Every Minute Counts

By

Cherilyn G. Murer, J.D., C.R.A.

In this era of compliance consciousness, outpatient rehabilitation providers have certainly become much more aware of the importance of documentation, not only as a means of ensuring accurate reimbursement for services rendered, but for establishing a thorough "paper trail" in the event of an investigation by state or federal authorities. Nevertheless, one vital aspect of documentation continues to bedevil outpatient providers in the outpatient facility, office and skilled nursing facility environments: Properly documenting the time spent actually treating the patient.

In the setting of the therapist's or physician's office or in an outpatient facility such as a hospital outpatient department or CORF, CMS, its fiscal intermediaries, and carriers have identified two basic time documentation errors that therapists commonly make: 1) Recording and billing the total session time spent with each patient, and not the actual time spent on each treatment modality, and 2) incorrectly calculating the number of units provided for timed modalities of treatment.

As to the first error, CMS has stated that the total time spent with the patient does *not* equate to total treatment time. Instead of simply recording the total time spent on a patient session, Medicare requires documenting the exact treatment times for each treatment modality provided. According to CMS:

> When documenting outpatient OT, PT, and SLP services, providers must document the exact number of minutes that were spent providing ***each***, separate modality each treatment. Providers must also include start and stop times for the therapy sessions. The person providing the therapy should sign or initial the documentation related to the length of time they provided each modality.
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> The total amount of therapy billed cannot exceed the total time documented.
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> For example: Patient received 24 minutes of 97112 and 23 minutes of 97110. The total amount of therapy time was 47 minutes. You would bill two units of 97112 and one unit of 97110, assigning more units to the service/modality that took more time.

*Claims may be denied for insufficient documentation if **minutes per modality** are not documented by the therapist providing the service.*

Note that CMS requires **both** the beginning and ending time of the session and the start-stop times or total times of each modality to be recorded. It should be stressed in this regard that CMS does not permit treatment preparation time to be counted as time spent in treatment:

> Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post- delivery services are not to be counted in determining the treatment service time. In other words, the time counted as intraservice care begins when the therapist or physician or an assistant under the supervision of a physician or therapist is delivering treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.
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> The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can only count as one unit of 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.[1]

Another important aspect of this requirement, is that it does not permit rounding. Both treatment times and session times should be recorded to the exact minute. Impermissibly "rounding up" the actual treatment minutes may lead an auditor to view with skepticism a therapist's time log that records three fifteen-minute units of treatment when the session time is recorded as beginning at exactly 10:00 and ending at exactly 10:45.

No less critical to compliance than recording the exact amount of treatment minutes, is correctly computing the number of timed units of treatment provided in a given session. Most physical, occupational, and speech therapy procedure codes require documentation in the form of 15-minute units. Simple miscalculation of units can lead to either an inquiry or adjustment from the fiscal intermediary or less reimbursement than has been legitimately earned. A pattern of incorrect unit computation can lead to a fraud and abuse investigation from enforcement authorities.

[1] CMS Program Memorandum AB-01-68 (May 1, 2001).

CMS permits a rehabilitation provider to bill a 15-minute unit of treatment for each treatment increment of 8 to 15 minutes. No units may be billed to Medicare for any treatment modality that takes less than 8 minutes. Therefore, if the start and stop time for a modality shows 23 minutes of treatment, two units may be billed for that modality. CMS has provided the following schedule for the calculation of treatment units:

> If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:
> 3 units > 38 minutes to < 53 minutes
> 4 units > 53 minutes to < 68 minutes
> 5 units > 68 minutes to < 83 minutes
> 6 units > 83 minutes to < 98 minutes
> 7 units > 98 minutes to < 113 minutes
> 8 units > 113 minutes to < 128 minutes

When outpatient rehabilitation providers treat patients of a skilled nursing facility ("SNF"), their initial expectation may be that exact recording of treatment times, in the manner of outpatient facility or office patients is not so important. After all, the manner is which Medicare reimburses skilled nursing facilities does not directly rely on the minutes of treatment provided. However, an analysis of the system underlying SNF reimbursement reveals that precise, to-the-minute documentation for SNF patients is also crucial to compliance.

Under the SNF Prospective Payment System ("PPS"), a SNF uses a resident assessment instrument known as the "Minimum Data Set" ("MDS") to periodically report a patient's condition, the "resources" (services commonly provided SNF patients) actually expended in the patient's care, and projected resource consumption. CMS classifies these resources into 44 categories, known as Resource Utilization Groups ("RUGS"). The per diem reimbursement rate increases with the resources expended on the patient during a given assessment period. RUG categories incorporating intensive use of rehabilitation services command the highest daily rates. Therefore, a bill whose charges reflect too many or too few therapy units than were actually expended results in an erroneous MDS and, hence, a patient assigned to an improper RUG. Patients assigned too high a RUG score are receiving too high a reimbursement amount, while patients assigned to low a RUG score are receiving too little reimbursement. In either case, a pattern of incorrectly assigned RUG scores is a potentially serious compliance problem.

In order to assure that the provision of therapy services to SNF patients does not result in improperly assigned RUG scores, CMS has issued the following guidance for therapy services rendered to SNF patients:

- Therapists should record only actual minutes of therapy provided—not rounded to the nearest 10 or 15 minute minutes;
- Therapists should not record documentation time as therapy;
- Initial evaluation time should not be billed as treatment time;
- Group therapy is billed only when conducted with four or fewer patients and only if it does not exceed 25 percent of a patient's overall minutes of that therapy discipline;
- A physician signs the order for therapy and the plan of treatment;
- A physician signs any modification to the treatment plan;
- All documented therapies are appropriately supervised;
- RUG classification of minutes is not manipulated to maximize reimbursement;
- Residents in non-rehabilitation RUG classifications receive therapy services appropriate to their needs; and
- Therapists reasonably record on the MDS estimates of the therapy minutes expected to be expended.

For documenting therapy treatment time for SNF patients, CMS offers the following specifics:

- Therapists must record the exact number of minutes of each rehabilitation therapy (i.e., PT, OT, and/or SLP) furnished to the patient each day;
- Only the time therapist spends actually delivering therapy, not the total time the therapist spent with the patient may be recorded;
- Therapy starts only when the treatment activity or task begins (but does include set up time) and ends when the treatment activity ceases;
- Only time in which the patient is under a therapist's or a therapy assistant's direct supervision may be recorded;
- Time spent on documentation may not be recorded;
- In recording the duration of therapy, practitioners may *not* round therapy time upward;
- Billing in minimum incremental units (e.g., 10 or 15 minutes) is forbidden
- Therapists may *not* bill time spent on the patient's initial evaluation or on the development of treatment goals or plans of care that may be required from time to time during the patient's stay;
- Time expended on subsequent evaluations during the same course of treatment is billable provided they are actual, hands-on examinations and not simply updates to documentation or revision of care plans; and
- The RUG classification should not be used to place an upper limit on the therapy time offered to the patient.

In short, the documentation for a SNF patient, should include only the time that the patient actually receiving treatment.

In sum, no compliance plan is complete without including all aspects of documentation. And no aspect of documentation is more basic—or more important—for outpatient rehabilitation providers than the accurate measurement and recording of treatment time.

About the Author:

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Group, a legal based health care management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on web site: http//www.murer.com