RehabCare
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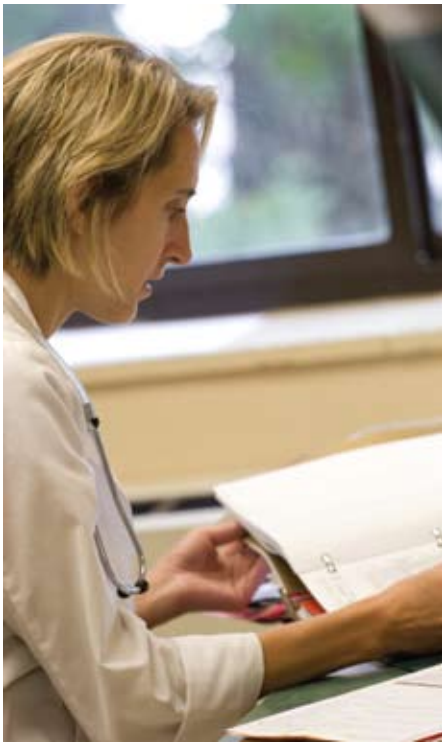
Keeping Watch For the Latest Industry News



American Taxpayer Relief Act of 2012

by Susan Feeney, Senior Director of Communications and Policy

As we reported in the previous edition of The Monitor, Congress had much to accomplish after the elections and before the end of 2012 to avoid the so-called "fiscal cliff". By the end of January 1, 2013, the Senate and House of Representatives finally agreed to legislation, the American Taxpayer Relief Act of 2012 (H.R. 8), which in addition to addressing taxes, included several changes that specifically impact rehab services.

The new law, signed by the President on January 2, included significant changes for Medicare providers. The provisions that directly impact rehab are:

One year "doc fix": Congress was able to once again, delay implementation of the "sustainable growth rate" for the physician fee schedule, which averted a 27 percent cut in reimbursements for physicians and therapists alike. With a high price tag of about $30 billion for just a one-year delay of the sustainable growth rate, Congress looked to other providers to foot the bill with the largest cuts impacting hospitals and dialysis providers.

Extension of Therapy Cap Exceptions Process and MMR: As a result of significant advocacy efforts by our therapists and our government relations team, the law extends the Part B Medicare therapy cap exceptions process through the end of 2013 for all outpatient locations – to now also include Critical Access Hospitals. The cap for 2013 is $1,900 for occupational therapy and a combined cap of $1,900 for physical therapy and speech language pathology. The KX modifier will continue to be used to indicate the medical necessity for therapy above and beyond the cap.

Last year's Middle Class Tax Relief and Job Creation Act, established the $3,700 annual Medical Manual Review (MMR) process for therapy and tied it to the extension of the exceptions process. The new law extends the annual MMR trigger at the same $3,700 threshold for occupational therapy and at $3,700 for physical therapy and speech language pathology combined.

Increase in MPPR for Outpatient Therapy: Starting in 2011, a payment reduction for therapy services provided to the same patient on the same day – known as the Multiple Procedure Payment Reduction (MPPR) – was applied. At that time the reduction was 20 percent for therapy provided in physician offices and 25 percent for all other outpatient settings. The new law increases the MPPR reduction of

the Practice Expense component to 50 percent for all outpatient therapy regardless of setting.

Delay in Sequestration: Of significant impact to all Medicare providers, the American Taxpayer Relief Act of 2012 delays the automatic 2 percent cut – known as "the sequester cut" – for several months until April 1, 2013. Because this is only a temporary delay, Congress will need to address alternatives to the cut to all Medicare providers over the next several months.

It is significant to note that neither the Senate nor the House included any provisions to increase the Inpatient Rehabilitation Facility (IRF) 60 percent rule to 75 percent, despite several proposals to do so had been circulated by outside groups during the extensive negotiations process.

The RehabCare government relations team will use the opportunity to continue to advocate to protect critical Medicare funding, preserve the 60 percent rule, and promote common sense measures that preserve appropriate access to rehabilitative care across the continuum.

Therapy Coding Changes for 2013

The Middle Class Tax Relief and Job Creation Act, signed into law in February 2012, mandated that the Centers for Medicare and Medicaid Services begin collecting "functional status information" as part of the claims submission process. There is an initial voluntary six-month testing period until July 1, 2013 when it will become mandatory and billing submitted lacking "information on beneficiary function and condition, therapy services furnished, and outcomes achieved" will be rejected. The reporting of the "G code" will apply to all therapy modalities.

RehabCare will be communicating more detail on the regulation as well as provide extensive training and support to our therapists throughout the voluntary reporting period to ensure that we are fully prepared for the July 1 deadline.

