

INTRODUCTION TO REIMBURSEMENT & DOCUMENTATION FOR THE NEW GRADUATE
Saturday, November 21, 2009 Baltimore, MD

AOTA Reimbursement and Regulatory Policy

Advocate for the Profession

- CMS and it's Contractors
- Private Insurers
- Physicians and Non-physician Practitioners
- Rehabilitation / Education Partners
- AMA / CPT Editorial Panel

Provide Education and Communicate

- Payers
- Government Agencies/ Commissions
 - Submit comments
 - Technical Experts
- AOTA and State Association Leadership
- Members

Understanding the Mysteries of Payor Reimbursement and Documentation

Why Medicare as a Model?

United States largest insurer, providing health insurance coverage for almost 45 million Americans (Kaiser Family Foundation, 2008).

Therapist's work in many settings that do not use Medicare funding, however, **Medicaid and private insurance companies** follow Medicare rules and apply the same coverage guidelines as "gold standard"

Medicare Basics

Part A

- Hospital inpatient services, SNF, home health, hospice, rehab facilities

Part B

- Physician services, hospital outpatient, durable medical equipment, orthotics, prosthetics, supplies

Part C

- Medicare Advantage, private insurance alternative to federal government's Part A and B

Part D

- Prescription drugs

Medicare Terminology

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CMS - Centers for Medicare & Medicaid Services

Transmittals / Program Memorandums

- http://www.cms.hhs.gov/Transmittals/01_overview.asp

CMS Online Manual System

- <http://www.cms.hhs.gov/Manuals/IOM/list.asp>

Prospective Payment System (PPS) (Part A)

Medicare rates set in advance based on expected resource use by patient

Medicare PPS rates

- ✳ Time (per diem, per case, per episode)
- ✳ Patient classification system (e.g., DRGs, RUGs)

Medicare Reimbursement under PPS

Inpatient hospitals

- Diagnosis-related groups (DRGs)

Inpatient rehabilitation facilities (IRFs)

- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

Inpatient psychiatric facilities

- DRG rate based on diagnosis and other factors

Long-term care hospitals

- DRG system based on diagnosis and other factors

Medicare Reimbursement under PPS

Skilled nursing facility (SNF)

- Minimum Data Set (MDS 2.0)
 - Resource Utilization Groups (RUGs)

Home Health

- Outcomes and Assessment Information Set (OASIS)

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- The OASIS gathers data on the patient's discharge needs
- Home Health Resources Group establishes payment

Hospice

- Payment rates are based on four categories: routine home care, continuous home care, inpatient respite, and general inpatient care.

Medicare Part B

Physician Fee Schedule (MPFS)

CPT Coding

Specific rate for a procedure

Based with on time spent on a procedure, e.g. every 15 minutes of self care or

Untimed codes single flat rate per procedure per day, e.g. evaluation

Qualifying settings:

- Occupational therapist private practitioners
- Clinic, rehabilitation, agencies
- Hospital outpatient
- SNFs
- Physician office - Therapy incident to
- Home health care
- Comprehensive outpatient rehabilitation facilities (

Documentation requirements

Medicare Coding Terminology Parts A and B

CPT - Current Procedural Terminology

- Bill methodology

CCI – Correct Coding Initiative (Medicare)

- Gate-keeping coding system

ICD-9 - International Classification of Diseases, 9th revision, Clinical Modification

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- Diagnosis

Similar coding scheme followed by private payors, Medicaid, worker's compensation payors, etc

Medicare Part B

Therapy Cap still required under statute, \$1840 for 2009

Exception Process in place currently through Dec. 31, 2009

- Therapist attestation

ICD-9 Codes

- Exception code ; complicating factor codes

CPT codes

- Timed and untimed codes

- 8 minute rule

- Medically unbelievable edits

- CCI edits

Codes

CPT Codes - Procedures

Most rehab codes are in:

- Section:**

- Medicine

- Subsection:**

- Physical Medicine and Rehabilitation

- 97001 – 97755

- **OT eval 97003**

- **Timed**

- Ther Ex , ADLS, The Act

- **Untimed**

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Group , several modalities

ICD-9 - Diagnosis

ICD-9 use a digit system

Section:

- Fractures (800-829)

Category:

- Fracture of upper limbs (810-819)
- 813 Fracture of radius and ulna

Subcategory:

- 813.4 Lower end closed

Sub-classifications:

- 813.41 Fractures, Colles' fracture, closed

Documentation

Importance of Documentation

Limited resources for health care have **increased the need to justify** in writing the necessity of OT and **to distinguish OT** from other therapy disciplines.

Our documentation needs to **support the specific OT skills**

Medicare and other payers can require **focused medical reviews** which add additional administrative time and effort.

Documentation has become a **key component in making payment and coverage decisions.**

Uniform billing and coding requirements have enabled payers to look at **practice patterns** and compare providers, identifying those outside the norm.

