Objectives

1. Define the top ten components of effective rehab clinical documentation to include in therapy staff training.
2. Understand rehabilitation service medical review trends.
3. Identify steps to improve medical review outcomes, documentation quality and program compliance.

1st Component of Effective Rehab Clinical Documentation

Establish Medical Necessity

Medical Necessity

Support Intensity & Duration/LOS
Progress Reports
Quantify Impairments
Skilled Assessment & Individualized POC

2nd Component of Effective Rehab Clinical Documentation

Prior Level of Function

Rehab Medical Necessity

Why are skilled therapy services needed now?
- Recent change in condition that warrants an evaluation.
- New events + new changes + likely to benefit from skilled rehab
  - Medical need (diagnosis, complexities)
  - PLOF compared to current function with objective measurements
  - Defined positive expectation for timely improvement with skilled rehab.
  - OR Defined need for skilled services to establish or update a maintenance program.
Prior level of Function (PLOF)

- Compare current function to prior function to clearly define a significant change
- PLOF = patient's BEST functional performance within the last 3-6 months
- PLOF noted outside of therapy notes is helpful (physician, social services, nursing, ...)
- LTGs should not be set higher than the PLOF

Training Tip: Provide Examples

- Living Arrangement: home alone, home with daughter who works 10 hrs./day, apartment with non-ambulatory husband
- Living Environment: stairs with/without hand rail, 1 or 2 story home, carpet/hardwood, bed/toilet 2nd floor
- Adaptive Equipment: shower chair, standard w/c, rolling walker, grab bar in bathroom
- IADL's: driving, house work, meal preparation, communication, med management, bills
- Community: grocery shopping, church, exercise class 3 days/week, walking distance, social
- Roles/Hobbies: babysits grandkids, cares for a dog, golf
- Previous Therapy/Restorative Programs: SLP in December 2019 for dysphagia with good outcome consuming regular diet, participated in a restorative walking program (300 ft. daily) prior to new onset knee pain hindering participation

Establish Effective Baselines

Establishing Baseline: Objective Measures

Why can't the patient ambulate safely?
- Due to his narrow BOS of 2" compared to the norm of 3" and slow cadence of 60 steps/minute compared to norm of 81-126 steps/minute.

Quantify Impairments

- Summarize objective functional findings that support goals such as level of assistance, pain, activity tolerance, etc.
- Objective data at evaluation to prove functional progress later
- Clarify analysis of underlying impairments that are contributing to deficits
- Go above & beyond Functional Assessment Scoring

Formal Testing

- Testing & interpretation of result reflects skill
- Guides goal setting & evolution of treatment
- Helps to justify evaluation complexity code

"The use of scientific evidence, obtained from professional literature, and sequential measurements of the patient’s condition during treatment is encouraged to support the potential for continued improvement that may justify the patient's need for therapy."

CMS Benefit Policy Manual (Pub 100-02, 220.2)
**Measurable & Functional Goals**

- POC should include one LTG for each STG
- Each goal should have baseline measure, PLOF, & be functional/measurable
- LTGs set for the full duration of the plan
- STGs set to be achieved in a single progress report period
  - Use %s to show incremental gains when not met
  - Update STGs as you achieve them
  - Provide status update each progress report & revise goals that are not progressing
  - Break down tasks into component skills
- Avoid duplication of services across disciplines

**Therapy POC: ICD-10 Codes**

- Diagnosis codes should describe the condition(s) and symptoms that support medical necessity of therapy.
- Effective coding is the first level of defense to succeed under automated medical review.
- Take the time to choose individualized codes to paint the picture of why you are getting involved.

**Updated COVID-19 ICD.10-CM Codes**

Six New ICD.10-CM Diagnosis Codes added related to COVID-19 effective January 1st, 2021:

- J12.82 - Pneumonia due to COVID-19
- M35.81 - Multisystem Inflammatory Syndrome
- M35.89 - Other specified systemic involvement of connective tissue
- Z11.52 - Encounter for screening for COVID-1 (Note: Per ICD-10-CM coding guidelines, this code should NOT be used during the pandemic)
- Z20.822 - Contact with and suspected exposure to COVID-19
- Z86.16 - Personal History of COVID-19


**Skilled Interventions**
Therapy Denial Example - Lack of Skill

... the therapy progress notes contain very little information about the services actually provided, especially considering the number of minutes spent in therapy per day and the duration of the services, which was approximately four weeks. Although the beneficiary may have benefited from the intense rehabilitation provided, this is not sufficient reason for Medicare to cover such services. Those services that were documented were not so inherently complex as to require the sophistication and knowledge of a therapist. Most deconditioned elderly Medicare beneficiaries would benefit from skilled therapy services, but the extent and duration of the services must be reasonable. The evidence does not support that skilled therapy services were reasonable and necessary... and are therefore denied.

