Welcome

• This session will be recorded
• Link to the recording and resources will be emailed to all registrants

• Questions can be asked in the “Question panel”
• Webinar will be extended an additional 1/2 hour for Q & A

Jim Plymale
CEO
Clinicient

Ninth in a series of Compliance Webinars
Healthcare Reform: It’s Only the Beginning

- Current Medicare Issues
  - MPPR and Sequestration
  - RAC Audits
- Future Issues: What is Medicare Thinking?
  - MedPac
  - OIG: Report on Spectrum
  - Strategic Health Solutions Audits
  - GAO: Report on Manual Medical Review
- Best Practices
- Medicare Case Management
Welcome Nancy Beckley

- Compliance expert in the Rehab industry; certified in healthcare compliance
- Senior Editor RacMonitor.com, author of 20 articles on Recovery Auditor (RAC) program
- Monitor Mondays Weekly Webcast/Podcast on RAC program for 4 years
- Popular industry speaker and author on compliance topics related to outpatient therapy
- Serves as a Compliance columnist for IMPACT - the magazine of the APTA Private Practice Section
- Author for Compliance Today, journal of the Healthcare Compliance Association

Nancy Beckley
President
Nancy Beckley and Associates
Welcome Jerry Henderson

• Physical Therapist, Co-Founder of Clinicient

• 25 years of private practice experience

• Co-founder of the Independent Private Practice Therapy Association

• Co-founded “PT Link”, one of the first developers of physical therapy EMR software

Jerry Henderson, PT
VP of Clinical Community
Clinicient
Current Issue: MPPR and Sequestration

- The Medicare Fee Schedule is based on a calculation of relative value of each procedure code, based on the physical expense of providing the procedure, the liability cost of providing the procedure, and the effort required to provide the procedure.

- To calculate the Medicare Allowed Fee, a conversion factor is multiplied by the Relative Value (RVU) of each procedure, adjusted to account for geographic variations in cost.

- There was an additional Sequestration Cut effective April 1, 2013 of 2% of the total allowed payment after the allowable fee is calculated and the MPPR reduction is taken into account.
MPPR and Sequestration – Why We Care

- Revenue impact

- Compliance – accurate forecast for applying KX modifier

- Patient care decisions - accurate forecast for Manual Medical Review point

- Other payers following MPPR
  - Humana – now processing retroactive takebacks
  - HealthNet, Aetna, Tricare
Current Issue: MMR and RAC Audits*

- RAC Prepayment Demonstration Project States
  - 7 High Fraud States
  - (Florida, California, Michigan, Texas, New York, Louisiana, Illinois)
- 4 High States with high volume short stay admissions
  - (Pennsylvania, Ohio, North Carolina and Missouri)

MAC Receives Claim
ADR Letter to Provider
Provider Responds to RAC
RAC Reviews
Findings to MAC , Letter to Provider*
MAC Adjudicates
Current Issue: MMR and RAC Audits*

Applies to all other states (not mentioned on previous slide)

*in states without pre-payment audits
What is Medicare Thinking?

• Four Clues:
  1. Med Pac Report
  2. OIG Report on Spectrum Rehabilitation
  3. Strategic Health Solutions Audits
  4. GAO Report on Manual Medical Review
**MedPAC Recommendations**

**RECOMMENDATIONS**

9-1. The Congress should direct the Secretary to:
- reduce the certification period for the outpatient therapy plan of care from 90 days to 45 days, and
- develop national guidelines for therapy services, implement payment edits at the national level based on these guidelines that target implausible amounts of therapy, and use authorities granted by the Patient Protection and Affordable Care Act of 2010 to target high-use geographic areas and aberrant providers.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

9-2. To avoid caps without exceptions, the Congress should:
- reduce the therapy cap for physical therapy and speech-language pathology services combined and the separate cap for occupational therapy to $1,270 in 2013. These caps should be updated each year by the Medicare Economic Index.
- direct the Secretary to implement a manual review process for requests to exceed cap amounts, and provide the resources to CMS for this purpose.
- permanently include services delivered in hospital outpatient departments under therapy caps.
- apply a multiple procedure payment reduction of 50 percent to the practice expense portion of outpatient therapy services provided to the same patient on the same day.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

