Functional Outcome: Reimbursement Issues

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I was asked to participate in this section because of my long-term involvement as Minnesota's speech-language pathology consultant to Medicare. Reviewing Medicare claims since 1981, I sometimes feel as if I have joined the *enemy,* but having found myself behind enemy lines, I struggle with others to neutralize the *battle grounds.* Actually, I feel that I have played a part in an important effort to increase the productive communication between service providers (in hospitals, rehabilitation centers, and nursing homes) and administrators within the Medicare system.

It is fitting to focus on Medicare as we discuss functional outcome from the perspective of reimbursement. A close look at trends in Medicare coverage policies regarding speech-language pathology services provides insight into which policies other third-party payers are likely to enact.

I will briefly summarize the current practices that govern coverage or noncoverage of claims for speech-language pathology services received by Medicare patients. I will also summarize what my peers and I see as two pressures that are changing the process of determining Medicare reimbursement.

CURRENT PRACTICES IN MEDICARE REIMBURSEMENT

Medicare guidelines governing coverage of speech-language pathology services are written in very general terms. The first requirement is that all services be directly and specifically related to a written treatment plan that has been established by a qualified speech-language pathologist. This plan must be signed by a physician. The second requirement is that the services must be "reasonable and necessary" to the treatment of the patient's

illness or injury. The guidelines are more specific in defining what is "reasonable and necessary"; they list some conditions that must be met. These include:

> —The services must be within accepted standards of professional practice.
>
> —The services must require the expertise of a qualified speech-language pathologist.
>
> —There must be an expectation that the patient's condition will improve *significantly* in a reasonable (and generally predictable) period of time.
>
> —The *amount, frequency, and duration* of the services must be reasonable under accepted standards of practice (*Medicare Part A Intermediary Manual,* 1981).

Of course, interpreting phrases such as "a reasonable time period" can be inexact. However, years of review experience and conferencing with other consultants from across the country help us recognize out-of-the-ordinary situations. Individual claims are looked at very carefully. Also, the coverage guidelines generally encourage giving the service provider the benefit of the doubt in difficult cases (in fact, some providers serve as reviewers). At this time there is no way to remove subjectivity from the review process. Indeed, there are many providers who do not want to see subjectivity removed because each patient's circumstances are unique.

Recent Medicare guidelines (*Medicare Hospital Manual,* 1989) consistently emphasize to service providers that there must be documentation of *significant functional change* in patient performance. The guidelines suggest that long-term goals should be *functional,* realistic, and should reflect a positive effect on the quality of the patient's everyday activities. These goals must be written to reflect the level of communicative independence that the patient is expected to achieve outside the therapeutic environment.

A manual designed to help medical reviewers make coverage decisions for speech-language pathology services (*Medicare Intermediary Manual,* 1989) provides examples of functional communication goals that work toward achieving optimum communication independence. These include the following goal statements:

> —The patient will communicate basic physical needs and emotional status.
>
> —The patient will engage in social communicative interactions with immediate family or friends.
>
> —The patient will carry out communicative interactions in the community.

These guidelines also attempt to define the elusive term "significant" as follows: "*Significant* means a generally measurable and substantial increase in the patient's present level of communication, independence, and competence compared to their levels when treatment was initiated" (p. 424). This definition is functional, referring to communication and independence rather than to how many percentage points of improvement were measured in a specific language modality. Additionally, the medical reviewer is advised that documentation should include both objective information presented in a clear, concise manner, and a short narrative progress report interpreting the objective information.

Progress must be measured within the short-term objectives in percentage points or scores on standardized tools or facility measures. Often there is a weak connection between the measures we traditionally make to objectify progress in ongoing treatment and the actual functional changes that occur in the patient's everyday life.

Our treatment and, therefore, our documentation often fall short when we interpret the meaningfulness of changes made as a result of short-term objectives relative to long-term functional communication goals. But this process is the key to effective treatment and documentation, and this is what medical reviewers are expecting speech-language pathologists to provide.

