# MDS Alert

## SNFs: Does Your Therapy Match Your Documentation? The OIG Is Watching

**Follow 3 golden rules to safeguard your therapy billing.**

The **HHS Office of Inspector General** (OIG) has released its Work Plan for fiscal year (FY) 2016, and skilled nursing facilities' (SNFs') therapy billing practices are directly in the watchdog's crosshairs. Could taking a closer look at your therapy documentation be your best strategy to prepare?

**What the OIG Has in Store for You**

In the first new initiative for FY 2016, the OIG plans to review SNFs' compliance with various aspects of the SNF prospective payment system (PPS), including documentation requirements for Medicare claims, according to a Nov. 11 analysis by associate attorneys **Benjamin Fee and Nicole Burgmeier** of the law firm **Dorsey & Whitney LLP**. But the real focus is on therapy billing, especially situations where SNFs billed Medicare at the highest level of therapy.

Another new initiative that the OIG is undertaking is reviewing State Agency (SA) verification of deficiency corrections. Specifically, the OIG wants to determine whether SAs verified correction plans for deficiencies identified during nursing home recertification surveys.

**Insight:** "This topic has been something that the OIG has been planning to review since the FY 2013 Work Plan, but it is listed as a new part of the Work Plan," explained the **CMS Compliance Group Inc.** The OIG should issue the report on SA verification of nursing home correction plans in FY 2017.

**Stakeholders Differ on Interpretation of the Numbers**

As volume-to-value transformative initiatives abound, some see the OIG's scrutiny of SNF therapy billing as counter-productive.

"Many around the country are energized and excited about new initiatives to improve quality and efficiency, return more patients safely to the community, and implement new and exciting treatments to medically complex patients in the SNF setting," noted Director of Business Development **Matt McGarvey** in a Dec. 1 **Harmony Healthcare International** blog posting.

"Yet, according to the FY 2016 OIG Work Plan, the OIG is ready to hammer down on the delivery of SNF therapy in the upcoming year," McGarvey lamented. Partly, this new OIG focus is due to Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) showing a significant increase in high-intensity therapy during the past three years  up nearly 9 percent.

And a recent OIG report reaffirmed its concerns regarding potentially excessive therapy billing by SNFs (see "Watch Out: Your Therapy Billing Is Way Too High, OIG Says," MDS Alert, Vol. 13, No. 10, page 113). The OIG has also found that Medicare therapy payments were significantly higher than the cost for therapy.

But McGarvey points to other key factors that contributed to this increase, such as SNFs taking on a more medically complex patient population than ever before and shorter acute care stays that demand more therapy for improved

outcomes.

**3 Keys to Prepare for Heightened Scrutiny**

**Protect yourself:** With the OIG ready to pounce on your therapy billing, your best preparation lies in the basics, according to McGarvey:

**1. Rule of thumb:** Your residents need therapy to improve, achieve functional goals, and achieve their highest state of well-being.

**2. Prove it:** Skilled nursing needs to anchor the patient's care and depict why he needs a nurse's skills, knowledge, and judgment on a daily basis regarding therapy services.

**3. Document thoroughly:** Make sure your therapy documentation is free of duplicative goals, and shows clear and measureable progress toward those functional goals.

**Keep an Eye on Therapy Caps, Too**

Also in 2016, you'll need to watch your therapy expenditures in terms of the therapy cap. The Medicare therapy cap for 2016 will be $1,960 — this is the cap for physical and speech-language pathology combined, with a separate $1,960 cap for occupational therapy, according to a Nov. 25 blog posting by **Nancy Beckley, MS, MBA, CHC,** president of **Nancy Beckley & Associates LLC**.

The 2016 cap is a $20 increase per cap over the 2015 amount of $1,940, and the **Centers for Medicare & Medicaid Services** (CMS) based the cap increase on a medical economic index. Despite the increased therapy cap, what won't change is the therapy "threshold" for manual medical reviews (MMRs), which is still $3,700.

You can, however, still enjoy the therapy cap exceptions process through Dec. 31, 2017, thanks to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Beckley said. Also, CMS changed the MMR process so that it no longer includes all claims over the $3,700 threshold, but instead targets reviews based on provider profiling and advanced data analytics — focusing on providers with patterns of aberrant billing practices, high claims denial percentages, new enrollment, and other criteria.

**Resource:** To read the OIG Work Plan for FY 2016, go to http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf .