part B services but did not meet the requirements for a Part A inpatient stay. In addition, this demonstration is expected to lower the appeals rate which will protect the trust fund and reduce hospital burden. Beneficiaries will be held harmless with respect to changes in hospital coinsurance liability.

OIG Workplan for 2012

The Office of Inspector General Work Plan for Fiscal Year 2012 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 2012. For each review, the Work Plan describes the subject, primary objective, and criteria related to the topic. In 2012, the areas of therapy services that will be a focus are:

Nursing Home Compliance Plans (New)

The OIG will review Medicare- and Medicaid-certified nursing homes' implementation of compliance plans as part of their day-to-day operations and whether the plans contain elements identified in OIG's compliance program guidance. The OIG will assess whether CMS has incorporated compliance requirements into Requirements of Participation and oversees provider implementation of plans. Section 6102 of the Affordable Care Act requires nursing homes to operate a compliance and ethics program, containing at least 8 components, to prevent and detect criminal, civil, and administrative violations and promote quality of care. The Affordable Care Act requires CMS to issue regulations by 2012 and SNFs to have plans that meet such requirements on or after 2013. OIG's compliance program guidance is at 65 Fed. Reg. 14289 and 73 Fed. Reg. 56832. (OEI; 00-00-00000; expected issue date: FY 2013; new start; Affordable Care Act)

Medicare Part A Payments to Skilled Nursing Facilities

The OIG will review the extent to which payments to SNFs meet Medicare coverage requirements. The OIG will conduct a medical review to determine whether claims were medically necessary, sufficiently documented, and coded correctly during calendar year (CY) 2009. 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. (OEI; 02-09-00200; expected issue date: FY 2012; work in progress)

Independent Therapists: Outpatient Physical Therapy Services

The OIG will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations. Previous OIG work has identified claims for therapy services provided by independent physical therapists that were not reasonable, medically necessary, or properly documented. The OIG focus is on independent therapists who have a high utilization rate for outpatient physical therapy services. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) Documentation requirements for therapy services are in CMS's Medicare Benefit Policy Manual, Pub. 100-02, ch. 15, § 220.3.

OIG Released Report on Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors

On 12/16/2011 the Office of Inspector General (OIG) released a report entitled Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors. One way that Medicare benefit integrity contractors help prevent fraud, waste, and abuse is by identifying program vulnerabilities. For this study, the OIG identified the actions that CMS took to resolve vulnerabilities reported by Program Safeguard Contractors, Zone Program Integrity Contractors, and Medicare Drug Integrity Contractors in 2009. The OIG also determined the monetary impact of these vulnerabilities and reviewed CMS's policies and procedures for tracking, reviewing, and resolving reported vulnerabilities. The OIG found that contractors reported monetary impact for only one-third of vulnerabilities, but their estimated impact was \$1.2 billion. None of these vulnerabilities had been fully resolved as of January 2011. Because contractors reported monetary impact inconsistently or not at all, the actual monetary impact of the vulnerabilities reported in 2009 could be significantly greater than \$1.2 billion.

The OIG found that as of January 2011, CMS had not resolved or taken significant action to resolve 77 percent of vulnerabilities reported by contractors in 2009. CMS took significant action to resolve 14 of the 62 vulnerabilities, but only 2 of these had been fully resolved by January 2011.

The OIG found that although CMS has procedures to consistently track and review vulnerabilities, it lacks procedures to ensure that vulnerabilities are resolved. The three CMS divisions that are responsible for tracking and reviewing vulnerabilities each have procedures that outline the general steps they take to track and review vulnerabilities. However, although contractors have been submitting vulnerability reports since at least 2007, CMS did not begin developing procedures until 2010. Furthermore, only one of the three divisions has developed procedures to follow up on the implementation of corrective actions.

Therefore, the OIG recommend that CMS (1) determine the status of all vulnerabilities that have not been resolved and take action to address them; (2) require all benefit integrity contractors to report monetary impact, when calculable, in a consistent format; and (3) ensure that vulnerabilities are resolved by establishing formal written procedures that include timeframes for follow up and that outline CMS and contractor responsibilities regarding vulnerability resolution. CMS concurred with the first recommendation, did not concur with the second recommendation, and partially concurred with the third recommendation.

OIG Released Report on South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities

On 11/22/2011 the Office of Inspector General (OIG) released a report entitled South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities. CORFs provide multidisciplinary outpatient rehabilitation services at a single location. Medicare allowed approximately \$70 million for almost 40,000 beneficiaries nationwide who received CORF services in 2010. Of this amount, more than \$22 million was for claims by South Florida CORFs. In 2010, over 25 percent of all CORFs were in South Florida. The OIG found that eighteen of the one hundred one Comprehensive Outpatient Rehabilitation Facilities (CORF) in South Florida were not operational. Ten were not at the location on file with CMS. Eight were not open during business hours.

As a result of a special enrollment project and routine oversight, CMS took action against 16 of the 18 nonoperational CORFs in the months after the OIG completed their site visits. The special enrollment project resulted in actions against 10 nonoperational CORFs, and routine oversight resulted in 6 such actions.

Co-owners of Pocatello Physical Therapy, P.A. Sentenced in Federal Court

On December 12, 2011 the AUSA announced that the co-owners of Pocatello Physical Therapy, P.A., were sentenced in U.S. District Court for altering records in a federal health care audit. DesFosses and Benedetti were each sentenced to three years of probation. DesFosses was fined \$1,000 and ordered to pay \$9,757.66 in restitution. Benedetti was ordered to pay \$2,442 in restitution. Both will be required to do 300 hours of community service.

The charges arose out of changes made to patient records requested for audit by the Western Integrity Center (WIC), a program safeguard contractor for Medicare. According to court documents, in March 2006, Pocatello Physical Therapy Clinic, P.A. was asked to provide randomly selected documents to the WIC's Maryland location. At the time, DesFosses and Benedetti were business partners and licensed physical therapists in Idaho. According to court documents, DesFosses and Benedetti made additional entries to some of the patient files submitted for the March 2006 audit. A comparison of unaltered files showed that seven patient files were altered. The alterations, or additional entries, were consistent with amounts previously billed to Medicare.

Contact Information:

Liz Barlow
Vice-President of Clinical Services
502.400.1619
liz@evergreenrehab.com



Shawn Halcsik
Director of Compliance
414.791.9122
shalcsik@evergreenrehab.com