T- 09
Up Up and Away with Mediocre Therapy Documentation

Carol Ashdown M. A. CCC-SLP
RAC-CT CHC

Carol Ashdown is a Regional Vice President of Consulting for Exponential Consulting Services specializing in Medicare, Therapy, PPS, MDS, and Medicaid consulting services. She is a Speech Language Pathologist and an expert clinician in the areas of dysphagia management; cognitive linguistic training; Medicare guidelines for documentation; coding; and reimbursement. Carol has more than 22 years of experience in the long term care industry. She has held a variety of positions within those settings including staff therapist; Director of Rehabilitation; Regional and Area Director of Operations; Clinical Specialist; Director of Clinical Operations and Regional Consultant. In these roles, Carol has been responsible for staff development and education in order to facilitate the delivery of quality clinical rehabilitation services; optimize reimbursement; maintain regulatory compliance. Carol has experience in Medicare reviews and the denials process. As Regional Vice President of Consulting, Carol provides multi-state on-site auditing of the MDS, nursing and rehabilitation documentation; and consults on the prevention, management and response to denials; as well as contributes to the development of effective skilled nursing and rehabilitation programs. Carol has presented on topics related to clinical service delivery; Medicare reimbursement; Meeting the Needs of the Long Term Resident; Skilled Nursing and Rehabilitation Documentation; Case Mix; ADL Coding; Mentoring; PEPPER. She belongs to the ASHA special interest divisions for geriatric care and supervision. Carol is a graduate of the ASHA Leadership Development Program. Carol holds the Healthcare Compliance Certification and is RAC-CT certified as well as has completed training on the implementation of electronic health records. She is a member of the Healthcare Compliance Association.

Objectives:

- Participants will comprehend basic Medicare criteria for Skilled Rehabilitation Services
- Participants will understand Medicare covered rehab services as well as coverage limitations.
- Participants will identify key aspects of therapy documentation that are reviewed to support medically necessary services
- Through group exercises, participants will demonstrate effective documentation skills that reflect clinical reasoning and supports medical necessity.

For Medicare Part A which of the following are areas of skilled coverage:

A. Observation & Assessment.
B. Management & Evaluation.
C. Teaching & Training.
D. Direct Skilled Nursing Services.
E. Skilled Rehabilitation Therapies
F. Rest and Relaxation
G. All but F

G. All but F.

True or False:

Nursing and Therapy documentation needs to be supportive and collaborative.

- True

Documentation is:

A. Busy work
B. A means of communicating quality of care
C. A means for reimbursement.
D. Demonstration of the skilled service provided.
E. All but A
F. All of the above.

E. All but A

True or False:

A factor in determining if services provided are medically necessary is whether the skills of a therapist are required.

True

For therapy to reasonable and necessary:

A. There needs to be a significant change of condition
B. The therapists just needs to say so
C. Accepted standards of medical practice
D. Specific and effective treatment for the patient's needs
E. Amount, frequency and duration meets the patient's medical needs.
F. All but B

F. All but B

Question

What does ADR stand for?

A. Additional Development Request
B. A Dumb Request
C. Assessment Reference Date
D. A Doctor's Referral
E. All of the above

A. Additional Development Request

Question

Lack of quality documentation will lead to:

A. Reflection of poor nursing and therapy care
B. Poor resident outcomes
C. Poor survey results
D. Increase in denials
E. Ultimately loss of revenue
F. All of the above

F. All of the Above.

Medicare Part A

Defined 5 Fundamental Areas of Skilled Coverage

1) Management & Evaluation.
(2) Observation & Assessment.
(3) Teaching & Training.
(4) Direct Skilled Nursing Services.
(5) Skilled Rehabilitation Therapies.

A skilled service is a service that:

- **Requires the skills of a qualified technical of professional health personnel (RN, LPN, PT, OT, ST, RT)**
- **Is provided directly by or under the general supervision of a licensed nurse of skilled rehabilitation personnel (requires initial directions and periodic inspections of activity)**
- **Is ordered by a physician**
- **Is provided on a daily basis for nursing and 5 days per week by therapy.**

What is Medicare Entitlement?

A Government Benefit Earned by the Recipient

- Available to people 65 years or older
- Available to people who are disabled for greater than 24 months who are under 65 years of age
- End stage renal disease-dialysis or transplant

Medicare Eligibility in a SNF

- Person must have had a 3 consecutive day (midnights) hospital stay within 30 days of admission to the SNF
- Person must reside in a certified bed
- Must require a daily skilled service
- Must be certified and re-certified by the physician

Importance of documentation:

- Professional responsibility
- Ensures good communication between disciplines
- Legal requirement
- Tool to ensure that services were provided safely and effectively
- Compliance with local, state, and federal guidelines.
- Ensures reimbursement for services provided.
- Research