Documentation

- Legal record
- Communicate to others
- Patient status
- Clinical interventions
- Justification of skilled services
- Patient response to treatment and outcomes
- Professional responsibility

Medicare Part B Requirements

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Why Medicare Part B – model for Medicare

Medicare Benefits Policy Manual, Chapter 15, section 220.3 identifies minimum expectations of documentation by providers.

<http://www.cms.hhs.gov/Manuals/IOM/list.asp>

- These standards are excellent for all Medicare settings

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) should also be used as reference. Available on Medicare Coverage Database.

<http://www.cms.hhs.gov/med>

General Conditions of
Medicare Coverage

Under the care of a physician

Reasonable and necessary

Patient need for services

Qualified professional

Reasonable and Necessary

Expectation of improvement

Reasonable and predictable period of time

Typical amount, frequency and duration of services

Reasonable and Necessary

Patient's medical complexity and need for services

Why the skills of a therapist are needed to perform these services

- Specific and effective treatment for the patient's condition
- Of a level of complexity and sophistication

Medical Necessity Factors include:

diagnoses,	age,	time since onset/acuity,
complicating factors,	severity,	self efficacy / motivation,

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cognitive ability,

prognosis,

medical, psychological and social
stability

Reasonable and Necessary

Continued justification in evaluations and monthly summaries

Medical Necessity

“Patient is motivated; however, progress has been slow this week because of illness.”

Medical Necessity

“Patient’s progress continues to be steady but slowed due to her increased fatigue related to reoccurring respiratory issues (bronchitis). She is experiencing difficulty with movement due to her obesity. Both conditions further complicate her COPD, requiring frequent rest breaks and shortened treatment sessions.”

Medical Necessity

“Progress was slow this week in OT. Very minimal gains due to hand pain. Doctor notified. Continue the plan of care.”

Improved Note

“This week, progress has been slowed due to the development of swelling and pain (8/10) in the left hand resulting in decreased ability to use his hand in functional activities. Patient was diagnosed this week with reflex sympathetic dystrophy syndrome and is currently being treated for the symptoms with modalities and positioning strategies provided in therapy, as well as medication ordered by his physician.”

Skilled Therapy Required

Services must have the level of complexity and sophistication that only a therapist/assistant is qualified to provide them.

- The skills of a therapist/assistant are necessary to meet client’s need.

We need to link how our services are specialized and required.

Skilled Therapy Statement

“Patient is s/p CVA. Patient would benefit from OT services.”

Skilled Therapy Improved

“Patient is s/p recent CVA (6/1/08) resulting in right UE/LE hemiparesis, apraxia and dysphagia. Patient would benefit from skilled OT treatment for hemi-technique self care retaining, neuromuscular reeducation, graded UE

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strengthening, motor function treatment (motor control, motor learning and perceptual motor activities) and postural stability intervention to improve functional balance for self care activities and safety in order to return home.”

Tips for Successful Documentation

1. Expectation of Improvement
2. Reasonable and predicible period of time
3. Typical amount, frequency and duration of services
4. Patient’s medical complexity and need for services
5. Why the skills of a therapist are needed to perform these services

Types of Documentation

Evaluation

Daily Treatment Notes

Monthly Summary

Goal Writing

Progress Notes

Discharge Summary

Evaluation

Include patient demographic information

The Evaluation has Four Components:

1. Decline in function.
 - ✓ Document the diagnosis/diagnoses and specific problems to be evaluated.
 - ✓ Document the client’s prior level of function.
 - ✓ Document any complicating conditions (diabetes, RA) that may impact treatment (describe why or how).
2. Objective measures.
 - ✓ Identify baseline function to measure future performance outcomes.
 - ✓ Document the link between tests, measures, clinical judgments and the client’s function.
3. Reasonable and necessary skilled service.
4. Qualified personnel providing services.

Prior Level of Function

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“Pt lives alone in Sr. complex apartment (dinner provided). Prior to her CVA, she was ambulatory, independent in all self-care and light meals; she had a helper who cleaned, did her laundry and shopped for her.”

Objective Measures

CMS has suggested using one of four measurement instruments when evaluating and assessing patient progress:

- National Outcomes Measurement System (NOMS)
- OPTIMAL
- Patient Inquiry Tool by Focus on Therapeutic Outcomes, Inc. (FOTO)
- Activity Measure for Post Acute Care (AM-PAC)

Other Options

Documentation to include functional assessment scores or other measurable progress toward goals.

CMS has made three alternative suggestions.