These guidelines are published by the Department of Health and Human Services, a division of the Health Care Financing Administration (HCFA), which is the agency that sets policies for Medicare. The guidelines are sent to the medical review sections of insurance companies that have contracts with Medicare and serve as intermediaries for Medicare throughout the United States.

Who reads these guidelines and who makes the coverage decisions for speech-language pathology services based on them?

The first two levels of medical review are done by computers and health-care personnel such as nurses and physical therapists. The third review level of speech-language pathology claims is done by speech-language pathology consultants or physicians. Currently, 29 states have Level III consultants who are speech-language pathologists, many of whom have PhDs. Claims are referred to Level III review when Level II reviewers such as nurses or physical therapists think they do not have sufficient background or information to make a coverage decision.

In the last few years the speech-language pathology consultants to Medicare have met regularly at the American Speech-Language-Hearing Association (ASHA) headquarters in Rockville, Maryland, to discuss current issues and questions about guidelines and policies related to coverage of speech-language pathology services. These discussions have been well-attended and usually include meeting with medical review specialists from the Health Care Finance Administration (HCFA).

The recent Medicare guidelines that emphasize the functionality of goals for patients have been largely influenced by input from the ASHA and the speech-language pathology consultants at these and other regional meetings with HCFA. Strong recommendations to include objective data collected at regular intervals in documentation of treatment regimens have also come from the ASHA and the consultants. Throughout the Medicare medical review guidelines there is an expression of the need to consider each patient claim on an individual basis. Appropriate review depends on a claim that provides a comprehensive look at the intervention goals, the treatment plan, the objective measurements of progress made toward the goals, and an interpretive summary of the objective information. The medical review system can work well if the documentation is complete and the review process is functioning as it is outlined in the guidelines.

However, there are two pressures that are changing the current process of determining Medicare reimbursement. First, HCFA apparently needs to implement cost-cutting measures. Second, coverage decisions lack uniformity among different state intermediaries.

CURRENT PRESSURES FOR CHANGE IN THE REVIEW PROCESS

One major pressure for change in Medicare coverage is based, of course, on soaring health-care costs, including rising costs in medical review of Medicare claims. Massive federal budget cuts inevitably make HCFA interested in reducing these medical review costs, and it has instituted a number of new policies. One of these is a new edit procedure in which under specific diagnoses (such as aphasia) a certain number of visits or treatments over a certain number of days will automatically be paid without review. Claims for service will not be denied if they exceed these numbers; however, they will be selected for the next level (Level II) review, which is usually done by nurses or physical therapists. This is but one example of significant changes in medical review policy that are designed to cut administrative costs.

But there is more widespread expression of concern from all corners—including from officials in HCFA, in the ASHA, from the service providers in hospitals, clinics, and rehabilitation centers, and from speech-language pathology reviewers—about another major problem in medical review of speech-language pathology services that are provided to Medicare patients. The different intermediaries across the country are apparently inconsistent in their interpretations of Medicare law and guidelines. A claim for service that was denied in Ohio might be covered in Michigan, even if the services were obviously similar and provided to patients with a similar

diagnosis and rehabilitation potential. This may lead to the mandating of a new national form for documenting all services provided to Medicare patients. This form and its very specific instructions for providers and reviewers is currently being piloted in nine states, and it is expected that after some modifications have been made it will be put into use in 1992.

A copy of this piloted form is in Appendices A and B. Notice that on the first two pages there are a number of white spaces for documentation of the initial assessment information, the functional level of initial communication skills, the plan of care, the statement of short- and long-term goals written in measurable objective terms, the summary of progress made (in objective terminology) toward functional goals, and the statement of justification for continuing. On the optional third page (Appendix C), there are boxes for presentation of time-series data from objective tests and other measurements.

