Emerging Issues in Medicare

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Disclosure

- **Roshunda Drummond-Dye:** No relevant financial relationship exists
- **Heather Smith:** No relevant financial relationship exists

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Session Learning Objectives

• Identify the latest developments in federal legislation and determine how it will affect the physical therapy profession.
• Adapt your practice to comply with new regulations and policies.
• Take steps to prepare your practice for new payment changes.

Session Topics

Part 1
• Future of the ACA
• Quality updates
• Alternative payment and episodic payment models

Part 2
• Payment updates
• Coding and Billing Issues
• Medicare Coverage Requirements
• Program Integrity Efforts

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PT Spending and Utilization via Medicare Fee Schedule

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Estimated 2015 Allowed Charges</th>
<th>Percent Change in Allowed Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>Therapeutic Exercise</td>
<td>$1.3 B</td>
<td>9 %</td>
</tr>
<tr>
<td>97140</td>
<td>Manual Therapy</td>
<td>$550 M</td>
<td>8 %</td>
</tr>
<tr>
<td>97112</td>
<td>Neuromuscular Education</td>
<td>$300 M</td>
<td>5 %</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic Activities</td>
<td>800 M</td>
<td>4 %</td>
</tr>
<tr>
<td>97001</td>
<td>PT Evaluation</td>
<td>$200 M</td>
<td>8 %</td>
</tr>
</tbody>
</table>
Table 3: Medicare Margin for Therapy, by Selected Fiscal Years

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Medicare Margin for Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>25%</td>
</tr>
<tr>
<td>2004</td>
<td>34%</td>
</tr>
<tr>
<td>2006</td>
<td>36%</td>
</tr>
<tr>
<td>2008</td>
<td>40%</td>
</tr>
<tr>
<td>2010</td>
<td>42%</td>
</tr>
<tr>
<td>2011</td>
<td>31%</td>
</tr>
<tr>
<td>2012</td>
<td>29%</td>
</tr>
</tbody>
</table>

Source: OIG analysis of SNF cost reports, 2015.
Medicare Physician Fee Schedule

CY 2017 Final Rule

- Implementation of the tiered evaluation codes
- PT codes identified on the potentially misvalued code list
- Coverage for PT Telehealth Services

Medicare Fee Schedule Payment Update

TABLE 50: Calculation of the Final CY 2017 PFS Conversion Factor

<table>
<thead>
<tr>
<th>Conversion Factor in effect in CY 2016</th>
<th>35.3043</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Factor</td>
<td>0.50 percent (1.0050)</td>
</tr>
<tr>
<td>CY 2017 RVU Budget Neutrality Adjustment</td>
<td>-0.013 percent (0.99987)</td>
</tr>
<tr>
<td>CY 2017 Target Recapture Amount</td>
<td>-0.18 percent (0.9982)</td>
</tr>
<tr>
<td>CY 2017 Imaging MPFR Adjustment</td>
<td>-0.07 percent (0.9993)</td>
</tr>
<tr>
<td>CY 2017 Conversion Factor</td>
<td>35.8887</td>
</tr>
</tbody>
</table>
Medicare Fee Schedule Payment Update

- 2017 therapy cap amount is $1,980
- Exceptions process PTs can attach a KX modifier to claims for services that exceed $1,980 for the year
- By using the KX modifier, the PT attests that the services are medically necessary and meet Medicare requirements for payment.
- The current exceptions process expires December 31, 2017
- Congress will need to act by then to either further extend the exceptions process or repeal the therapy caps altogether.

Overview of Evaluation Coding Structure

- 3 levels of complexity
  - Low complexity
  - Moderate complexity
  - High complexity
- The level of the PT evaluation dependent on clinical decision making and the nature of the condition (severity).
- Medicare Fee Schedule RVU 1.20
2017 Evaluation Codes for Physical Therapy

• Evaluation
  97161  Low Complexity Evaluation
  97162  Moderate Complexity Evaluation
  97163  High Complexity Evaluation
• Re-evaluation
  97164  A single code

New Evaluation Structure: Defining Process

• 4 primary elements that will inform your choice of the complexity level of the evaluation:
  • History
  • Examination
  • Clinical Presentation
  • Clinical Decision Making
• Must communicate information regarding these elements and then decide what level of evaluation to report
Elements of a Physical Therapy Evaluation

