

Concerning Compliance Issues

Inpatient facilities must stay abreast of regulatory issues like Medicare conditions of participation, and billing, licensure, certification, and supervision concerns.

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What do most rehabilitation facilities have in common? Compliance issues. To minimize the potential for compliance problems, it is important for all staff members to thoroughly understand laws and regulations regarding the provision of therapy services in general, as well as those relating specifically to their workplace.

MEDICARE CONDITIONS OF PARTICIPATION

Medicare Conditions of Participation (CoP) defines many of the duties that rehabilitation hospitals and units must meet in order to participate in the Medicare program. One important requirement is that patients must be screened prior to admission to determine whether they are likely to benefit significantly from an intensive inpatient program or assessment. This particular CoP is further defined in the Medicare Hospital Manual, §211 Inpatient Hospital Stays for Rehabilitation Care, which states: "A hospital level of care is required by a patient needing rehabilitation services if that patient needs a relative intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his or her ability to function.

The manual further describes what is commonly known as the 3-hour rule. This rule sets a threshold for those patients needing inpatient rehabilitation care, where patients who need 3 hours of rehabilitative care in a 24-hour period require an inpatient level of treatment. In some instances, patients who require inpatient hospital rehabilitation services may need, on a priority basis, other skilled rehabilitation modalities such as speech-language pathology services or prosthetic-orthotic services, and their stage of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate. In such cases, the 3-hour per day requirement can be met by a combination of these therapeutic services instead of or in addition to physical therapy and/or occupational therapy.

BILLING AND DOCUMENTATION CONCERNS

A majority of the compliance problems in rehab involve therapy billing, and most of those problems stem from documentation. Upcoding is a common violation in the therapy setting. Upcoding involves charging Medicare for services other than the actual services performed because they have a higher reimbursement level than the actual services rendered. The most common type of upcoding occurs when a therapist bills a modality as an individual treatment. Individual therapy treatments are labor intensive and require constant supervision. Modalities are reimbursed at lower levels since their use permits therapists to see more than one patient at the same time. For example, a patient is charged for a half hour session of physical therapy when actually only hot packs were applied. The law requires that modalities be billed using the appropriate HCFA Common Procedure Coding System codes.

Another common compliance violation involves duplicate billing, which occurs most often in the therapy setting when treatment is provided at the same time by more than one individual in the same therapy session. In the instance where a patient who receives simultaneous therapy for a half hour from both the therapist and the therapy assistant, the documentation and billing can only reflect 30 minutes of therapy as opposed to 30 minutes with the therapist and 30 minutes with the assistant.

Billing for services not medically necessary is a particularly common compliance violation. Even needed therapy services, rendered in a setting that is other wise reasonable, may not be necessary if the patient's condition is such that the same services could be performed at a lower, less expensive level of care.

All therapists furnishing services should periodically review all charting by all material by all medical and therapy providers. Limiting review to the entries made by therapists in the same field is not sufficient. Each individual involved with documentation has a professional responsibility to ensure that each record contains sufficient information and documentation of medical necessity, all other required appropriate documentation is completed (including signatures, dates, and times) and the record is sufficient to permit billing for services actually performed.

LICENSURE, CERTIFICATION, AND SUPERVISION

Other areas where many rehabilitation facilities see compliance problems arise include licensure, certification, and supervision of therapists. Therapy services are eligible for Medicare reimbursement and other federally funded health care programs only when licensed or certified staff provides them. The services must also be within the scope of the licensed therapist's practice, ie, therapists whose licenses from their state. Continuing to bill Medicare and other federally funded programs for services rendered when the provider is without a valid license is illegal.

Some Medicare-reimbursable therapy services may be provided by licensed personnel. For example, a non-licensed staff member such as rehabilitation aides can generally provide services if their provision is in direct, line-of-sight supervision of a licensed or otherwise qualified therapist and within the scope of the state's practice act. However, direct supervision must be provided. The licensed therapist's mere presence in the building is not sufficient.

The use of non-licensed staff has unique ramifications in the inpatient setting. Those unlicensed staff members cannot provide the therapies that qualify for the 3-hour rule, unless they receive direct line-of-sight supervision by licensed therapists.

There are additional compliance concerns regarding rehabilitation units and hospitals. These facilities must take special care not to bill for non-billable items such as assisting patients with toileting, meal service, bed transfers, documentation time, time spent responding to patient call lights, telephone calls, and treatment provided by assistants. In addition, 75% of patients admitted to Medicare-certified rehabilitation units and hospitals must fall within 10 diagnostic categories.

The use of group therapy has gone under the HCFA microscope as well. Group therapy can be an effective alternative to individual therapy when properly conducted and supervised. Historically, therapists have relied on group therapy as a means of increasing productivity levels and dealing with staffing shortages. However, in response to perceived billing abuses, HCFA has adopted strict rules governing billing for group therapy in various settings for rehabilitative care.

To remain compliant, providers must conduct group therapy for a small group of patients. Through HCFA does not specifically indicate how many patients constitute a small group, the *Federal Register* has specified that four patients or less led by at least one licensed therapist constitute a small group. HCFA also mandates that group therapy must be individually oriented and goal-directed. In addition, the group therapy must also be on the patient's specific plan of care.

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