What you do not see on this form and what you may be wondering about is a reference to any type of *functional outcome scale.* Under current guidelines such a performance measure in documenting for Medicare reimbursement is not used. Both Steven White and Carol Fratalli in the Governmental Affairs division at the ASHA feel that HCFA will not soon incorporate such a functional performance scale as a requirement for reimbursement because of the very real legal concerns related to the questionable validity and reliability of these instruments. Fratalli has expressed optimism that there is relatively widespread concern about these issues, as well as about the inadequate sensitivity of the current instruments such as the Functional Independence Measure (FIM) (Hamilton, B., Granger, C., Sherwin, F., Zielezny, M., & Tashman, J., 1987). Fratalli, with clinical aphasiologists Cindy Thompson, Catherine Yorkston, Reg Warren, and others has been at the center of the effort to attain grant monies to support the necessary research to refine these tools. We have a very serious obligation to educate policymakers and regulators about the current inadequacies of these functional assessments so that they are not put into practice without careful examination. These tools must be refined before they can be used appropriately.

There is considerable agreement that functional assessment of some type is in the future for most reimbursement organizations, including Medicare. Use of an outcome scale certainly would help address the concern about the current lack of uniformity in interpretation of Medicare guidelines in coverage decisions. Presumably such a scale could also serve as a cost-cutting measure in this expensive federal healthcare program. Officials at the HCFA are already using functional outcome measures in skilled-nursing facilities.

In a recent communication, HCFA Medical Review Specialist Neil Hartman revealed that he has been studying a classification system published by the World Health Organization (*International Classification of Impair-*

ments, Disabilities and Handicaps, 1980). This classification system includes a seven-point *scale of severity of disability* that reflects the degree to which an individual's activity performance is restricted, and a seven-point *assessment of outlook scale* that reflects the likely course of the individual's disability status. This classification system and its various scales are obviously pertinent to outcome measurement and will be one of many performance scales that are likely to be considered as a way to measure functional change in rehabilitation as part of the review process.

In summary, current Medicare guidelines governing coverage of speech-language pathology services require documentation that includes statements of functional communication goals, time series measurement of change that significantly affects the patient's functional communication, and a narrative interpretation of the objective measurements. Currently, required use of functional outcome scales for Medicare reimbursement is not imminent. It seems clear, however, that Medicare and other third-party payers are likely to begin using such performance scales.

It is our professional responsibility to stay involved with these developments and try to influence future policy decisions that could affect our ability to serve our patients. We can try to ensure that any instruments which may be adopted are designed and used appropriately. My 10-year experience as Medicare consultant with the intermediary in Minnesota, and with representatives from the regional and national offices of the HCFA, makes me optimistic that our involvement can make a difference.

REFERENCES

Hamilton, B., Granger, C., Sherwin, F., Zielezny, M., & Tashman, J. (1987). A uniform national data system for medical rehabilitation. In M. J. Fuhrer (Ed.), *Rehabilitation outcomes analysis and measurement.* Baltimore, MD: Paul H. Brookes Publishing Company.

International classification of impairments, disabilities, and handicaps. Geneva: World Health Organization.

Medicare hospital manual. (1989). (Transmittal No. 565). Washington, DC: Department of Health and Human Services, Health Care Finance Administration.

Medicare intermediary manual. (1989). (Transmittal No. 1424). Washington, DC: Department of Health and Human Services, Health Care Finance Administration.

Medicare part A intermediary manual. (1981). (Transmittal No. 942). Washington, DC: Department of Health and Human Services, Health Care Finance Administration.

APPENDICES
MEDICARE OUTPATIENT REHABILITATION SERVICES FORMS

Department of Health and Human Services
Health Care Financing Administration (HCFA)

Form 700: Plan of Care/Assessment for Outpatient Rehabilitation (Initial Claims Only)

Form 701: Updated Plan of Care/Progress for Outpatient Rehabilitation (Interim to Discharge Claims)

Form 702: Updated Progress for Outpatient Rehabilitation (Optional)

These rehabilitation services forms are currently being tested (pilot test commenced November 1990) by about 20 Medicare intermediaries throughout the country. After 6 to 12 months of use, feedback will be evaluated to determine if changes should be made. HCFA intends to implement these forms nationally rather than continue with unique forms for each of the almost 70 intermediaries.

