

RehabPerspectives

Fall 2007



Surviving in a Changing Regulatory Environment

Say Hello to Your MAC!

CMS Wants to Hear Your Whole Story



President's Message

We in healthcare work in a tumultuous environment. Government regulations and the finely tuned directives from the Centers for Medicare & Medicaid Services (CMS), change constantly, are complicated, and can be intimidating. The information that your employees labored to learn last week is apt to be out of date this week.



Yet in the midst of it all, we can't lose sight of the interests of our patients. We must constantly advocate for them, working to provide the care they need. And because reimbursement for that care is dependent upon doing the paperwork correctly, Aegis is committed to educating providers on how to merge the latest government policies with the best patient care and the appropriate reimbursement.

We've devoted many of the past issues of Rehab Perspectives to patient care. For this issue, we decided to tackle some pretty important upcoming changes in the way Medicare will pay for therapy treatment. CMS is replacing Fiscal Intermediaries with Medical Administrative Contractors. That could make claim submissions for Medicare a whole new ballgame with a whole new team of players. Understandably, some facilities are nervous.

And as if that weren't enough, after 40 years of vague therapy documentation requirements from CMS, its recent Transmittals 60 and 63 have given us very detailed instructions with respect to therapy documentation. Document correctly and payment follows. Leave anything out and denials will rock your reimbursement boat.

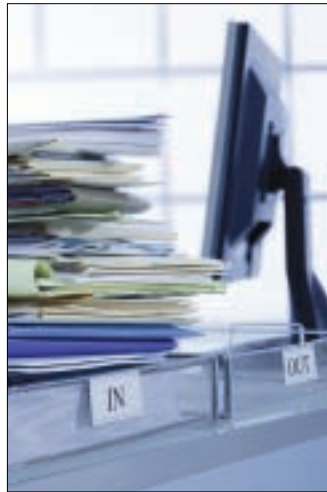
Aegis believes the only way for providers to survive — and indeed thrive — amid the chaos is to choose a partner who can tell you what's on the horizon and how it will affect you. Our Aegis professionals spend their time monitoring and “decoding” government regulations. Read what they have to say about the new MAC system and the documentation requirements.

We hope this issue of Rehab Perspective will put your mind at ease and show you that although the waters may look turbulent, your reimbursement boat will stay afloat.

As always, Aegis is your rehab resource.

Martha Schram
President
Aegis Therapies

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Say Hello to Your MAC!

Medicare contracting reform will benefit providers



It's not easy building relationships. Particularly when one party seeks reimbursement for services and the other is the gatekeeper of payment. So nursing home providers and their Fiscal Intermediaries (FIs) — those contractors who have controlled the purse strings for Medicare — have endeavored to forge workable connections in which the bills get paid. If somewhat uneasy, these relationships are at least familiar.

But as the song says, “There’s a new day coming.” The Centers for Medicare & Medicaid Services (CMS) is overhauling its claims-processing system. And a lot of nursing homes are as nervous as kids starting a new school year. Even if Mrs. McGilacuddy sent you to detention in the second grade, at least you knew what to expect from her.

The impetus for change was spawned by confusion in the current Fiscal Intermediary system, in which 48 FIs held Medicare contracts to process fee-for-service claims, 17 of whom processed Part B only. Each FI developed its own specific guidelines for payment, called Local Coverage Determinations (LCDs). “The LCDs often represent significantly different approaches to paying for the same Medicare covered service,” says Bill Goulding, national director for outcomes and reimbursement for Aegis Therapies. “A company with facilities in several geographic locations may have completely different reimbursement for the same services based on the LCD of the local FI.”

Conceivably, two facilities on the same street could provide identical services, yet only one might be reimbursed. One FI may cover 10 diagnostic codes for wound care, while the other may use descriptions of services rather than codes. Yet another may have nothing at all written on wound care. Such discrepancies have not been helpful for providers seeking reimbursement for services ren-

What the MACs Will Do

- Claims Processing
- Beneficiary and Provider Customer Service
- Appeals
- Provider Education
- Financial Management
- Provider Enrollment
- Reimbursement
- Payment Safeguards
- Information Systems Security

The coming system promises a simplified claims-processing interface. That means providers will spend less time on paperwork, and should see faster payments.



dered. You might call it a difficult business environment.

Even from a beneficiary standpoint, the system has been pretty dysfunctional.

“Why should a patient’s benefit be different because he or she lives in Georgia instead of North Dakota and has a different FI?” asks Mark Besch, vice president of clinical services for Aegis Therapies. “The patient didn’t sign up for the FI, she signed up for Medicare.”