9-3. The Congress should direct the Secretary to:
- prohibit the use of V codes as the principal diagnosis on outpatient therapy claims, and
- collect functional status information on therapy users using a streamlined, standardized, assessment tool that reflects factors such as patients’ demographic information, diagnoses, medications, surgery, and functional limitations to classify patients across all therapy types. The Secretary should use the information collected using this tool to measure the impact of therapy services on functional status, and provide the basis for development of an episode-based or global payment system.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

**Lowlights**

- Reduce certification period
- Reduce the cap to $1270
- MMR for requests to exceed the cap
- Collect functional status information using a streamlined, standardized assessment tool**
MedPAC – Some Inherent Industry Cautions

- Congress “plucked” the 50% MPPR recommendation and it appeared in the 2013 therapy fee schedule/policy updates

- Is there a presumption by MedPAC that something is wrong? It sure seems that way if you read the transcript of the meeting

- Therapy cap coalition not able to use their lobbying largess to stop the MPPR dramatic increase to 50% of PE component of 2nd and subsequent codes

- Will MedPAC tackle data analysis on FLR? Do we have an understanding of what havoc this might bring?
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

SPECTRUM REHABILITATION, LLC,
CLAIMED UNALLOWABLE MEDICARE
PART B REIMBURSEMENT FOR
OUTPATIENT THERAPY SERVICES

Link to the OIG Report
OIG Report: Certification of POC

“Services were not certified in a timely manner…”

“Certifications were signed by a physician or non-physician practitioner but were not dated…”

“For one claim, services were not certified…”
OIG Report: Treatment Notes

“Total treatment time not documented. For 31 claims, the total treatment time in minutes for timed procedures was not documented in the treatment note.”

“No treatment note. For three claims, there was no treatment note for some services.”

“Treatment note did not support the number of units billed. For three claims, the treatment note did not support the number of units billed for some services.”
For 35 claims, … services provided by therapists that were not enrolled in Medicare … “

…no evidence in the case records to indicate that these services were directly supervised by a therapist who was enrolled in Medicare.”
For 21 claims, Spectrum received Medicare reimbursement for services that exceeded the therapy caps and for which the beneficiaries’ medical record did not support the medical necessity of services above the therapy caps.
For four claims, Spectrum received Medicare reimbursement for services that were not provided in accordance with a plan that met Medicare requirements. Specifically, for these four claims, the plan did not include the type of service provided and billed to Medicare.
These deficiencies occurred because Spectrum did not have a thorough understanding of Medicare reimbursement requirements related to outpatient therapy services and did not have adequate policies and procedures to ensure that it billed services that met Medicare requirements.
Text from ADR:

“Analysis of Medicare claims data between August 2012 and March 2013 identified provision and billing for therapy services *that either stopped or delayed just under the allowed therapy cap*. This constitutes new and material evidence that establishes good cause for reopening as required under 42 CFR 405.908(b).

Strategic Health Solutions, LLC is requesting additional documentation for these claims for Supplemental Medical Review of Outpatient Therapy Services authorized by CMS.”
Analysis of Medicare claims data for October and November 2012 identified a continuation in billing and payment for Outpatient Therapy Services during a period of time that healthcare facilities were inaccessible to the public as a result of power outages and flooding caused by Hurricane Sandy.

This constitutes new and material evidence that establishes good cause for reopening as required under 42 CFR 405.980(b). CMS has requested that the SMRC perform post payment medical review of therapy services.

Strategic Health Solutions, LLC is requesting additional documentation for these claims for Supplemental Medical Review of Outpatient Therapy Services authorized by CMS.
Lowlights

- CMS did not issue complete and timely guidance
- MACs unable to automate their systems
- Instructions on 10 days not clear
- New guidance issued throughout the process
- Report biased toward MACs
- Beneficiary side?
- Provider side?

- MACs reviewed an estimated total of 167,000 preapproval requests and claims for OP therapy above $3,700 threshold 10/1 – 12/31 2012

- Estimated 110,000 were for preapproval requests and 57,000 were for claims submitted without prior approval.

- However, due in part to the lack of automation, CMS officials reported that the total number of reviews should be considered estimates of the results of the MMR process at the time of this report.

- CMS estimated that the MACs affirmed about two-thirds of the preapproval requests and about one-third of the claims submitted without preapproval.

- Due to appeals, final outcome of the MMRs remains uncertain.