The forms were developed over a period of almost three years with input from various national rehabilitation associations and Medicare intermediaries. Many changes to the several draft forms suggested by the American Speech-Language-Hearing Association (ASHA) have been incorporated into the pilot test verison. ASHA supports these forms as an important step toward uniformity.

Instructions for Completion of the Form HCFA-700
(Enter dates as 6 digits month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial.
2. **HICN** - Enter the patient's health insurance claim number as shown on his health insurance (Medicare card); certification award, utilization notice, temp. elig. notice, or reported by SSO.
3. **Provider Number** - Enter the number issued by Medicare to the billing provider.
4. **Residence** - Check box if the patient resides in a SNF, NF, or MR facility. Check N/A, if not applicable.
5. **Type** - Check the type therapy claimed. CORFs may check SN or SW for skilled nursing or social services.
6. **Prior Therapy** - Same Condition - Enter inclusive dates of most recent therapy for the same condition. Enter N/A or unknown, if appropriate.
7. **Prior Hospitalization** - Enter inclusive dates of the most recent hospitalization (1st to DC day) pertinent to the patient's current POC or condition. Use N/A or unknown, if appropriate.
8. **Primary DX** - Enter the medical diagnosis written resulting in the therapy disorder and related to 50% or more of effort in the POC.
9. **Secondary DX** - Enter the next important medical diagnosis relating to the therapy disorder (written) resulting in less than 50% of effort in the POC.
10. **Onset Date** - Enter the date of onset of the primary DX or date of the most recent exacerbation. Use 01 if exact day is unknown
11. **Referral Date** - Enter the date verbal orders were received or date of the written physician referral.
12. **Start of Care (SOC) Date** - Enter the date services began at the billing provider (the date of the 1st Medicare billable visit).
13. **Prior Level of Function: Pertinent HX** - Enter a brief narrative of the pertinent history and functional deficits. Enter prior relevant surgical procedures; outcomes of prior rehabilitation. State how function changed following an exacerbation.
14. **Initial Assessment** - Enter level of function on assessment. List problems. State in objective, measurable terms. Include baseline tests and interpretation, as needed. For speech reading, include audiologic results, vision status and use or status of amplification.
15. **Treatment Diagnosis** - Enter the treatment DX for which services are rendered. For example for SLP, while CVA is the primary medical DX, the treatment DX might be aphasia. If same as medical DX enter SAME.
16. **Date of Assessment** - Enter the date your assessment was completed.
17. **Initial POC** - Enter the specific nature of therapy to be provided. Include specific modalities and/or procedures you plan to use. Enter the short and long-term functional (CORFs-specific rehabilitation goals) goals stated in measurable objective terms. Justify intensity, if appropriate.
18. **Frequency** - Enter an estimate of the frequency of treatment to be rendered (e.g., 3 x week).
19. **Duration** - Enter an estimate of the length of time over which the services are to be rendered and express in days, weeks or months. If visits are to be over 1 hour long state in item 17, justify.
20. **Functional Level (end of claim period)** - Enter functional levels obtained at the end of the claim period compared to levels shown on initial assessment. Use objective terminology. Enter any change in functional levels related to goals.
21. **Date Last Visit** - Enter the date of the last visit made in this claim period.
22. **Signature** - The signature (or name) and professional designation of the professional who established the POC.
23. **Date POC Established** - Enter the date the POC was initially established.
24. **Physician Signature** - Enter the signature of the physician who certified the POC. Check on-file box if form is not used for certification. Enter N/A if certification is not required.
25. **Date** - Enter the date of physician certification, even if the on-file box is checked in #24. Enter N/A if not required.
26. **Certification Period** - Enter the inclusive dates of the certification period, even when the on-file box is checked in #24. Enter N/A if not required.