All this diversity of opinion was confusing to CMS as well. “FIs were meant to administer the Medicare program, not make policy,” says Goulding. “I think the amount of interpretation, rather than administration, has produced some angst on the part of CMS, which found it impossible to monitor its own payments.”

The Big Fix

So in 2003, Congress gave CMS the six years between 2005 and 2011 to transition Medicare fee-for-service claims to competitively bid contracts that conform to the Federal Acquisition Regulation (FAR). Brand new entities called Medicare Administrative Contractors (MACs) will replace Fiscal Intermediaries in a gradual rollout. CMS plans to beat the deadline and award all MAC contracts by July 31, 2009.

CMS is counting on the fact that once the MACs are established, a much higher degree of uniformity and efficiency will follow. That should be good news for everyone — even the most nervous providers.

There are lots of reasons to be hopeful. For providers under its

jurisdiction, each MAC will be the primary point of contact for all Medicare reimbursement, including receiving, processing, and paying claims for both Part A and B. CMS asserts that the new system will “achieve operational economies, promote competition, balance the allocation of workloads, and account for integration of claims processing activities.” Each MAC will consolidate all the LCDs for its jurisdiction by selecting the least restrictive LCD from the existing LCDs on a particular topic.

“The system initially was meant to be this way — with a consolidated point of contact for providers — but the system became so large that it was out of control,” notes Goulding. “It was like a growing family that kept adding on to the home with no overall plan. Suddenly Medicare was saddled with an albatross of a structure. So now CMS is remodeling the house.”

Fifteen MACs will divide the country geographically for both Part A and Part B processing, replacing the plethora of FIs. An additional four MACs will process DME claims, and another four will process home health and hospice.

To balance the workload, CMS has carved the country into geographical areas, with a timed implementation of contract awards (see timetable on page 5).

In general, the transition time from the award of contract to the actual submission of claims is expected to take about a year, so providers will have some warning time. In addition, CMS offers chain organizations some options in terms of billing, allowing them to choose to file some claims with the MAC in their corporate jurisdiction and others in the jurisdiction where facilities are located. According to CMS, it will “provide manual guidance at a future date setting forth chain-organization policy on details such as the acceptable ratio of providers billing centrally versus those billing locally.”

Smooth Transition One Facility’s Experience

Planning ahead was the key to success when the Evangelical Lutheran Good Samaritan Society in Sioux Falls, SD, learned that its fiscal intermediary would be replaced with Noridian, the new medical administrative contractor (MAC) for South Dakota. “To make the transition as seamless as possible, we immediately set up an internal task force that included clinical people, the payment and billing staff, and the IT department,” says Joanne Powell, director of payment programs and services. “Individuals from various Noridian departments came to our campus and met with the various managers of our departments — education and benefit protection, medical review, provider enrollment, electronic imaging, and provider audit. The whole purpose was to streamline communication.”

Powell says both large and small changes in the following systems and departments were explored:

- Technology and new software needed to submit claims
- Security and new passwords for all facilities and users
- Education on the specifics of the new local coverage determinations (LCDs)
- Medical review edits
- Coverage and documentation requirements
- Appeals
- Provider enrollment
- Electronic data transfer
- Provider audit and flow of cost reports

The hardest part of the transition was overcoming the fear factor. “We were concerned,” admits Powell. “We had worked with the fiscal intermediary staff for a long time and so we worried what the new people would be like.” But, she notes, the transition couldn’t have gone any better. “It just goes to show that if you do a team approach and get everyone involved, it can work, whether you are a small nursing home or a large one.”

The Accountability Factor

Historically, Fiscal Intermediaries had to be chosen from health insurance companies and were not subject to performance incentives. The MAC contracts must be renewed every five years and will be performance based. “Providers have no input into the contract awards,” notes Goulding, “but they can contact their CMS regional offices on an ongoing basis with feedback on their MAC.” And CMS will be listening. The performance-based system will keep contractors on their toes in terms of fulfilling CMS’ requirements for provider education, timely claims processing, and customer service.

In addition to the MACs, existing entities called “functional contractors” will continue to play an essential role in managing and delivery services to beneficiaries and providers in order to increase efficiency. CMS lists the functional contractors as follows:

Coordination of Benefits (COB): Consolidates prepay Medicare secondary payer activities among all fee-for-service contractors, identifies the health benefits available to a Medicare beneficiary, and coordinates the payment process to prevent erroneous payments.

Qualified Independent Contractors (QICs): Conducts second level of appeals. This is a new level of appeal for Part A claim, and replaces the fair-hearing level of appeal for Part B claims.

