The Year of Living Dangerously
What Happened to Outpatient Therapy?

What happened to outpatient therapy?
A few short years ago the outpatient therapy community was humming
along expecting the ritual annual extension of the therapy cap and a
safe haven for hospitals from the cap.
In the span of a year we have been bombarded with manual medical
review, recovery auditors (RACs), functional limitation reporting, therapy
caps temporarily at acute hospitals and permanently at critical access
hospitals, MPPR doubling to 50%, penalties for not reporting quality
measures, revised ABM rules, the Jimmo settlement and clarification of
CMS skilled maintenance policy and now an appeals system not
scheduling new ALJ hearings for 2 years.
All this in addition to draconian recommendations to Congress from
MedPAC. Providers are challenged to keep up with the rules, and CMS
is challenged to keep up with the fixes needed to try and make it all
work.
Well, is it? Working that is?

The necessary objectives.....
- Therapy Caps 101 (for Hospitals, Private Practice, SNFs, Rehab
  Agencies & CORFs) use of KX and ABN.
- Danger zone of mandatory 100 percent recovery auditor review
  (RAC) at the $3,700 thresholds.
- Unravel the G code confusion – first, what is a G code? Then the
  confusion.
- Hospital rules affecting ALL OP providers that you need to know.

RAC and Ruin: Manual medical review of outpatient therapy over
$3,700 by the Recovery Audits and how it is affecting not only
therapy practice but beneficiary care

ABC’s of the ABN: How to use the ABN to protect your practice,
and legally transfer liability to beneficiaries for care that is not
medically necessary

Mythical Medicare Improvement Standard: the Jimmo
settlement, maintenance and what it means for therapy in the
SNF, HHA, IRF and OP settings

Therapy Caps Attack: All outpatient settings are now included –
what does this “permanent” situation mean for hospitals, critical
access hospitals, rehab agencies, CORFs, SNFs and private
practice?

Let’s review...
- Therapy caps legislation
- Caps or “Stop the Therapy Cap”
- Exceptions process
- Acute care hospitals
- CAH
- Manual Medical Review
- Modifier -59
- ICD-10
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MedPAC

Low: From your friends at the Medicare Payment Advisory Commission

MedPAC — 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 largesse 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?

MedPAC Recommendations

- 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

Medicare Benefit?

Explaining the Therapy Caps Two Different Ways

2014 Therapy

- Medicare Limits on Therapy Services:
  - Medicare limits on therapy services are in place to ensure that Medicare pays only for what it considers to be medically necessary services.
  - You can find more information on Medicare limits on therapy services on the Medicare.gov website.

Fine Print of Therapy Benefits

- Physical Therapy:
  - Medicare covers physical therapy services for injuries and illnesses that affect your ability to function, such as your vision or other health conditions. Services are covered when they are medically necessary and reasonable. Medicare also pays for therapy services that help you recover from an illness or injury.
  - Medicare pays a benefit period. After the benefit period ends, Medicare does not cover benefits for the same illness or injury again.

Resources:

- Medicare Benefits Brochure from Medicare.gov
- Medicare Limits on Therapy Services from NancyBeckley.com
It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap.

Resource: Medicare Claims Processing Manual, Chapter 5, Section 10.3

In general, if your therapist provides documentation that your services were medically reasonable and necessary, you won’t have to pay for costs above the $1920 therapy cap limit.

Resource: Medicare Claims Processing Manual, Chapter 5, Section 10.3


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Ref: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Ref: https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/ABN-Noncoverage-FAQ.pdf

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Ref: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Modifier GA
- Waiver of Liability
- Statement on file
- Expecting "not medically necessary denial"
- Mandatory ABN is properly executed

Modifier GZ
- Item or service expected to deny as not reasonable or necessary
- No ABN obtained
- All claim line(s) with a GZ modifier "shall be denied automatically and will not be subject to complex medical review"
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#1 — Therapy Cap NOT Met

Mr. X has been receiving PT 3x per week, and has **achieved all his therapy goals** in his POC. Total amount applied to therapy cap is $780 in 2014.

- **Mr. X requests** continued PT services 2x per week, even though PT is no longer medically necessary.

