PREDICTING REHABILITATION MANAGER KNOWLEDGE OF MEDICARE GUIDELINES IN SKILLED NURSING FACILITIES

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Abstract

Health care providers must have a clear understanding of regulatory guidelines to support successful payment of clinically appropriate and medically necessary services. Limited research has examined the knowledge of Medicare documentation and reimbursement guidelines for occupational therapy (OT), physical therapy (PT) and speech language pathology (SLP) clinicians functioning as clinician managers. A cross-sectional, online survey was conducted to determine the perceived and actual knowledge regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the skilled nursing facility (SNF) rehabilitation setting. A total of 374 surveys were completed. Respondents perceived their overall knowledge to be much higher than their actual knowledge (median scores of 80.0% versus 66.7%). This low percentage of correct responses highlights a persistent deficiency in knowledge across participants. Scores were significantly different by practitioner level, gender, and across categories of level of education, current clinician manager role, and hours of employer-sponsored formal training related to Medicare guidelines. Positive low correlations were found between overall Medicare knowledge score with years of experience in current role and with perceived knowledge score. Regression analysis showed that perceived knowledge score, level of education, current clinician manager role, years of experience in current role, and gender accounted for 20.9% of variance in overall Medicare knowledge score. While the results did not identify a strong single predictor for actual Medicare knowledge scores, having insight into how well clinician managers understand Medicare documentation and reimbursement guidelines can help

guide educators and providers in structuring trainings to limit the spread of misinformation and keep clinicians well-informed.

Keywords: rehabilitation, management, Medicare, reimbursement, documentation, occupational therapy, physical therapy, speech language pathology, skilled nursing facility, regulation, long term care, policy, self-assessment

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Predicting Rehabilitation Manager Knowledge of Medicare Guidelines in Skilled Nursing Facilities

As the older adult population of the United States (U.S.) continues to age, the number of individuals age 65 years and older is growing at an unprecedented rate. According to the Centers for Disease Control and Prevention ([CDC], 2013), older adults will account for approximately 20% of the population by the year 2030. Two of every three older adults have one or more chronic diseases or degenerative illnesses. Treatment for chronic conditions accounts for two-thirds of U.S. health care expenses, and increases to 95% of expenses with older adults. Medicare spending is anticipated to nearly double from $555 billion in 2011 up to $903 billion by 2020 (CDC, 2013).

As the primary payer for rehabilitation services within the skilled nursing facility (SNF) setting, Medicare has sought ways to ensure their dollars are spent wisely and judiciously for services deemed reasonable and medically necessary, particularly occupational therapy (OT), physical therapy (PT), and speech language pathology (SLP). As focus sharpens on therapy claims in the SNF setting through various audits and reviews, clinician awareness and implementation of Medicare documentation and reimbursement guidelines continue to be key to successful reimbursement by Medicare for therapy services (Coffman, 2003). Ensuring that documentation meets both clinical requirements for successful provision of care and financial requirements for justification of medical necessity and reimbursement requires that clinicians be savvy about specific Medicare regulations related to therapy provision (Baeten, 1997).

Therapy providers are the entities actually billing Medicare for therapy services rendered. Providers can range from a single, independent skilled nursing facility to a

large network of many facilities. Providers then employ therapy clinicians, either directly or through contracting with an external therapy company, to deliver therapy services to clients. Often, one individual clinician has responsibility for oversight of the rehabilitation department as a whole, and directs the clinical staff. As such, providers, clinician managers, and therapy clinicians each play a role in the delivery of and subsequent payment for therapy services.

Therapy services for older adults can take many forms such as: therapy rendered as part of a skilled rehabilitation stay in the SNF following a 3-night qualifying hospital stay for an acute medical issue; therapy to address chronic or recent functional declines in long term care residents of a SNF; or outpatient therapy services provided to older adults. A significant amount of funds are at risk for denial of payment to SNF providers by Medicare due to incomplete understanding or lack of compliance with Medicare guidelines (Senft, 2010).

As documentation of therapy services is the responsibility of the treating clinician, therapy providers must determine how well their clinicians understand Medicare documentation and reimbursement guidelines and what can be done to optimize training and education opportunities for maximum carryover and understanding. Entry-level therapy education programs provide the necessary basic instruction for general documentation of therapy services across practice settings, leaving most payer-specific and setting-specific guidelines to be learned on the job (Accreditation Council for Occupational Therapy Education [ACOTE], 2012; Commission on Accreditation in Physical Therapy Education [CAPTE], 2013; Council on Academic Accreditation in Audiology and Speech-Language Pathology [CAA], 2015). A variety of educational and

training resources exist to impart this information to clinicians, but limited research has been conducted to look at specific factors predicting how well OT, PT and SLP clinicians understand Medicare documentation and reimbursement guidelines and how well they implement this knowledge within their practice.

The purpose of this study was to determine the knowledge rehabilitation (OT, PT, and SLP) clinician managers have regarding Medicare documentation and reimbursement guidelines and whether this knowledge varies by clinician manager characteristics. Specifically, this study addressed the following objectives:

1. To determine perceived knowledge of Medicare documentation and reimbursement guidelines in OT, PT and SLP clinicians functioning as clinician managers in a SNF setting.
2. To determine actual knowledge of Medicare documentation and reimbursement guidelines in OT, PT and SLP clinicians functioning as clinician managers in a SNF setting.
3. To determine if OT, PT, and SLP clinician manager characteristics, including their perceived knowledge of Medicare documentation and reimbursement guidelines, are significant predictors of their actual knowledge of Medicare documentation and reimbursement.

By knowing if Medicare knowledge differs across these demographics, therapy providers can better target education efforts and structure trainings to best meet the specific learning needs of their employees.

Literature Review

For many older adults, Medicare is the primary payer of the health insurance costs associated with treatment of both chronic and acute conditions. During 2012, Medicare was the primary payer for 23% of total health care costs across the U.S., which included $28.4 billion in Medicare spending for skilled nursing facilities alone (Medicare Payment Advisory Commission [MedPAC], 2014). The Medicare Board of Trustees anticipated that Medicare spending would increase from $523 billion in 2010 to $932 billion by 2020, and that by the year 2030, enrollment will be expected to nearly double while the ratio of health care workers to beneficiaries is expected to decline from 3.7 to 2.4 (Board of Trustees, 2010). This disparity between enrolled beneficiaries and the number of available health care workers to deliver services may result in challenges for older adults to receive the occupational therapy, physical therapy, and speech therapy services they need.

Medicare regulations that govern the documentation and delivery of occupational, physical, and speech therapies are largely established by Medicare Administrative Contractors (MACs) via Local Coverage Determinations (LCDs). These regional policies are used to establish medical necessity and technical requirements for reimbursement when there is not a National Coverage Determination (NCD), or if there is a need to further define an NCD (Allen & Keysor, 2005; Lee, 2012). Periodic review of therapy documentation is overseen by the MACs, as well as by Recovery Audit Contractors (RACs) and other contractors who specifically target claims and seek evidence of overpayment by Medicare for services deemed not reasonable or medically necessary. Nearly $1 billion in Medicare overpayments was identified in 2008 following the initial

RAC demonstration project which reviewed Medicare Part A and Part B claims in three states (Robin & Gershwin, 2010). Based on these results, Congress mandated in 2010 that RAC reviews would be conducted nationally (Robin & Gershwin, 2010; Scott & Camden, 2011). Specific to therapy, Congress mandated automatic manual medical review of all therapy claims above a certain annual dollar threshold (therapy cap) in 2012. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) passed in April 2015 changed the mandated review to a targeted review program for claims over the therapy cap (CMS, 2015).

Clinicians asked about the most prevalent ethical dilemmas faced by occupational therapists in rehabilitation settings cited dilemmas related to reimbursement as their top concern (Foye, Kirschner, Wagner, Stocking, & Siegler, 2002). The risk for denial of reimbursement for services is often under-recognized by clinicians due to poor understanding that inadvertent and often unintentional billing, coding, or documentation errors can lead to denial of reimbursement, and can be characterized as fraud, waste, and abuse during these reviews (Rapsilber & Anderson, 2000; Ries, 2014). Technical errors such as missing signatures or required documents result in denials even with clear evidence of medical necessity for therapy services (Senft, 2010; Senft 2016). Appropriate billing and coding for services provided is the professional responsibility of every clinician, including adherence to the most recent policies and guidelines (Ries, 2014). As these guidelines change frequently, clinicians may struggle to keep up with current standards.

Policy changes and updates within each payer, particularly Medicare, can create drastic changes in how therapy services are provided. Thomesen (1996) found that

reimbursement mechanisms in skilled nursing facilities directly impacted the focus and documentation of the occupational therapy services provided in that setting. The 1998 implementation of the Prospective Payment System (PPS) in skilled nursing settings included a new payment delivery system based on minutes of therapy and resource utilization groups (RUGs) with a fixed per diem rate instead of the previous exclusively fee-for-service payment structure also affected the provision of therapy services. This paradigm shift in provision of services within the skilled nursing environment created lasting effects across multiple levels.