- Examination (includes history, systems review, and tests and measures)
- Evaluation (the thought process leading to identifying impairments, functional limitations, disabilities, and needs for prevention)
- Diagnosis (impact of the condition on function)
- Prognosis (professional judgement regarding the predicted functional outcome and the estimated duration of services required)
- Plan of Care (the culmination of an evaluation)

Potentially Misvalued Codes Initiative

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032</td>
<td>Electrical stimulation</td>
</tr>
<tr>
<td>97035</td>
<td>Ultrasound therapy</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic exercises</td>
</tr>
<tr>
<td>97111</td>
<td>Neuromuscular reeducation</td>
</tr>
<tr>
<td>97113</td>
<td>Aquatic therapy/exercises</td>
</tr>
<tr>
<td>97116</td>
<td>Gait training therapy</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy l/s regions</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care management training</td>
</tr>
<tr>
<td>G0283</td>
<td>Electric stimulation other than wound</td>
</tr>
</tbody>
</table>

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Home Health: Affordable Care Act Rebasing Adjustments (2014-17)

- Fixed dollar reduction per year to 60 day episode: $80.95
- Annual fixed dollar increase to per visit rates:
  - Skilled Nursing: $3.96
  - Home health aide: $1.79
  - PT: $4.32
  - SLP: $4.70
  - OT: $4.35
  - Medical social services: $6.34
- Annual decrease to NRS conversion: 2.82%

Site Neutral Payment (Sec. 603) and Outpatient Hospital Final Rule 2017

- Requires that certain items and services furnished by certain off-campus PBDs not be considered covered outpatient department services for purposes of OPPS payment and be paid “under the applicable payment system” beginning January 1, 2017
- Creation of Comprehensive Ambulatory Payment Classifications and implications for PT services provided in the ER
IMPACT Act

• Signed into law October 6, 2014
• The Act requires the submission of standardized assessment data by:
  – Long-Term Care Hospitals (LTCHs): LCDS
  – Skilled Nursing Facilities (SNFs): MDS
  – Home Health Agencies (HHAs): OASIS
  – Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
• The Act requires that CMS make interoperable standardized patient assessment and quality measures data, and data on resource use and other measures to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes

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MedPAC Work on Unified Payment System

Must evaluate and recommend design of one PAC-PPS based on patient characteristics

Address considerations of replacement of existing PAC payment systems

Current plan is to build a bigger beta test off of PAC demo that included the CARE tool

Report due to Congress by June 30, 2016

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### Table 1

<table>
<thead>
<tr>
<th>Mandate</th>
<th>Methodology</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluate and recommend features of a PAC PPS using data from the PAC-PRD</td>
<td>&quot;Full&quot; model uses data from PAC-PRD sample to predict relative costs of stays</td>
<td>Use unique data in the PAC-PRD to test feasibility of a PAC PPS</td>
</tr>
<tr>
<td></td>
<td>&quot;Administrative&quot; model uses only existing data to predict relative costs of stays (in PAC-PRD sample)</td>
<td>Assess the accuracy of administrative model (without the unique data), which could be used on a large number of stays</td>
</tr>
<tr>
<td></td>
<td>&quot;Full&quot; and &quot;administrative&quot; models using the same PAC-PRD stays are compared</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If accuracy is similar, use &quot;administrative&quot; model on 2013 PAC stays to estimate effects</td>
<td>Estimate impact using a large number of stays</td>
</tr>
</tbody>
</table>

**Note:** PAC = Postacute care; PPS = prospective payment system; PRD = Payment Reform Demonstration.

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**Conclusions by MedPAC on Unified Payment System Development**

- A common unit of service and uniform adjustment method is feasible
- The system can be risk-adjusted based on patient characteristics
- A separate payment model is needed for therapy, routine services and ancillary services
- Separate adjustment for HHA to prevent overpayments
- A common assessment tool will improve cost accuracy
- Initial payments can be based on current practices and costs but needs to transition value-based care

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SNF Alternative Payment System

- Three main project goals:
  - Develop an alternative payment system that improves adequacy and appropriateness of payment
    - Evaluate performance of alternative payment system
    - Support implementation of alternative payment system
  - To ensure a readily implementable alternative, the project will make recommendations under two constraints:
    - Statutory requirements (e.g. per diem payments, base rates)
    - Currently available data
  - Project recommendations focus on all case-mix-adjusted components of the SNF PPS

SNF Alternative Payment System

- Current PPS consists of three components:

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Nursing</th>
<th>Non-Case-Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy (PT)</td>
<td>Nursing services</td>
<td>Room and board</td>
</tr>
<tr>
<td>Occupational therapy (OT)</td>
<td>Social services</td>
<td>Administrative costs</td>
</tr>
<tr>
<td>Speech-Language Pathology (SLP)</td>
<td>Non-Therapy Ancillary (NTA) services</td>
<td>Capital-related costs</td>
</tr>
<tr>
<td>Evaluation for therapy (PT+OT)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Recommended payment alternative consists of five components:

<table>
<thead>
<tr>
<th>PT+OT</th>
<th>SLP</th>
<th>NTA</th>
<th>Nursing</th>
<th>Non-Case-Mix</th>
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<td></td>
<td></td>
<td>Capital-related costs</td>
</tr>
</tbody>
</table>
SNF Alternative Payment System

Current: 153 Home Health Resource Groups
- Timing (early/late episodes; exception 20+ therapy group)
- 3 clinical levels
- 3 functional levels
- 9 service use categories (number of therapy visits)

Proposed: 128 Home Health Resource Groups
- Timing (early or late; period is placed into 1 of 2 groups)
- Referral source (community or institutional source; period is placed into 1 of 2 groups)
- Clinical grouping (musculoskeletal (MS) rehab, neuro/stroke rehab, wounds, Medication Management Teaching and Assessment (MMTA), behavioral, or complex nursing care; period is placed into 1 of 6 groups)
- Functional level (low or high; low, medium, or high; period is placed into 1 of 2 groups (MS Rehab and Behavioral Health) or 1 of 3 groups for the other clinical groups)
- Comorbidity adjustment (no or yes; based on secondary diagnoses; period is placed into 1 of 2 groups)
Home Health Resource Groups

- Impacts Overview:
  - Per design, overall HHGM mean payments are equal to those under the current payment system
    - Case types (see graph)
    - Early episode +$ / late -$ 
    - Institutional referral +$ / community -$ 
    - Surgical wound +$
    - Parenteral nutrition +$
### Coding and Billing Issues

**Issues with CCI Edits and New Evaluation Codes**

- January 1, 2017 version of NCCI incorrect procedure-to-procedure (PTP) edits for CPT code PT and OT evaluation code combinations 97162/97165, 97163/97165, and 97165/97164
- CMS issued a technical direction letter (TDL) to the Medicare Administrative Contractors (MACs) to utilize a workaround from January 1 through March 31, 2017 to bypass until April 1, 2017 version of the NCCI edits table
- CMS anticipates that the action required by the TDL and the change in the NCCI modifier indicator form “0” to “1” for these three PTP edits in the April 1 retroactive to January 1, will not impact the Medicare functional limitation reporting requirements for the CPT codes in these three pairs.
Medicare Orthotics and Prosthetics

- Implements section 427 of BIPA (2000)
- New definitions for qualified supplier and practitioner for the furnishing of custom fabricated orthotics and prosthetics
- Expressed evidence of training, education and licensure
- New requirements for ABC, BOC or equivalent entity accreditation
- Establishment of new O & P quality standards
- Rule would be effective one year after publication
- Comments due March 13, 2017

TriCare “Reorganization”

- DoD selection of Humana Military and Health Net Services to manage TriCare system
- New contracts are worth a combined $59 million
- Notices of significant reductions in PT payment rates
TriCare and the Use of PTAs

- 32 CFR 199.6 – recognizes only PTs as authorized “paramedical” providers under TriCare
- TriCare does not recognize the use of PTAs in any setting in which the military healthcare reimburses for services
- APTA is pursuing legislative action to correct this issue

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MEDICARE COVERAGE REQUIREMENTS

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Home Health Conditions of Participation

• Use of PTs as clinical managers
  – Physical therapists and other licensed clinicians may be appointed to provide oversight of all patient care and services. These supervision activities could include assigning staff, identifying qualifications for staff, and creating policies for HHA personnel.

Home Health Conditions of Participation

• Requirement for skilled professional services
  – The rule provides broad expectations of professionals who are a part of a patient’s care delivery team. Skilled professionals will include physicians, skilled nurses, physical therapists, speech language pathologists, occupational therapists, and medical social workers.
  – The rule also spells out supervision requirements for “rehabilitative therapy assistants” (including physical therapist assistants), stating that their services must be “provided under the supervision of a physical therapist or occupational therapist.”
Home Health Conditions of Participation

- Privacy Requirements
- Patient’s Rights
- Care planning, coordination of services, and quality of care
- Effective July 13, 2017