- **ABN must be issued** prior to providing the services that won’t be covered by Medicare because they are **no longer medically necessary**.

Example: Per CGS

<table>
<thead>
<tr>
<th>#2 Therapy Cap Met</th>
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</table>

Ms. X has been receiving PT 3x per week, and has achieved all her therapy goals in her POC. Total amount applied to therapy cap is $1920 in 2014.

- Mr. X requests continued PT services 2x per week, even though PT is no longer medically necessary.

- ABN must be issued prior to providing the services that won’t be covered by Medicare because they are **no longer medically necessary** and **exceed the cap** in order to transfer liability and charge the beneficiary.

Example: Per CGS

<table>
<thead>
<tr>
<th>#3 Therapy Cap Met</th>
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Ms. A has been receiving PT 3x per week, and has **NOT achieved all her therapy goals** in her POC. Total amount applied to therapy cap is $1920 in 2014. But more medically necessary therapy is required.

- Ms. A **qualified for an exception**, therapy above cap is covered.

- Therapist appends –KX modifier to attest that therapy beyond the cap is medically reasonable and necessary.

- An ABN is **not necessary**.

Example: Per CGS

<table>
<thead>
<tr>
<th>ABN — Top 5 Tips</th>
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1. It is **not** appropriate to use ABN for medically necessary services
2. Medicare providers are responsible for knowing Medicare coverage rules – the "stop sign" approach
3. Therapists must use clinical judgment and knowledge of Medicare coverage policies to determine medical necessity
4. -GZ modifier (**no ABN issued**) – under law means “not medically necessary”
5. -GA modifier (**ABN on file**) – use for denial to pass over to secondary (not supplemental)

<table>
<thead>
<tr>
<th>CASH and Compliance — the ABN</th>
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<thead>
<tr>
<th>Manual Medical Review</th>
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NancyBeckley & Associates
Rehab Compliance Resources
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What Happened to Outpatient Therapy?

Therapy Threshold - History

- 4th Quarter 2012
- Phased in by provider number
- GAO Report on Findings
- So popular it returned again in 2013 and 2014

GAO Recommendations

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?

Manual Medical Review

- Triggers 100% review of claims over $3700 threshold
- Prepayment and Post-payment review
- Prepayment – 10 day review period for pay/no-pay
- Postpayment – “encourage” 10 day
- How is this going for you?
- Have you met your RAC?
- Do you know the process?
- Who is managing the process internally?

MMR Approvals

- Approvals? Congratulations!
- Payment based on 10 day limit?
  - Congratulations - you ducked a bullet!
- Denials?
  - Timed out
  - Not medically necessary

FCSO Problems

- Issue: Adjustment of some hospital claims for therapy services
  - Certain hospital claims for therapy services processed between April 7 and July 28, 2014, may have been paid in error because Medicare claims processing systems did not apply the services to the therapy cap appropriately.
- Resolution
  - The claims affected had one or more lines with revenue code 042x, 043x, or 044x with modifier GN, GO, or GP. The system problem was corrected July 28. Affected claims will be adjusted.
- Status/date resolved
  - Open. Claims will be adjusted beginning July 28, 2014. All adjustments will be complete by October 31, 2014.
- Provider action
  - None
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.

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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.

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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.

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Additional documentation is need 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 documentation supporting the services provided and medically necessity for the physical therapy on XXX for 97110, G0283 and 97140.

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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.

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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.

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Recovery Auditors (RACs)

MMR Therapy by the RACs
- February 28, 2014 was last day for MACs to send ADR letters for the Recovery Auditor Prepayment Demonstration (complex reviews).
- This date also applies to prepayment reviews of Outpatient Therapy claims over the $3700 Threshold.
- Florida is a pre-payment review state

MMR Therapy by the RACs
- Therapy claims are now paid without complex review, but will continue to be tracked.
- When CMS awards the new contracts, RACs will review all claims over the $3700 Threshold, that were not previously reviewed, as post-payment reviews.
  - Once “backlog cleared”, return of pre-payment review
- CMS announced limited “restart” with current RACs
  - Outpatient therapy included in limited restart

A RAC Reminder.....