Originally intended to be a cost-saving measure, the overall volume and intensity of rehabilitation services was found to remain relatively constant before and after PPS implementation (Grabowski, Afendulis, & McGuire, 2011; White, 2003). Kennedy, Maddock, Sporrer, and Greene (2002) cited the changes in billing per minute (versus the customary fifteen minute billing unit) as evidence that under the PPS system clinicians would be more accountable for their intervention time and that discernible outcome differences would be seen based on total therapy treatment time. Surveyed occupational therapy personnel described concerns related to quality of care and productivity expectations under the PPS system, and demonstrated a significant decrease in provision of client-centered interventions such as activity of daily living (ADL) retraining and cognitive-perceptual interventions as compared to pre-PPS billing (Kennedy et al., 2002). Giffin (2000) examined potential ethical issues for physical therapy clinicians that could arise from provision of services under the PPS system, including scenarios related to minimal billing to meet resource utilization groups (RUGs) categories and

underutilization of therapists for provision of direct patient care in an effort to minimize costs.

Kennedy et al. (2002) also hypothesized that changes in billing structure would impact expectations for frequency, duration and documentation of therapy services. Harrison and Kuhlemeier (2000) explored clinician manager usage of financial and efficiency indicators as a part of their management strategy for planning and provision of PPS therapy services within the SNF setting. They noted significant differences across the OT, PT and ST disciplines with the diversity of indicators utilized to effectively monitor and manage therapy service provision.

Billing and coding correctly for therapy interventions under the changed policies was cited as being instrumental in determining reimbursement and continued ability to provide therapy services to patients (Erhart, Delehanty, Morley, Pickens, & Greene, 2005). Within the past decade, clinically appropriate billing for therapy services provided under a skilled rehabilitation stay have continued to be cited as a concern for payers, as noted in the Office of Inspector General (OIG) report published in December 2010. The OIG (2010) identified 348 SNFs with "questionable billing" (p. ii) and cited a significant increase in billing of higher paying RUGs from 2006 to 2008, with the highest RUG frequency increasing from 17% to 28% of total RUGs billed. These concerns were echoed in the 2012 and 2014 OIG Work Plans (OIG, 2012, 2014).

A significant policy change occurred with the implementation of the 2010 Affordable Care Act (ACA) and a shift toward appraising quality and efficiency of health care services using value-based purchasing (VBP) (Fisher & Friesema, 2013). For Medicare services, the ultimate goal of VBP programs is to incentivize reimbursement

for providers based on "efficient use of resources, provision of high-quality care, and achievement of positive patient outcomes" (Fisher & Friesema, 2013, p. 503). The Centers for Medicare and Medicaid Services (CMS) implemented requirements for functional outcome reporting specific to therapy in 2013 through use of G codes to report functional changes during a Medicare Part B episode of care (CMS, 2012). More recent passage of the *Improving Medicare Post-Acute Care Transformation* (IMPACT) *Act of 2014* provided a framework for the gradual development and implementation of reporting mechanisms to gather more extensive patient assessment data, quality measures, and resource use measures for Medicare beneficiaries across the post-acute setting (Dejong, 2016). Changes needed for therapy documentation and billing in response to new quality measures and reporting requirements necessitate continuous updates to training and education of clinicians so they can understand and comply with the programs.

Frequent reinterpretations and changes to the Medicare Benefit Policy Manual result in changes to the broadly defined term *medical necessity* of services in efforts to explain what is or is not covered by a payer. Medicare's interpretation of medical necessity may or may not align with the clinician's opinion regarding the actual reasonableness of the service to meet the patient's medical needs (Granger et al., 2009; Lee, 2012). The term medical necessity can have such varied meanings across services and practice settings that its interpretation is often challenging and can make documentation training particularly difficult. Interpretation and application of medical necessity standards may also influence a practitioner's clinical reasoning and documentation skills, resulting in a different set of standards to guide clinical decisions during treatment versus the reasoning presented in documentation to third party payers

(Jongbloed & Wendland, 2002). Therapy documentation must meet the requirements for medical necessity as well as requirements dictated by Medicare policy for signatures, supervision of therapy assistants, claims form submission, and reimbursement. This wide variety of requirements can result in a significant training and compliance challenge for providers and managers of therapy services to help OT, PT, and SLP clinicians stay current (Ciavarella, 2012).

Anemaet, Krulish, Lindstrom, Herr, and Carr (2004) indicated that physical therapy clinicians were increasingly challenged under the PPS reimbursement model by "external, non-clinical and professional factors" (p. 550) that impacted clinician ability to effectively plan and implement therapy services. Sieck, Lohman, Stupica, Minthorne-Brown, and Stoffer (2017) found that occupational therapy practitioners felt similar challenges with staying up-to-date regarding policy changes and reimbursement requirements impacting their daily practice. Occupational therapist participants reported they relied heavily on their contract therapy company employer for provision of updates and training related to changing Medicare guidelines and rarely sought out independent resources beyond those provided by their employer (Sieck et al., 2017).

This challenge to help clinicians meet the continually evolving requirements of Medicare for documentation and reimbursement has been echoed by physicians and nurse practitioners as a significant concern in their practice as well (Sa, Cohen, & Marculescu, 2001; Towers, 2013; Zuzelo et al., 2004). Prior studies examining clinician knowledge related to reimbursement have focused on several distinct areas of clinician knowledge: billing and coding expertise; awareness of costs for ordered procedures; documentation requirements; and Medicare structures, processes and policies. A limited number of

studies explored clinician knowledge and expertise as they related to reimbursement requirements and guidelines. Despite the limited number of studies in this area, there were consistent trends related to analysis and discussion of influencing factors. These influencing factors crossed disciplines and practice settings in the studies reviewed.

Knowledge of billing and coding expertise, including Current Procedural Terminology (CPT), was explored with nurse practitioners (Sa et al., 2001) and physicians practicing internal medicine and pediatrics (Adiga, Buss, & Beasley, 2006; Andreae, Dunham, & Freed, 2009) to determine both basic knowledge of requirements and accuracy of billing. Attitudes and beliefs regarding the importance and relevance of billing and coding knowledge influenced the accuracy and clinical decision-making of nurse practitioners and hospital physicians (Pilkinton & Brustman, 2014; Sa et al., 2001). Experience also proved an influencing factor on billing and coding knowledge of medicine and nursing participants. Adiga et al. (2006) found a significant correlation between self-assessed level of knowledge and tested scores related to Medicare billing and reimbursement with second year internal medicine residents, while Lee et al. (2007) found mean scores related to CPT billing and coding knowledge were highest amongst nurse practitioners with 11-15 years of practice experience.

Several studies examined physician awareness of the costs for procedures and testing and the impact of their awareness on clinical decision-making (Broadwater-Hollifield et al., 2014; Lee, Sai, & Turner, 2007; Pilkinton & Brustman, 2014). Broadwater-Hollifield et al. (2014) found only 37.3% of their survey respondents could estimate reimbursement rates for medical services within 50% of the actual rate, and 65% of emergency physicians surveyed indicated they felt they had inadequate knowledge of

medical procedure costs, which correlated with the tested knowledge of costs included as part of the survey. Lee et al. (2007) also found a significant knowledge deficit related to prescription drug and billing guidelines among surveyed medical students, residents and attending physicians. While experience did not seem to influence tested knowledge of hospital billing costs between residents and attending physicians, the more experienced attending physicians reported significantly higher incidence of allowing the costs of tests and procedures to influence their clinical decision-making than did their residency counterparts (Pilkinton & Brustman, 2014).

The impact of successful documentation and the consistency between documentation and provision of services provided has been explored across multiple disciplines, including medicine, nursing, occupational therapy and physical therapy. Challenges identified by these studies consistently related to the quality and thoroughness of the documentation as well as the importance of clinician familiarity with the specific regulations governing the services they provided (Ciavarella, 2012; Coffman, 2003; Granger et al., 2009; Samuels & Fetzer, 2009; Thomesen, 1996; Yount et al., 2014). Knowledge specific to Medicare structures, processes and policies was examined among surveyed clinical nurse specialists with noted deficits in essential knowledge evidenced by an average percentage correct score of 62.7% (Zuzelo et al., 2004). Self-assessment of expertise and perception of competence with knowledge of reimbursement guidelines was shown to correlate with tested knowledge of Medicare billing and reimbursement guidelines with internal medicine residents and clinical nurse specialists (Adiga et al., 2006; Zuzelo et al., 2004).

Training and education related to billing, coding, reimbursement and documentation guidelines can occur at all levels of education and employment. Several studies further examined participants' perception of the adequacy of their training within the reimbursement-related knowledge area being addressed. Results indicated that between 66% and 81% of surveyed clinicians felt (and their knowledge scores supported) that both academic and post-academic training related to reimbursement was inadequate. This lack of knowledge undermined their ability to make clinically and fiscally responsible decisions on behalf of their patients (Adiga et al., 2006; Andreae et al., 2009; Zuzelo et al., 2004).