- CMS also estimated that by 12/31, > 115,000 beneficiaries affected by the reviews in 2012.
Documentation - What We Want to Hear:

“Review of medical record documentation shows the therapy codes billed are medically necessary and sufficient documentation was provided to approve these codes as reported.”

CGI, Region B Recovery Auditor (RAC), on Manual Medical Review Pre-payment Review Summary of Findings.
7C499 – Review of medical record does not show sufficient documentation supporting services provided & medical necessity for therapy amount, frequency & duration of physical therapy services delivered on XX for code 97140.

Documentation...insufficient in identifying rationale for use of manual therapy intervention...does not indicate...patient response to treatment or benefits obtained to support the use of...procedure.
Documentation: Is This the Detail We Want?

“Documentation supports... provision of repetitive exercises & functional activities with no clear complexity of services that... indicate a need for ongoing skilled clinician care or input, no verbal tactile cueing was noted.

“In summary, medical record does not show sufficient documentation supporting the services provided and medical necessity for the therapy amount, frequency and duration of physical therapy services on XX for code 97XXX.”
5RACQ – The medical record does not show sufficient documentation supporting the services provided on XXX for CPT codes 97110, G0283 and 97140. The patient has been seen for 3 months after shoulder surgery. At the time of the review, the patient continues to have ongoing functional difficulties including reaching items in closer to cupboard, donning seatbelt etc. The patient has made little progress especially within the last month. There is no change in the POC or focus on specific activities she is having difficulties with. The exercise and treatment plan are repetitive with no change especially when progress seems to have slowed or plateaued.
Documentation: Is This the Detail We Want?

“Documentation indicates the **same exercises and/or functional activities** are being performed daily with **no clear complexity of services** that indicate a need for ongoing skilled clinician input, i.e. no ongoing progressive instruction or verbal/tactile cueing was noted. **The professional skills of a therapist are not required to improve or restore full function that could reasonable be expected to improve as the patient gradually resumes normal activities.** There are **no additional medical complexities** noted that would inhibit the patient from continuing to **progress on her own.**”
Additional documentation is needed regarding why a clinician was required to provide the care or reasoning behind the decline that would warrant skilled care. The fact that services are typically billed is not necessarily evidence that the service are typically appropriated. "Documentation for an exception should indicate how the patient’s medical complexity directly and significantly affects the treatment for a therapy condition and the medically necessity of ongoing skilled care." Services that exceed those typically billed should be carefully documented. In summary the medical record does not show sufficient documentaiton supporting the services provided and medically necessity for the physical therapy on XXX for 97110, G0283 and 97140.
The Phantom Medicare “Improvement Standard”

- Jimmo v. Sebelius
- Settlement approved 1/24/2013
- CMS to issue guidance, policy revisions and training to contractors by 1/2014.
- Standards for Medicare coverage of skilled maintenance services apply now.
- CMS “no expansion of benefit”

Skilled Maintenance Services Are Covered by Medicare.

CMS has issued a Fact Sheet outlining the Jimmo v. Sebelius settlement. Use this fact sheet now as evidence that skilled maintenance services are coverable for skilled nursing facility care, outpatient therapy, and home health care. The Center for Medicare Advocacy has Self-help Packets to help pursue Medicare coverage, including for skilled maintenance nursing and therapy.

The Jimmo settlement was approved on January 24, 2013 after a fairness hearing, marking a critical step forward for thousands of beneficiaries nationwide. (See the Order Granting Final Approval). The lawsuit was brought on behalf of a nationwide class of Medicare beneficiaries by six individual beneficiaries and seven national organizations representing people with chronic conditions, to challenge the use of the illegal Improvement Standard.

The proposed Jimmo settlement agreement[2] was originally filed in federal District Court on October 16, 2012. The plaintiffs joined with the named defendant, Secretary of Health and Human Services Kathleen Sebelius, in asking the federal judge to approve the settlement of the case. With only one written comment received, and no class members appearing at the fairness hearing to question the settlement, Chief Judge Christina Reiss granted the motion to approve the Settlement Agreement on the record, while retaining jurisdiction to enforce the agreement in the future, as requested by the parties.

With the settlement now officially approved, the Centers for Medicare & Medicaid Services (CMS) is tasked with revising its Medicare Benefit Policy Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, nursing home and outpatient settings. CMS must also develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve.