Administrative Qualified Independent Contractors (AdQICs): Fosters consistency and accuracy across the QIC operation and is the central repository for all case files that have gone to the Office of Medicare Hearings and Appeals (OMHA) or the Medicare Appeals Council at the Departmental Appeals Board. Includes training and data analysis.

Program Safeguard Contractors (PSCs): Reviews provider activities, including medical, utilization, and fraud within each Mac’s jurisdiction, conducts cost report audits, makes Medicare secondary payer determinations, and provides education regarding program integrity.



Beneficiary Contact Centers (BCCs): A single point of contact call center where beneficiaries can receive answers to Medicare questions and resolve problems.

Quality Improvement Organization (QIO): Peer group to review and improve the care given to Medicare patients. Safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care.

Recovery Audit Contractor (RAC): A demonstration project to identify Medicare underpayments and overpayments and to recoup overpayments for both Part A and Part B services.

Enterprise Data Center (EDC): A consolidation of the large number of data centers now servicing FIs which will house claims processing software systems for Medicare claims. The foundation of the future CMS enterprise infrastructure.

Standard Front End (SFE): Supports a logical communications entry point for all in-coming and out-going Electronic Data Interchange (EDI) transactions.

Medicare Secondary Payer Recovery Contractor (MSPRC): Con-

solidates all group health plan and non-group health plan Medicare Secondary Payer (MSP) post-payment recovery activities.

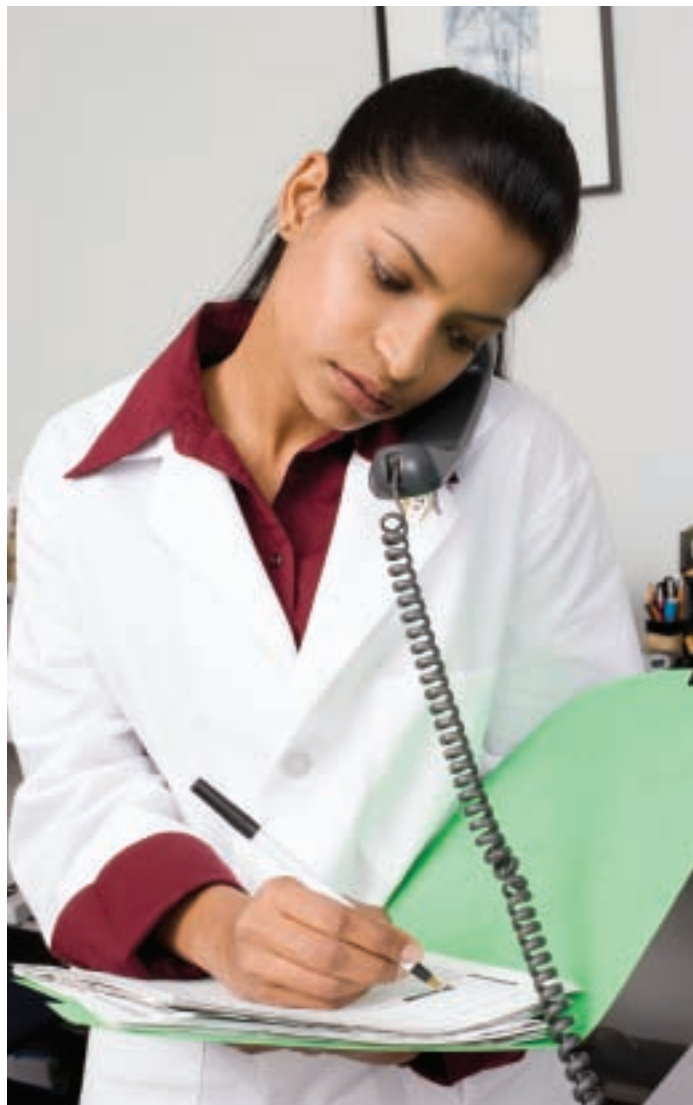
Benefits to Providers

“Generally providers should embrace this change to MACs,” says Aegis’ Besch. “Any kind of change is difficult, especially when relationships have been established. But in the long run, the thought that claims will be processed more consistently should be attractive to all providers.”

Here are a few ways providers will benefit from the MAC system:

1. Improved provider education and training. Competitive bidding will force MACs to demonstrate their capabilities for provider outreach and education. Increased CMS oversight should result in more consistency. Under the FI system, education varied widely, from sketchy websites to good, informative education. “The new larger entities have a greater ability to provide higher quality training via Webcast, web posting, and seminars,” says Besch. “That should be to the advantage of the provider.”

2. Increased contractor competition. “With the current system,



Medicare Administrative Contractors (MACs) will soon replace Fiscal Intermediaries. One benefit should be less time on the phone dealing with claims.