APPENDIX B

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0227

UPDATED PLAN OF CARE/PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Send Photocopy of HCFA-700.)

1. PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	2. HICN	3. VISITS FROM SOC	4. INTERIM ☐ D.C. ☐

5. PROVIDER NO.	6. OTHER REHABILITATION PROVIDED ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	7. CHANGED PRIMARY DIAGNOSIS ☐ NA	8. DATE OF CHANGE ☐ NA

9. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify procedures or modalities and dates used. Photocopy of HCFA-700 is required.)*

10. CHANGED FREQUENCY - PREVIOUS CURRENT 11. DATE CHANGE ☐ NA

12. FUNCTIONAL LEVEL *(start of claim)* OR ☐ PHOTOCOPY OF PREVIOUS 701 ATTACHED *(in lieu of)*, OR ☐ NA *(2nd claim or intermediary instructs otherwise)*

13. FUNCTIONAL LEVEL *(at end of billing period or when providing 5 or more treatments per week update at 2 weeks and at end of claim)*

14. NO. OF VISITS THIS CLAIM _____

15. JUSTIFICATION FOR CONTINUING *(or reason for DC)*

16. SIGNATURE: *(professional establishing POC)*	17. DATE

18. PHYSICIAN'S SIGNATURE ☐ ON FILE OR ENTER HERE: _____ 19. DATE _____

I have reviewed this plan of care and recertify a continuing need for services.
I estimated services will be needed for another _____(DAYS, WKS, MOS).

20. RECERTIFICATION FROM THROUGH

FORM HCFA-701 (9-89)

Pilot testing of this form commenced 11/90.

Instructions for Completion of the Form HCFA-701
(Enter dates as 6 digits month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial.

2. **HICN** - Enter the patient's health insurance claim number as shown on his health insurance (Medicare card), certification award, utilization notice, temp. elig. notice, or reported by SSO.

3. **Visits from SOC** - Enter the total patient sessions completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill.

4. **Interim, Discharge** - Check if an interim claim or the last (discharge claim).

5. **Provider No.** - Enter the number issued by Medicare to the billing provider.

6. **Other Rehabilitation Provided** - Check the box if any of these services are being concurrently provided.

7. **Changed Primary Diagnosis** - If the primary diagnosis has changed from that shown on the HCFA-700, enter the change (in arabic). Check N/A, if applicable

8. **Date of Change** - Enter the date the primary DX changed. Check N/A if applicable.

9. **Current Plan Update, Functional Goals** - Enter the current plan of care and treatment goals for the patient for this billing penod. Enter the short-term goals to reach overall long-term goals (*CORFs enter specific rehabilitation goals).* Justify intensity, if appropriate.

10. **Changed Frequency** - Enter the previous and current frequency of visits occurred. If no change enter N/A.

11. **Date** - Enter the date the change in frequency of visits occurred. If no change check N/A.

12. **Functional Level (start of claim)** - Enter a brief objective statement of functional levels and progress reached at the start of the claim period. In lieu of summary, you may photocopy and send the prior HCFA-701. Check box. Check N/A only if intermediary instructs you not provide or if your 2nd claim.

13. **Functional Level** ***(at end of billing period)*** - Enter progress made at end of claim period. Use objective terminology. Date progress when function can be consistently performed or when meaningful functional improvement is made or when regression in function occurs. Stress function, medical complication and safety.

14. **No. of Visits This Claim** - Enter the total visits you made in this claim period.

15. **Justification For Continuing** - Enter the major reason justifying the need to continue skilled rehabilitation. Stress function, medical complication, and/or safety.

16. **Signature** - Enter the signature and professional designation of the professional rendering care of supervising services for this claim period.

17. **Date** - Enter the date of signature.