It is important to note that the Settlement Agreement standards for Medicare coverage of skilled maintenance services apply now – while CMS works on policy revisions and its education campaign. The
The Holy Grail of Medicare Compliance

sshhh.... it’s a secret!
Medicare POC Management

**Initial Visit**
- Establish POC
- Get POC Approval
- Establish FLR Classification and Impairment Ratings
- Report PQRS
- Medicare Cap

**10th Visit**
Same POC
- Progress Report
- Update FLR Impairments

**12th Visit**
Daily Note
- Changes to Plan?

**14th Visit**
Discharge
- Discharge Report
- Report Discharge Impairment Rating
- Follow up?

Hypothetical Example
Remember George?

George is 89 years old and lives independently in a two story house with his wife, Martha. Martha is in frail health, and George is her primary caretaker. They have a housekeeper come in twice a month to do heavy cleaning, but George has to do all of the cooking and other household tasks.

He can no longer drive, so he walks to the grocery store twice a week.

George has had R. knee pain for years, but it has worsened over the past several months. He has difficulty going up and down stairs without pain and walking to the grocery store. He also has fallen a few times in the past year. He is very concerned that if the pain gets any worse, he will no longer be able to take care of Martha.
Initial Eval and Establishing the POC

- The “Whats”:
  - Functional deficits (the big problem)
  - Prior level of function
  - Current level of function
  - What you are trying to accomplish

- The “Whys”:
  - Why it is important

- The “Hows”:
  - How your treatment plan will work
  - How do your clinical findings relate to the functional deficits?
What is the Big Problem?

"Primary Functional Limitation: Patient is unable to ascend or descend stairs or walk for any length of time without pain."

He lives with his wife in a 2 story home. His wife is very dependent upon George for her care.
Why is the Big Problem Important?

“He lives with his wife in a 2 story home. His wife is in frail health and is dependent upon him for his care.”
What was the Prior Level of Function?

- “Prior Level of Function:
- … patient had no difficulty ascending or descending stairs.”
- “… patient had no difficulty with ambulation.”
What is Current Level of Function?

• “Has to lead with affected extremity when descending stairs.”
• “Unable to walk for any distance without pain.”
• Widely accepted Functional Assessment Tool Score
### What is Current Level of Function?

#### Right Lower Extremity

<table>
<thead>
<tr>
<th>Lower Extremity Function</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior Step down</td>
<td>2 inches</td>
<td>6 inches</td>
</tr>
<tr>
<td>One leg stance, eyes open</td>
<td>10 seconds</td>
<td>30 seconds</td>
</tr>
</tbody>
</table>

#### Right Knee

<table>
<thead>
<tr>
<th>Patellofemoral Integrity</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patellar Apprehension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patellar Compression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Tender Structures

| Tender Knee Structures: Infrapatellar   |               |              |

#### Knee AROM

| Knee Extension AROM                    | 85 degrees    | 110 degrees  |
| Knee Flexion AROM                      |               |              |

#### Knee Muscle Testing

| Hamstring Strength                      | 4 /5          | 5 /5         |
| Quadriceps Strength                     | 4 /5          | 5 /5         |

#### Right Ankle

#### Foot and Ankle AROM

| Ankle Dorsiflexion AROM, Knee Extended | 0 degrees     | 10 degrees   |
| Ankle Dorsiflexion AROM, Knee Flexed  | 10 degrees    | 10 degrees   |

#### Foot and Ankle Muscle Testing

| Anterior Tibialis Strength             | 4 /5          | 5 /5         |
| Gastroc-Soleus Strength               | 4 /5          | 5 /5         |

- Performance based functional tests
- Important clinical findings related to functional deficit
How will the Treatment Plan Work?

• “Balance and proprioception exercises to improve balance for safe ambulation.”

• “Heel cord stretching to address loss of normal ankle dorsiflexion which affects his gait”

Knee Plan of Care

**Duration:** Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Balance and proprioception exercises to improve balance for safe ambulation, exercises to improve ambulation endurance. **Heel cord stretching to address loss of normal ankle dorsiflexion ROM which affects his gait.** Other instructions on controlling swelling and decreasing patellofemoral compression. **Supervised Exercises:** Functional exercise program. Closed chain static isometrics to improve lower extremity strength. Proprioceptive activities to improve gait and balance. **Treatment Modalities:** Ice Packs as needed to control inflammation. **Treatment Progression:** Progress to more active independent home exercise program after symptoms subside.
### Relate Clinical Findings to Functional Deficits