Source: CGI Federal RAC Region B

CMS RAC Update
- CGI files suit to block new RAC awards
  - CGI Federal loses in United States Court of Claims (8/22/2014)
- CMS cleared to award new contracts
  - Likely award protests
- CMS on August 4th announces “limited” restart
  - Outpatient therapy is included
- Further announcements and instructions from CMS are pending
- Be prepared to submit all claims over $3700 for prepayment review
  - Current RAC – Region C Connolly
  - New RAC – Region 3

New “RAC” Regions

Source: www.cms.gov/rac
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Somewhere in Time…….
CMS Appeals system is hopelessly behind
OMHA (ALJ) announces slow down/stoppage
Backlog to be cleared
Beneficiary claims to be “expedited”
30 months backlog
Once backlog cleared
Assigned to ALJ district
Wait time to court docket
Understand appeal rights… and administrative burden

Consolidate as many similar claims as possible into one appeal request starting at Level 1
Consider providing advance permission to sample claims to extrapolate the total
File requests timely with the appropriate contractor
Include all required items and, most importantly, sign your request for appeal

Mediation*
Part B Providers
Authority: ALJ
Extrapolation

Two Demonstration Programs

Functional Limitation Reporting
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What Happened to Outpatient Therapy?

G Codes & Severity Modifiers
- Functional Limitation Reporting
  - CMS mandated to collect information on function and condition
    - Onset of every therapy episode, every 10th visit at a minimum, discharge
    - However, 10/1/2013 enforcement date + glitches
  - Discharge 7/1/2013 mandatory report
  - How is it going for you?
  - MM SE1307; eff: 7/2/2013

Hospitals — Special Concerns
- Inpatients with Part B only
  - IRF — due to RAC denials — may be problem
- Observation
  - OP documentation requirements
- Has this been thought out?

Functional Limitation Reporting
- Mandated in MCTRJCA (2012)
- All Outpatient Rehab, Part A and Part B
- Based largely on Functional Assessment
- Data collection exercise to assist in future payment system
  - No suggestion of program integrity initiatives
  - Compliance measure via claims, not chart review
- Therapist driven (clinical), not biller/coder driven

Other Definitions
- Medicare fee-for-service only
  - Medicare advantage plan may opt for “mini-me”
  - Verify if codes reported that claim will not be rejected
  - Safety net:
- Medicare Secondary Payor
  - Clarified by CMS to APTA

FLR Problems
- CMS did not anticipate scenarios...
  - Second evaluation
    - Same POC
    - Different POC
    - During initial POC
- CMS did anticipate scenarios, not working...??
  - Patient self-discharge & 60 day window
- Providers told to “file redetermination”
  - Rather than reopening for clerical error on some
  - Or correct instructions on reporting
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FLR Reporting Problems

- Codes not paired correctly
- Different code set from initial report
- Subsequent eval/re-eval do not have code sets
- Claims received out of sequence
- Reporting by 10th visit not completed
- Open reporting period – when new episode starts

OIG

They Make it so Easy to Self-Disclose

OIG 2014 Work Plan

Physical therapists—High utilization of outpatient physical therapy services

Billing and Payments. We will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations.

Context—Prior OIG work found that claims for therapy services provided by independent physical therapists were not reasonable or medically necessary or were not properly documented.

Our focus is on independent therapists who have a high utilization rate for outpatient physical therapy services. Medicare will not pay for items or services that are not “reasonable and necessary.”

Office of Inspector General

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…”

Link to the OIG Report
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What Happened to Outpatient Therapy?

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.”

“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.”

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

OIG Report: Credentialing and Supervision

“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.”

OIG Report: Medical Necessity

“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.”

OIG Report: Non-Specific Plan

“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.”

OIG Summary: Spectrum Didn’t Know

“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.”

JIMMO Settlement

The Myth of the Medicare Improvement Standard
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What Happened to Outpatient Therapy?

Jimmo v. Sebelius Settlement

- On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius.
- Medicare mythical “improvement standard”
- Goal to ensure that
  - claims are correctly adjudicated in accordance with existing Medicare policy,
  - so that Medicare beneficiaries receive the full coverage to which they are entitled.

Medicare on Maintenance

Maintenance Program (MP)

- “a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.”

