NARA

PROACTIVE MEDICAL REVIEW

Rehab Medical Review & Auditing

Fundamentals of Success

Presented by:
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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

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

2nd Component of Effective Rehab Clinical Documentation

Prior Level of Function

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

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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

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3rd Component of Effective Rehab Clinical Documentation

Establish Effective Baselines

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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

LB Dressing: Min/Extensive assist 20%
Underlying impairments: LOB when standing requires mod A to correct, lower back pain 5/10 worse with forward flexion, unable to reach feet, impaired functional reach test (see score), and is unable to gather clothing items from closet or dresser due to visual impairment and SOA after only 2 minutes of ADL activity in standing

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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 81-125 steps/minute.

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 patients need for therapy."
CMS Benefit Policy Manual (Pub 100-02, 220.2)

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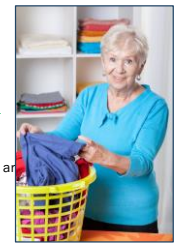
4th Component of Effective Rehab Clinical Documentation

Measurable & Functional Goals

Substantive 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



5th Component of Effective Rehab Clinical Documentation

Effective Medical & Treatment Diagnosis

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

See 2021 ICD-10-CM Coding Guidelines (pp 28-33) January update: https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

6th Component of Effective Rehab Clinical Documentation

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 benefitted 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.

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Demonstrating Skill

Skilled Documentation	Non-Skilled Documentation
✓ Skilled terminology, clinical reasoning, frames of reference, standards of care for condition being treated	▪ General observations & records of performance (ambulated 40'; 15 reps UE exercise)
✓ Tests with interpretations of results	▪ Vague CPT descriptors (gait training, coordination activities)
✓ Review & management of complexities impacting achievement of LTG/return to PLOF	▪ Routine management based on established care plan
✓ Evolution of Course: Planned adjustments based on patient response	

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MAC Example - Skilled Therapy Definition

- *A service is not considered a skilled therapy service merely because it is furnished by a therapist*
- *If a service can be self-administered or safely and effectively 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 furnishes 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 can proceed safely and effectively through a HEP**, self management program, RNP, or caregiver assisted program, payment cannot be made for therapy services.*
- *Services shall be of such a **level of complexity and sophistication** or the condition of the patient shall be such that the services required can only be safely and effectively performed by a qualified clinician.*
- *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 that 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**, or whether the service(s) can be carried out by non-skilled personnel*
- *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 services are non-covered.*
- *There may be circumstances where the patient, with or without the assistance of an aide or other caregiver, does activities planned by a clinician. Although these activities may be supportive to the patient's treatment, **if they can be done by the patient, aides or other caregivers without the active participation of qualified therapist, they are considered unskilled.***
- *The use of therapy equipment such as gym machines alone does not necessarily make the treatment skilled.*

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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
  - Ex: If there is not a goal for FMC, and FMC was marked intact on the POC – then do not select EMR phrases such as FMC techniques, thera-putty, zipping, buttoning, …
- Avoid repeating the same phrases each progress report
- Define evolution of care & ongoing skilled need

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Assessment and Summary of Skilled Services	
Skilled Interventions	Skilled Interventions Provided: Ther ex, ther act, self care management
Tests / Measures	Tests/Measures Administered in Reporting Period = Other
Patient Progress	Progress & Response to Tx: Patient is making consistent progress towards reaching ST and LT goals. Pt is currently sup for toileting. Mod a for lb dressing secondary to pain with bending. Pt has shown improvement in standing balance. Pt would benefit from continued therapy to further address deficit areas to maximize independence with ADLs.
Tests / Measures	Other : Fra
Supervision	OT/Asst. Supervision : Skilled services provided by therapist this reporting period, as well as with assistant.
Communication	Team Communication / Collaboration: Consultation with therapists to facilitate patient's highest level of functional independence and initiated patient discharge/transition planning with team.
Justification for Continued Skilled Services	
Impairments	Remaining Impairments: Decreased dynamic balance, Decreased safety awareness, Pain, Strength impairments and Balance deficits.
Continued Skill	Reason for Skilled Services: Patient requires skilled OT services to develop and instruct in exercise program, develop and instruct on adaptation techniques, develop and instruct on compensatory strategies, facilitate dynamic standing balance, facilitate independence with ADLs, increase functional activity tolerance, increase independence with ADL's and increase safety awareness in order to enhance patient's quality of life by improving ability to be able to return to prior level of living. Level of Skilled Services: The recommended level of skilled therapy services is required due to the following complexities and comorbidities that impact treatment: Age and Complicated medical history
Rehab Potential	Potential for Achieving Rehab Goals: Patient demonstrates good rehab potential as evidenced by High prior level of function and Motivated to participate.
Plan of Tx Focus	Focus of Plan of Treatment = Restoration,Compensation,Adaptation

Vague & ill-defined. Does not support need for therapist.