Medicare Administrative Contractors (MACs) Jurisdictions

Requests for Proposal from Contractors	Award of Contract Date	Jurisdiction Date
Sept. 19, 2005	July 31, 2006	3 (Awarded: Noridian)
Sept. & Dec. 2006	July & Sept. 2007	4,5,12 & 1,2,7,13
Sept. 2007	Sept. 2008	6,8,9,10,11,14,15

Source: CMS

there was a distinct lack of competition in certain geographical areas,” says Goulding. “Under competitive bidding, CMS can choose the contractor that provides the best value to the government.” Performance incentives will reward contractors for greater efficiency, innovation, and cost-effectiveness. As more organizations are attracted by the competition, CMS will better be able to manage contracts and contractors will be motivated to deliver better service.

3. Simplified interface for claims processing. Consolidating Medicare Parts A and B and standardizing administrative services at a single point of contact for beneficiaries and providers will improve access to information.

4. Increased accuracy and consistency of payment. Historically FIs haven’t been held accountable for the decisions they have made. Competition between companies seeking MAC contracts means the CMS can hold them to a higher standard.

5. Provider input. Satisfaction surveys will provide a formalized process for providers to give feedback on the performance of their MACs. This not only increases accountability, but allows providers to make their concerns known.

According to CMS, “The successful implementation of MAC contracts represents the first step in CMS’ initiatives designed to improve service to beneficiaries and providers, support the delivery of coordinated and quality care, and provide greater administrative efficiency and effectiveness for fee-for-service Medicare.” While any kind of change is stressful, this one should be welcomed by providers.

For more information about contract reform, go to <http://www.cms.hhs.gov/MedicareContractingReform>. The site is continually updated with new information. ■



CMS Wants to Hear Your Whole Story

Why therapy and why now?

The Centers for Medicare & Medicaid Services (CMS) is looking for some really good stories. The people who watch over Medicare payments don't want some vague plot outline — they're looking for real life stories with all the juicy details. You know — not just that Mrs. Smith needs therapy so she can ambulate 50 feet to the bathroom, but exactly why she's not able to get there. Is it because of weak hip flexors, balance problems, pain when weight-bearing, or limited range of motion? Does she have a neuromusculo-skeletal problem? Why is the therapist the only one who

can help her at this moment in time? And what special skills will the therapist employ to get Mrs. Smith on her feet?

The answers to those questions must appear in therapy documentation, and proper documentation may be the most important component of reimbursement for rehab. "Although the system is changing, the basis of payment is still documentation," says Jack MacDonald, senior vice president of Golden Horizons. "It is critical both in assuring the delivery of appropriate services and the accuracy of claims submitted for payment. While it has been important in the past, it is even more important as providers work through the exception process with Medicare's Transmittals 60 and 63. Proper documentation is the cornerstone of assuring compliance with that process."

Yet a lot of clinicians struggle with documenting the treatments they provide.

"How to fill out a Medicare claim form is not a part of a clinician's education," says Bill Goulding, regional director of clinical services for Aegis Therapies. "Unless you have a company that is savvy in this area and provides an appropriate training program for educating therapists on how to get the right information on the form, you can open yourself up to non-defensible claims. Clinicians work very hard helping patients to reach their potential, but that hard work must be reflected on paper."

Therapy documentation requirements for Medicare reimbursement have been somewhat hazy for the last 40 years, allowing Fiscal Intermediaries to exercise great latitude in their Local Coverage

Highlights of New Requirements from Transmittals 60 and 63

The therapist must personally furnish in its entirety at least one billable service on at least one day of treatment at least once every 10 treatment days.

Progress Reports must be completed at least once every 10 treatment days.

Only the therapist can write the Progress Report. Reports written by assistants are not complete Progress Reports.

Evaluation and treatment may occur and are both billable either on the same day or at subsequent visits.

Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same therapist who establishes the plan.



Operators will need to implement new training processes so therapists know how to address both medical necessity and the need for skilled services on claim forms.



How to Turn Around a Targeted Medical Review

A facility in North Carolina went on targeted medical review in November 2006. After receiving 14 denials out of 20 charts pulled for the month of July, it was time to rethink documentation. "We did some really intense documentation training," says Dena Brown, district manager for Aegis Therapies. "The second month we had two denials out of 20 and those were because of nursing errors in transcribing orders. The building came off of review in six months, which is pretty unheard of. Review usually lasts a year."

Key areas targeted for improvement:

- Documentation by nursing and other departments that included three instances of patient need for therapy as specifically requested by the fiscal intermediary.
- Identification of ICD-9 codes that the intermediary felt helped to reflect proper medical necessity.
- Addition of details, such as underlying impairments, that establish the "why" behind the skilled need for treatment.

