Eli's Rehab Report

Inpatient Insights: Hospital Rehabs--Turn Your Eye to Outpatient Therapy Policies

According to CMS, your expectations aren't far from Part B settings'

If you are happily settled in your world of Medicare Part A policies, you may want to cross the fence to see what your colleagues in Part B settings are doing.

Why: CMS announced in Transmittal 65 on Jan. 26 that hospital inpatient rehab settings, hospital acute care settings, critical access hospitals, long-term care hospitals and psychiatric hospitals under Part A are subject to the same documentation and provider requirements as Part B settings.

Find out Where You're off the Hook

First, these new inpatient rules are not asking you to conform your billing practices to that of Part B settings. That means you will not have to face the therapy caps your outpatient colleagues are wrestling.

You'll continue to bill using diagnostic related groups (DRGs) if you're in an acute care hospital setting, or by the inpatient rehabilitation facility (IRF) prospective payment system (PPS) if you're in an IRF setting.

SNFs and HHAs: You can count yourself out if you're a skilled nursing facility or home health agency.

"This transmittal specifically addresses hospital inpatient therapy services -- it makes no mention of other Medicare Part A settings that have rehab services, such as SNFs and HHAs," says **Angie Phillips, PT,** president and CEO of Images & Associates, an Amarillo, Texas-based physical therapy consulting firm. That means you're only affected if you're an acute hospital, critical access hospital, IRF, long-term care hospital or psychiatric hospital, she says.

Exceptions: Although CMS directs you to Part B policies, it notes certain exceptions that won't apply to hospital Part A. For example, inpatient hospital therapy services will follow their own certification and recertification requirements appropriate to the applicable PPS.

Review the Meaning of 'Therapy Services'

One of the biggest challenges in conforming to Part B policies will be rethinking what CMS does and doesn't consider skilled therapy. For example, a hospital staff member assisting a patient with independent activities between treatment sessions may be valuable to the patient's progress but is not a therapy service, according to the transmittal. In other words, unless the service requires a therapist's skills, CMS does not consider it a therapy service.

Don't miss: And you can't talk about skilled therapy services without considering qualified personnel and supervision policies as well. "Services provided by a technician or aide, regardless of the level of supervision, are not considered therapy services," Phillips says.

Important: In addition, IRFs must provide three hours of therapy per day, a minimum of five days a week -- which is a tight squeeze for many postacute patients. "Those organizations that have utilized non-licensed extenders under direct-line-of-site supervision will need to revise their treatment models," Phillips says, because only a therapist's or assistant's

work can count toward the three hours of therapy.

Eliminate Concurrent Therapy

Another challenge is CMS' elimination of "concurrent therapy" and the standardization of group therapy use, Phillips says. Definition: Concurrent therapy is when a therapist or therapist assistant works with two or more patients at the same time, but the patients are performing different tasks. The entire time the therapist or therapist assistant works with these patients counts as one-on-one time for the purpose of documenting minutes for billing.

Twist: Concurrent therapy really only exists in an SNF Part A setting, as far as CMS references, but many IRFs have practiced it anyway because CMS never said not to, says **Rick Gawenda, PT,** director of physical medicine and rehabilitation for Detroit Receiving Hospital. "But now, CMS is clearly stating IRFs cannot practice concurrent therapy."

How it works: If the therapist or therapist assistant works with two or more patients at the same time but provides intermittent one-on-one time with each patient, then the therapist or therapist assistant may not count the time the patient was working without direct therapist or therapist assistant intervention. "You could count only the minutes the therapist or therapist assistant was actually with each patient toward the three-hour rule," Gawenda says.

Important: "You can't consider that time as group therapy either, because it is impossible for one therapist or therapist assistant to bill one-on-one time to one patient and group time to another patient during the same time period," Gawenda says. If, however, a therapist or therapist assistant is working with the patients at the same time and is in constant attendance of all patients, he could count each patient's time toward the three-hour requirement as group time.

Rethink Student Supervision

Although a therapist cannot supervise a tech or an aide and count that as therapy, the therapist can supervise a therapy student and count it as therapy -- but CMS is spelling out strict rules as to how.

Watch for: Don't get confused with certain Part B student supervision requirements that say the therapist must be present in the room directing and participating in the treatment, making skilled judgment, and being responsible for the assessment and treatment. "This is one of the examples of not taking all Part B policies and applying them to Part A," Gawenda says. For now, "in the inpatient hospital setting, the term 'direct supervision' for therapy services provided by students means the therapist is present on the same unit or on the same floor while the patient is treated and is immediately available according to the circumstances appropriate to the service rendered," Transmittal 65 says.

Beware: "Most confusion regarding therapy policies on supervision lies in the state practice acts," says **Denese Estep, OTR,** senior consultant for Fowler Healthcare Affiliates Inc. in Atlanta. "Many state practice acts do not require supervision on-site for students, aides, techs or licensed assistants," she says. But you need to follow the strictest requirements, and for some states, that could be these new Medicare requirements.

Re-Examine Documentation Practices

Another major Part B area you'll want to mimic is documentation policies. For example:

• You must write **progress reports** once every 10 treatment days (visits) or 30 calendar days, whichever occurs first. This provides justification of medical necessity and proof that the therapist was an active participant in the therapy.

Key: A PT, OT or SLP must write the progress reports, which should include an assessment of improvement, plans for continuing treatment, and any goal changes.

• You must write **treatment notes** (daily notes) for each day of treatment by each discipline. These notes should include the treatment date, identification of each intervention or modality the clinician provided, and his signature. Key: You must record the total treatment time. That includes both timed and untimed procedures.

Helpful: If your treatment notes already contain each required progress report element at least once during the progress report period, you don't need to write a separate progress report. For more detailed requirements, see CMS Pub 10-02, Chapter 15, Section 230.

For other Part B documentation requirements listed in this Pub, remember there will be exceptions for hospital inpatient therapy services. For example, these settings do not require a renewed therapy plan of care for each 30-day period. "Plan modifications and re-evaluations shall be provided as indicated by the patient's progress rather than by calendar date, unless the applicable PPS specifically incorporates the Part B policies in this area," CMS says.

Note: To read Transmittal 65, visit www.cms.hhs.gov/transmittals/downloads/R65BP.pdf. To read Part B documentation policies in Transmittal 63, visit www.cms.hhs.gov/transmittals/downloads/R63BP.pdf.