MAC Example - Skilled Therapy Definition

- A service is not considered a skilled therapy service merely because it is furnished by a therapist.
- A service can be self administered or safely and independently furnished by an unskilled person, without the direct supervision of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnished the service.
- The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a therapist furnishes the service.
- If a patient’s therapy program was planned and effectuated through a HEP, self-management program, RNP, or some similar assisted program, payment cannot be made for therapy services.
- If a service can be done by the patient, aides, or other caregivers without the active participation of a qualified therapist, they are non-skilled.
- While a beneficiary’s particular medical condition is a valid factor in deciding if therapy services are needed, a beneficiary’s diagnosis or prognosis should never be the sole factor in deciding if a service is or is not skilled.
- The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury.
- If at any point in the treatment it is determined that the treatment becomes repetitive and does not require the unique skills of a therapist, the service is non-skilled.
- The use of therapy equipment such as gym machines alone does not necessarily make the treatment skilled.
- Avoid repeating the same phrases each progress report.
- Skilled terminology, clinical reasoning, self management program, RNP, or use only relevant.
- Evolution of Course: Planned.
- Routine management based on established care plan.

Tips for Skilled Intervention Documentation

- Describe skilled techniques to support each CPT code billed
- Limit the software library phrases – use only relevant phrases that correlate with a goal
- Avoid repeating the same phrases each progress report
- Define evolution of care & ongoing skilled need

Skilled OT Example: Unique Skills

Non-skilled:
- Do not performed 25 reps of UE exercise all planes with 5 lb. resistance

Skilled:
- Functional postural-core stability for dynamic functional activity through progressive balance, arm exercise, and bilateral integration challenges. Reedco score 10/100 integrated reciprocal movement patterns based on PNF guidelines within limits of prescribed cardioregulatory precautions.
**Skilled PT Example: Knowledge**

- **Non-skilled:**
  Pt. ambulated 75' with extensive assist

- **Skilled:**
  Gait cadence 40 steps/min with RW (55 steps/min appropriate for unit/hallway locomotion). Impaired bilateral knee flexion ROM 25° (norm 35°) increasing risk of tripping due to foot/toe clearance during swing phase.

**Skilled ST Example: Sophistication**

- **Analysis of Functional Outcome/Clinical Impression**
  - Patient demo improved bolus control, oral transit & time of swallow initiation by 2 seconds with pureed consistency solids and thin liquids via cup without s/s of aspiration. Directed trials of soft solids and mechanical soft solids with patient demonstrating wet vocal quality in increased episodes of coughing pre/post swallow during therapeutic trials. Use of comp swallow strategies of throat clear/re-swallow was effective in clearing wet vocal quality. Patient required to continue with pureed consistency diet with thin liquids due to increased s/s and risk of aspiration.

- **Skilled Services**
  - Addressed laryngeal elevation/excursion and tongue base retraction with provision of MMES in 3b position with increasing intensity and no ill effects. Instructed patient in OME’s focused on laryngeal elevation/excursion and tongue base retraction with SLP providing verbal, visual and tactile cues. Educated patient regurgitating completing OME’s outside of therapy sessions with written instructions provided for exercise program. Facilitated oral clearance and airway protection via trained compensatory swallow strategies including bolus size modification. Therapist directed trials of soft and mechanical soft solids with analysis of bolus formation/control, oral transit, oral clearance and s/s of aspiration.

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**Reasonable Progress Expectation**

**Objective measures of:**
- Reduction in care requirements
- Reduced impairment
- Improved functioning
- Reduced risk

**Gains required SKILL**

**Gains sufficient in relation to resources expended**

**Therapeutic Goals**

- **Goals MET**
  - May choose to upgrade goal
  - Add new upgraded goal

- **Goals NOT MET**
  - Downgrade goal
  - Discuss how you will change your treatment approach, what new technique you will try
  - May include medical complexities
  - If you discontinue a goal, need to explain your reasoning

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**8th Component of Effective Rehab Clinical Documentation**

**Teaching & Training**
Effective Documentation for Teaching & Training

- Each Progress Report should include detailed patient/caregiver teaching and training that was completed.
- Teaching/Training should evolve & reflect a safe dc.

Example:
Instructed caregivers in safe set up of w/c in bathroom for sliding board transfer with placement of environmental markers for consistency across staff, placing sliding board and proper handling technique to initiate the transfer when moving toward non-hemiplegic side.

9th Component of Effective Rehab
Clinical Documentation

Mode(s) of Treatment & Minutes Management

Decisions on the modes of treatment, volume, intensity, frequency and duration of services should always be based on the clinical needs of the patient.

