Eli's Rehab Report

Documentation: Don't Just Correct -- Perfect -- What You Know About Certifications

Plus, your progress report deadlines aren't what they used to be

When the Medicare Physician Fee Schedule Final Rule hit the press last November, rehab providers were happy to see certification periods extend to 90 days on Jan 1, 2008. If you've been applying this new guideline since the beginning of the year, you're on the right track, but CMS has a few more bones to pick when it comes down to the details.

Read on to learn more about what recently released CMS transmittal 88 (CR 5921) has to say about your physician certifications.

90 Days Isn't Always the Magic Number for POCs

One of the first points the transmittal brings up is that certification intervals aren't automatically 90 days. Instead, they may be "90 calendar days or less, based on an individual's needs," CMS says (emphasis added). This was implemented on June 9 and retroactive to Jan. 1.

Example: Suppose you evaluate a Medicare patient and establish a plan of care for therapy two times a week for eight weeks. "When the physician signs and dates that plan of care, the certification will only be valid for those 16 visits -- which would equal out to about 56 days, as opposed to 90," says **Rick Gawenda, PT,** director of PM&R at Detroit Receiving Hospital and owner of Gawenda Seminars. In fact, "most plans of care are not going to be developed for 90 days; this policy just allows the therapist the freedom to establish longer care plans that are 'up to 90 days' if needed."

Don't miss: Although your initial certification interval can be up to 90 days, that doesn't mean you can wait that long for the physician's signature. You must obtain a physician's (or NPP's) signature within 30 days of the initial treatment date or significantly modified plan of care, says **Ellen Strunk, PT, MS, GCS,** owner of Rehab Resources and Consulting in Birmingham, Ala. For initial certifications, remember that the first day of treatment includes your evaluation, CMS says.

For recertifications, CMS considers them timely "when dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less."

Know the New Progress Report Deadlines

When CMS changed the certification interval to a maximum of 90 days last November, therapy progress report guidelines suddenly became a little fuzzier. Previously, progress reports were due once every 10 visits or once every certification interval -- whichever came first. But with the much longer, 90-day certification interval, that ruling was a bit outdated.

The result: In this transmittal, CMS changed the requirement to state that progress reports are due once every 10 visits or once every 30 calendar days -- whichever comes first. "A lot of people thought that since CMS changed the certification interval to 90 days that the progress report would be due only once every 90 days, but now the due date is no longer based on the certification interval," Strunk says.

This ties into the important clarification that progress reports and recertifications aren't the same thing -- a common misinterpretation, Gawenda says. "It wouldn't be uncommon for people to have the physician sign a progress note every 30 days (back when the progress report was due on the certification interval) and count it as a recertification." But this won't work anymore unless your recertification deadline and progress report due date somehow match up, which is unlikely with the new guidelines. Now, in most cases your progress report will be due before you have to recertify. Also,

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keep in mind that the required elements for a recertification are vastly different from the required elements in a progress report, Gawenda says.

Good idea: To keep your Medicare contractors happy -- and to give yourself a better shot at good reimbursement -- don't do the bare minimum when it comes to progress report deadlines.

In this new transmittal, CMS actually encourages (although doesn't require) therapists to write progress reports more often -- and with good reason. "If I write a note on a patient today and don't write another progress report for 10 visits, and the insurance company is considering a denial, it may go all the way back to that last progress report as its first reference and deny the entire 10 visits in between because there wasn't enough documentation to support the medical necessity of my treatment and the functional improvement of the patient," Gawenda says.

Remember These Facts When Modifying POCs

CMS also had comments on your plans of care. First, the agency officially states that it may be appropriate "to taper the frequency of visits as the patient progresses" even if you're providing less therapy than you intended in your plan of care or end your visits sooner than expected. "This means your Medicare contractor can't deny therapy simply because of a tapered or low frequency of visits," Gawenda says. In fact, in the directions for contractors, the transmittal specifically states, "Contractors shall not deny services on the basis of a low frequency or duration of treatment."

Requirement: If you make a "significant change" to a plan of care, you must have the physician sign it within 30 days. CMS explains that a significant change would be a change in long-term goals. "This takes away the myth that every time you change something you have to get a physician signature," Strunk says. "Essentially, as long as the patient is progressing according to the plan, you can alter things like short-term goals or frequency of therapy.

Note: To view the full transmittal online, visit http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf.

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