LTC Conditions of Participation

- **Outpatient Rehabilitative Services (§483.67)**
  - CMS proposed to add outpatient rehabilitative services to the list of therapy services that LTC facilities must provide to meet the needs of qualifying residents.
  - CMS decided not to address outpatient therapy in LTC facilities, as this topic presents a number of new complex issues that CMS has not yet addressed in its reform rule.
  - Providers in LTC facilities may continue to furnish outpatient therapy under the existing guidelines, and CMS will clarify outpatient therapy in LTC facilities in future rulemaking.
LTC Conditions of Participation

• **Physician Delegation of Services to Qualified Therapists (§483.30)**
  – Requires a physician, physician assistant, nurse practitioner, or a clinical nurse specialist to give orders for a new resident’s immediate care and needs.
  – Physicians will be able to delegate the task of writing therapy orders to physical therapists and other qualified therapists.

LTC Conditions of Participation

• **New Requirements for LTC Admissions, Transfers, and Discharges (§483.15)**
• **New Requirements to Develop Compliance and Ethics Programs (§483.85)**
• The rule was effective November 28, 2016
Jimmo Update (Skilled Maintenance)

✓ Center for Medicare Advocacy’s Jimmo Council
✓ Lawsuit to direct CMS to expand education campaign
✓ Declarations of support
✓ Court ordered CMS to comply and uphold provision to provide a more comprehensive education campaign

Jimmo Corrective Action Plan

• CMS will disavow the application of the so-called "Improvement Standard" on the Jimmo webpage and in the transmittal message notifying stakeholders of the webpage.
• CMS issues technical directive letters to Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations (MAOs).
• CMS will publish a new webpage dedicated to the Jimmo settlement.
• CMS will post one set of Jimmo Frequently Asked Questions (FAQs). With input from plaintiffs counsel
• CMS must comply by September 4, 2017
Definition: Program Integrity

- Encompasses efforts by the Center for Medicare and Medicaid Services (CMS) to ensure that federal resources are being properly maintained and utilized
  - Reduce fraud, waste, abuse and improper payments
  - Pay claims correctly by:
    - Ensuring proper application of the rules for covered services
    - Checking to see if services are correctly coded
    - Eligible beneficiaries
    - Legitimate providers are participating in the program
Types of Improper Payments

Figure 1. Types of Improper Payments

<table>
<thead>
<tr>
<th>Type</th>
<th>Result in Errors</th>
<th>Result in Waste</th>
<th>Result in Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mistakes</td>
<td>Incorrect Coding</td>
<td>Excessive Testing</td>
<td>Upcoding</td>
</tr>
<tr>
<td>Inefficiencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denying the Rules</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intentional Deception</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS Office of Program Integrity

Table 2. Contractors Who Support Efforts to Prevent, Detect, and Investigate Fraud and Abuse

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Error Rate Testing (CERT) Contractors</td>
<td>Help calculate the Medicare Fee-For-Service (FFS) improper payment rate by reviewing claims to determine if they were paid properly</td>
</tr>
<tr>
<td>Medicare Administrative Contractors (MACs)</td>
<td>Process claims and enroll providers and suppliers</td>
</tr>
<tr>
<td>Medicare Drug Integrity Contractors (MEDIcs)</td>
<td>Monitor fraud, waste, and abuse in the Medicare Parts C and D Programs</td>
</tr>
<tr>
<td>Recovery Audit Program</td>
<td>Reduce improper payments by detecting and collecting overpayments and identifying underpayments</td>
</tr>
<tr>
<td>Recovery Auditors</td>
<td></td>
</tr>
<tr>
<td>Zone Program Integrity Contractors (ZPICs)</td>
<td>Investigate potential fraud, waste, and abuse for Medicare Parts A and B, Durable Medical Equipment Prosthetics, Orthotics, and Supplies; and Home Health and Hospice</td>
</tr>
<tr>
<td>Formerly called Program Safeguard Contractors (PSCs)</td>
<td></td>
</tr>
<tr>
<td>Unified Program Integrity Contractor (UPIC)</td>
<td>Will operate under restructured/consolidated Medicare and Medicaid Program Integrity audit and investigation work (Not yet implemented)</td>
</tr>
</tbody>
</table>

Within CMS, the Center for Program Integrity (CPI) promotes the integrity of Medicare through audits, policy reviews, and identifying and monitoring program vulnerabilities. CPI oversees CMS collaborative interactions with key stakeholders on program integrity issues related to the detecting, deterring, monitoring, and combating fraud and abuse. Visit the CMS Blog for the latest CPI news.

