



REHAB REPORT™

The Practical Advisor on Reimbursement, Regulations & Business Strategies for Rehab Facilities

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INDUSTRY OUTLOOK

Get the Big-Picture Scoop on Healthcare Reform

► *Rehab gets a piece of the essential benefits package pie.*

Listening to the healthcare reform buzz and wondering how it affects you? Discover the direct links in the Patient Protection and Affordable Care Act (PPACA) to the therapy world, including good news for OTs, claims filing tweaks, and a growing list of open-ended questions worth tracking as the Centers for Medicare & Medicaid Services begins writing its detailed regulations for PPACA.

Best news: The PPACA established an essential benefits package for which Americans of all ages will be eligible (which takes effect Jan. 1, 2014). And rehabilitative services are included under the essential benefits package.

Even better, the essential benefits package includes devices, as well as habilitative services, points out **Ingrida Lusic**, director of federal and political advocacy for the American Speech-Language Hearing Association.

That's a big victory in particular for speech and occupational therapy. "Habilitation is particularly important for children and adults with developmental disabilities, autism spectrum disorders and many other chronic conditions," says **Tim Nanof**, federal affairs manager for the American Occupational Therapy Association.

Normally, insurance denies claims for habilitative services, so "the inclusion of this new requirement for private insurance to cover both rehabilitation and habilitation should be a big benefit," Nanof continues.

Another perk: The PPACA disallows excluding coverage due to pre-existing conditions, Lusic points out.

Get Claims Filed Faster

You now have one year to submit claims. In the past, Medicare Part B providers had 15 months or more to submit their claims to Medicare, but section 6404 of the new legislation requires you to submit your claims "one calendar year after the date of service" for service provided on or after Jan. 1, 2010.

Caveat: The legislation states that "the Secretary may specify exceptions to the 1 calendar year period" but does not yet indicate what types of situations might qualify for exceptions.

continued on next page

INDUSTRY OUTLOOK, continued

And speaking of exceptions ... Section 3103 of the PPACA extends the therapy cap exceptions process for outpatient therapy caps. The current outpatient therapy cap is \$1,860 for physical therapy and speech language pathology services combined, and a separate \$1,860 limit for occupational therapy services provided in a calendar year.

A downside: “We were not happy that reform didn’t include a repeal of the flawed sustainable growth rate,” says **Kelly Lavin**, director of federal government affairs for the American Physical Therapy Association. (See the related story in the *News Briefs* section for more information.) “We were also not happy about the Medicare market basket cuts to such settings as SNFs, home health, etc.,” she adds.

OTs Win Victory in Workforce Provision

The PPACA explicitly lists occupational therapy in all relevant workforce sections of the bill (P.L. 111-148), Nanof cheers. These inclusions will help address the growing demand for occupational therapists, he says. (See related story in the *News Briefs* section.)

Workforce provisions will provide opportunities for program expansion and funding streams for occupational therapy education and training, Nanof says. “Expansion in the area of prevention, particularly under Medicare could be an area of growth opportunity for occupational therapy as the provision is fleshed out in the regulatory process.”

Plus: OTs may see opportunities to explore home modifications, lifestyle supports, and other interventions not typically covered by health insurance under the newly created CLASS (Community Living Assistance Supports and Services) program, Nanof points out. This program will provide for community-based supportive services for people with disabilities and/or functional impairments.

Tune In to Details Down the Road

Right now, the news from the healthcare legislation is quite broad, and the devil is in the details. “So much depends on what will happen in regulations,” Lavis points out. “And there are always little caveats.”

“This is a multi-year process with many unknowns at this point,” Lavin agrees. “Currently most provisions could either be an opportunity or a concern, depending on how the Secretary [of Health and Human Services] creates programs.”

Example: The following parts of PPACA may be good for PTs or may negatively impact PTs, Lavin says:

- The role of the PT in new models of care;
- The impact of new payment methodologies on physical therapy across the continuum;
- Prevention initiatives;
- Limited progress on physician self-referral; and
- The creation of an Independent Payment Advisory Commission. ■

PRACTICE POINTERS

Steer Your Auto Insurance Claims to Speedy Reimbursement

► **Plus, beware a potential payment delay with your Medicare patients.**

For auto accident rehab cases, many patients have a lump sum from the accident settlement that they can use to pay you upfront. But it’s not always that cut-and-dried. How do you submit a claim for a physical therapy date of service to an automobile insurance company? Put these tips in your back pocket so you have a starting point when an auto accident patient walks into your door.

