Bridging the Gap:

Proving Medical Necessity for Skilled Care through IDT Documentation
Objectives

1. Learn strategies to protect reimbursement through accurate skilled documentation
2. Incorporate techniques to eliminate conflicting data between the interdisciplinary team
3. Review best practices to improve physician communication and documentation supportive of the RUG level provided
4. Discuss audit processes to meet regulatory standards for services provided in the SNF
5. Implement appropriate documentation to support ICD.10 specificity
Trends Under Scrutiny
Recent Medicare Denial Trends

**Medicare A**
- Insufficient Documentation
- RUG not supported
- Medical Necessity  
  - Skilled interventions  
  - Rehab Ultra High therapy intensity support  
  - Length of SNF Stay  
  - IDT/Physician involvement
- Extrapolation of error

**Medicare B**
- CERT task force findings
- RAC-MMR reviews  
  - Skilled interventions  
  - Medical necessity  
  - Clinician involvement  
  - Physician involvement

How are you bridging the gap between the skilled services you provide in your facility and the documentation that is completed to support reimbursement for those services?
## Rehab PEPPER markers

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Median</th>
<th>High Outlier</th>
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</thead>
<tbody>
<tr>
<td>Rehab Ultra</td>
<td>57.8%</td>
<td>75.9%</td>
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<tr>
<td>Rehab RUGs</td>
<td>93.4%</td>
<td>97.4%</td>
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<tr>
<td>Hi-ADLs + Rehab RUG</td>
<td>33.4%</td>
<td>48.4%</td>
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<tr>
<td>COT OMRA</td>
<td>10.0%</td>
<td>18.2%</td>
</tr>
<tr>
<td>90+ day stays</td>
<td>14.0%</td>
<td>33.3%</td>
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All SNFs nationally with data in FY2014 -- TMF Health Quality Institute
March 2015: A New York nursing home chain agreed to pay $3.5 million to settle government allegations it failed to prevent a rehab subcontractor from overbilling Medicare for therapy. Three skilled nursing facilities ... submitted inflated Medicare claims “based on either the provision of unreasonable or unnecessary rehabilitation therapy, or false reports of therapy being delivered,” according to the Justice Department.

2015 settlements...

March 2015: A Maine skilled nursing facility has agreed to pay $1.2 million to the federal government to settle allegations it did not prevent the contract therapy company from providing unnecessary therapy. The provider was accused of letting inflated, unreasonable or unnecessary rehab claims be submitted to Medicare prior to October 2011. “This settlement is the latest in a series of resolutions involving Medicare billing for rehabilitation therapy at skilled nursing facilities,” said U.S. Attorney Carmen M. Ortiz in a statement announcing the agreement Monday. “We will continue our work to ensure that the provision of care in skilled nursing facilities is based on patients' clinical needs and not tied to the financial targets of the companies providing their care.”

Source: http://www.mcknights.com/snf-agrees-to-pay-12m-to-settle-rehab-claims/article/406481/
Skilled stay support begins BEFORE day 1 of admission
4 General Requirements

Four Main Requirements For Skilled Coverage

- Reasonable and Necessary
- Physician Certified
- AND
- Skilled Nursing/Rehab
- Inpatient
- DAILY

rendered for condition(s) related to inpatient hospital stay.
General Requirements #1

Physician Certified AND Skilled Nursing / Rehab

- Skilled nursing or skilled rehabilitation services
- Performed by or under the supervision of professional or technical personnel
- Ordered by a physician
- Care is needed on a continuing basis for the condition(s) for which the patient was receiving inpatient hospital services prior to transfer to the SNF or
- A condition that arose while receiving SNF care
Sample denial: hip fx with ST

The beneficiary received a Speech Therapy evaluation...while no swallowing issues had been noted in the hospital records, the nursing staff at the facility noted that she needed to be fed and had trouble swallowing that was complicated by ill-fitting dentures. The beneficiary also had trouble communicating. Following an assessment, a POC was developed to treat dysphagia...(and) implemented to modify the diet and reduce her risk of weight loss, dehydration and aspiration.