Ultimately, clinician knowledge of Medicare regulations and guidelines impacts compliance, patient care, accuracy with documentation/billing/coding of services and overall success with reimbursement. Previous research examined the knowledge of reimbursement and factors impacting reimbursement competency for nurses, nurse practitioners, and physicians, but limited studies have examined rehabilitation professional (OT/PT/SLP clinician) knowledge of Medicare documentation and reimbursement guidelines. There exists a potentially significant negative financial impact for non-compliance with Medicare guidelines, and stakeholders such as SNFs, therapy providers, and clinicians have a vested interest in ensuring compliance with these regulations to support reimbursement. Research to highlight awareness of current knowledge of Medicare documentation and reimbursement guidelines among OT, PT, and SLP clinicians and to identify potential predicting factors for this knowledge can help employers improve and target learning opportunities for clinicians to make the largest positive impact.

Method

This study examined OT, PT, and SLP clinician manager perceived and actual knowledge regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting. Prior to the start of the study, the University of Indianapolis Human Research Protections Program determined the study was exempt from Institutional Review Board review.

Study Design

This cross-sectional study utilized an online survey to collect data between 4/10/2017 and 5/1/2017. Clinician managers were surveyed about their perceived knowledge of Medicare documentation and reimbursement guidelines followed by a test of their actual knowledge. Survey results were assessed across participants and analyzed to identify any significant relationships and predictors of performance across multiple demographics.

Participants

Participants were OT, PT and SLP clinician managers practicing within the skilled nursing facility rehabilitation setting. They were recruited from a large national contract rehabilitation therapy provider.

Criteria. Inclusion criteria included: (a) employed as Area Directors of Operations (ADOs), Market Program Directors (MPDs), single-site Program Directors (PDs), and Rehab Clinical Leaders (RCLs), and performing within a clinician manager role at the time of survey initiation, defined as overseeing a rehabilitation department or departments within the company's contracted skilled nursing facilities; (b) clinician manager participants had to be OT, PT or SLP clinicians (thereby excluding non-clinician

managers found in a small number of the contracted facilities), and could be therapists or assistants ; and (c) clinician manager participants had to be able to access corporate email via computer to utilize the link to the survey. Participating clinician managers could have varying levels of experience within that role, and years of experience as a clinician manager was part of the demographics requested. Exclusion criteria included: (a) non-clinicians performing the clinician manager role; and (b) acting clinician managers from another practice setting (such as hospital-based therapy services or exclusively outpatient settings) who were filling in temporarily for the SNF clinician manager position.

Clinician Manager Roles. Titles for manager positions included the following: Area Director of Operations (ADO), overseeing regional operations of 20-50 facilities; Rehab Clinical Leader (RCL), overseeing day-to-day clinical operations within a single facility; Market Program Director (MPD), overseeing administrative and clinical operations of 2-10 facilities each managed by an RCL; and single-site Program Director (PD), independently overseeing administrative and clinical operations at a single facility. Additional survey respondents included divisional vice presidents and clinical performance specialists.

Sampling

Convenience sampling strategy was used. Participants were identified using internal corporate email and facility information to select clinician managers who met the inclusion criteria at the time of the survey initiation. Participation in this study was voluntary and anonymous, conducted via online survey. Similar survey studies have ranged in sample size from 97 to 1200 participants. Based on the geographical variability and number of possible participants, use of this large sample pool could possibly be

described as leaning more towards a probability sample, and the number would be similar in size and scope to a professional organization membership sampling frame. Sample size, as determined using a 95% confidence interval and a 5% sampling error, would be approximately 287 completed responses (Creative Research Systems, Petaluma, CA). This would require a survey response rate of at least 25% of the 1135 surveys requested.

Procedures

Individuals identified as possible participants received a recruitment email (see Appendix A) stating the purpose of the study and containing the link to the online survey. Inclusion criteria were listed in the email and responses indicating exclusion criteria were not used (see Appendix B). An estimate of the time necessary to complete the survey was also given. Responses were accepted for three weeks following the initial survey email. Two follow-up email reminders were also sent to the participant distribution list during the course of the survey (at one week and two weeks following the original request) to maximize the response rate.

Confidentiality was maintained by the reporting of all responses in aggregate. A submitted online survey was considered consent to participate in the study. Participants were asked to complete the Medicare guideline questions without the use of any additional resources. The Qualtrics© [2017]survey software (Qualtrics, Provo, UT) independently and anonymously tracked responses to ensure respondents completed only one survey by preventing multiple submissions from the same internet protocol (IP) address. Results were forwarded to the researcher after IP addresses were removed to ensure confidentiality of responses.

Questionnaire Development

The self-administered three-part survey questionnaire used in this study was created by the researcher. In Part 1, the following demographic data were collected: geographic region of practice, gender, years of experience as a clinician, years of experience within the skilled nursing facility setting, years of experience within current clinician manager role, clinical specialty/discipline(s), degree/level of education, preferred learning style, and whether their clinical degree curriculum included coursework related to Medicare regulatory and/or documentation requirements. Part 2 included questions asking participants to rate the following using a 5-point Likert-like scale:

(a) confidence with their perceived level of knowledge regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting (rated from highly confident to not confident at all);

(b) perceived level of knowledge regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting as compared to other clinician managers (from much higher than other clinician managers to much lower than other clinician managers);

(c) perceived level of knowledge regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting as compared to other non-management/staff clinicians (from much higher than other non-management/staff clinicians to much lower than other non-management/staff clinicians); and

(d) satisfaction with previous training regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting (from highly satisfied to not satisfied at all).

Part 3 included 18 closed-ended questions designed to test each participant's current knowledge of Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting. Part 3 produced a total knowledge score (between 0 and 18) based on the number of correct answers.

Content Validity of the Medicare Knowledge Quiz

Content validity of Medicare-related knowledge questions was determined using review by content specialists during questionnaire development. A pilot survey was issued to a group comprised of two SNF documentation auditors, three clinician managers with extensive documentation experience, a Medicare Fraud Consultant with the Department of Justice, and six rehabilitation denial/appeal specialists. This expert group possessed 15-30 plus years of experience in the skilled nursing rehabilitation environment and their expertise ensured that Part 3 questions reflected current knowledge considered necessary for clinicians in this practice setting. Pilot participants were asked to rate questions based on difficulty and content. Final draft of questions was submitted to AOTA, APTA, and ASHA for review and comment. The final Medicare quiz included three sections: questions related to Medicare Part A therapy regulations, questions related to Medicare Part B therapy regulations, and questions related to therapy documentation regulations in general.

Statistical Analysis

Data were analyzed using IBM SPSS Statistics for Windows, Version 24.0 (IBM Corp., Armonk, NY). Descriptive statistics were conducted on the total sample. Categorical variables are reported as frequency and percentage while continuous variables are reported as mean and standard deviation or median and interquartile range, depending on whether the data were normally distributed. Normality of data was determined using the Shapiro-Wilk test.

Bivariate and multivariate comparisons were conducted on clinician manager demographic variables and clinician manager perceived knowledge scores to look for differences in or correlation with actual knowledge scores. Nominal variable comparisons were conducted using the Mann-Whitney *U* test or Kruskal-Wallis test. Post hoc tests using a Bonferroni correction were conducted for all statistically significant Kruskal-Wallis test results. Continuous variable correlations were conducted using the Spearman rho correlation. Any participant characteristic found to demonstrate a significant difference in or a significant correlation with ($p < .05$) actual knowledge scores was further analyzed to determine if they were significant predictors of participant knowledge scores. The strength of correlation coefficients was interpreted as: $r = .00$ - .30, negligible; $r = .30$ - .50, low; $r = .50$ - .70, moderate; $r = .70$ - .90, high; $r > .90$, very high (Hinkle, Wiersma & Jurs, 2003).

Finally, multiple linear regression analysis using manual procedures was used to model the predictors of Medicare knowledge. Explanatory variables that demonstrated a statistically significant difference or correlation with the overall actual Medicare knowledge score were introduced into the regression model simultaneously using the

Enter method. Data screening and preliminary analyses were performed to confirm assumptions of normality, linearity, multicollinearity, and homoscedasticity. All tests were two-tailed, and an alpha level of .05 was considered statistically significant.

Results

A total of 1135 possible respondents received recruitment emails for the study. Following the three-week sampling timeframe, 439 responses were received. Ten responses from non-clinicians were excluded, and 55 responses contained incomplete answers to the Medicare quiz portion of the survey. One single choice quiz item had two possible correct answers which were combined for analysis purposes. After exclusion criteria were applied, final responses for analysis totaled 374, meeting sample size criteria for a 95% confidence interval and a 5% sampling error (>287 completed responses) and demonstrating a 33% survey response rate (Creative Research Systems, Petaluma, CA).