Adding specific clinical components to reports made the difference in reducing the denial rate, according to Brown. No detail went unreported. "We included a lot more testing that showed a base line and then we could show progress," she says. "You don't just document ambulation with an assist level; you provide the actual ambulation, breaking down the gait pattern, breaking down the weight-shifting pattern, breaking down the coordination of upper body ADLs."

All important was the reason for treatment. Why are the skills of a therapist needed for this patient? "It's not just a contracture," says Brown, "its how the contracture will impede the patient from getting dressed." In addition, patient and staff education was included in every note and on the plan of care. "The bottom line was to imagine that we were the intermediary and ask ourselves if we would pay this claim. That really challenges you to look very closely at what is on the page."



Facilities will need to create standard documentation forms that ask appropriate questions. Clinicians will record information that the government is looking for.

Determinations (LCDs). But all that changed with CMS' Transmittals 60 and 63, issued last year and effective in January 2007. The guidelines clarify general documentation requirements and coverage under the Therapy Cap Exception Process (implemented in March 2006) and spell out specific expectations for therapy documentation.

"This national policy will give providers clear guidance as to what documentation is required in order to receive Medicare payment," says Kim Brandt, director of the Medicare Program Integrity Group for CMS. "It will provide Medicare contractors with a standardized framework against which to medically review records supporting Medicare claims."

CMS wants all the details. The basic question is: Why therapy and why now?

"You have to make sure you document the medical necessity and the need for skilled services," says Goulding. "At Aegis we call this the two-headed monster. You must justify the medical reason for the therapist to be involved and demonstrate that the skill the therapist brings is valid and practical. That means including the right details."

Processes for Good Documentation

Medicare has an outline for good documentation, notes Goulding, "so shame on us if we don't have a check and balance process in place to meet the requirements." Here are her suggestions for ensuring that documentation tells the whole story:

1. Implement training processes to educate therapists on how to address medical necessity and the need for skilled service on the

claim forms.

2. Create standard forms for documentation that ask the right questions so the clinician is prompted to record the specifics of coding, language, and the goals that Medicare is looking for.

3. Apply quality measurements that allow someone to audit claim forms for the inclusion of complete information about services rendered and which serve to finely tune training to ensure therapists create exceptional documentation.

From Small Steps to the Big Picture

Because Medicare wants to see a functional outcome, therapists habitually write goals such as "patient will increase the ability to ambulate 50 feet to go to the bathroom." What's missing is an indication of the skill that it takes to get the patient to that goal. "It's a good long range goal, but shorter term goals need to be noted as well," says Goulding. "We call short-term goals 'The Ruler' because when you write good short-term goals you really create a ruler that the payer can use to judge the impact your treatment has made. The short-term goals move you forward inch by inch in incremental steps toward the long-range plan. But instead of measuring changes by deficit areas (for example, walking a certain distance), we use it to measure the underlying impairments, such as strength, balance, and range of motion. To become a more skilled documenter, you need to write goals in a more incremental process. Then you have the framework for the care." ■



Aegis Therapies and You Together We Can

At Aegis Therapies, collaboration is at the heart of our work, and our nationwide network of therapists, master clinicians, clinical specialists and others benefit from the rewards of sharing their insights with the facility, the patient and each other.



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Who We Are

With decades of experience providing physical, occupational and speech therapies, Aegis is considered the nation's premier provider of rehabilitative therapy with operations in 37 states and the District of Columbia. More than 6,000 therapists and clinicians provide care and services every day to some 16,000 patients in more than 1,000 nursing homes and other healthcare companies.

The Benefits of Our Partnerships

Our dedication to creating the solutions to each patient's rehabilitation needs has led to some of the most effective therapy tools and programs in the industry:

- *Freedom Through Functionality*—a machine-based strength-training program established in partnership with Nautilus®
- *Geriatric Enhanced Modalities*—a therapy program designed to treat joint pain, swelling and circulatory problems in patients
- *Rehabilitation Outcome Measure*—clinical outcomes measurement providing substantial aggregate data for reports on patients and trends

In addition, Aegis Therapies leads the way in replacing manual processes with more efficient technologies such as interactive training programs and web-based documentation tools that provide therapists with more hands-on treatment time. Our computer billing interface systems speeds billing processes and reduces labor costs by eliminating the need to enter therapy charges into billing systems.

Applying our programs and technologies to your rehabilitation services is a great way to raise your therapeutic effectiveness. We've been there, we've proven it—now let us share our experience with you.