Regulation 42C.F.R. 409.31(b)(2)(i) states that the SNF services must be furnished for a condition “for which the beneficiary received inpatient hospital services or, which arose while...receiving care in a SNF or swing bed hospital or CAH services.” In this case, the evidence does not support that the need for speech therapy services resulted from the hospitalization or while the Beneficiary was receiving care in the SNF to regain function after this injury. There is insufficient evidence that she suffered from an acute change of cognitive functioning or change in her feeding ability as a result of this condition. Therefore the speech therapy services must not be included when assessing the proper RUG code for reimbursement.
Resident:_________________________________ MRN_________________ RM#__________
Physician_________________________

This resident was admitted requiring SNF care after a qualifying hospitalization related to:

Left hip fracture requiring ORIF repair with complexities of HTN, chronic UTI and cataracts

☐ OT  ☐ PT  ☐ ST services were initiated in the hospital and ordered to continue during the
SNF stay. Subsequently, the following condition has arisen while receiving care in the SNF
for a condition for which he received inpatient hospital services:  Impaired communication
of wants and needs related to word finding difficulty reported by the resident and
documented in the nurses notes on 2/14/15 and 2/15/15__________.

☐ OT  ☐ PT  ☐ ST skilled services are required to address this condition.

☐ OT  ☐ PT  ☐ ST  Evaluate and Treat

☐Treatment Clarification:

________________________________________________________________________________________
________________________________________________________________________________________

Updated Orders Requested on:  ____/____/____

________________________________________ DATE:  ____/____/____

Dr. A. Lincoln, MD

NPI: 123456789
General Requirements #2
Daily Skilled Services

- Resident requires skilled services on a daily basis
  - Nursing - 7 days a week
  - Rehab - ≥5 days a week
  - Restorative Nursing - 2 programs at least 6 days a week
As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.
Example: Inpatient Requirement

• Criteria NOT met:
  Beneficiary has completed 2 weeks of intense rehab following exacerbation COPD and pneumonia. Social service notes report her daughter will live with the beneficiary to ensure safe transitions home. The beneficiary is able to complete self care and basic mobility tasks with contact guard assistance, but she has not yet met her previous modified independent level.

• Criteria MET:
  Same situation as above, but the beneficiary will not have any caregiver assistance upon return home. Therapy could be provided via home health, however the beneficiary would have increased risks of falls and ability to care for herself. She may also be at risk for dehydration and/or malnutrition due to lack of assistance at home.
General Requirement #4
Reasonable & Necessary

• For the treatment of a patient’s illness or injury
• Consistent with the nature and severity of the individual’s illness or injury & medical needs
• Accepted standards of medical practice
• Duration and quantity

Managing Conditions vs. Managing RUGS
Example: Reasonable / Necessary

• Rehab Ultra High intensity level may not always be appropriate for the following conditions:
  o Debility – brief hospital stays (UTI, pneumonia)
  o Dementia related conditions
  o Orthopedic – non weight bearing status
  o Speech therapy services for with cognition focus following orthopedic procedure
Prior level of function detail is critical to defend Medical Necessity.
Prior Level of Function Tips

- Defined at admission or part B therapy SOC
- Best documented function within last 3 mo.
- Prior MDS should corroborate (if applicable)
- PLOF outside of therapy notes is extremely helpful
- Functional level for each goal area

Clarify activity level & involvement
  - Were they going to the dining room independently?
  - Managing meds? housework?
  - Involved in the community?
    (driving, shopping, church, volunteering)
PT and OT were initiated with treating diagnoses of general weakness and muscle weakness respectively. The prior level of function (PLOF) on the PT plan of care was noted to be “independent for home environment.” The prior level of function on the OT plan of care was noted to be the same with the additional information “family reportedly checked in daily.” While the beneficiary was projected to return home, the family was considering an independent living facility.

The ALJ does not have a full, complete picture of the beneficiary’s PLOF. The plan of care does not describe the baseline, pre-hospitalization level of function with sufficient detail, nor does it explain the need for, or the advantages of over 100 minutes of therapy per day as opposed to a program of lesser intensity. A PLOF of “independent for home environment” does not sufficiently describe baseline status. The beneficiary could have been very active in activities outside the home or could have been independent with ADLs but homebound. Without more detailed documentation, the ALJ finds the intensity of therapy excessive. The intensity seems particularly excessive considering the COPD, advanced age, absence of a specific rehabilitation need (such as orthopedic issue) and her generalized weakness. The ALJ is unsure why a less intense program, if not an unskilled exercise regimen, would not have been more appropriate...as her health improved, she would have been able to regain lost function without intense rehabilitation...
Collaborative Clinical Decision Making

coming together is a beginning, staying together is progress, and working together is success." - Henry Ford
### RU Supportive Documentation