18. **Physician's Signature** - Enter the physician's signature who is recertifying care. Check the on-file box if the form is not used for recertification. Enter N/A if recertification is not required. Estimate need in days, weeks or months.

19. **Date** - Enter the date of signature even if the on-file box is checked in #18. Enter N/A if recertification is not required.

20. **Recertification** - Enter the recertification inclusive dates even if the on-file box is checked in #18. Enter N/A if not required.

APPENDIX C

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0227

(OPTIONAL) UPDATED PROGRESS FOR OUTPATIENT REHABILITATION

1. PATIENT'S LAST NAME FIRST NAME MIDDLE INITIAL	2. HICN	3. PROVIDER NO.	4. INIT ☐ INTERIM ☐ D.C. ☐

PROGRESS REPORTING *(SHORT TERM GOALS/OBJECTIVES CONTINUED FROM HCFA-700 OR 701)*

5. GOAL:

9. MEASURE:	6. INITIAL MEASURE DATE: ____		7. PRIOR REMEASURE DATE: ____		8. CURRENT REMEASURE DATE: ____	
	10. SCORE	11. %	10. SCORE	11. %	10. SCORE	11. %

5. GOAL:

9. MEASURE:	6. MEASURE DATE: ____		7. REMEASURE DATE: ____		8. REMEASURE DATE: ____	
	10. SCORE	11. %	10. SCORE	11. %	10. SCORE	11. %

5. GOAL:

9. MEASURE:	6. MEASURE DATE: ____		7. REMEASURE DATE: ____		8. REMEASURE DATE: ____	
	10. SCORE	11. %	10. SCORE	11. %	10. SCORE	11. %

5. GOAL:

9. MEASURE:	6. MEASURE DATE: ____		7. REMEASURE DATE: ____		8. REMEASURE DATE: ____	
	10. SCORE	11. %	10. SCORE	11. %	10. SCORE	11. %

5. GOAL:

9. MEASURE:	6. MEASURE DATE: ____		7. REMEASURE DATE: ____		8. REMEASURE DATE: ____	
	10. SCORE	11. %	10. SCORE	11. %	10. SCORE	11. %

12. INTERPRETIVE SUMMARY *(Continued from HCFA 700 or 701)*

16. SIGNATURE *(Individual rendering care)*	17. DATE

FORM HCFA-702 (9-89)

Pilot testing of this form commenced 11/90.

Instructions for Completion of Form HCFA-702
(Enter dates as 6 digits month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial.
2. **HICN** - Enter the patient's health insurance claim number as shown on his health insurance (medicare card), certification award, utilization notice, temp. elig. notice, or reported by SSO.
3. **Provider No.** - Enter the number issued by medicare to the billing provider.
4. **Initial, Interim or D.C.** - Check box to indicate if this represents an initial, interim, or discharge documentation.
5. **Goal** - Enter the specific goal from the HCFA 700/701 for which the measurements relate.
6. **Initial Measure Date** - Enter the date that the initial measurement was completed.
7. **Prior Remeasure Date** - Enter the date of measurement recorded in the prior claim period.
8. **Current Remeasure Date** - Enter the date of measurement recorded in this claim period.
9. **Measure** - Identify the specific test used, anatomical part, or function to be measured. *(e.g., Boston Naming Test, ROM, strength, vital capacity)*
10. **Score** - Enter the test score recorded. Leave blank if not applicable.
11. **%** - Enter the percentage score recorded. Leave blank if not applicable.
12. **Interpretive Summary** - Enter an interpretation of the test scores, measures or other objective information recorded, as needed. Describe the relationship between current scores and prior/initial scores to clarify progress made.
13. **Signature** - Enter the signature and professional designation of the individual administering the measures/scores.
14. **Date** - Enter the date of signature.

NOTE: This form is not required. You may optionally complete and send it with the HCFA 700/701 to help explain objective tests and measurements and progress. Do not attach or send other medical information unless requested by your intermediary.