Respondent Characteristics

Demographics. Table 1 illustrates demographic information for survey respondents. Respondents were split fairly evenly over five distinct disciplines, with only three respondents reporting a dual degree. Approximately one-third (33.4%) of respondents held an associate degree as an assistant (OTA and PTA), while 20.1% held a bachelor degree, and 37.2% held a master's degree. Less than 10% of respondents held degrees at the doctorate level. A majority of respondents (70.3%) were clinician managers over a single site facility (single-site PD and RCL). Over a quarter of respondents (27.5%) held clinician manager roles over multiple facilities (MPD and ADO), and remaining respondents were executive managers (1.1%) and operational consultants (0.8%). Over half the respondents (53.5%) reported working in sites in the

Midwest, but overall geographic distribution was largely consistent with contracted facility locations (Figure 1). Finally, female respondents significantly outnumbered males at 82.9%, but this ratio does reflect current national trends within the OT, PT, and SLP clinician population.

Experience. Respondents were experienced clinicians, with approximately 70% of respondents reporting more than 10 years of clinical experience (M = 16.43, SD = 8.63), and nearly 60% of respondents reporting more than 10 years of experience in the SNF practice setting (M = 12.89, SD = 6.77). However, many respondents were very new to the clinician manager role (M = 8.18, SD = 6.83), as evidenced by 31.3% reporting only 0-3 years in their current manager role. Table 2 shows a breakdown of clinician manager role into therapist and assistant by years of experience within that manager role.

Training history and learning preferences. Only 30.5% of respondents reported that training related to Medicare guidelines for documentation and reimbursement was included as part of their degree curriculum (Table 3). Of those who reported this training during their clinical education, only 8% were speech pathology clinicians, and 75.0% reported their training occurred within an associate or master level degree program. The vast majority of respondents (72.2%) reported they received less than five hours during the past five years. In contrast, 30.5% of respondents reported receiving 10 or more hours of formal training on this topic from their employer during the same timeframe. Respondents identified the most popular preferred learning style as employer-provided training (34.0%), followed by continuing education courses (29.4%).

Objective 1: Perceived Knowledge of Medicare Documentation and Reimbursement Guidelines

The first three questions in the self-assessment portion of the survey sought to establish participants' perceived level of knowledge related to Medicare for documentation and reimbursement. Internal consistency for self-assessment questions 1-3 was established with .77 α coefficient. A fourth question requested feedback regarding satisfaction with previous training related to this subject matter. Responses to the four questions can be found in Table 4. Most clinicians were confident in their knowledge of Medicare guidelines, perceived their knowledge of the guidelines to be higher compared to other clinician managers and non-clinician managers, and were at least satisfied with previous training they had received on the guidelines. A total perceived knowledge score was calculated by adding the Likert response scores together for questions 1-3. Total scores ranged from four to 15 (of 15 possible points) with a median of 12 points (IQR = 2).

Objective 2: Actual Knowledge of Medicare Documentation and Reimbursement Guidelines

Ten questions on the quiz were missed by 30% or more of respondents, and five questions were missed by more than half of respondents (Table 5). Raw scores for correct responses on each of three quiz sections (Medicare Part A, Medicare Part B, and Documentation) and the overall score (out of 18 total questions) were converted to percentages. Respondent Medicare Part A scores ranged from 16.67% to 100% (*Mdn* = 66.67%; IQR = 16.67%); Medicare Part B scores ranged from 0% to 100% (*Mdn* = 66.67%; IQR = 33.33%); Documentation scores ranged from 0% to 100% (*Mdn* =

66.67%; IQR = 33.33%); and total overall scores ranged from 27.78% to 100% (*Mdn* = 66.67%; IQR = 22.22%). These percentages were used as a possible predictor of actual knowledge scores.

Objective 3: Predictors of Actual Knowledge of Medicare Documentation and Reimbursement Guidelines

Clinician manager demographics. A Spearman rho correlation was conducted to assess the relationship between non-categorical demographic characteristics and actual knowledge of Medicare guidelines in survey respondents. A positive low correlation was found between overall Medicare knowledge score and years of experience in current role (r_s (374) = .36, R^2 = .13, p < .001). Years of experience in SNF (r_s (374) = .27, R^2 = .07, p < .001) and years of experience as a clinician (r_s (374) = .18, R^2 = .03, p < .001) were found to significantly correlate with the overall Medicare knowledge score but had only a negligible relationship.

Significant differences in actual knowledge scores were found for several of the clinician manager characteristics that were collected.

- Gender: Female respondents had a higher median score than the male respondents (66.67% versus 61.11%) with the differences in the scores being statistically significant (U = 7594.50, p = .023).
- Level of education: Median scores increased as degree level increased from associate degree (61.11%) to bachelor degree (66.67%) to master's degree (72.22%). However, respondents with a doctorate degree had a median score equal to that of those with a bachelor degree (66.67%). The differences among the scores was found to be statistically significant ($\chi^2(4) = 26.93$, p < .001).

- Current clinician manager role: Median scores improved as the complexity of the respondent manager role increased from RCL (61.11%) to single-site PD (66.67%) to MPD and ADO (72.22%), $\chi^2(5) = 38.479$, $p < .001$.
- Hours of employer-sponsored formal training related to Medicare guidelines: Respondents reporting less than two hours of training scored the lowest (*Mdn* = 61.11%). The difference in scores by the categories was statistically significant ($\chi^2(4) = 11.37$, $p = .023$). However, no specific trends for improved Medicare knowledge score were seen with increased amounts of training, as median scores remained consistent across remaining categories: no training (66.67%); 2-5 hours (66.67%); 5-10 hours (66.67%); and 10 or more hours (66.67%).
- Clinical discipline: Initial analysis included grouping of one respondent who reported dual OT and PTA degrees into the OT category, and two respondents who reported dual OTA and "other" (non-therapy) degrees into the OTA category. Median scores were found to be identical for OTA and PTA respondents (*Mdn* = 61.11%, IQR = 16.67%), so OTA and PTA categories were combined into a single assistant group. Similarly, a significant difference was not found between OT, PT, and SLP scores [*Mdn* (IQR) = 66.67% (16.67%), 69.44% (16.67%), 72.22% (16.67%), respectively; p = .691], so therapist categories were also combined into a single therapist group. The assistant clinician group (OTA/PTA) had a lower median score (61.11%) than the therapist clinician group (66.67%) and the difference in scores was statistically significant [$\chi^2(1) = 17.73$, $p < .001$].. Finally, respondents were grouped into three clinical specialty categories (OT/OTA, PT/PTA, and SLP) and knowledge scores were compared. A

statistically significant difference was not found [Mdn (IQR) = 66.67% (22.22%), 66.67% (18.06%), 72.22% (16.67%), respectively; $\chi^2(2) = 4.27$, $p = .118$].

A significant difference was not found for overall Medicare knowledge score by geographic region ($p = .252$), hours of non-employer-sponsored training ($p = .671$), preferred learning style ($p = .538$), or reported Medicare-related training in degree curriculum ($p = .059$).

Perceived knowledge of Medicare documentation and reimbursement guidelines. A statistically significant positive but low correlation was found between overall actual Medicare knowledge scores and perceived knowledge scores (r_s (374) = .37, $R^2 = .14$, $p < .001$).

Multiple linear regression. Multiple linear regression was performed to determine if clinician manager characteristics or their perceived knowledge of Medicare documentation and reimbursement guidelines could be used to predict their actual knowledge of Medicare documentation and reimbursement guidelines. The variables that were significantly correlated with or differed in knowledge scores were entered into the model. Linearity was assessed by visual inspection of partial regression plots and a plot of studentized residuals against the predicted values. Multicollinearity was determined to be present if a correlation coefficient was > .80 and tolerance values were > 0.10 (Field, 2013). Multicollinearity was present between years of experience in SNF, years of experience as a clinician, and years of experience in current clinician manager role. Based on the bivariate correlation results, years of experience in current clinician manager role had a slightly higher correlation with actual knowledge scores, therefore, it

was entered into the model and years of experience as a clinician and within the SNF setting were removed.

Multiple regression analysis showed an independence of residuals, as assessed by a Durbin-Watson statistic of 1.88. There were no leverage values greater than 0.2, and no values for Cook's distance above 1 (Field, 2013). There were two studentized deleted residuals greater than ±3 standard deviations (two cases had an overall knowledge score of 33.33% at 3.05 and 3.06 SD) but these were felt to be significant to the overall analysis and therefore left in the model. Residuals were approximately normally distributed as visualized on histogram and P-P Plot. Homoscedasticity was confirmed by visual inspection of a plot of studentized residuals versus unstandardized predicted values.