<table>
<thead>
<tr>
<th>Protocols w/ timeframes</th>
<th>PLOF last 3 months</th>
<th>Objective measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for 24 hour care detail</td>
<td>Functional change from PLOF</td>
<td>Interval formal assessments</td>
</tr>
<tr>
<td>D/C plan w/timeframe</td>
<td>Daily skilled need detail</td>
<td>Skilled intervention detail</td>
</tr>
<tr>
<td>Rehab intensity expectation</td>
<td>Specific medical condition management (why not home health?)</td>
<td>Intensity Analysis</td>
</tr>
<tr>
<td>Specific obstacles to DC</td>
<td>Weekly rehab skilled need/IDT RUG analysis</td>
<td>New learning ability</td>
</tr>
<tr>
<td>Timely signatures therapy (orders/POC/CERTs)</td>
<td>RUG/ADL coding support</td>
<td>Compensatory strategies</td>
</tr>
<tr>
<td>Close oversight of rehab course</td>
<td>Rehab nursing procedures</td>
<td>Skilled Teaching</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Functional impact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk of early DC/less intensity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safe DC Transition</td>
</tr>
</tbody>
</table>

- Medical complexities impacting rehab course and rehab time requirements
- Individualized approaches to manage specific conditions and complexities
- Impact of deficits on care outside of therapy and ability to return to PLOF
- Statements of specific progress in rehab goal areas due to therapy
- Interval safe DC transition planning
Example: Managing conditions vs. RUGS. 82yo admitted following COPD exacerbation with 3 day hospital stay

**Preadmission Screening**
- Medical conditions
- Hospital services/ECF needs
- PLOF

**IDT Collaboration day of admission**
- Skilled needs discussed
- Physician Orders verified

**Therapy Evals**
- With analysis of skilled needs, appropriate intensity & LOS estimates; physician collaborates

**Weekly collaboration**
- On estimates of progress, ongoing skilled needs, appropriate intensity and duration of care

**IDT communication & consensus on plan**
- On rehab, MDS, nursing, social services, administration

**Clinical documentation reviews and care plan communication to caregivers**

**Daily informal communication**
- On response to treatment, case management and clinical needs (rehab, nursing, MDS)

**Plan adjustments based on IDT analysis of clinical needs and response to interventions**

**Ongoing DC planning**
Rehabilitation Intensity

The minutes/days of treatment provided and RUG level billed (RU, RV, RH) should be supported in documentation.

Why does the patient require high intensity?

- Specific MD protocol for conditions being treated
- To address barriers to DC home
- Return to community
- Clinical Complexities being addressed
- Acute Changes
- Planned Short Stay
- High level D/C expectation
- Advancement of strategies
- Split treatments /BID would benefit condition and facilitation goal progression
Physician Involvement

Proactive Medical Review & Consultants, LLC
Physician Involvement

• Training: Medicare signature requirements, Medicare skilled service requirements, physician skilled service supportive documentation

• Auditing/monitoring to include physician documentation compliance reviews with feedback to medical director

• Include physician orders, certifications as part of triple check pre-billing process review
MD supervision

- Failing to show adequate proof of physician supervision can result in denials of therapy claims.
- Timely signature/date on POC/updated POC, MD progress notes, orders, and certifications help to show appropriate oversight and involvement. MD notes that mention therapy goals and progress are especially beneficial.
MD Progress Reports to support skilled rehabilitation

Include updates on the rehab course in progress notes:

- What deficits are hindering return to prior level of function (PLOF) that require continued services?
- Summarize rehab goals, progress & patient response to therapy.
- Provide updates on the DC plan in relation to rehab course progression
- Speak to the intensity of therapy services (RUG) —why is it warranted? *Short term stay goal, high functioning previously, progress hindered by less rehab service, following standard clinical protocol for condition*
Patient continues PT and OT with 12 degrees of right knee flexion ROM improvements in the past week. Pt. is ambulating with a walker to meals, but needs reminders to follow weight bearing precautions. He is requiring less help with ADLs but has difficulty managing lower body tasks and still needs weight bearing help to get up from the toilet. He will need to be independent in ambulation, stairs and self care skills to return home due to spouse being gone all day at work. Current intensity of rehab appropriate & necessary to advance independence and meet short stay DC goals. Continue therapy at least 2 hours daily.
Physician Certifications

• Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. Check the facility policy. Within 3 days is generally acceptable.