If something is not documented—it did not happen

Current Healthcare Audits

Auditor	Auditing Contractors	Type of Claims	Claim Selection	Type of audit	Purpose of review
CERT	N/A: CERT Contractor administered by the Centers for Medicare and Medicaid Services (CMS)	All medical claims.	Random	Post payment review; complex only (involving additional documentation).	To measure improper payments.
MAC	J1: Palmetto GBA J9: First Coast Service J2: CIGNA, NAS, WPS Options, Inc. J3: Noridian (NAS) J10: Cahaba GBA J4: Trailblazer J11: Palmetto GBA J5: WPS J12: Highmark J6: Noridian (NAS) Medicare Services J7: Cahaba, Pinnacle J13:NGS WPS J14: NHIC J8: NGS J15: CIGNA Medicare Administrative Contractors	All Medicare fee-for-service claims.	Targeted	Prepayment and post payment; automated and complex.	To prevent improper payments.
RAC	Region A: Diversified Collection Services (DCS) Region B: CGI Region C: Connolly, Inc. Region D: HealthDataInsights, Inc. RAC States and Contact Information	All Medicare fee-for-service claims; Medicare Advantage claims; Medicaid claims.	Targeted	Post payment; automated and complex.	To detect and correct past improper payments.
ZPIC/PSC	Health Integrity; AdvanceMed; SafeGuard Services; Trust Solutions; and Integriguard	All Medicare fee for service claims.	Targeted	Post payment; automated and complex.	To correct improper payments, to identify potential fraud.
Office of Inspector General (OIG)	N/A: Department of Health and Human Services OIG	All medical claims.	Targeted.	Post payment; complex.	To identify potential fraud

Most Common Reasons for Denial

14. ADR not responded to within the required timeframe.
13. Services are considered to be of a maintenance not restorative nature.
12. Services are not specific to the patient's condition or the referring physician's diagnosis.
11. Amount, frequency, and duration of services were unreasonable given the diagnosis.
10. Subjective measurement as opposed to more measurable data.

9. Services provided did not require "skilled" services.
8. No evidence of initial referral or renewal referrals for therapy services.
7. Unmodified treatment for a prolonged period.
6. Patient fails to make "significant, sustained, functional progress".
5. Paucity or lack of skilled/clinical documentation.
4. Low/no patient compliance. Therapist fails to document "significant, sustained, functional progress"

3. Failure to use ICD-9 codes from the FI's LCD.

2. No prior level of function and/or baseline function for the functional areas addressed in the goals.

1. Lack of Medical Necessity

CMS Guidelines for Documentation

- The documentation guidelines in sections 220 and 230 of the **Medicare Benefit Policy Manual Chapter 15** identify the minimal expectations of documentation by providers or suppliers for payment of therapy services to the Medicare program.
- Local Coverage Determinations **(LCD)** will identify more specifically coverage and coverage limitations to your specific FI and/or MAC.
- **State or local laws and policies**, or the policies of the profession, the practice, or the facility may be more stringent.
- Additional documentation not required by Medicare is encouraged when it conforms to professional guidelines of the **state practice act** and/or state professional associations.

Medical Necessity

- Significant potential for improvement in response to therapy
- Restoration of impaired functions
- Development of maintenance programs
- Amount of improvement anticipated should be reasonable when compared to amount of therapy required to achieve goals
- Realistic functional outcomes

Medical Necessity

- Requires unique skills of therapist to make functional improvements
  - Complex patient condition and/or sophistication of treatment provided
  - Services that can be performed by or taught to nonskilled persons or can be completed as an independent program are not skilled therapy
- The diagnosis or prognosis is never the sole factor in deciding that a service is or is not skilled
- The key issue is whether the skills of a therapist are needed to treat the illness or injury

Where do we document medical necessity?

- Evaluation
- Plan of care
- Daily Therapy Notes
- Progress Reports
- Recertification
- Discharge Summaries

Therapy documentation

Painting the picture……

- Create an initial impression of the patient
- Provide the details of the current status
- Detailed Treatment plan
- Ongoing demonstration of your role in the patient's recovery

Evaluation: Introductory Information

- **Coding**
- **Reason for Referral**
  - History of current illness
  - Past medical history
- **Prior level of function**
- **Current Level of function**
  - Precautions
- **Plan of Care:**
  - Correlates with diagnosis
  - Supported by the evaluation findings
- Treatment Goals:
  - Reflect evaluation findings
  - Correlate with treatment plan
  - Patient oriented, measureable, functional and time based.

Coding:

- Primary medical diagnosis:
  - Results in the condition that requires skilled
  - therapy intervention
  - ***Must*** match or be directly related to the diagnosis
    - for the qualifying 3-day hospital stay
- Treatment diagnosis:
  - Code that best describes your treatment intervention.

Does this coding support Medical Necessity?

PT Evaluation:

Primary Diagnosis: S/P Left hip fracture ORIF

Treatment Diagnosis: Difficulty Walking

Does this coding support Medical Necessity?

ST Evaluation:

Primary Diagnosis: Left hip fracture

Treatment Diagnosis: Oral Pharyngeal Dysphagia

Reason for referral:

Specific information related to functional improvement; functional decline; safety issues; potential or risk for exacerbation or decline in medical condition.