In the final model, gender, perceived knowledge score, level of education, current clinician manager role, and years of experience in current role significantly predicted overall actual Medicare knowledge scores as follows:

- Predicted overall Medicare knowledge score was found to be 4.26% higher for female respondents than male respondents.
- Predicted overall Medicare knowledge score increased by 1.82% for each increase of one point (out of 15 possible) in perceived knowledge score.
- Predicted overall Medicare knowledge score increased by 1.52% as level of education increased by degree level.
- Predicted overall Medicare knowledge score decreased by 1.26% as clinician manager role narrowed in complexity to the single facility level (ADO down to RCL level).

- Predicted overall Medicare knowledge score increased by 0.35% for each year of experience in current manager role.

All five variables added statistically significantly to the prediction, $p < .05$ and together accounted for nearly 21% of variance, $F(5,366) = 20.65$, $p < .001$, $R^2 = .21$. Regression coefficients and standard errors can be found in Table 6.

Discussion

As discussed, clinician knowledge of Medicare regulations can impact compliance, patient care, accuracy with documentation, billing, and coding of services, and overall success with reimbursement. Non-compliance with current regulations carries the potential for significant negative consequences at all levels of care provision, from executives within a SNF provider down to the therapy clinician providing the services. This study focused on examining the perceived and actual knowledge of OT, PT, and SLP clinician managers related to Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting.

The overall scores for the Medicare knowledge quiz highlighted a persistent deficiency in knowledge across participants. Questions missed by 30% or more of respondents were spread almost evenly across question type (Medicare Part A, Medicare Part B, and documentation), indicating no consistency with the type of guideline being misunderstood. However, six of the ten most frequently missed questions had a single incorrect answer as the most popular response meaning clinician managers may be misinformed with the same incorrect information about those particular guidelines. For example, 77.3% of respondents incorrectly identified the treatment scenario for *concurrent therapy* (Documentation, Question 17) with the answer describing *group*

therapy. Under the Medicare Part A questions (Question 2), 47.1% of respondents incorrectly identified that individual certification of each individual therapy plan of care is required under a Medicare Part A rehabilitation stay, instead of completion of the facility certification/recertification only. These tendencies towards large numbers of respondents selecting the same incorrect answer are indicative of the widespread misinformation regarding these guidelines and the need for continued efforts to teach and train as changes in regulations occur. As clinician managers are often integral to training of staff clinicians, results also indicate clinician managers may not have sufficient grasp of the knowledge to effectively train their clinical teams, possibly leading to further issues with compliance and reimbursement.

Demographic characteristics of participants were collected to investigate if Medicare knowledge could be predicted by clinician manager characteristics. Significant variance between subgroups was expected and found for levels of experience (years total, years within the SNF setting, and years within current clinician manager role). In addition, significant variance was found between subgroups for gender, practitioner level, level of education, current clinician manager role, and hours of employer-sponsored training.

Analysis of these characteristics further as coefficients within the regression model showed that education level and clinician manager role impacted the overall Medicare knowledge score nearly as much as the self-assessed perceived knowledge score. Although it may be expected that clinician managers with advanced educational degrees and more complex manager roles would be anticipated to show increased Medicare knowledge, it was interesting to note that gender appeared to have the largest

impact on overall Medicare knowledge score prediction within the regression model. Within related literature reviewed for this study, gender was not studied as a predictor of performance for knowledge of billing, coding, and documentation guidelines. However, as the sample and the general clinician population are skewed heavily female, this difference in performance may be related more to the ratio of responses from male participants than to any significant knowledge gap between genders.

Though significant, perceived knowledge scores showed only a low correlation with actual Medicare knowledge scores, indicating that self-assessment or self-report by clinician managers of their perceived knowledge of Medicare guidelines should perhaps not be used in isolation to determine competency. This correlation also suggests that insight at the clinician manager level is perhaps not as clear as it pertains to this subject as it may be for other management skills. Implications for future study may include analysis of perceived and actual knowledge pre- and post-training related to Medicare documentation and reimbursement guidelines to see if specific trainings promote improvements in both self-awareness and knowledge.

Years of experience in the current clinician manager role also showed a low positive correlation with actual Medicare knowledge scores, indicating that clinician managers performed better the longer they reported having worked in their current manager position. Breakdown of clinician manager role by discipline showed that the percentage of therapy assistants within the role increased and years of manager experience decreased as the role narrowed focus from multi-site to single facility level (Table 2). Inexperienced clinician managers in their first three years of practice may be especially vulnerable to mistakes and misconceptions about Medicare guidelines. Based

on the significant variance in knowledge found by this study between assistants and therapists, it may benefit contract rehab providers to ensure that clinician managers with less experience, particularly those with associate level backgrounds, receive mentoring and training from more seasoned managers to promote improved understanding of Medicare guidelines impacting clinical practice and reimbursement within their facility.

Finally, recent research has noted that occupational therapists in the SNF setting may rely heavily on their employer to provide necessary updates and information regarding regulatory changes impacting practice (Sieck et al., 2017). Although employer-sponsored training was excluded from the final regression model, it is worth noting that analysis of the overall Medicare knowledge score across the ranges of hours of employer-sponsored training showed no specific range of training time that seemed to significantly impact overall Medicare knowledge scores. Scores were lowest in participants who reported less than two hours of formal training but median scores for respondents reporting no training rivaled those of other respondents reporting five or more hours of training. As employers often invest a great deal of time, energy, and resources into training activities for clinical staff, these results indicate that increased training could be more beneficial overall, but the content and approach may need to be continually updated to reflect and correct previously mentioned misconceptions.

Limitations

The sample for this study was taken exclusively from employees of a single, national contract rehab therapy provider, and may not be representative of the entire population of OT, PT, and SLP clinician managers working in SNF settings across the country. However, the general ratio of male to female clinicians roughly correlated to the

ratios reported within the OT, PT, and SLP professions. Although numbers were not readily available to compare the ratio of clinicians across disciplines within this practice setting on a national level, participants in the sample were fairly evenly distributed and responses should not be skewed based on significantly higher response from exclusively one discipline. The sample was heavily distributed in the Midwest due to the large number of contracted facilities in that region. Finally, the survey instrument did not have reliability and validity established beyond the content validity previously discussed.

Conclusion

Knowledge of Medicare documentation and reimbursement guidelines specific to rehabilitation services is essential for successful therapy provision within the SNF setting. However, this study did not provide a strong single predictor for actual Medicare knowledge scores indicating there is not a simple way to use the demographics of OT, PT, and SLP clinician managers to predict their understanding of Medicare documentation and reimbursement guidelines in this setting.

Data from this study could be further analyzed to explore in greater detail the trends of incorrect responses for Medicare quiz questions across demographic subgroups to better inform providers of possible reasons for misinterpretation of guidelines. Some participants contributed qualitative comments and information regarding the survey questions that could be explored further in a future study. Adding further detail and a qualitative component to the Self-Assessment (Part 2) section for *Perceived Knowledge* may help provide better insight into how clinicians assess their own knowledge of Medicare guidelines. Further research would also be advised to explore non-manager

clinician knowledge with these guidelines as individual clinicians also have a professional responsibility to maintain competency with regulations that affect practice.

This study provided an opportunity to assess OT, PT, and SLP clinician manager knowledge of Medicare documentation and reimbursement guidelines and the results indicate that rehabilitation managers may not fully understand or have clear insight into their own limitations with this subject matter. This research provides insight into how clinician managers obtain, utilize, and communicate information regarding Medicare documentation and reimbursement guidelines to promote best practice in the SNF rehabilitation setting. Knowing the base level of understanding for this information can help guide educators and providers in structuring trainings to limit the spread of misinformation and help keep clinicians well-informed. Ultimately, therapy providers can only deliver SNF therapy services to meet the needs of the aging population if they clearly understand the billing and documentation requirements necessary for successful reimbursement of those services.