Use This 3-Step Checklist

Create a protocol for the most important things to cover with an auto insurance patient. Consultant

Dick Hillyer, DPT, MBA, MSM, with Hillyer Consulting in Cape Coral, Fla., recommends you do the following:

1. Verify coverage first. Have your receptionist, or whoever deals with insurance or billing, verify the patient’s coverage with the insurance company *before* you schedule the patient for an initial evaluation.

2. Collect the deductible and co-pay at each visit — not every Friday or the end of the month. “Patients often self-discharge early and are never seen again,”

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Inject Prowess and Productivity Into Your Team Conferences

► *Show your Medicare payer the good work your team is really doing.*

Last month you read about avoiding key mistakes in your inpatient rehab facility's team conferences. With the troubleshooting under your belt, now get tips to make your meetings flow even more smoothly.

Focus on Progress in Your Questions

The main point of having a team conference is to evaluate patient progress, so most of your discussion topics should stick to that theme. "To ensure that staff focus on the important issues, I recommend they use a set of questions aimed at producing documentation that indicates progress," says **Fran Fowler, FAAHC**, principle of Fowler Healthcare Affiliates in Marietta, Ga. Your questions should include the following, she says:

- Is this patient making progress to goal as compared to admission evaluation (or compared to the last meeting)?
- What are the facts that support the above statement? (Get input from all therapy disciplines and nursing staff.)
- Is the patient's progress at the point we projected for this time in the IRF stay? If yes, what's the clinical evidence? If no, what barriers are interfering with progress, and what can we do differently to improve the course and the outcome? "Barriers could include medical, motivational, psychosocial, and physical factors," Fowler says.
- Is the progress leading to useful gains for the patient? "If yes, document the gains in laymen's terms," Fowler recommends.

Make the Most of Everyone's Presence

Everyone at the meeting should have something important to share so you can create a big-picture report. "We truly use a multidisciplinary approach," says **Laurie Martin, OTR/L, MSHS**, senior director rehabilitation services at Beaufort Memorial Hospital in Beaufort, S.C.

"Everyone who works with the patient has the opportunity to express information," points out **Kathy Campbell RN**, program director of Beaufort Memorial Hospital's rehabilitation unit. "We include a MSW, nutritionist, pharmacist, and a diabetic specialist, in addition to nursing and therapy services." Occasionally, the team may even include a recreation therapist or wound care specialist, she adds.

Campbell leads the meeting, the physician clarifies questions as needed and offers the opportunity for further education. Then, the team as a whole decides on a discharge date or a plan for continuing care. "It is very interactive," Campbell confirms.

Perk: During the team meeting, members have the opportunity to clarify discharge plans, family support, and FIM scores, which "helps in supporting the accuracy and quality of patient needs and outcomes," Campbell says.

5 Ways to Sharpen Your Team's Decisions

The Centers for Medicare & Medicaid Services declared that it is looking for the *quality* of information and decision-making from the team conference, not the actual meeting structure itself. Try these suggestions to come to a conclusion that's best for the patient — and best for your records should you be reviewed:

1) Develop a checklist that addresses the scope of changes the team expects for the patient, and use the checklist to ensure that all areas that need to be addressed are addressed, Fowler suggests. "This checklist does not become part of the patient chart but, rather, serves as an aide to the team participants."

2) Don't just focus on functional status. "Add documentation to support that adequate discussion occurred in relation to the individual's problems impeding progress and possible resolutions to such problems," says **Ann Lambert Kremer, OTR/L, MSHA, CPC**, with Beacon Rehab Solutions in Portland, Maine. Then reassess the validity of the initial rehab goals.

3) Compare the patient's current status to an earlier time frame to show progress in the areas you're addressing, Fowler suggests.

4) Stay away from using only numbers or "mid, max and mode" figures to document patient status, Fowler adds.

When it's all said and done, don't let your team's hard work go to waste. "Make certain the changes you've noted during the team conference are also reflected in changes to the plan of care," Fowler emphasizes. ■

HOME CARE

5 Ways to Give Your Agency's Therapy Outcomes — And Revenue — a Boost

► *In predicting therapy use, focus on patient need.*

Incorporating therapy more consistently into your patients' care plans can improve patient care, outcomes, and your agency's finances. But beware of falling into old patterns.

Adhering to the traditional types of cases for therapy referrals and using physical therapists as the gatekeeper for occupational therapy and speech therapy is a mistake, experts say. So is dividing the patient in half and saying PT works with the lower half and OT with the upper half.

