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MDS Alert

Compliance: Be on the Lookout for These 2 Part B Rehab Therapy Issues

Your Medicare and Medicaid payment could be at stake.

If these two potential problematic patterns aren't on your compliance radar screen, watch out. You can bet they could pop up on auditors' computerized algorithms, or when medical reviewers compare MDSs, therapy logs, billing, and documentation.

1. T herapy minutes on the MDS that consistently don't jibe with the units billed. "The RACs could compare the MDS therapy minutes and the billed Part B therapy units," says **Pauline Franko, PT, MCSP,** president and owner of Encompass Consulting & Education in Tamarc, Fla.

And "if the facility or therapist always billed three units for 38 minutes or provided the minimum of what it took to take them to the next level consistently, that could be a trigger for a review," she cautions.

Not for Part B only: The same concept applies to Part A where "always keeping therapy to the minimum RUG level can be a review issue," says Franko.

2. A questionable pattern of providing therapy that affects the facility's case-mix rate. Facilities should also watch out for what could be construed as a blanket approach to putting residents on Part B rehab to affect their Medicaid case-mix payment, if the state has one.

"A pattern of having everyone going on therapy twice a year, for example, at case-mix time where [the corporate office] is saying to go find patients to put on therapy could be a red flag," cautions **Elisa Bovee, MS, OTR/L,** director of education for Harmony Healthcare International in Topsfield, Mass**.**

Example: New York has a RUG-based Medicaid payment system where the more therapy a person receives, the higher the CMI weight, reports **Michael Sciacca,** reimbursement analyst at Zimmet Healthcare Services Group in Morganville, N.J. And "New York has two picture dates that lend themselves more to ramping up therapy programs as you get close to the picture date in the calendar year." Sciacca says that he would imagine that if a facility is only doing biannual screening in tandem with the picture date -- and its documentation doesn't really support the need for rehab therapy -- "the facility's Medicaid case-mix claims and Part B billing will be highly vulnerable."

Be proactive: "Look at the strength of documentation not only from therapy but also nursing," advises Sciacca. He finds that therapy documentation by itself doesn't always justify why the person requires rehab therapy. "For example, it might not document the decline in function or loss of skills."

Other tips: "Statistically, you could probably look at the Part B revenues for therapy and identify a hot month versus a cold month where Part B doesn't impact casemix," says Sciacca. That's one way to identify whether you have an issue -- for example, "if you see $50,000 in Part B billing the last month of a picture window and $10,000 or $15,000 afterwards."

The facility should develop a clearly documented process of system for doing therapy screening and referral, advises **Glenda Mack, MSPT, CWS, CLT,** senior director of clinical operations for Peoplefirst Rehabilitation in Louisville, Ky.

For example, instead of doing quarterly reviews, Mack says her organization has encouraged facilities to screen all residents at admission and at least annually. Beyond that, the therapists screen residents based on referrals from nursing and the interdisciplinary team. Using this approach, "you screen in real-time to identify needs" as they emerge, Mack says. You may screen a resident a number of times in a quarter if he has clinical problems affecting his functional

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skills, she adds.

Very often, a resident referred for therapy has undergone functional changes that qualify for a significant change in status assessment, Mack observes. If so, "it is critically important that the interdisciplinary team is clearly documenting their assessments and identifying the clinical change and the need for therapy -- and the reason the SCSA was completed," she says.

"You do want to capture the therapy on the MDS, if possible, as the goal of the SCSA is to capture the resource utilization necessary to meet the residents new needs," which is "where the SCSA comes into play." You don't want to create extra work for the team, however. So "whenever possible, we encourage facility MDS coordinators to combine an SCSA with a quarterly, for example," says Mack.

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