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Table 1

Respondent Demographics (N = 374)

	N	%
Discipline		
Occupational Therapist (OT)	77	20.6
Occupational Therapy Assistant (OTA)	75	20.1
Physical Therapist	64	17.1
Physical Therapist Assistant (PTA)	86	23.0
Speech Language Pathologist	69	18.4
OT/PTA dual degree	1	0.3
OTA/other dual degree	2	0.5
Degree Level of Education		
Associate	125	33.4
Bachelor	75	20.1
Master	139	37.2
Entry-level doctorate	15	4.0
Post-professional doctorate	17	4.5
Research doctorate (PhD, EdD, etc)	3	0.8
Current Clinician Manager Role		
Area Director of Operations	21	5.6
Market Program Director	82	21.9
Single-site Program Director	123	32.9
Rehab Clinical Leader	140	37.4
Vice President	4	1.1
Operations Consultant	3	0.8
Geographic Region		
West (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY)	26	7.0
South/Central (AR, LA, NE, OK, MS, ND, SD, TX)	37	9.9
Midwest (IA, IL, IN, KY, MI, MN, MO, ND, OH, WI)	200	53.5
Southeast (AL, FL, GA, NC, SC, TN, VA, WV)	54	14.4
Northeast (MD, DC, DE, PA, NJ, NY, MA, CT, RI, VT, NH, ME)	56	15.0
Gender		
Male	60	16.0
Female	310	82.9
Prefer not to answer	4	1.1

Figure 1

Geographic Distribution of Targeted Participant Facilities

(Retrieved from http://www.rehabcare.com/careers/locations/)

Table 2

Clinician Manager Experience by Role

	Area Director of Operations N=21	*Market Program Director N=82*	*Single-site Program Director N=123*	*Rehab Clinical Leader N=140*
% Therapist (OT, PT, SLP)	76	65	54	44
% Assistant (OTA, PTA)	24	35	46	56
Years in current manager role by %	19			
< 5 years	33	38	31	63
5-10 years	38	24	34	18
10-15 years		34	29	18

Note: OT = occupational therapist, OTA = occupational therapy assistant, PT = physical therapist, PTA = physical therapist assistant, SLP = speech language pathologist

Table 3

Respondent Training History and Learning Preferences

	N	%
Preferred Learning Style		
Independent study outside work	3	8.0
Continuing education course	110	29.4
Employer-provided training	127	34.0
Computer-based training	66	17.6
Professional organization conference	48	12.8
Other	18	4.8
Employer-Sponsored Training (within the past 5 years)		
None	15	4.0
<2 hours	52	13.9
2-5 hours	112	29.9
5-10 hours	72	19.3
10 or more hours	114	30.5
Non-Employer-Sponsored Training (within the past 5 years)		
None	79	21.1
<2 hours	101	27.0
2-5 hours	90	24.1
5-10 hours	60	16.0
10 or more hours	41	11.0
Medicare Guidelines Covered in Degree Curriculum		
Yes	114	30.5
No	180	48.1
Do not remember	55	14.7

Table 4

Respondent Self-Assessed Rating of Perceived Knowledge from Part 2 of Survey

	N	%
Confidence with *perceived level of personal knowledge* regarding Medicare guidelines		
Not confident at all	1	.3
Slightly confident	13	3.5
Somewhat confident	57	15.2
Confident	193	51.6
Very confident	110	29.4
Perceived level of *personal knowledge* regarding Medicare guidelines *compared to other clinician managers*		
Much lower	1	0.3
Lower	18	4.8
About the same	152	40.6
Higher	164	43.9
Much higher	39	10.4
Perceived level of *personal knowledge* regarding Medicare guidelines *compared to non-manager clinicians*		
Much lower	-	-
Lower	7	1.9
About the same	43	11.5
Higher	162	43.3
Much higher	162	43.3
Satisfaction with previous training regarding Medicare guidelines		
Extremely dissatisfied	4	1.1
Fairly dissatisfied	45	12.0
Neither satisfied nor dissatisfied	81	21.7
Fairly satisfied	190	50.8
Extremely satisfied	52	13.9

Table 5

Questions missed by 30% or more of respondents

	*% with **wrong** answer*	*Other options chosen*
Medicare A Questions		
Physicians certify therapy services under Medicare Part A skilled rehabilitation stays by: a. Completing the facility certification/recertification b. Completing individual certification of each individual therapy plan of care c. Physician certification of therapy services is not required under Medicare Part A d. None of the above e. To be honest, I'm really not sure.	47.1%	(b)—42%
The 7-day lookback for skilled Medicare Part A stays reviews the number of days/minutes of therapy provided during those 7 days to see if what kind of MDS assessment might be required? a. Change of Therapy (COT) assessment b. End of Therapy (EOT) assessment c. Start of Therapy (SOT) assessment d. Any of the above might be required e. To be honest, I'm really not sure.	54%	(a)—50%
According to Medicare Part A regulations, what is the level of supervision for a student providing treatment in a skilled nursing facility? a. Line of sight supervision b. Direct supervision as determined by the supervising therapist/assistant c. Off-site supervision, supervising clinician must be available by phone d. Students cannot independently provide and code treatment minutes under Medicare Part A e. To be honest, I'm really not sure.	59.9%	(a)—41.2%

Medicare B Questions		
The **MAXIMUM** timeframe a Medicare Part B therapy plan of care can be certified by the physician (before recertification would be required) is ____ days. a. 30 b. 60 c. <u>90</u> d. There is no maximum. The plan of care duration can be as long as the evaluating OT/PT/SLP deems appropriate. e. To be honest, I'm really not sure.	39.3%	(a)—19.3% (d)—12.6%
Modifier-**59** is added to Medicare Part B therapy service charges to denote a separate and distinct procedural service. Which of the following is a situation where the -59 modifier should be used? a. A clinician performed manual therapy (97140) and therapeutic exercise (97110) during the same 15 minute block of time. b. A speech language pathologist provided dysphagia treatment (92526) and speech treatment (92507) on the same day. c. <u>Physical therapy performed gait training (97116) on the same day that occupational therapy provided orthotics fitting of a hand orthotic (97760)</u>. d. None of these would require the -59 modifier. e. To be honest, I'm really not sure.	87.2%	(a)—14.2% (b)—19% (d)—17.6% (e)—36.4%
According to Medicare Part B regulations, what is the level of supervision for a student providing treatment in a skilled nursing facility? a. Line of sight supervision b. Direct supervision as determined by the supervising therapist/assistant c. Off-site supervision, supervising clinician must be available by phone d. <u>Students cannot independently provide and code treatment minutes under Medicare Part B</u> e. To be honest, I'm really not sure.	42%	(a)—16.6% (b)—21.7%

Documentation Questions		
Medicare requires that occupational therapy, physical therapy, and speech therapy plans of care contain which of the following: a. Amount, frequency, and duration of treatment to be provided b. Results of standardized tests performed on evaluation c. Legible handwritten signature (or validated electronic signature) and professional identity of individual who established the plan d. Answers a and b e. <u>Answers a and c</u> f. Answers b and c g. To be honest, I'm really not sure	33.7%	(d)—25.9%
Which of the below represents a way to correctly code and bill a 60-minute therapy session using the 8-minute rule? a. 60 minutes of dysphagia treatment (1 unit 92526) b. 20 minutes of therapeutic procedures (1 unit 97110), 20 minutes of therapeutic activities (1 unit of 97530), and 20 minutes of neuromuscular re-education (1 unit of 97112) c. 52 minutes of gait training (3 units of 97116) and 8 minutes of therapeutic activities (1 unit of 97530) d. Answers a and b e. <u>Answers a and c</u> f. Answers b and c g. To be honest, I'm really not sure.	61%	(c)—17.4% (d)—17.1% (f)—11.2%
<u>Group therapy</u> provided by one therapy clinician for multiple patients requires which of the following**:** a. Patients are performing different activities but working on similar goals b. Groups must contain at least 4 and no more than 6 patients c. <u>Minutes are divided by number of group participants and coded as group minutes on the MDS for skilled Medicare Part A patients</u> d. A 45 minutes group therapy session would be coded as 3 units of group therapy (97150 or 92508) for each participating Medicare Part B patient e. To be honest, I'm really not sure	35.3%	(d)—11.8%

Which of the following treatment scenarios would be considered **concurrent therapy**: a. One clinician providing treatment to two patients at the same time; patients are performing same or similar activities b. A therapy student treating one patient and the supervising clinician treating another patient c. A clinician providing treatment to one patient while another patient receives treatment from a rehab aide d. Two clinicians providing therapy to a single patient during the same treatment session e. To be honest, I'm really not sure	77.3%	(a)—65.8%

Note: Correct response is underlined.

Table 6

Predictors of Medicare Knowledge Score

Variable	*p*	*B*	SE_B	95% CI	
				LL	UL
(Constant)		34.03	5.57	23.08	44.98
Self-Assessment Score	<.001	1.82	.35	1.12	2.51
Gender	.006	4.26	1.55	1.21	7.31
Current Clinician Manager Role	.036	-1.26	.60	-2.44	-.08
Level of Education	.005	1.52	.54	.46	2.58
Years of Experience in Current Role	<.001	.35	.10	.17	.53

Note: *B* = unstandardized regression coefficient; SE_B = standard error of the coefficient; CI = confidence interval; *LL* = lower limit; *UL* = upper limit

Appendix A

Recruitment Email to Participants

Dear Clinician Manager,

My name is Becky Finni and I am an Occupational Therapist and Appeal Specialist with RehabCare. I am conducting this research study as part of my completion of the Doctor of Health Sciences degree at the University of Indianapolis. The purpose of this research study is to better understand the knowledge base and expertise of Occupational Therapy (OT), Physical Therapy (PT), and Speech Language pathology (SLP) clinician managers regarding Medicare guidelines for documentation and reimbursement of rehabilitation services in the skilled nursing facility (SNF) setting.

This survey should take no more than 10 minutes to complete. Your answers will help provide important information about current awareness and understanding of Medicare regulations utilized daily as part of managing a rehab department in a SNF setting. To date, little to no research has been conducted studying this critical piece of management expertise in the SNF setting.