• The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program.

• There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.
Re-certifications

• Recertification statements must contain:
  o written record of the reasons for continued need for extended care services
  o estimated period of time required for the resident to remain in the facility
  o any plans for home care

• The first recertification must be made no later than the 14th day of inpatient extended care services.

• Subsequent recertifications must be made at intervals not exceeding 30 days from the last dated signature.
CERTIFICATION AND RECERTIFICATION (Skilled Nursing Facility)

I certify that SNF services are required to be given on an inpatient basis because of the above named resident's need for skilled nursing care and/or rehabilitation services on a continuing basis for the condition(s) for which he/she was receiving inpatient hospital services prior to his/her transfer to the SNF:

Physician

Date 1/4/14

I certify that continued SNF inpatient care is necessary for the following reason(s):
COPD, pneumonia, anemia, HTN - OT, PT to address balance and gait for ambulation, and self care completion (ability to return home with spouse).

I estimate that the additional period of SNF inpatient care will be _____ days (or ___ weeks).

Plans for post-SNF care are: [ ] Home Health Agency [ ] Office Care
[ ] Other (specify)

Continued SNF care is for same condition(s) for which resident received inpatient hospital services OR For a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services:
[ ] Yes [x] No

Date Due 1/4/14

Physician

Date 1/4/14

I certify that continued SNF inpatient care is necessary for the following reason(s):
COPD, pneumonia, OT, PT addressing balance, mobility, self care deficits; for PT to return home with spouse.

I estimate that the additional period of SNF inpatient care will be _____ days (or ___ weeks).

Plans for post-SNF care are: [x] Home Health Agency [ ] Office Care
[ ] Other (specify)

Continued SNF care is for same condition(s) for which resident received inpatient hospital services OR For a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services:
[ ] Yes [x] No

Date Due 2/14/14

Physician

Date 2/14/14
CERTIFICATION AND RECERTIFICATION
(Skilled Nursing Facility)

Admission Date
2/6/14

Resident Name - Last
Resident

I certify that SNF services are required to be given on an inpatient basis because of the above named resident's need for skilled nursing care and/or rehabilitation services on a continuing basis for the condition(s) for which he/she was receiving inpatient hospital services prior to his/her transfer to the SNF.

Physician

Date 2/18/14

I certify that continued SNF inpatient care is necessary for the following reason(s):
Subdural hematoma, encephalopathy, DM - OR, PT, ST
To address key deficit areas for resident to return to poor level of functions for communication, dexterity, swallowing on least restrictive diet, self care, and mobility, tasks in daily environment.
I estimate that the additional period of SNF inpatient care will be _______ days (or _______ weeks).

Plans for post-SNF care are:
☐ Home Health Agency
☐ Office Care
☑ Other (specify) ICF

Continued SNF care is for same condition(s) for which resident received inpatient hospital services OR For a condition which arose while he/she was in the SNF for treatment of the condition(s) for which he/she received inpatient hospital services:
☐ Yes
☒ No

Date Due 2/19/14

Physician

Date 2/17/14
Skilled Nursing and Interdisciplinary Documentation
Skilled Nursing Services

• Management & evaluation of care plan
• Observation & assessment of conditions
• Direct skilled nursing services
• Teaching & training
• Rehab Nursing Procedures and supportive documentation for rehab RUG levels
Denial Example: Skilled Nursing

The ALJ finds that the Beneficiary did not require or receive daily skilled nursing services during the period at issue. Instead, the nursing notes support that she was skilled by virtue of rehabilitation services and that her needs were mostly custodial. She was monitored on a daily basis, but skilled care was not required...(with) no expectation of any acute medical changes.
Nursing Documentation To Support Rehab

- Nursing should document to show a change in status warranting a new therapy evaluation.
- Nursing should document weekly to support therapy services with a summary of progress for key goals, remaining rehab problems, & nursing carry-over interventions.
- Regular communication of the most pertinent info regarding: recent week’s therapies to nursing is important. Weekly rehab meeting and/or written communication forms are good tools.
- MDS coding should support not contradict the interdisciplinary team charting.
- Nursing daily skilled entries should focus on nursing skilled services to support the non-rehab RUG.
Nursing Note Examples: PT Support

• Through PT participation, Mr. Jones has improved ambulation from extensive assist to limited assist, and is now ambulating with limited assist to the dining room with his rolling walker. His wheelchair use has been discontinued. He will begin working on stairs and safe turning techniques in therapy to prepare for discharge to home with his wife next week.