Instead: Focus on what the patient needs, and make therapy referrals when patients have functional deficits. To maximize patient and agency success and minimize denials, consider discussing the following areas with your clinical team:

1. Changes in utilization patterns. The fastest growing group of patients by percentage is those with 20 or more visits, reported **Cindy Krafft, MS, PT, COS-C**, Peoria, Ill.-based consultant with Fazzi Associates. Many clinicians will remember the popularity of 10 visits when that number created a big jump in payment, Krafft said. Now that the prospective payment system changed therapy reimbursement in 2008, 10 visits shows up less often in episodes, but 20 visits are more common, she told listeners at the American Physical Therapy Association Annual Conference in Baltimore last June.

Best bet: Make sure your plan of care can stand up to intermediary scrutiny by concentrating on documenting a quality assessment, explaining reasons for your patient goals, and focusing on the patient's needs, Krafft said. When choosing goals, remember to compare patients to people of the same age in the community or to what the patient was doing before the illness, she stressed.

2. Length of visits. The length of therapy visits is creeping downward since the PPS system began, Krafft noted. And although PPS requires no specific visit length, agencies should remember that the average pre-

PPS therapy visit lasted 48 minutes, she warned. Not every visit needs to last this long, but shorter visits need specific documentation about the reason for this. For example, if the patient was unable to continue because of fatigue or unusual circumstance, the therapist should note that.

3. Therapy access. Look at what percentage of your patients receive no therapy visits, Krafft urged. A large percentage may indicate your agency is unaware of many areas in which therapy use can improve patient outcomes, she said. "Agencies that are doing well from an outcomes and financial perspective are seeing around 80 percent of patients in first or second episodes receiving at least one therapy visit," Krafft reported.

4. Homebound status. In considering what a therapist can provide home health patients, "homebound status is the qualifying condition; it is not the goal," Krafft emphasized. The goal may be that the patient is able to leave the home without requiring assistance, she said, especially if that was what the patient was capable of before this illness or injury.

Example: If the patient needs to be able to walk across the grass to take the bus, stopping therapy when he is able to walk across the room does not help, Krafft illustrated. Taking this patient outside to practice on grass does not cancel out his homebound status, she stressed.

Make your goals understandable on medical review by including the reasons for them, Krafft advised. Include why it is important that this patient practices walking on grass (or other uneven surfaces). Or explain that walking a certain distance is important so the patient can walk as far as her mailbox.

Tip: One trip to WalMart does not disqualify a patient from home care. First find out what happened on the trip. If the patient experienced major difficulty with part of the trip, document these problems, Krafft urged.

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CLINICAL REHAB ROUNDUP

Tune Up Your Older Patients' Stooping, Crouching, Kneeling Difficulties

Decreased muscle strength relates to self-reported stooping, crouching, or kneeling difficulty in older adults. Hernandez ME, Goldberg A, Alexander NB. Phys Ther. 2010 Jan; 90(1):67-74.

Strength measurements are even more important to document for your elderly patients. Recent research published in the January issue of *Physical Therapy* suggests that decreased muscle strength is linked to difficulty performing functional activities such as stooping, crouching, or kneeling (SCK) in older adults.

The study's purpose was to compare trunk and lower-extremity muscle strength differences in older adults who had difficulty with stooping, crouching, or kneeling with older adults who did not have these difficulties.

"As with standing up from a chair, stooping, crouching, and kneeling movements require coordination of the whole-body center of mass over a wide range of postures in order to prevent a loss of balance or fall," said researcher **Allon Goldberg, PT, PhD**, assistant professor in the Department of Health Care Sciences, Program in Physical Therapy, Mobility Research Laboratory, at Wayne State University in Detroit. "More research is needed, but it is reasonable to predict that a physical therapy program to improve strength in older adults who have difficulty performing basic stooping, crouching, or kneeling movements could lead to improvements in performing these activities, and these improvements could be associated with reduced number of falls."

Findings: Results suggest that older adults who reported trouble with basic stooping, crouching, or kneeling also had decreased strength in their legs, according to a press release from the American Physical Therapy Association on the study. Researchers also discovered a relationship between SCK difficulty and both the level of strength and the ability to maintain proper balance. And distal leg musculature appeared to be a major contributor to SCK difficulty in the study. Future investigation will examine how other trunk and lower-extremity muscle strength may be related to these daily tasks, according to the release.

Specifics: For now, researchers found that adults with SCK difficulty had significant decreases in adjusted strength measurements of trunk extensor, knee extensor, and ankle flexion muscles.

Other researchers have suggested that older adults with SCK difficulty are more likely to have limitations in other lower-body functional tasks, such as lifting and prolonged standing, APTA reported.