This survey is being sent to RehabCare clinician managers, including Area Directors of Operations (ADOs), Market Program Directors (MPDs), Program Directors (PDs), and Rehab Clinical Leaders (RCLs). Participation in this research is completely voluntary.

Your individual responses will be anonymous and will not be shared with anyone, including your employer.

As a token of appreciation, respondents who complete the survey will be given the option to enter into a drawing for one of 15 $25 Amazon or Visa gift cards. Estimated odds of winning are approximately 1 in 30.

This research project has been reviewed and approved by the University of Indianapolis Human Research Protections Program. Please direct any questions or concerns about this study to Dr. Beth Ann Walker at walkerba@uindy.edu or Rebecca Finni at finnir@uindy.edu.

If you are interested in participating in this study, please click the link below to begin the survey.

Begin Survey

Thank you in advance for your time and consideration. We look forward to your responses!

Rebecca Finni, MS, OTR/L

University of Indianapolis

finnir@uindy.edu

Appendix B

Inclusion Criteria

- Currently employed as Area Directors of Operations (ADOs), Market Program Directors (MPDs), single-site Program Directors (PDs), and Rehab Clinical Leaders (RCLs), and performing within a clinician manager role at the time of survey initiation, defined as overseeing a rehabilitation department or departments within the company's contracted skilled nursing facilities
- Must be an occupational therapy, physical therapy or speech language pathology clinician (thereby excluding non-clinician managers found in a small number of the contracted facilities), and could be therapists or assistants
- Must be able to access corporate email via computer to utilize the link to the survey

Exclusion criteria

- Non-clinicians performing the clinician manager role
- Acting clinician managers from another practice setting (such as hospital-based therapy services or exclusively outpatient settings) who were filling in temporarily for the SNF clinician manager position

Appendix C

Survey

My name is Becky Finni and I am an Occupational Therapist and Appeal Specialist with RehabCare. I am conducting this research study as part of my completion of the Doctor of Health Sciences degree at the University of Indianapolis.

Purpose: The purpose of this research study is to better understand the knowledge base and expertise of Occupational Therapy (OT), Physical Therapy (PT), and Speech Language pathology (SLP) clinician managers regarding Medicare guidelines for documentation and reimbursement of rehabilitation services in the skilled nursing facility (SNF) setting.

Participants: This survey is being sent to all clinician managers, including Area Directors of Operations (ADOs), Market Program Directors (MPDs), Program Directors (PDs), and Rehab Clinical Leaders (RCLs). Participation in this research is completely voluntary.

Survey: Time for completion is estimated to be less than 10 minutes. This survey will: 1) gather clinician manager demographic data; 2) ask you to rate your perceived level of knowledge regarding Medicare guidelines for documentation and reimbursement of rehabilitation services in the SNF setting; and 3) test your knowledge regarding

Medicare guidelines for documentation and reimbursement of rehabilitation services in the SNF setting through a series of 18 questions. **This survey should be completed without the use of any additional resources, as it is meant to test your basic knowledge and awareness of Medicare guidelines.**

Responses: While answering every question is not mandatory, please answer to the best of your ability. You may choose to leave a question blank in Parts 1 and 2 of the survey. In Part 3, if you are unsure of the answer, please choose the last answer choice.

Confidentiality: Your privacy and the confidentiality of your information will be maintained to the degree permitted by the technology used. To further protect your privacy, you should complete the following research activity in a private location (e.g., home, personal office, etc.) using a private device and a secure transmission/ communication system. Your participation in this online research project involves risks similar to a person's everyday use of the Internet.

All survey responses will be kept completely confidential. Please do not include any personally identifying information (e.g. your name, initials, facility name) in your responses. All data will be stored on a password-protected computer, and submission of responses will be encrypted. The survey will not associate your internet protocol (IP) or email address with your responses. Only study researchers will have access to your responses and all demographic data will be reported in aggregate (individual demographics will not be reported).

Withdrawal: Participants may withdraw from this study at any time by exiting the survey or closing their browser window.

Contacts: This research project has been reviewed and approved by the University of Indianapolis Human Protections Administrator, who has the responsibility of protecting the rights and safety of research participants. If you have questions about your rights or protections as a participant in this research project, then contact the Human Protections Administrator, Dr. Greg E. Manship, at manshipg@uindy.edu or (800) 232-8634, ext. 5774.

Please direct any questions or concerns about this study to Dr. Beth Ann Walker at walkerba@uindy.edu or Rebecca Finni at finnir@uindy.edu.

Consent: Your individual responses will be anonymous and will not be shared with anyone, including your employer. If you agree to participate in the study, please go to the next page to begin the survey.

Thank you so much for your time!

Part 1 – Demographics

1. Please identify the credential you are currently using for clinical practice (if you are currently working with more than one credential, please check all that apply):

   ____Occupational Therapist (OT)

   ____Occupational Therapy Assistant (OTA)

   ____Physical Therapist (PT)

   ____Physical Therapist Assistant (PTA)

   ____Speech Language Pathologist (SLP)

   ____Other (please specify) _____

2. What is the highest level of education/degree you have completed?

   ____Associate

   ____Bachelor

   ____Master

   ____Entry-level doctorate

   ____Post-professional doctorate

   ____Research doctorate (PhD, EdD, etc.)

3. Please describe how many years of experience you have as a practicing clinician in the discipline identified in question 1:

   ____ years

4. Please describe how many years of experience you have as a practicing clinician within the SNF setting:

____ years

5. What is your current clinician manager role:

____ Area Director of Operations

____ Market Program Director

____ Single-site Program Director

____ Rehab Clinical Leader

____ Other (please specify)

6. Please describe how many years of experience you have in a clinician manager role:

____ years

7. Please identify the geographic region in which you perform your clinician manager role:

____West (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY)

____South/Central (AR, LA, NE, OK, MS, ND, SD, TX)

____ Midwest (IA, IL, IN, KY, MI, MN, MO, ND, OH, WI)

____Southeast (AL, FL, GA, NC, SC, TN, VA, WV)

____ Northeast (MD, DC, DE, PA, NJ, NY, MA, CT, RI, VT, NH, ME)

8. Please identify your gender:

____male

____female

____prefer not to answer

9. In the past 5 years, approximately how many FORMAL hours of training have you received **from your (current or previous) employer** related to Medicare guidelines for documentation and/or reimbursement?

____ None

____ Less than 2 hours provided

____ 2 to 5 hours

____ 5-10 hours

____ 10 or more hours

Comments: _____

10. In the past 5 years, approximately how many FORMAL hours of training have you received **from a non-employer source (e.g. conference, online course, etc.)** related to Medicare guidelines for documentation and/or reimbursement?

____ None

____ Less than 2 hours provided

____ 2 to 5 hours

____ 5-10 hours

____ 10 or more hours

Comments: _____

11. Please identify your preferred method of learning information related to your clinician manager role. Select all that apply:

____independent study outside of work

____continuing education course

____employee-sponsored presentation

____computer-based training

____professional organization conference

____other (please specify)_____

12. Did your degree curriculum include any coursework on Medicare regulatory and/or documentation requirements?

____yes

____no

____ do not remember

Comments: _____

Additional comments or information you would like to share:

_____

_____

_____

Part 2 - Self-Assessment

Part 2 refers to *Medicare guidelines for documentation and reimbursement of rehabilitation services in the SNF setting*. These are guidelines directly impacting provision of therapy services, such as:

- **planning for and calculating Minimum Data Set (MDS) 3.0 Resource Utilization Groups (RUGs),**
- **requirements for specific documentation components (e.g. treatment notes, progress notes, co-treatments, etc), and**
- **regulatory requirements related to certifications, student supervision, and Part A versus Part B reimbursement.**

These regulations would be utilized daily as part of managing a rehab department in a SNF setting.

Part 2 does NOT refer to billing methods, claims processing, or other tasks typically performed by the billing department.

1. How confident are you with **your** perceived level of **personal knowledge** regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting?

very confident	confident	somewhat confident	slightly confident	not confident at all
5	4	3	2	1

2. What is **your** perceived level of **personal knowledge** regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting **compared to <u>other clinician managers</u>**?

much higher	higher	about the same	lower	much lower
5	4	3	2	1

3. What is **your** perceived level of **personal knowledge** regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting **compared to <u>other non-management/staff clinicians</u>**?

much higher	higher	about the same	lower	much lower
5	4	3	2	1

4. How **satisfied are you with your previous training** regarding Medicare documentation and reimbursement guidelines specific to rehabilitation services in the SNF setting?

highly satisfied	fairly satisfied	neutral	not very satisfied	not at all satisfied
5	4	3	2	1

Additional comments or information you would like to share:

_____

_____

_____

Part 3 - Medicare Knowledge Questions Related to SNF Therapy Services

Part 3 tests your knowledge of *Medicare guidelines for documentation and reimbursement of rehabilitation services in the SNF setting*. These are guidelines directly impacting provision of therapy services, such as:

- **planning for and calculating Minimum Data Set (MDS) 3.0 Resource Utilization Groups (RUGs),**
- **requirements for specific documentation components (e.g. treatment notes, progress notes, co-treatments, etc), and**
- **regulatory requirements related to certifications, student supervision, and Part A versus Part B reimbursement.**

These regulations would be utilized daily as part of managing a rehab department in a SNF setting.