#### Goals

<table>
<thead>
<tr>
<th>Impairment Category</th>
<th>Current Impairment Rating (G8978)</th>
<th>Goal Impairment Rating (G8979)</th>
<th>Projected Goal Completion Date</th>
<th>Rationale for impairment rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75% Impairment Level (CI: At least 60 percent but less than 80 percent impaired, limited or restricted)</td>
<td>20% Impairment Level (CI: At least 20 percent but less than 40 percent impaired, limited or restricted)</td>
<td>12/27/2013</td>
<td>Functional Assessment Score Correlated to Impairment Rating, Clinical Tests, Clinical Judgment</td>
</tr>
</tbody>
</table>

#### Item | Current | Goal | 
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Primary Functional Limitation</td>
<td>Patient is unable to ascend or descend stairs or walk for any length of time without pain. He lives with his wife in a 2 story home. His wife is very frail and dependent upon George for her care.</td>
<td>He needs to be able to walk 2 blocks to the grocery store and ascend and descend stairs safely and with less pain to be able to continue living independently.</td>
</tr>
</tbody>
</table>

#### Right Knee

<table>
<thead>
<tr>
<th>Item</th>
<th>Current</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A: Knee Flexion AROM</td>
<td>65 degrees</td>
<td>120 degrees</td>
</tr>
<tr>
<td>1B: Knee Extension AROM</td>
<td>-10 degrees</td>
<td>0 degrees</td>
</tr>
<tr>
<td>1C: Patellar Compression</td>
<td>Positive</td>
<td>Negative</td>
</tr>
</tbody>
</table>

#### Right Lower Extremity

<table>
<thead>
<tr>
<th>Item</th>
<th>Current</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1D: One leg stance, eyes open</td>
<td>10 seconds</td>
<td>60 seconds</td>
</tr>
<tr>
<td>1E: Anterior Step down</td>
<td>2 inches</td>
<td>8 inches</td>
</tr>
<tr>
<td>1F: Six Minute Walk</td>
<td>200 meters</td>
<td>600 meters</td>
</tr>
</tbody>
</table>

#### Patient Specific Functional Scale Modified for Medicare Impairment Ratings

<table>
<thead>
<tr>
<th>Item</th>
<th>Current</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1G: Patient Specific Functional Scale Modified for Medicare Impairment Ratings</td>
<td>3 - CL: 60 to 79% Impaired (3 - 4)</td>
<td>10 - CH: 0% Impaired</td>
</tr>
<tr>
<td>1H: Ambulation Tolerance</td>
<td>Unable to walk for any distance without pain</td>
<td>Able to walk without significant pain for 10-15 min.</td>
</tr>
<tr>
<td>1I: Stair Climbing Gait</td>
<td>Has to lead with affected extremity when descending stairs. Has to lead with unaffected extremity when ascending stairs</td>
<td>Ascends and descends stairs with normal reciprocal gait.</td>
</tr>
</tbody>
</table>
Managing the Plan of Care

Status as of 10/9/2013

Patient: Jeppesen, George
Appt Type: Standard Visit
# of Visits: 10
Referred by: William Kildare, MD
Insured by: Medicare
Diagnoses: 717.7: Chondromalacia patellae
781.2: Abnormality of gait
728.87: Muscle weakness-general
Precautions: Balance Problems: Has fallen 3 times in the past year.
Medicare Cap: $868.33 used
Plan of care: expires on 12/15/13
Progress report: due in 0 visits
Daily Notes

- Reflect changes in the plan?
- Is there an end in sight?

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Minutes</th>
<th>Measure</th>
<th>Note</th>
<th>CPT</th>
<th>Mod</th>
<th>Performed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance Strategies: 1 foot on step</td>
<td>1</td>
<td>min's</td>
<td></td>
<td>97530</td>
<td></td>
<td>Henderson, Jerry</td>
</tr>
<tr>
<td>Balance Strategies: ankle rocks</td>
<td>4</td>
<td>mins</td>
<td></td>
<td>97530</td>
<td></td>
<td>Henderson, Jerry</td>
</tr>
<tr>
<td>Balance Strategies: Bosu Ball</td>
<td>5</td>
<td>min's</td>
<td></td>
<td>97530</td>
<td></td>
<td>Henderson, Jerry</td>
</tr>
<tr>
<td>Balance Strategies: Eyes Closed</td>
<td>5</td>
<td>min's</td>
<td></td>
<td>97530</td>
<td></td>
<td>Henderson, Jerry</td>
</tr>
</tbody>
</table>

Plan

Decrease visit frequency to once weekly to review exercises. Hope to discharge in two more visits.
Discharge

- FLR Discharge Impairment Rating?
- Discharge Instructions?

