Eli's Rehab Report

SNF Therapy Usage: Brace Yourself: RACs Ready to Dig into Your RU & RV RUGs

Key indicator: Percentage of patients receiving therapy at minimum minutes' threshold.

The therapy minutes totted up by your residents could land you in hot water. Thanks to newly released data on RUGs, you may soon face scrutiny from Recovery Audit Contractors (RACs). And that's not all manual medical reviews (MMRs) of your therapy claims that exceed the cap are also on the horizon.

On March 3, the **Centers for Medicare & Medicaid Services** (CMS) released a new dataset, the Skilled Nursing Facility Utilization and Payment Public Use File (SNF PUF), which detailed Medicare data from SNFs for calendar year 2013. The dataset specifically looks at the RUGs, and CMS analyzed the patterns of utilization and total Medicare payment amounts for the top 10 RUGs.

The SNF PUF also contains data on the two highest-paying therapy RUG categories: Ultra-High (RU) and Very High (RV) Rehabilitation RUGs. And what CMS has determined from this data is that for these two RUGs, "the amount of therapy provided is often very close to the minimum amount of minutes needed to qualify as a patient for these categories." In fact, the figures were often within only 10 minutes.

Examples: CMS found that for the RV category, for which the resident must receive at least 500 minutes of therapy each week, approximately 51 percent of all RV assessments showed between 500 and 510 minutes of therapy provided. And 65 percent of all RU assessments showed between 720 and 730 minutes of therapy provided, when a resident must receive at least 720 minutes of therapy per week to qualify for this RUG category.

Beware: Due to these findings, CMS stated that it's referring the issue to RACs for "further investigation." You can read a fact sheet on the SNF PUF dataset at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-09.html.

Watch Out for New Medical Review Entities

RACs won't be conducting MMRs of your claims that exceed the therapy cap, but a supplemental medical review contractor (SMRC) will be.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy cap exception process through Dec. 31, 2017 and modified the requirement for MMRs of services exceeding the $3,700 therapy threshold.

On Feb. 9, CMS announced that it has contracted with **Strategic Health Solutions** as the SMRC that will perform MMRs on a post-payment basis. The SMRC will select claims for review based on the following criteria:

- Providers with a high percentage of residents receiving therapy beyond the threshold as compared to their peers during the first year of MACRA.
- Therapy provided in SNFs, therapists in private practice, and outpatient physical therapy or speech-language pathology providers or other rehab providers.

And in particular, the SMRC will focus on the number of units/hours of therapy provided in a day. Remember that for calendar year 2015, the therapy cap was $1,940 for physical therapy and speech-language pathology services

combined, and $1,940 for occupational therapy services.

More Doesn't Mean Necessarily Better

Federal enforcers don't find it credible that elderly patients can really require ultra-high care, which entails at least 12 hours of physical, occupational or speech therapy every week.

In an Orange County Register article, **Deborah Schoch** and **Ron Campbell** raised concern that 72 percent of patients in nursing homes in Orange County receiving Medicare rehabilitation clock in as ultra-high well above the 66 percent statewide and 58 percent nationwide rates.

An extra hour of therapy per week proved more beneficial for patients recovering from hip fractures, according to a **Cornell University** led study, which was published in the Jan. 1 edition of Physical Therapy. However, ultra-high therapy minutes weren't as effective as lower intensity therapy in helping patients return home, the study said.

Caution: The **HHS Office of the Inspector General** (OIG) has been eyeing the SNF billing for a non-therapy RUG followed by a therapy RUG for quite some time now, as reported in Eli's Rehab Report, vol. 22, no. 12, "Your Changes in Therapy Billing Gets Increased Scrutiny." Now, CMS is also getting suspicious and you need to be wary about the amount of therapy you are providing and whether it meets medical necessity and outcomes requirements.

The Register story can be read in full at http://www.ocregister.com/articles/therapy-705981-nursing-medicare.html.