“Skilled” Maintenance

- “..services ...required to maintain the patient’s current function or to prevent or slow further deterioration
  - are of such complexity and sophistication that...skills of a qualified therapist...required to perform...procedure safely and effectively,
  - the services would be covered physical therapy services.

“Skilled Maintenance”

- “...patient’s special medical complications require ..skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled,
  - such services would be covered physical therapy services.”

Not An Expansion of Coverage

"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."

CMS: Settlement Agreement does not expand existing Medicare benefits or coverage for outpatient therapy, skilled nursing or home health therapy/nursing services.

- CMS has updated:
  - Therapy documentation/coverage (MBPM)
  - Provided training to the Medicare Administrative Contractors (MACs) and other review entities
  - Updated the 1-800 MEDICARE call scripts – as many patients get their information from calling

CMS Examples

- CMS provides multiple scenarios – let’s take a look at 3 typical scenarios
  1. Skilled Maintenance at conclusion of therapy
  2. Skilled Maintenance therapy/program that is based upon intermittent review/eval of patient
  3. Skilled Maintenance therapy performed by therapist due to specific needs of patient and the medical necessity of skilled intervention
A patient with Parkinson’s disease is nearing the end of a rehabilitative physical therapy program and requires services of therapist during the last week(s) of treatment to determine what type of exercises will contribute the most to maintain function or to prevent or slow further deterioration of the patient’s present functional level following cessation of treatment. (MP vs HEP)

Establishment of a maintenance program appropriate to the capacity and tolerance of the patient. Instruction of the patient or family members in carrying out the program, + reevaluations as may be required may constitute covered therapy.... because of the need for the skills of a qualified therapist.

Patient has progressive degenerative disease performing activities in maintenance program (established by PT) with the assistance of family members. Program needs to be re-evaluated to determine whether assistive equipment is needed and to establish a new or revised skilled maintenance program to maintain function or to prevent or slow further deterioration.

Intermittent re-evaluation of the skilled maintenance program would generally be covered: service that requires the skills of a therapist. Should the PT conducting the re-evaluation determine program needs to be revised, these services would generally be covered.

HX Multiple Sclerosis recent exacerbation: difficulties wheelchair transfers, maintaining LE ROM (increased spasticity muscle tone)

Unable to walk...independent use of wheelchair...needs to be able to safely transfer in and out of wheelchair by herself or w/assistance of family member or caregiver

After eval, (given patient’s overall medical and physical condition)

- Skills of PT required to instruct patient and/or caregivers in proper techniques (see above) due to special medical complications from progression of MS

When PT determines patient can carry out above safely and effectively, alone or with the assistance of caregivers, skills of PT are no longer necessary to furnish the skilled maintenance therapy, and, the patient is discharged from PT.

Intermittent re-evaluation of the skilled maintenance program would generally be covered: service that requires the skills of a therapist.

Should the PT conducting the re-evaluation determine program needs to be revised, these services would generally be covered.

The leading cause of payment errors for therapy services is “insufficient” documentation in the medical records. Documentation is often missing the required elements as outlined in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230.
**Insufficient Documentation**

- Missing or illegible signature on the plan of care;
- Missing or illegible signature for physician's certification; and
- Missing legible signature and required treatment minutes in narrative or on flow sheet.

**Signature and Certification of the Plan of Care**

- The legible signature and professional identity (e.g., MD, OTR/L) of the individual that established the plan, as well as the date it was established, must be recorded with the plan.
- A physician or NPP must certify (and date) the plan of care (note: for CORF services, NPPs may not order or certify therapy services). Certification may be established in the patient’s medical record through:
  - Physician's or NPP's progress note
  - Physician or NPP's order
  - Plan of care that is signed and dated by a physician/NPP
  - Documentation must indicate that the physician/NPP is aware that the therapy service is or was in progress; and
  - Agrees with the plan, when there is evidence the plan was sent to the physician/NPP or is available in the patient’s medical record for the physician/NPP to review.