Plan

**Discharge Plan**

Following Discharge: Continue with home exercises. Our clinic will phone patient in approx 2 weeks for follow up. Patient to return to physician for follow up. **Telephone Clinic immediately:** Upon any increase in symptoms; including pain, swelling, tingling, or numbness.

Discharge Summary:

George Jeppesen was seen in physical therapy for 14 visits since the initial evaluation on 09/16/2013. The goals we established at his initial evaluation on 09/16/2013 are reported in the Goals Section of this report.
# "Top 5" Best Practices: For Demonstrating Medical Necessity and Skilled Care

<table>
<thead>
<tr>
<th>Best Practice:</th>
<th>Monitoring &amp; Auditing:</th>
</tr>
</thead>
</table>
| **1 Initial Evaluation:** Test, measure and document **functional scores, performance tests and clinical findings** | 1. Relate functional scores to norms  
  2. Identify complexities and comorbidities and impact on therapy progression  
  3. Provide contralateral measurements and significance |
| **2 Initial Evaluation and Plan of Care:** Relate clinical findings and short term goals to functional deficits and long term goals | 1. Prior level of function identified for each identified ADL item  
  2. Current level of function contrasted to prior level of function for each item  
  3. Relate pain scores to inability to perform functional activities |
| **3 Daily Notes:** Demonstrate skilled intervention through ongoing patient assessment, exercise, functional progression, and techniques and parameters utilized | 1. Identify patient compliance with HEP  
  2. State exercise progressions and introduction of new exercises  
  3. Relate functional activities to ADL deficits and patient progression |
| **4 Progress Evaluation:** Serially track and update important clinical and functional findings related to goals | 1. Compare initial objective tests & measures to current, comment on status  
  2. State % goal achievement and status  
  3. Update patient functional ADL status |
| **5 Discharge Summary:** Summarize entire episode of care to include patient progress, goal achievement, and reason for discharge | 1. Summary of entire episode.  
  2. Identify goals not achieved and state reason  
  3. Reason for discharge |
# “Top 6” Best Practices: For Reducing Medicare Billing Risks

<table>
<thead>
<tr>
<th>#</th>
<th>Best Practice:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Always make sure your documentation supports the claim</td>
</tr>
<tr>
<td>2</td>
<td>Document total treatment minutes and timed treatment minutes in each daily note</td>
</tr>
<tr>
<td>3</td>
<td>Convert minutes to units appropriately</td>
</tr>
<tr>
<td>4</td>
<td>Apply CCI edits properly, and by a therapist or certified coder</td>
</tr>
<tr>
<td>5</td>
<td>Use PTAs and Extenders appropriately, and document correctly</td>
</tr>
<tr>
<td>6</td>
<td>Appropriate use of KX modifier for attestation</td>
</tr>
</tbody>
</table>
Conclusions

• This is not going to get easier

• Have a system in place

• Monitor it continuously

• Educate everyone on requirements

• Treatment is either Medically Necessary or Not: “Treating to the Cap” is an audit risk

• Managing the POC is the Holy Grail of Medicare Compliance
Resource Page: www.clinicient.com/mmr-resources/

Visit Us at PPS:

- **Nancy Beckley**: Friday Nov. 8th, 10:00AM “Compliance Metrics: Dashboarding Your Way to Compliance Success”
  Thursday Nov. 7th Rehab Management Booth

- **Clinicient**: Booth #363/365 Stop by for tea and see why Clinicient customers are more relaxed about meeting Medicare requirements

Samples of “Good” Documentation & Documentation Best Practices Infographic:

Keep the Conversation Going:

LinkedIn Groups:

NEW “PT and Rehab Compliance Group”
*Moderated by Nancy Beckley*
Community group for sharing discussions and questions surrounding Medicare and compliance regulations

Clinicient User Group: “Clinicient User Group”

Twitter:

#RehabCompliance  
@nancybeckley  
@clinicient
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