• Mrs. Smith is now transferring with extensive assist using a slide board instead of the Hoyer lift for bed to w/c transfers. Physical therapy continues to work with patient on goal to transfer independently and instructed first shift nursing staff on safe sliding board transfer technique. Sliding board from bed to w/c completed safely this shift using techniques PT recommended.

• Mr. Walters is working with physical therapy to improve his gait to reduce the risk of falls. He requires extensive assist with ambulation because he shuffles his feet and trips easily. PT reports working on improving heel strike to reduce tripping. Nursing used verbal cue “BIG STEPS” today as advised by PT while ambulating patient to the bathroom to help reduce shuffling his feet.
Nursing Note Examples: OT Support

• Patient is participating in OT to improve dressing ability, and is now dressing upper body with only set-up (improved from last week) and lower body with extensive assist using reacher. OT to continue to work toward dressing independence since res. goal is return home to apt. alone. Mrs. Jones stated “how will I put on my shoes at home?” Requested OT follow up with her on this concern.

• Through OT intervention, patient is now propelling w/c in the hall independently to go to day room, but still requires cues to lock w/c brakes prior to transferring and leans left after up for more than an hour. OT reports they continue to address safety with functional transfers and trunk control. Restorative initiated up to 15 mins/day of reaching activities on edge of bed today at OT’s request to increase core stability for sitting up longer periods. She tolerated 7 minutes of the reaching exercises.

• Patient improved to complete grooming routine with set up on OT maintenance program with toiletries placed left to right on bathroom shelf. Educated resident’s daughter today on this method of setting up items to assist with sequencing deficits during functional activities.
Nursing Note Examples: ST Support

• Patient participates in speech therapy sessions and has improved her fluid intake and management as seen by only having 1 coughing episode at lunch compared to up to 4 episodes per meal last week. Speech is focusing on instructing restorative in oral motor exercises this week.

• Patient is now coming out of her room and even attending some activities. Nursing incorporating ST recommended communication strategies including giving a choice of two, using limited words when asking a question, and reminiscing topics of interest including Cardinals baseball, her work in Washington DC during WWII and tap dancing.

• Patient noted to have a 20% decrease in repetitive statements (see behavior log), “what do I do now” following ST initiated schedule. Nursing has started to reference to this schedule if the patient starts the repetitive statements.
Medicare Meeting:

Objectives:
- Formalize interdisciplinary communication
- Review medical conditions, rehab status & DC plan
- Collaborate on MDS scheduling, identify and address potential COT issues
- Document collective analysis & team consensus on skilled need, RUG/intensity, LOS and DC plan
Medicare Meeting Documentation

Weekly documentation entry (e.g. in the nursing notes or IDT report) supporting the past week’s skilled services and detailing ongoing medical necessity and continued therapy needs. Include:

• Entry that demonstrates interdisciplinary care coordination
• Skilled needs (services, complexities and why inpatient care is required.)
• Review RUG level—still appropriate? why or why not?
• Describe rehab cycle, estimates of progress and DC transition accomplishments and plans for the coming week
• Review LOS averages by RUG level; document support for duration of care
• Communicate primary nursing rehab procedures recommended
• Check for errors, omissions, contradictory statements in the medical record since last meeting
Rehab Goals / Gains
- What are nursing/therapy goals? Discharge goals?
- Rehab achievements last week? How have these successful changes making a positive impact in daily nursing care?
- What is rehab focus for upcoming week?