In 2010, HHS and CMS launched an ambitious national effort to obstruct criminals at every step in the act of committing fraud. The Fraud Prevention System (FPS) is the state-of-the-art predictive analytics technology that runs predictive algorithms and other analytics nationwide on all Medicare FFS claims prior to payment. For the first time in Medicare history, CMS systematically applies advanced analytics to the Medicare FFS claims on a streaming, nationwide basis.
Strategies to Reduce Improper Payments

- Strengthen provider enrollment
- Improve prepayment reviews
- Focus postpayment reviews on vulnerable areas
- Improve oversight of contractors
- Develop a robust process to address identified vulnerabilities

Source: GAO.
Federal Fraud and Abuse Efforts

• Program Integrity Command Center
  – brings together Medicare and Medicaid officials, clinicians, policy experts, CMS fraud investigators, and the law enforcement community, including the OIG and FBI
  – develops and improve intricate predictive analytics that identify fraud and mobilize a rapid fraud response
  – Instant connectivity with CMS field offices to evaluate fraud allegations through real-time investigations

• Office of the Inspector General (OIG)
  – protects the integrity of HHS’ programs, including Medicare, and the health and welfare of its beneficiaries
  – carries out its duties through a nationwide network of audits, investigations, inspections, and other related functions
  – has the authority to exclude individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs and to impose CMPs

• Health Care Fraud Prevention and Enforcement Action Team (HEAT)
  – established by DOJ and HHS
  – Purpose is to build and strengthen existing programs combatting Medicare fraud while investing new resources and technology to prevent fraud and abuse
  – Stop Medicare Fraud website, which provides information about how to identify and protect against Medicare fraud and how to report it.

Reviews, Audits and Investigations

• Reviews and Audits typically –
  – Review claims
  – Notifies and identifies affected providers
  – Examination of documentation and medical record
  – Red flags and problematic issues are discussed
  – Results are delivered to providers and period for review and discussion is afforded
  – Findings of improper payments are highlighted
  – An opportunity for appeal is afforded
  – Findings of fraud is referred for investigation
## Reviews, Audits and Investigations

### Reviews
- Broader in range and scope
- May cover subject matter that has not been identified to be materially incorrect
- Limited to feedback that there were no negative findings

### Audits
- Methodical inspections
- Follows specific standards
- More latitude to providers of negative as well as positive findings

### Investigations
- Generally involve law enforcement entities (FBI, DOJ)
- Noncompliance beyond a reasonable doubt
- May result in civil or criminal penalties
- Collection of physical evidence
- Individual violation can lead to conviction
OIG 2016/2017 Work Plan

- Focus on outpatient physical therapy services provided by independent therapists who have a high utilization rate
  - Determination of compliance with Medicare
  - States that prior findings are that claims were not reasonable or were not properly documented or that the therapy services were not medically for outpatient physical therapy services
- SNF and Home Health Compliance
- Case Review of IRF Patients to ensure intensive therapy is necessary
  - Assess a sample of IRF admissions to determine participation and benefit from intensive therapy
  - Identification of unsuitable candidates

Targeted Manual Medical Review

- MACRA replaced the manual medical review process for Medicare Part B therapy services that exceed a $3,700 threshold with new medical review process that became effective in July 2015
- CMS will determine which therapy services to review by considering:
  - aberrant billing practices
  - high claims-denial percentages or issues with compliance
  - newly enrolled providers
  - Treatment of specific medical conditions that warrant increased scrutiny
  - groups that includes another therapy provider identified for medical review.
Targeted Manual Medical Review

- Strategic Health Solutions (Supplemental Medical Review Contractor) will perform targeted MMR on a post-payment basis.
- Claims for review based on:
  - Providers with high percentage of patients receiving therapy beyond $3700 as compared to peers during the first year of MACRA.
  - Therapy provided in SNFs, private practice, and outpatient physical therapy (OPTs) or other rehabilitation providers
- Emphasis on evaluation of the number of units/hours of therapy provided in a day.
- 30 day Discussion Period to fix minor errors and communicate with SMRC prior to appeal denial

Appealing a Medicare Denial

There are five levels in the claims appeal process under Original Medicare:

- **Level 1**: Redetermination by a Medicare Administrative Contractor (MAC)
- **Level 2**: Reconsideration by a Qualified Independent Contractor (QIC)
- **Level 3**: Hearing before an Administrative Law Judge (ALJ)
- **Level 4**: Review by the Medicare Appeals Council (Appeals Council)
- **Level 5**: Judicial review in United States (U.S.) District Court