Office of Inspector General Report – Inappropriate SNF Medicare Payments

In November, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released a report entitled: Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More than A Billion Dollars in 2009 (OEI-02-09-00200). The report asserted that skilled nursing facilities (SNF) billed one in four claims in error in 2009, which the OIG calculated to be $1.5 billion in inappropriate Medicare payments. For perspective, Medicare paid $32.2 billion for SNF services in fiscal year 2012.

The OIG conducted the report by selecting a stratified random sample – 245 stays and 499 claims from those stays – of Part A SNF Claims with a service date in 2009. The reviewers were three registered nurses – each with at least 12 years of experience in a SNF – who compared the claim to the medical record. When needed the reviewers were provided assistance by one physical therapist, one occupational

therapist, and one speech-language pathologist.

Ultimately, the review found that of the 25% of claims that they found to be in error, the majority (20%) were upcoded; many of these claims were for ultrahigh therapy. They also determined that 2.5% were downcoded and 2.1% did not meet Medicare coverage requirements. The report also indicates that the SNFs commonly misreported therapy.

While the OIG report highlights the growing focus on fraud and inappropriate billing practices in SNF settings, there are several items to note regarding the findings. First, there was no opportunity for those centers for whom the claims applied – and that provided the medical record – to appeal the determination of the review panel. In fact, those providers received no feedback from the OIG as to the claims from their facility. Therefore, there is a strong possibility that the "inappropriate claims" were in fact, largely, human error. This highlights the need for accuracy in all patient documentation.

Secondly, and as the report admits, since 2009 CMS has made several changes to SNF payment systems – including moving to RUGs 53, then RUGs IV, MDS 3.0, the RAI, and changes to group and concurrent therapy practices. Though recognizing these changes, the OIG recommended to CMS: (1) increase and expand reviews of SNF claims, (2) use its Fraud Prevention System to identify SNFs that are billing for higher paying RUGs, (3) monitor compliance with new therapy assessments, (4) change the current method for determining how much therapy is needed to ensure appropriate payments, (5) improve the accuracy of MDS items, and (6) follow up on the SNFs that billed in error. CMS concurred with all six recommendations.

We anticipate that the OIG and other federal entities will continue increased scrutiny into the use of ultra-high RUGs in SNFs and the provision of therapy services and at RehabCare we will continue to monitor for elevated oversight activities.

Proposed Settlement – Jimmo vs. Sebelius

Last fall, the Court issued a proposed settlement in the Jimmo v. Sebelius case that alleged that CMS violated its legal obligations by applying an "Improvement Standard" for the provision of Medicare covered therapy services.

According to the proposed settlement, CMS will – among other actions – "revise relevant portions of the Medicare Benefit Policy Manual, after considering input from Plaintiffs' Counsel, to clarify the coverage standards for the SNF, HH, and OPT benefits when a patient has no restoration or improvement potential but when that patient needs skilled SNF, HH, or OPT services to maintain his or her condition or prevent or slow further deterioration."

RehabCare supports the proposed settlement in that it will provide access to medically necessary therapy services for at risk patients, particularly those patients who suffer from chronic conditions such, Multiple Sclerosis, Parkinson's Disease, spinal cord injury,

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respiratory disease and contractures. At this time, however, the total implications for the change in policy are unclear.

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Focus on Medicare Fraud, Waste & Abuse

Upon returning to Washington, DC, after the November elections, the U.S. House Energy & Commerce Committee – which has jurisdiction over Medicare Part B services – indicated their ongoing efforts to target Medicare fraud, waste and abuse. At the initial hearing chaired by Congressman Joe Pitts (R-PA), and attended by representatives of Kindred's Government Relations team, the health subcommittee sought new innovations to better track and eliminate costly abuses of the system. While the hearing did not explicitly target therapy services, the committee made its intent clear in pushing the OIG for more information and reporting on fraud, waste and abuse activities for providers throughout the Medicare program.

We anticipate that the committee will hold follow-up hearings that may target specific provider types in the coming future, and our Government Relations team will continue to represent our RehabCare therapists and clinicians in Washington, DC, and provide timely updates.

RehabCare

About RehabCare

RehabCare is the leading provider of rehabilitation services, including physical, occupational and speech-language therapies, to over 2,000 hospitals and long-term care facilities in 46 states. We are the premier provider of rehab throughout the full continuum of care, including long-term acute care hospitals, nursing and rehabilitation centers, inpatient acute rehab units, independent rehabilitation facilities and hospice and home care locations.

Because RehabCare therapists treat patients throughout acute and post-acute settings, they are able to facilitate effective care coordination, management of patient episodes, as well as understand and comply with myriad regulations targeting rehabilitative care and services. Our vast network enables you to access best practices and geographic market knowledge that will take your care center to the next level.

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