Part 3 questions should be answered without the use of any additional resources. If you are unsure of the answer to a particular question, you may choose the last answer choice ("To be honest, I'm really not sure").

Medicare Part A Regulations:

1. To qualify for a skilled rehabilitation stay in a skilled nursing facility under Medicare Part A following an acute hospitalization for sepsis, patients must have been admitted to the hospital for a minimum of ___ consecutive midnights.
    1. 0
    2. 1

c. 2

d. 3

e. There is no minimum.

f. To be honest, I'm really not sure.

2. Physicians certify therapy services under Medicare Part A skilled rehabilitation stays by:

a. Completing the facility certification/recertification

b. Completing individual certification of each individual therapy plan of care

c. Physician certification of therapy services is not required under Medicare Part A

d. None of the above

e. To be honest, I'm really not sure.

3. A patient is receiving therapy services as part of a Medicare Part A rehabilitation stay. Which of the following calculations of rehab RUG level would be most accurate?

a. **RV** based on 5 days/265 minutes of occupational therapy and 4 days/242 minutes of physical therapy

b. **RU** based on 4 days/300 minutes of occupational therapy, 4 days 300 minutes of physical therapy, and 3 days/180 minutes of speech therapy

c. **RH** based on 3 days/95 minutes of occupational therapy and 5 days/200 minutes of speech therapy

d. **RM** based on 4 days/140 minutes of speech therapy.

e. None of the above

f. To be honest, I'm really not sure.

4. The 7-day lookback for skilled Medicare Part A stays reviews the number of days/minutes of therapy provided during those 7 days to see if what kind of MDS assessment might be required?

a. Change of Therapy (COT) assessment

b. End of Therapy (EOT) assessment

c. Start of Therapy (SOT) assessment

d. Any of the above might be required

e. To be honest, I'm really not sure.

5. A skilled Medicare Part A patient is currently being treated at the RU RUG level. If the patient receives 700 of the projected minutes during the 7-day lookback period, what happens to billing/reimbursement?

a. Continue to bill the RU RUG and provide an extra 20 minutes the following week

b. Complete an EOT assessment and discharge the patient; patient can be re-evaluated after 3 days

c. Complete a COT assessment and prior seven days will be billed at the next lower RUG (RV)

d. Continue to bill the RU RUG; no additional minutes will be required the following week

e. To be honest, I'm really not sure.

6. According to Medicare Part A regulations, what is the level of supervision for a student providing treatment in a skilled nursing facility?
    a. Line of sight supervision
    b. Direct supervision as determined by the supervising therapist/assistant
    c. Off-site supervision, supervising clinician must be available by phone
    d. Students cannot independently provide and code treatment minutes under Medicare Part A
    e. To be honest, I'm really not sure.

Medicare <u>Part B</u> Regulations:

7. Therapy services billed under Medicare Part B require a physician (or non-physician practitioner) signature to certify the plan of care (evaluation or recertification) within ____ days of plan of care completion.
    a. 10
    b. 14
    c. 30
    d. 90
    e. To be honest, I'm really not sure.

8. The **MAXIMUM** timeframe a Medicare Part B therapy plan of care can be certified by the physician (before recertification would be required) is ____ days.
    a. 30

b. 60

c. 90

d. There is no maximum. The plan of care duration can be as long as the evaluating OT/PT/SLP deems appropriate.

e. To be honest, I'm really not sure.

9. Therapy services for occupational therapy, physical therapy, and speech therapy billed under Medicare Part B require therapy providers to meet the 10th visit requirement for progress notes. Medicare's "10th visit" requirement includes:

a. A written progress note by the physical therapist, occupational therapist or speech language pathologist

b. Therapist co-signature on a progress note written by a therapy assistant to demonstrate supervision

c. A minimum of 30 minutes of billable service on 1 day of treatment by the physical therapist, occupational therapist or speech language pathologist

d. Physician certification for the next 10 days of treatment

e. To be honest, I'm really not sure.

10. Modifier-**59** is added to Medicare Part B therapy service charges to denote a separate and distinct procedural service. Which of the following is a situation where the -59 modifier should be used?

a. A clinician performed manual therapy (97140) and therapeutic exercise (97110) during the same 15 minute block of time.

b. A speech language pathologist provided dysphagia treatment (92526) and speech treatment (92507) on the same day.
c. Physical therapy performed gait training (97116) on the same day that occupational therapy provided orthotics fitting of a hand orthotic (97760).
d. None of these would require the -59 modifier.
e. To be honest, I'm really not sure.

11. Medicare Part B therapy services provided in calendar year 2017 require the use of the KX modifier for charges above and beyond which therapy cap amounts?
a. $1980 for PT; $1980 for OT; $1980 for ST
b. $1980 for OT, PT, and ST combined
c. $1980 for OT; $1980 for PT and ST combined
d. $1980 for PT; $1980 for OT and ST combined
e. To be honest, I'm really not sure.

12. According to Medicare Part B regulations, what is the level of supervision for a student providing treatment in a skilled nursing facility?
a. Line of sight supervision
b. Direct supervision as determined by the supervising therapist/assistant
c. Off-site supervision, supervising clinician must be available by phone
d. Students cannot independently provide and code treatment minutes under Medicare Part B
e. To be honest, I'm really not sure.

Medicare Regulations related to <u>Therapy Provision and Documentation</u>:

13. Medicare requires that occupational therapy, physical therapy, and speech therapy plans of care contain which of the following:
    a. Amount, frequency, and duration of treatment to be provided
    b. Results of standardized tests performed on evaluation
    c. Legible handwritten signature (or validated electronic signature) and professional identity of individual who established the plan
    d. Answers a and b
    e. Answers a and c
    f. Answers b and c
    g. To be honest, I'm really not sure

14. Daily treatment notes required by Medicare **MUST** include which of the following:
    a. Date and time treatment was performed
    b. Identification of each specific intervention/modality provided and billed (both timed and untimed codes)
    c. Total treatment minutes for timed codes only
    d. Patient's subjective comments and response to treatment
    e. To be honest, I'm really not sure.

16. Which of the below represents a way to correctly code and bill a 60-minute therapy session using the 8-minute rule?

a. 60 minutes of dysphagia treatment (1 unit 92526)
b. 20 minutes of therapeutic procedures (1 unit 97110), 20 minutes of therapeutic activities (1 unit of 97530), and 20 minutes of neuromuscular re-education (1 unit of 97112)
c. 52 minutes of gait training (3 units of 97116) and 8 minutes of therapeutic activities (1 unit of 97530)
d. Answers a and b
e. Answers a and c
f. Answers b and c
g. To be honest, I'm really not sure.

16. **Group therapy** provided by one therapy clinician for multiple patients requires which of the following**:**
    a. Patients are performing different activities but working on similar goals
    b. Groups must contain at least 4 and no more than 6 patients
    c. Minutes are divided by number of group participants and coded as group minutes on the MDS for skilled Medicare Part A patients
    d. A 45 minutes group therapy session would be coded as 3 units of group therapy (97150 or 92508) for each participating Medicare Part B patient
    e. To be honest, I'm really not sure

17. Which of the following treatment scenarios would be considered **concurrent therapy**:

a. One clinician providing treatment to two patients at the same time; patients are performing same or similar activities
b. A therapy student treating one patient and the supervising clinician treating another patient
c. A clinician providing treatment to one patient while another patient receives treatment from a rehab aide
d. Two clinicians providing therapy to a single patient during the same treatment session
e. To be honest, I'm really not sure

18. **Co-treatment** provided to a single patient requires which of the following**:**

a. Documentation must support the medical complexity of the patient that necessitates two or more therapy clinicians during the same treatment session
b. For skilled Medicare Part A patients, both clinicians may code and bill the treatment minutes in full
c. For Medicare Part B patients, both clinicians may code and bill the co-treatment minutes in full
d. For Medicare Part A patients, a clinician may bill for treatment minutes provided with a therapy aide as part of an established therapy treatment plan
e. To be honest, I'm really not sure.

Appendix D

Final Page of Survey

Thank you for your willingness to participate in this study. Your responses will help provide new and important data regarding this critical piece of management expertise in the SNF setting.

To be entered into the drawing for one of fifteen $25 gift cards, please send your name and gift card preference (Amazon or Visa) to my email at finnir@uindy.edu.

This information will not be linked to your survey responses in any way. Winners will be notified by email on or before April 30th.