Make all appeal requests in writing.
Home Health Pre-Claim Review
Demonstration

• Administration Rationale –
  – Over 11,000 Home Health Agencies (HHAs) received more than $18 billion in Medicare payments in 2015
  – Out of that $18 billion in Medicare spending, CMS estimates that Medicare made more than $10 billion in improper payments
  – The HHS Office of the Inspector General and Department of Justice collected close to $1 billion in civil and criminal actions between 2011 and 2015 for claims paid under the Medicare home health benefit

Home Health Pre-Claim Review

• Beginning August 1, 2016, CMS launched a pre-claim review demonstration for home health agencies (HHAs) across 5 states.
• 3-year demonstration, CMS aims to lower the improper payment rate for home health services, which spiked drastically from 17.3% in 2013 to 59% in 2015.
• The demonstration will target HHAs in 5 high-risk states:
  – Illinois,
  – Florida,
  – Texas,
  – Michigan, and
  – Massachusetts
Home Health Pre-Claim Review

- In week 24, which ended on January 14, 2017, the majority (88.5 percent) of pre-claim review requests received a fully affirmed decision. Overall in week 24, 91.7 percent of pre-claim review requests received a provisionally affirmed or partially affirmed decision.

SNF Therapy Claims and the False Claims Act

- U.S. Department of Justice recently extracted a $10 million settlement payment from a SNF chain related to the issue as part of a $38 million total settlement payment—the largest ever paid by a SNF to resolve alleged False Claims Act (FCA) violations
- Both the OIG and CMS have expressed skepticism regarding the proportion of residents needing higher levels of (and thus more expensive) therapy
Skilled Nursing Facilities Therapy Services

- OIG June 2015 conducted a study of SNF therapy claims to analyze billing patterns after new therapy policies implemented in FY 2011 and 2012
- Found that under new policies, therapy still increased slightly
- SMRC conducting post payment medical review of SNF therapy

SNF Therapy Claims and the False Claims Act

- SNF PPS 2015 Final Rule
  - "given the comments highlighting the lack of medical evidence related to the appropriate amount of therapy in a given situation, it is all the more concerning that practice patterns would appear to be as homogenized as the data would suggest."
- CMS also noted that it found certain commenters’ explanations for the therapy trends “troubling and entirely inconsistent with the intended use of the SNF benefit.”
- CMS cited a commenter who noted that the minimum minutes for a RUG level are often perceived as maximum minutes and that some providers might implement internal rules that prohibit clinicians from providing therapy above RUG level minimums contrary to their professional medical judgment.
  - “Specifically, the minimum therapy minute thresholds for each therapy RUG category are certainly not intended as ceilings or targets for therapy provision."
SNF Therapy Claims and the False Claims Act

• Recent Settlement and Ongoing Cases have uncovered the following practices:
  – Providing unneeded care or unnecessarily extending resident stays to continue to provide therapy that residents allegedly did not need
  – Billing for care that was not actually provided
  – Billing for therapy care that was not “skilled”
  – Providing care to residents who could not tolerate the care, could not benefit from it or both
  – “Ramping up” care provided during assessment periods, which would then allow for higher RUG rates and higher reimbursement following those assessment periods, regardless of the minutes actually provided after the assessment periods

SNF Therapy Claims and the False Claims Act

• FCA remedy provisions: civil penalties ranging from $5,500 to $11,000 for each proven act violating the FCA and treble damages that the government proves that it has sustained

• Damages are calculated as the difference in the amount the government paid because of the fraud and the amount the government proves it would have paid in the absence of fraud—times three.
Steps to Ensure PTs are Protected

- No individual PTs have been prosecuted in these cases and DOJ/OIG has stated this is not their intent
- Understand your obligations and duties as an individual therapist
- Know the Medicare SNF benefit and always exercise clinical judgment first and foremost
- As much as possible, create an open dialogue with management and the compliance office to prevent conflicts in clinical judgment and business operations

Resources

- Strategic Health Solutions: https://strategichs.com/smrc/
Additional Resources

- Medicare Program Integrity Manual
- APTA Medicare Audits, Denials and Appeals
  - http://www.apta.org/Payment/Medicare/DenialsAppeals/
- APTA Integrity in Practice
  - http://integrity.apta.org/AboutUs/Campaign/Ads/

QUESTIONS

If you have additional questions please feel free to contact us at 800 999 2782 ext. 8511 OR advocacy@apta.org