Nursing Care / Impact
- In what areas have nursing / caregivers been trained? (appropriate transfer techniques, sequencing of ADLs / use of adaptive equipment, strategies to overcome swallow deficits, etc)
- Rehab Nursing Procedures in Place
- Medical changes, new interventions in place to promote recovery and stable medical condition

Intensity Needs / Care Transitions
- Why does patient continue to require current rehab intensity? (physician directed plan of care, medical complexities / complex rehab course, progress likely to slow with less intensity, goal to return home)
- What care transitions are in place? (caregiver training, home assessment planned, care conference, car transfers, stairs, etc)
Skilled care review this date. Patient continues skilled rehabilitation and nursing services related to healing left hip fracture and right knee infection. Medical complexities which may hinder progress / spontaneous recovery include CHF, anxiety, and dementia. Speech therapy has implemented environmental modifications and compensatory strategies based on patient’s cognitive level in order to facilitate optimal progress. Mr. H is experiencing 3+ bilateral lower extremity edema which is managed with elevating his lower extremities; daily weights are obtained to effectively monitor and assess active congestive heart failure. Patient has shown improvements in sitting balance in order to prepare for transfers, he no longer requires the use of a mechanical lift. Per OT teaching/ training, he is able to perform UB dressing and grooming tasks with limited assistance following set up. He is improving with swallow function and shows potential to advance to regular consistency diet with further ST skilled services. Mr. H is using external communication aides to effectively express his wants/ needs. ST will continue to focus on communication without use of external communication devices in order for Mr. H to return home without caregiver assistance. Services remain reasonable and necessary and pt continues to require current rehab intensity in order to achieve discharge goals.
Triple Check

• Takes place at least monthly at the beginning of the month
• Who should attend
  o Biller, MDS, Rehab, Coder, administrator, DON, social worker
• Ensure all MDSs for the previous month’s claims are completed, transmitted, and accepted
• Review part A & B, Managed Care
Triple Check Process

- Pre-Bill
- Verify resident name, HIC # against MCR card
- Verify the qualifying hospital stay
- Verify admission/re-admission date
- Verify census days/room and board to UB-04 billed days
- Verify appropriate bill type and occurrence codes on UB-04 for Med A/Managed Care with appropriate bill type, revenue code, and modifiers for Med B
- Billable ancillary services are validated
- Dx. Codes are accurate and correctly sequenced
Triple Check - continued

• MD completed and signed cert within 72 hours of admission
• MD first recertification is signed by day 14. MD ongoing recertification’s completed a minimum of every 30 days
• All physician orders are signed and dated
• Verify skilled services are based on extension of the hospitalization
• Nursing notes justify skilled need for full duration
• Rehab minutes/days accurate on MDS for each assessment period
Triple Check - continued

- Therapy units/mins/RUG/ARD match MDS and UB-04
- Confirm MDS verified/signed timely by relevant disciplines
- Timely MDS completion & transmission
- Rehab supported with justification of skilled need at billed intensity a minimum of every 10 visits for the full duration
Documentation Supporting ICD-10-CM Specificity
ICD-10-CM

With the increase in third-party audits from entities such as the Office of Inspector General (OIG), recovery auditors, and Medicaid Integrity Contractors, it is imperative that LTC facilities understand the ICD-10-CM guidelines for coding and reporting as required by HIPAA.
Physician Documentation Tips

Add the following to templates:
1. Side of Dominance
2. Laterality
3. Oridinality
4. NHLBI Asthma Severity Classification
5. General & Focal Seizure differentiation
6. Substance related to Adverse effect, poisoning, or toxic effect
Cerebrovascular Disease
Documentation Tips

Focus Documentation on:
1. Specific type of hemorrhage or infarction
2. Artery affected
3. Laterality
Focus Documentation on:
1. Type or etiology of diabetes
2. Body system affected
3. Any complications affecting that body system
Fracture/Orthopedic Documentation Tips

Focus Documentation on:
1. Fracture Type
2. Laterality
3. Type of encounter
4. Specific anatomical site
5. Routine vs. Delayed Healing
6. Nonunions
7. Malunions
8. Displacement Status
Pressure Ulcer Documentation Tips

Focus Documentation on:
1. Site
2. Laterality
3. Stage
Respiratory Failure Documentation Tips

Focus Documentation on:
1. Acute, chronic, or acute-on-chronic
2. Hypoxemia or hypercapnia
Audit Processes

meeting regulatory standards for services provided in the SNF
PEPPER Outliers = overpayment risk

- Rehab Ultra High (RU) RUGs
- Therapy RUGS
- High ADLs
- Length of Stay by RUG
- 90+ day episodes of care
- COT OMRAs
## Jurisdiction Top RUGs
### ALOS FY2014