**Functional Reporting (FLR)**

- Claims for therapy services that are required to contain the nonpayable G-codes and corresponding modifiers should include documentation of Functional Reporting in the medical record. Specifically, documentation of the nonpayable G-codes and severity modifiers regarding functional limitations reported on claims must be included in the patient’s medical record of therapy services for each required reporting interval as outlined in the CMS OIM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.4 (2.2 MB)
- Documentation of functional reporting must be completed by the clinician furnishing the therapy services. Therapists must also document his/her clinical judgment in the assignment of the appropriate severity modifier.

**Contents of Plan of Care**

- Diagnoses.
- Long term treatment goals – Should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care.
- Type – May be physical therapy, occupational therapy, or speech language pathology, or when appropriate, the type may be a description of a specific treatment of intervention. When a physician or NPP establishes a plan, the plan must specify the type of therapy planned.
- Amount – Refers to the number of times in a day the type of treatment will be provided. When amount is not specified, one treatment session a day is assumed.
- Duration – Number of weeks or the number of treatment sessions for the plan of care.
- Frequency of therapy services – Refers to the number of times in a week the type of treatment is provided. When frequency is not specified, one treatment is assumed.

**Treatment Note**

- The purpose of treatment notes is to create a record of all treatments and skilled interventions that are provided and to record the time of the services to justify the use of billing codes and units on the claim.
- Documentation is required for every treatment day and every therapy service.
- Documentation of each treatment note must include the following required elements:
  - Date of treatment.
  - Identification of each specific intervention/modality provided and billed (both timed and untimed codes).
  - Total timed code treatment minutes and total treatment time in minutes.
  - Signature and professional identification of the qualified professional who furnished the services; or, for incident to services, supervised the services, including a list of each person who contributed to the treatment.

**Avoid CERT Errors**

- **Tips to improve therapy documentation:**
  - Ensure the medical records submitted provide proof the service(s) was certified and rendered.
  - Ensure the medical records provide justification supporting medical necessity and that skilled services were needed.
  - Create a complete plan of care, making certain to include your legible signature, professional identification (e.g., PT, OTR/L) and date the plan was established.
  - Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met.
  - Confirm the plan of care is certified (recertified when appropriate) with physician/NPP legible signature and date.
  - Clearly document, in minutes, the total time spent on timed-code treatment only and the total treatment time (including timed and untimed codes) in the patient's record.
Compliance Hot Topics

- Safeguard Services (Also a ZPIC)
- Comparative Billing Reports
- High PT billers with KX Modifier
- Hand Therapy Upper Extremity Orthosis (just released)

Strategic Health Solutions
- Super Storm Sandy – targets OP therapy providers in NY
- Therapy stopped by 12/31/12, but resumed in January

Cash and Compliance™

- What's not to like?
  - Emerging trend
  - Generating a lot of interest by private practice, even hospitals
  - Enthusiastic grass roots movement and discussion via social media
  - Industry acknowledged gurus, happy to share their unique “story”
  - Many models: cash only, cash +, cash after

- Then of course, there's Compliance!
  - But I don't take Medicare.
  - I heard there was a “secret” HIPAA clause
  - I looked at HIPAA, and I'm not a covered entity...
  - Does Medicare cover “wellness services”?*
  - I’m also at ATC...can I “switch” practice modes?
  - The client didn't tell me they were going to bill their secondary...
  - The family is upset, and said they would report me to Medicare....
  - I didn’t know that Florida had privacy laws and I had to report a data breach...

Your “Library”

- National Coverage Determinations & Policy
- Local Coverage Determinations
  - Part A & B MAC
  - DME MAC (if applicable)
- CMS Educational Materials
  - MLN Network
  - FAQs
- MAC Communications
  - List serve
  - Educational Offerings
  - POE

- RAC Process – General
- RAC Process – Your RAC
- Appeals Process
  - Your MAC
  - CMS
  - OMHA

Medicare Resources Available:
www.clinicient.com/mmr-resources/
- Previously recorded webinars
- Cheat Sheets
- Samples of Documentation
- Blog Articles
- Video Demonstrations

Twitter:
#RehabCompliance
@nancybeckley

Outpatient Therapy Resource Page

Road To Compliance Success

Keep the Conversation Going:

LinkedIn Groups:
The “PT and Rehab Compliance Group”
Moderated by Nancy Beckley

Community group for sharing discussions and questions surrounding Medicare and compliance regulations
The Small Print

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