- Commercially available** functional assessment
- Tests and measures published in **professional literature**
- Documented **measurable progress** toward goals for the patient to function in his or her home environment.
 - Level of Independence Scales
 - Independence – level of assistance - dependent
 - Bladder diary

Objective Tests and Measures

Goniometric ROM Measures	Canadian Occupational Performance Measure, (COPM)	Grip/Pinch
Manual Muscle Test (MMT)	9 Hole Peg Test	Motor-Free Visual Perception Test (MVPT)
Kohlman Evaluation of Living Skills	Purdue Dexterity Test	
Functional Reach Test Scores	Minnesota Rate of Manipulation Test (MRMT)	
Loewenstein Occupational Therapy Cognitive Assessment (LOTCA)	O'Connor	

Objective Tests & Measures

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Last option:

- Patient's opinion on his/her health related to quality of life.
 - *"At the present time, would you say that your health is excellent, very good, fair or poor?"*

Objective Tests and Measures

Document the link between tests, measures, clinical judgment and the patient's function.

- "The patient scored average of 8 inches in three trials on a Functional Reach Test. As evidenced in the functional reach test, the patient has decreased balance. Based on these results, he has 2 times the normal risk for multiple falls."*

Document status at discharge.

Example

"Patient's right bicep strength is graded 2/5. With is level of strength, the patient is unable to flex his arm against gravity. This type of motion would be necessary fro him to (e.g., feed himself, participate in oral care, or use a grab bar during bathroom transfers)."

Goal Writing

Who →

Will do what →

Quality of the action →

Under what circumstances→

By when

Goal Writing

Who

- Resident, caregiver or family member
- Not the therapist

What

- Action task or activity

Quality of the action

- Measurable action, accuracy, frequency, duration

Under what circumstances

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- Conditions under which actions occur

By when

- Target date for goal to be achieved

Goal Writing example

Patient will don a button shirt using hemi-techniques with

minimal assistance during morning ADLs 3/5 times by 1/10/09

How could this OT goal be better written?

“Min A with self care”

Better:

“Patient will don his upper body using one-handed hemi- techniques with minimal assistance and verbal cues during morning ADLs by 1/10/09.”

Tips for Successful Documentation

Four Components to the Evaluation:

1. Decline in function
2. Objective measures
3. Reasonable and necessary skilled service
4. Qualified personnel providing services

Ongoing documentation

- Daily Treatment Note
- Progress Report

Daily Treatment Note

Record daily services delivered

- Date of treatment
- The services delivered in CPT codes
 - Time and units
- Name/credentials

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- Document unusual or unexpected occurrences
- Payer or state practice acts requirements

Progress Notes

Frequency depends on practice setting:

- Weekly Progress Note
- Monthly Summaries

Discharge Summaries

Progress Notes

Justifies the medical necessity of treatment by stating the relationship of skilled service to client's outcomes-why we make a difference.

- Provides objective evidence that the client's anticipated improvement is attainable in a reasonable period of time.
- Identifies how current functional performance is different from previous performance for each identified goal in objective measurements and comparative statements.

Depending on the setting may be the same as a treatment note.

Weekly Progress Notes Examples

"Patient is demonstrating improved tolerance and performance during showering activity.

OT provided instructions for energy conservation, work simplification, purse-lipped breathing techniques and how to use the Rate Perceived Dyspnea (RPD) for self monitoring the activity.

This week she did not demonstrate any SOB, her blood pressure remained within specified parameters of 120/84 – 140/90 and her self report for dyspnea was improved from a rating of '4' (severe difficulty) last week to a rating of '2' (some difficulty) this week."

Examples Weekly Progress Notes

"Patient was able to successfully don and doff shirt with minimal assist after completion of skilled program of graded upper extremity strengthening exercises."

Monthly Summary

Summarize the patient's functional status

Justify medical necessity to continue treatment

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Need for skilled therapy services

Update goals and treatment plan

Discharge Summary

Similar to a 30-day summary

Includes objective measurements and comparative statements from the evaluation to the time of discharge

“The skills of a therapist were necessary for... (list reasons).”

Recommendations for follow-up, home programs and referrals

Justify medical necessity, especially if services extend beyond customary length of time

Last chance to communicate your skilled services

Successful Documentation

1. Expectation of improvement
2. Reasonable and predictable period of time
3. Typical amount, frequency and duration of services
4. Patient’s medical complexity and need for services
5. Using objective tests and measures to validate findings.
6. Why the skills of a therapist are needed to perform these services
7. Types of documentation and related key elements

Our Responsibility

Know the requirements of our payers and adhere to them.

View documentation of service as important as the intervention we provide.

Prevent denials because of inadequate documentation.

Communicate why the skills of a therapist are needed.

Strategies for Success
in the Reimbursement World

Strategies for Success
in the Reimbursement World

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Know your payer's payment policies

- Medicare
 - Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database at <http://www.cms.hhs.gov/mcd>

Clinical Policies, Medical Review...

Excellent Documentation: Evaluation, progress notes, daily treatment record and billing records need to match

- Fluid flow to the story

Strategies for Success
in the Reimbursement World

Peer review

- Look for good documentation practices

Use your payers language in your documentation and in your appeal letters

Fight your denials to the final appeal process

Keep a library of evidence based resources

- Know what the standard of practice is for your practice or the patient's diagnosis

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