<table>
<thead>
<tr>
<th>WPS (IN)</th>
<th>LOS days</th>
<th>% RUG to total days</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUB</td>
<td>25.9 days</td>
<td>22.0%</td>
</tr>
<tr>
<td>RUC</td>
<td>28.3 days</td>
<td>16.3%</td>
</tr>
<tr>
<td>RUA</td>
<td>21.1 days</td>
<td>14.4%</td>
</tr>
<tr>
<td>RVC</td>
<td>21.8 days</td>
<td>9.9%</td>
</tr>
<tr>
<td>RVB</td>
<td>18.6 days</td>
<td>9.3%</td>
</tr>
<tr>
<td>RVA</td>
<td>16.8 days</td>
<td>7.0%</td>
</tr>
</tbody>
</table>
Rehab Audits

• Know what’s going on in your rehab gym.
• Outside risk assessment—especially objective review of therapy services
• Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist (42CFR §409.32)
• Repetitive strengthening vs. skilled interventions that require the complex knowledge and sophistication of a therapist
Rehab Audits – cont.

• Track compliance
• Customer service review
• Documentation supports rehab intensity and duration of care
• Consider objective review from auditor with rehab expertise
Worthless Service Trends

• Providers billed Medicare patients at the highest therapy reimbursement level
• Providing the minimum number of minutes of therapy required to bill at the highest reimbursement level
• Shifting number of minutes of planned therapy between different disciplines
• Providing significantly higher amounts of therapy on the final day of an assessment reference period to achieve minimum amount of therapy minutes
• Rounding treatment minutes instead of actual minutes of treatment provided
Denial examples: Rehab

1. By the initial look back period, the Beneficiary, per therapy documentation, was at a level of contact guard assistance for all transfers and ambulation for functional distances. **Ongoing complex functional deficits were not supported.**

2. Therapy interventions focused on **repetitive strengthening** and endurance activities.

3. **Sufficient time had passed to establish a restorative program** for strengthening.

4. Without **objective assessment** of the Beneficiary’s personal care ability documented, medical necessity for continued skilled therapy could not be supported.

5. Based on the documented **prior level of function**, the Beneficiary had met and exceeded same by the initial look back period.

6. By the look back period in review, the Beneficiary **remained maximal –total care assist** with personal care and **frequently refused to participate.**
Denial Example: Rehab

Previously, the Beneficiary was a resident of the Appellant's ICF and was receiving a restorative nursing program. When she was readmitted, the physician ordered PT and OT evaluate and treat her... The ALJ notes that the therapy documentation contains 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. 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.
Denial Example: MMR Results

For physical therapy, a fall without injuries does not show significant decline in function to warrant skilled therapy services. The patient should be able to recover to previous level of function. The patient was already established in RNP and was noted to be maximum assistance with most activities. Also for physical therapy per the service log there were 16 treatments performed by the assistant without a therapist’s evaluation of the treatments and plan. Progress reports provide justification for the medial necessity of treatment. Additional documentation is needed regarding why a clinical was required to provide the care and what medical complexity existed that other providers could not provide the care. Documentation for an exception should indicate how the patient’s medical complexity directly and significant affects the treatment for a therapy condition and the medical necessity for ongoing skilled care.
Medical Review Preparedness

- Rehab staff
- Nursing
- Biller/business office
- MDS
- Administrator
- Medical Records
Next Steps in Bridging the Gap

• Licensed nurse Medicare education
• Know the Medicare Benefit Policy Manual for Extended Care SNF Services (Chapter 8)
• Conduct Medicare meeting with weekly review of documentation and medical necessity for continued services
• ICD.10-CM Effective October 1, 2015
• Triple Check
• Internal / External Auditing
Process Refresher

Admission processes with discharge in mind

• Admissions procedure review and monitoring
• Prior level of function (PLOF)
• Safe DC transition planning
• DC destination and outcomes tracking
• 24/7 rehab stays
Recharge IDT Meetings

Formalize interdisciplinary communication

Document **collaborative** analysis/team consensus on:

- Continued skilled need (or not)
- RUG/intensity and care needs
- Medical conditions, complexities
- COT issues
- LOS estimates with reasoning
- DC planning
Remember:

One really good nursing or therapy note is better than a string of needless fillers that do not support the need for skilled service. The most important thing that facility staff can do to support their Medicare skilled decisions is to document, document, and document with meaningful information! Take time to discuss Medicare decisions as a team, set up detailed documentation guidelines, and audit the results to ensure that your claim is well supported.
Questions?

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