"The results of this study may have important implications for clinicians working to reduce falls risk in older adults," Goldberg explained. "Rehabilitation or intervention programs aimed at addressing deficits in self-reported performance in stooping, crouching, or kneeling should focus on improving distal strength."

So if you have patients who present with SCK difficulties, address their strength deficits, but even more important, consider a comprehensive physical therapy program that addresses balance confidence, coordination, leg joint limitations such as stiffness and pain, and sensory capacities, Goldberg suggested. ■

HOME CARE, continued

This shows clearly areas where the patient still needs therapy.

5. Frequency and duration of therapy. In an ideal world, frequency and duration would be based on patient need, but in reality they often are based on staffing concerns, geography, the experience level of the staff, and the relationship between physical, occupational, and speech therapy, Krafft said.

There is nothing wrong with daily therapy or visits by PT and OT on the same day, she insisted. That is what is

done when the patient goes to a rehab facility and it can be appropriate in home rehab as well.

What to do: Get away from cookie cutter therapy plans by taking the following actions, Krafft suggests: Look at other settings for ideas of appropriate frequency and duration. Use your clinical judgment, not just what is habitually done in home care. Communicate and coordinate with other therapists in your agency. Produce a coordinated, unified plan of care. ■

PRACTICE POINTERS, continued

Hillyer warns. And you may have slim luck getting them to respond to an invoice.

3. Have the patient sign a letter, before the evaluation, directing his or her attorney (if any) to pay your full charges first and in full before paying any other related bills.

Wouldn't hurt: "I also recommend highlighting the box on the claim to auto insurance that states the member has agreed you should be paid directly," says **Diane McKeon** with McKeon Services Medical Billing/Consulting. "Then attach your paperwork with the signature stating this." Doing this ensures that if the patient is receiving checks (and has an attorney) that the patient cannot cash them. The checks will be made out to you.

Beware the Payer's New Reporting Requirements

If you're treating a Medicare patient post-auto accident, don't be surprised if you encounter a payment delay. Thanks to the Medicare, Medicaid, and SCHIP Extension Act of 2007, Medicare now mandates that group health plans, liability insurance (including car insurance), no-fault insurance, and worker's compensation benefits must report when they have made a payment to a Medicare beneficiary, points out **Alisa Chestler, JD,**

counsel for Baker, Donelson, Bearman, Caldwell & Berkowitz in Washington, D.C. "The intent of the law is to preserve Medicare funds where other insurers are primary to Medicare."

Even though current law says Medicare should be the secondary payer to other insurance, Medicare will often pay first, especially if the agency isn't aware that the reason for rehab is a car accident.

Bottom line: As auto insurance companies become aware of their new reporting requirement and being under the spotlight as a primary payer, they may be fearful of paying a claim for a Medicare beneficiary if they do not have enough information to report to Medicare, Chestler says. That means claims payments to you may slow down as the auto insurance company attempts to comply with the law and play its card right.

Plus, the reporting requirements are fairly onerous for the auto insurance companies, Chestler adds. Because of all the patient information they need to report the case to Medicare, if they are missing any patient information, they could in fact hold a claim as leverage.

What to do: "The best thing you can do now is simply be aware of this issue, and if you do experience a payment delay, work with the auto carrier to see if the reporting requirement is indeed what is slowing them down," Chestler says. ■

READER QUESTIONS

Get the Skinny on Serial Casting

Question: *I am a physical therapist in private practice, and I have a Medicare patient who would benefit from serial casting. What do I need to do to properly bill this service for Medicare reimbursement? Are there CPT codes I can report? Finally, is serial casting reimbursable?*

— Montana subscriber

Answer: If you want to report serial casting, codes are available. You can find them in the 293xx and 294xx series of the CPT codes. Read through the code descriptors to see which codes best fit your case.

As far as getting reimbursed goes, that all depends on who your payer is. So, figure out which codes you want to use and see if they fall under your Medicare contractor's local coverage determination or other third party payer policies for a patient under a PT plan of care.

Watch for: Even if your Medicare contractor does reimburse the codes you'll be using, the serial casting CPT codes include the cost of the supplies. So, do not bill for them separately.

If your Medicare contractor does not reimburse for serial casting, have your patient sign an advance beneficiary notice, which informs the patient their services may not be covered and that you will bill them if that's the case.

Sniff Out the Discrepancies in Your SNF Re-Certifications

Question: *I need some clarification on Part A Medicare re-certifications in a skilled nursing facility. I've been getting conflicting opinions. My trusted colleagues and professional consultants have always told me that a re-certification was not necessary until the*

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READER QUESTIONS, continued

initial certification period was complete. For example, a patient may have goals and a plan of care set for a six-week period then get a re-certification at the end of the six weeks if therapy needs to continue. I recently heard, however, during a national continuing education course, that Medicare Part A certifications need to be completed every 30 days. Do you have any thoughts that might clarify these discrepancies?