Recording Therapy Time

- Record exact time with no rounding minutes
- Planned treatment time is appropriate based on individual needs
- Minimum minutes thresholds
- Initial evaluation and subsequent re-evaluation
- Family education when the resident is present
- Skilled therapy time
- Time required to adjust equipment

Technical Compliance
Technical Compliance Quick Tips

- Review process for physician/NPP certification of the POC
  - Reconcile POC, orders, documentation with billing
- Treatment frequency clearly followed
- Daily notes support refused or withheld treatments
- CPT codes are relevant to the treatment provided
- Daily notes are present for group, co-treatment, orthotics, DPAM, wound care, etc.
- Organization approved abbreviations
- Clinical reasoning for group/concurrent on POC
- Organization timely documentation standards

Hindrances to Medical Review Success

- No initial status for goals
- Insufficient detail for goals
- Lack detail re: skilled interventions
- Lists of treatment activities and observations without info on skilled facilitation
- Skilled interventions not shown to support every code billed
- No training that addresses obstacles for safe DC transition
- No modification of approaches based on clinical complexity
- No test scores or detailed measures to show objective gains outside of goals
- No test score interpretation
- No implementation of new approaches based on test results
- Goals not met, but no plan adjustments
- Untimely notes

Approved RAC Topics

- Untimed Therapy – Excessive Units
- Outpatient Therapy Services During Home Health
- SNF Medical Necessity & Documentation Requirements
- SNF with PDPM: Medical Necessity & Documentation Requirements (opened September 2020)
- IRF – Medical Necessity & Documentation Requirements

MEDICAL REVIEW TRENDS

Overley & Wilson, Raucous 2021 Awaits FCA Litigants After Low-Key Year January 22, 2021

“Some of the new cases probably relate to more than $1 trillion doled out under COVID-19 stimulus legislation. Whenever there’s a gusher of government spending — as seen during the Iraq and Afghanistan wars and the 2007-2008 financial crisis — a spike in FCA cases usually follows.”

–Overley & Wilson, Raucous 2021 Awaits FCA Litigants After Low-Key Year, Law360
Managed Part A & Part B Overview

- Managed Part B
  - use of 59 Modifier typically not recognized
- UHC, Aetna & Anthem
  - Continue Medical Necessity, Coding, Billing Practices
  - Recently transitioning from RUG to PDPM
- Humana
  - Navicare Health
  - PDPM Reviews

Considerations for Establishing an Effective Quality Documentation Audit Process

The Audit Program

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<tr>
<th>Audits</th>
<th>Outcome Measures</th>
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<tr>
<td>Defined Standards</td>
<td>• Key standards &amp; subcomponent performance</td>
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<tr>
<td>Detailed Findings</td>
<td>• Therapist specific</td>
</tr>
<tr>
<td>Quarterly Review</td>
<td>• Discipline specific</td>
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<tr>
<td>Feedback</td>
<td>• Dept/region/organization</td>
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<tr>
<td>Outcome Measures</td>
<td>• Medical review error rates/Issues</td>
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</tbody>
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Substantive Audit

1. Medical Diagnosis selected adequately describe primary reason for therapy services and relevant complications to the highest specificity to support skilled therapy
2. To code(s) adequately describe symptoms, support the established POC
3. To the extent supported by documentation/assessment measures

Recommended using additional diagnoses when using medical necessity for not being very vague
Suggest lack of documentation, difficulty in coding, and/or denial audit

Projected Tools & Tactics

- POI Scale 3/7 improved to 6/7 by discharge, suggest SAFE or ASA as well
## Sample Audit Dashboard

### Overall Accuracy
- 75.60%
- Record Review 3.6

### Peer Distribution
- % Most High
- % High
- % Medium
- % Low
- % Most Low

### Discipline Distribution
- % Most High
- % High
- % Medium
- % Low
- % Most Low

## Auditing & Monitoring Case Study

### Prioritize Focus

### Track Results

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Meadows #1</th>
<th>Breezy Hill #2</th>
<th>Pinelake #3</th>
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## Staff Development

### Systems Updates/ Areas to Monitor

- Modes of therapy
- CPT Definitions
- Clinical meetings
- Compliance work plan
- QAPI activities
- Therapy provision & medical necessity documentation
- Covered Diagnoses for Wounds
- Triple Check process

### Staff Development

- Jim PT
- Donna OT
- Kim SLP

### Systems Updates/ Areas to Monitor

- Admissions process
- IDT Data Collection, Code Selection, Function Scoring
- Tracking Interrupted stays
- IPA: Identification of changes in condition + potential payment impact
- Clinical outcomes
- PHE Waivers for Skilled Care
- Medical review response

## Questions

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