What is Fra? What is the interpretation of this test?

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Skilled OT Example: Unique Skills

Non-skilled:
Pt. performed 25 reps of UE exercise all planes with 5 lb. resistance

Skilled :
Facilitated postural-core stability for dynamic functional activity through progressive balance, proprioceptive, and bilateral integration challenges. Reedco score 55/100 moderate postural impairment impacting fall risk, functional reach & respiratory capacity. Initiated reciprocal movement patterns based on PNF guidelines within limits of prescribed cardiac precautions.

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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.

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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 NMES 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 regarding 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, solid/liquid alteration, effortful swallow and throat-clear/re-swallow. 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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7th Component of Effective Rehab Clinical Documentation

Reasonable Progress Expectation

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Reasonable Expectation of Progress

Objective measures of :

- **Reduction in care requirements**
- **Reduced impairment**
- **Improved functioning**
- **Reduced risk**

+

Gains required SKILL

+

Gains sufficient in relation to resources expended

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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

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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

Effective Documentation for Teaching & Training

Defend the skilled nature of the training conducted during each report period

- ✓ AE introduced,
- ✓ specific techniques taught
- ✓ specific cues
- ✓ environmental modifications made
- ✓ specific compensatory strategies
- ✓ specific caregiver training to improve performance and safety

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 mode(s) of treatment, volume, intensity, frequency and duration of services should always be based on the clinical needs of the patient.

Modes of Therapy Overview

Individual Therapy	The treatment of one resident at a time. The resident is receiving the therapists' or the assistants' full attention. Individual minutes do not need to be done consecutively. The total number of individual treatment minutes should be added together for each treatment
Concurrent Therapy	The treatment of 2 residents at the same time. These residents are not performing the same or similar activities. Both of these residents are in line of sight of the treating therapist or assistant. The 2 residents do not need to have the same insurance
Group Therapy	The treatment of two to six patients at the same time who are performance same or similar activities facilitated by a qualified rehabilitation therapist or therapy assistant
Co-Treatment	Two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each 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

10th Component of Effective Rehab Clinical Documentation

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

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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

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Update

MEDICAL REVIEW TRENDS

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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

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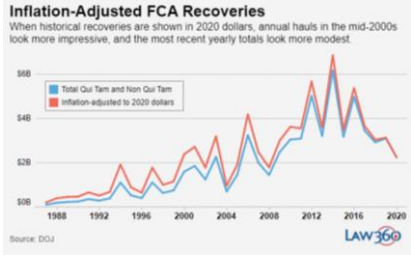

Overley & Wilson, *Raucous 2021 Awaits FCA Litigants After Low Key Year* January 22, 2021
Raucous 2021 Awaits FCA Litigants After Low-Key Year - Law360

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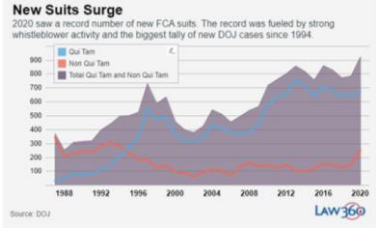

"Some of the new cases probably relate to more than $1 trillion doled out under COVID-19 stimulus legislation. Whenever there's a gusher of government spending — as seen during the Iraq and Afghanistan wars and the 2007-2008 financial crisis — a spike in FCA cases usually follows."
--Overley & Wilson Raucous 2021 Awaits FCA Litigants After Low-Key Year - Law360

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U.S. Department of Health and Human Services
Office of Inspector General

- Medicare Part B Payments for Speech-Language Pathology
- Home health Compliance with Medicare Requirements
- SNF Reimbursement
- Medicare Telehealth Services During the COVID-19 Pandemic
- Nursing Home Oversight During COVID-1 Pandemic
- Infection Control at HHA During COVID-10 Pandemic

https://www.oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

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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
  - NaviHealth
  - PDPM Reviews