— Massachusetts subscriber

Answer: When you say Medicare Part A, are you referring to therapy reimbursed under PPS in the SNF setting? If that is the case, *the physician* must recertify all services the resident requires within 14 days of admission and then every 30 days thereafter. Medicare policy does not mandate that therapy complete separate certifications and re-certifications.

Many skilled nursing facilities have therapists develop a separate plan of care for Part A patients that the physician then signs to ensure that the plan of care contains all required elements that may have been left out in the plan of care that the physician developed.

If, however, you're referring to outpatient therapy provided in the SNF setting reimbursed under Medicare Part B benefits, that's a different story. In such situations, a physician must sign the initial certification which is valid for the duration of the plan of care (that the therapist established and the physician signed) or 90 days from the start of care, whichever is less.

— Reader Questions were answered by **Rick Gawenda, PT**, director of finance for Kinetix Advanced Physical Therapy, Inc. and president/CEO of Gawenda Seminars & Consulting. ■

NEWS BRIEFS

Congress Stretches Fee Schedule Fix a Bit Longer

The monumental healthcare reform legislation was big, but not big enough to fix the physician fee schedule cuts.

The good news: The president just signed HR 4851 (the Continuing Extension Act) into law, which extends the 2009 Medicare fee schedule conversion factor through May 31, 2010. So therapy providers billing Medicare can avoid the 21.2 percent cuts for another two months.

Important: The law is retroactive to April 1, points out *News Now*, the American Physical Therapy Association's weekly newswire. This means that now, claims with dates of service of April 1 and later, which Medicare contractors were holding, are being released for processing and payment.

Statutory payment floors still apply, *News Now* reminded readers, and, therefore, Medicare contractors cannot pay clean electronic claims before 14 calendar days after the date they are received. And for clean paper claims, you're looking at the usual 29 calendar days.

Bring Entertainment Media Effects to the Rehab Forefront

Have pediatric patients performing poorly in school? Consider having your SLPs, OTs, and audiologists point out the hidden culprits to parents: entertainment media.

The American Speech-Language Hearing Association recently urged the Federal Communications Commission to consider the potential negative impact that the misuse of entertainment media (TV, music, internet, etc.) could have on children's hearing and communication development, according to a press release from the Association.

In terms of hearing, ASHA President **Tommie L. Robinson, Jr, PhD, CCC-SLP**, noted that even a mild hearing loss due to excessive noise can lead to delays in speech and language development, affecting a student's ability to pay attention in the classroom.

As far as communication development goes, Robinson noted that a child's overreliance on entertainment media reduces opportunities for language interactions and reading and writing skills. In other words, time spent in front of the computer screen or using other forms of entertainment media decreases the amount of time that parents

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NEWS BRIEFS, continued

have to talk to their children — something that could lead to language delay in young children.

Even texting can take its toll. For older children, sending text messages rather than talking to peers, can reduce or negatively affect the quality of written expression, Robinson said. Plus, overreliance on text messaging can impede a student's ability to read books and write papers that require understanding and the use of long, complex sentences with a variety of words.

Want something official to share with parents? Get a copy of ASHA President Robinson's letter to the FCC at <http://fjallfoss.fcc.gov/ecfs/comment/view?id=6015538111>.

Keep Your OT Staff Numbers Strong

Consider this when hiring new staff: According to the U.S. Bureau of Labor Statistics, employment of occupational therapy practitioners is expected to increase by 26 percent between 2008 and 2018, much faster than the average for all occupations, reports the American Occupational Therapy Association in a press release.

The BLS also noted that median annual wages of occupational therapists were \$66,780 in May 2008; occupational therapist assistants earned \$48,230.

In celebration of Occupational Therapy Month (April), and looking ahead to the profession's centennial in 2017, AOTA identified six overarching areas of practice; children and youth; health and wellness; mental health; productive aging; rehabilitation, disability and participation; and work and industry.

"We are compassionate, resourceful, creative, motivated, want meaning in life, enjoy science and the arts, are good communicators and listeners, and have a knack for problem solving," said **Penelope Moyers Cleveland, Ph.D., OTR/L, FAOTA**, president of AOTA. "I am a proud champion for the profession year-round, but Occupational Therapy Month in April is a wonderful reason for all practitioners to tell the world who they are and what they do." ■

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