Does this Reason for Referral support Medical Necessity?

OT Evaluation:

Reason for Referral: New admit

Does this Reason for Referral support Medical Necessity?

PT Evaluation:

Reason for Referral: Patient was referred to skilled PT to address gait abnormality, muscle weakness, balance impairment due to extended hospital stay for pleural effusion and sternal wound.

Prior Level of Function:

Specific information related to the resident's functional abilities prior to the onset of their injury or illness.

Goals are based upon prior level of function and specific to the discharge destination of the patient.

Documentation should answer the question, *what was the patient able to do prior to the incident or onset this will help justify your goal*

Does this statement describe **prior level of function**?

PT Evaluation:

Pt. lived at home I. He has 3 steps to get in and out of his home. He ambulated I with a WW. His only bathroom is on the second floor and he was able to negotiate up but required assist to negotiate down.

Does this statement describe **prior level of function?**

ST Evaluation:

Patient lived at home independently. Able to ambulate with a walker.

Current Level of Function:

- objective measurements
- standardized test measurements
- ensure functional deficits
- Rehab potential

Documentation should answer the question, *because of the deficits identified in the assessment what functional impairments does the patient exhibit?*

Does this **Current Level of Function** support medical necessity?

ST Evaluation:

Oral Phase swallow function: impaired

Pharyngeal phase swallow function: impaired

Does this **Current Level of Function** support medical necessity?

ST Evaluation:

Oral Phase swallow function: impaired, characterized by oral transit time 30 seconds, with 50% oral residue following swallow on 4/5 trials.

Pharyngeal phase swallow function: impaired, characterized by delayed swallow reflex, 30 seconds, with delayed cough and throat clear following swallow on 4/5 trials.

Plan of Care:

- Correlates with diagnosis
- Supported by the evaluation findings

Treatment Goals:

- Reflect evaluation findings
- Correlate with treatment plan
- Patient oriented, measureable, functional and time based.

Does this **Goal** support Medical Necessity?

PT Evaluation:

Patient will improve LE strength.

Does this **Goal** support Medical Necessity?

PT Evaluation:

In 2 weeks, Patient will improve LE strength from 3/5 to 4/5 to facilitate functional transfer status to min assist.

Daily Treatment Notes:

- Skilled Services provided
- Justification for the codes billed for that day.
- Patient/Caregiver Instruction
- Therapist/Assistant Supervisory Activities
- Physical Agent Modalities

What are we providing to this patient that requires your skill and knowledge as a healthcare professional?

Does this **Daily Treatment Note** support Medical Necessity?

ST Note: Resident is cooperative, instruction and training in compensatory swallow strategies including Musako and Shaker techniques to facilitate safe swallow. Resident is able to apply with max cues. Skilled observation and assessment during food intake of mechanical food items indicated no overt signs/symptoms of aspiration 100% of the time.

Does this **Daily Treatment Note** support Medical Necessity?

ST Note: Resident is cooperative, seen during meal. No problems noted.

Progress Report:

- Documentation of functional progress
- Justification for continued treatment
- Skilled intervention provided
- Evidence of therapist involvement

What functional progress toward this patient's goals have been made?

Recertification/ Update POC:

- Documentation of progress made
- Justification for continued treatment
- Adjustment and modifications of the plan based on patient's response to treatment
- Recommendation for modalities, frequency and duration, updated goals

Why does this patient continue to require medical necessary services; what adjustments to this plan of care need to be made and why does it require the skills of a licensed therapist?

Discharge Summary:

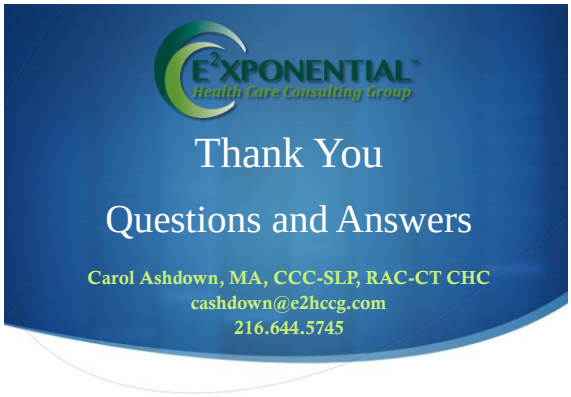
- Summary of patient progress and response to therapy
- Detail the appropriate discharge planning
- Reflection of the caregiver/patient education and the response to the education.

What overall functional progress has been made; what skilled services have been provided; what education and training have been addressed to ensure safe and effective discharge?

Case Study:

Review the documentation to determine whether you would pay this claim.

Be prepared to discuss why you would or would not pay the claim and rationale.


E2XPONENTIAL
Health Care Consulting Group
Thank You
Questions and Answers
Carol Ashdown, MA, CCC-SLP, RAC-CT CHC
cashdown@e2hccg.com
216.644.5745