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Considerations for Establishing an Effective Quality Documentation Audit Process

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The Audit Program

Audits

- Defined Standards
- Detailed Findings
- Quarterly Review
- Feedback
- Outcome Measures

Outcome Measures

- Key standards & subcomponent performance
- Therapist specific
- Discipline specific
- Dept/region/organization
- Medical review error rates/issues

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Substantive Audit

ICD-10-CM Coding				
3. Medical diagnoses selected adequately describe primary reason for therapy services and relevant complexities to the highest specificity to support skilled therapy	✓			Recommend using additional diagnosis when using muscle weakness due to being very vague. Suggest lack of coordination, difficulty walking, and/or abnormal posture
4. Tx Dx code(s) adequately describe symptoms, support the established POC		✓		
5. Tx Dx is adequately supported by assessment/baseline measures	✓			

Formalized Tests & Scales				
11. At least one formal test is completed within the 1st week of therapy. Formal test is appropriate, person centered and clearly related to both key deficit areas and the POC established. Considerations for the future include: Recommend interpretation of the formal test score(s) Test outcomes should guide the evolving tx plan Opportunity to provide routine updates to the formal test(s)	✓			FOI Scale 5/7 improved to 6/7 by discharge Suggest SAFE or MASA as well

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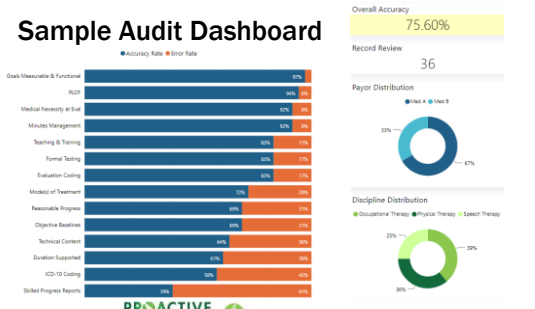
Sample Audit Dashboard



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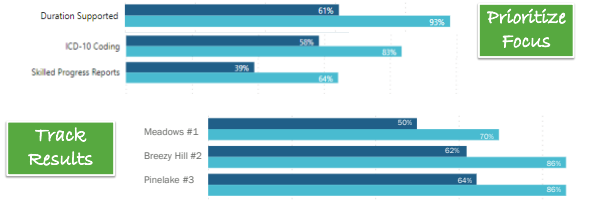
Auditing & Monitoring Case Study



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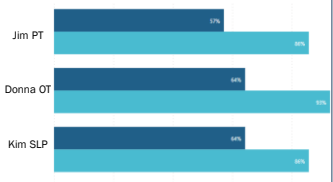
Staff Development



Therapist	Accuracy Rate	Audit Count
Tammy, PT	92.86%	1
Cheryl, OT	85.71%	1
Josh, PT	85.71%	2
Shelly, SLP	85.71%	3
Toni, SLP	85.71%	2
Marsha, PT	82.14%	2
Tobi, PT	78.57%	1
Summer, OT	78.57%	1
Ronald, SLP	75.00%	2
Jim, PT	57.14%	2
Susie, OT	50.00%	1
Total	78.57%	18

High Medium Low Performers

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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
- 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

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Questions

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Join Us! ICD-10 CM Coding Refresher for Skilled Nursing Facilities
2-Day Webinar 2/8-2/9/21 8:30-noon CST both days
6.5 contact hours
$150 for both days of training
What to Expect:
Diagnosis coding accuracy is paramount to appropriate payment under PDPM, as ICD-10 Diagnosis codes & other patient characteristics are used as basis for classification in determining MCR payment. The 5-day MDS establishes the PDPM payment category for the entire Medicare stay which is why it is so important to have good processes in place for establishing the principal diagnosis and having information to support coding all active diagnosis prior to the 5-day assessment reference date.
This program will include information regarding the Official ICD-10 Coding Guidelines, best practices for accurate ICD-10-CM code assignment, how to avoid common coding mistakes, and the importance of principal diagnosis identification.
Target Audience: Director of Nursing, Nurse Managers, Nursing Home Administrators, Nursing Staff and Leaders, Quality Assurance Director, Medical Records, MDS Staff, Therapy Staff

More information and register at:
ICD-10 CM Coding Refresher for Skilled Nursing Facilities | Proactive Medical Review

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