Interdisciplinary Team Documentation to Support Skilled Therapy Services
Medical Review
Preparedness & Response

As your partner in therapy, HTS is committed to Medical Review preparedness. As you know, National Government Services (NGS), the Medicare Intermediary for Indiana and Kentucky, is responsible for analyzing claims data to identify billing patterns that fall outside of norms. Based on this data analysis, NGS will conduct periodic probe reviews of Medicare funded services, including therapy. If your facility is selected to participate in a probe review of therapy services, a sample of billing and clinical records will be requested to go through the medical review process.

How do I know if my facility is selected for a probe review?
Communication of notice to participate in a probe review comes as a letter from NGS to the facility. “This letter also will state the reason for the review. Being reviewed does not suppose suspicion of fraud or abuse. It simply means that data analysis has shown that the use of codes, frequency, and/or length of treatment varies from that of the peer group to which the reviewed data was compared. Practitioners receiving such a letter should follow all instructions completely…” (John Wallace, PT, MS, APTA Board of Directors 1/06 APTA)

The Medical Review Process
Shortly after the notice letter, correspondence related to patient specific chart requests will be accessible on the Medicare online billing system. These chart requests are called “ADRs.” Please note that the biller must retrieve ADRs, as requests will not come via mail. All requested records for the timeframe specified on the ADR notice must be returned within 30 days of the notice to avoid an automatic denial of that claim. Please notify HTS promptly of probe review initiation and ADRs, so that we can assist in preparation of the requested documents in a timely manner. HTS has a system for tracking ADRs & timeframes effectively. Generally 20-40 claims are targeted for medical review (but this claim sample may be significantly lower depending on the volume of service provision.) Reviewers will gather enough claims from all facilities participating in the probe to formulate an effective data sample for analysis of probe criteria.

For prepay probes, payment for claims under medical review will be delayed until the documentation is reviewed. Reviews are completed within 60 days of the documentation submission. The biller will find claim payment information on the remittance advice once the medical review decision has been made. If the claim (or a portion of the claim) is denied, HTS will begin the appeals process. Please notify HTS of the outcome of each therapy medical review claim.

The Appeals Process
In the event that a therapy claim is denied based on the documentation submitted, HTS will initiate the appeals process. HTS has experienced staff to manage this process and has historically been very successful in overturning denials. The timeline for appeals is outlined on the chart below. The denial date is the "paid" date on the remittance advice.
Outcomes of probe reviews
Typically within a year or less of the probe initiation, a letter will arrive with results on probe outcomes for your facility compared to peer averages. There are two error rates calculated by which you will be measured. The denial error rate (total claims with any portion denied out of the total claims reviewed) and the payment error rate (total amount denied out of the total amount reviewed.) Facilities are retained in the probe review or released from further review based on their percentage error rate compared to peer rates in the sample. If retained, another 20-40 claim sample will be requested in the form of ADRs. Facilities are then retained or released at the end of that phase of review based on error rate improvements compared to the initial sample. Between phases of review, NGS will offer educational opportunities through their education outreach department.

HTS Preparation and Response
Expertise and Education
HTS consistently monitors for Medicare and other regulatory updates that will potentially impact our customers. We provide relevant compliance, billing, and documentation training to therapy staff. In fact, mandatory clinical documentation & billing training has recently been completed regionally for all therapy staff. HTS also offers education opportunities to our customers, such as a complimentary annual Medicare Seminar and nursing documentation inservices.

Billing and Documentation Systems
In addition to online billing, which provides automated reporting for coding edits and modifier requirements, HTS has recently updated our compliance program to include an electronic clinical documentation system. This allows for a more professional charting presentation, greater content controls and allows management to conduct online auditing and oversight in real time.

Quality Assurance and Auditing
HTS has a formal QA Program which includes comprehensive therapy department review and regular clinical documentation audits. In the event that a facility undergoes medical review involving therapy services, HTS has a response plan and designated staff to assist in the medical review process and any necessary appeals. HTS indemnifies our services based on facility contract terms.
How can the interdisciplinary team work together for medical review success?

Medical reviewers expect the entire medical record to cohesively support the services billed. The interdisciplinary team should focus on documentation that clearly supports the need for skilled interventions.

Tips for supporting medical review success in interdisciplinary team documentation:

- Describe changes in condition that may lead to therapy referrals to support skilled rehab service medical necessity. Changes in condition from a medical review perspective must be shown as a contrast between the prior level of function (within the past 3-6 months) and current function. *(e.g. Mr. Jones was transferring independently last month, but has consistently required moderate assist this month due to knee pain and instability.)* Changes must be significant enough to warrant skilled therapy services beyond the scope of what nursing staff could manage without rehab’s help. See the forms in this packet that can help to guide documentation of significant changes for current residents and prove prior level of function for new admissions & outpatients.

- For residents receiving therapy services, regularly document the functional impact of gains made in therapy, remaining functional problems, and how therapy goals are being reinforced outside of rehab *(e.g. Mrs. Smith only needs assist with her bath now and can dress herself completely since working with OT. She is improving on her toilet transfers, but still needs help to keep her balance in standing in the bathroom, especially when tired in the evening.)*

- MDS data should accurately reflect functional levels and relevant changes throughout the rehab course. Discrepancies between rehab documented status and MDS coding should be clarified in the documentation *(e.g. Resident required more assist 3rd shift during nighttime toileting than is typical during the day.)*

- Hold a regular rehab meeting *(e.g. weekly)* to discuss therapy progress, interdisciplinary care strategies, skilled need criteria and dc transition plans. This meeting is also a good time to make a strong weekly documentation entry in the nursing notes supporting the past week’s rehab services and detailing continued therapy needs when applicable.

Additional examples of supportive nursing documentation entries for rehab services are provided on the following page
Demonstrate the significant change in function to support the rehab referral

- Clearly identify prior level of function
- Describe changes in condition that may lead to therapy referrals to support skilled rehab service medical necessity.
  - Resident was transferring independently last month, but has consistently required extensive assist this month due to increased...(knee pain, instability, loss of balance episodes, dizziness, rigidity, LE weakness, difficulty bearing weight, etc.)
  - Resident is requiring more assistance with self care activities compared to 2 weeks ago due to increased...(ROM impairment, vision problems, postural control issues, pain, weakness, incoordination, confusion, etc.)
  - Resident is demonstrating changes in physical functioning related to...(balance, ability to sit up for meals, safety with swallowing, posture, position in wheelchair, hand use, mobility safety, etc.)
  - Care has become more difficult in recent week related to (communication, toileting, mobility assist required, ADLs, feeding, ability to swallow medications, restorative ROM program, restorative program for ambulation, wandering behavior, aggressiveness during showers etc.)
  - Pressure seems to be inadequately distributed due to recent tendency to lean excessively in when seated in wheelchair. This position is also impacting her ability to self feed.
  - Resident seems to be having difficulty managing fluids this week. After taking a drink, she was noted to (cough, choke, have a wet voice, have watery eyes, etc.)
  - Mealtimes have become more difficult for resident this week as she is now requiring assistance throughout the entire meal compared to 2 weeks ago when she only required set up help.

Document to support ongoing therapy services each week
For residents receiving therapy services, regularly document to show the ongoing need for skilled rehab services. This may include documenting:

- The functional impact of gains made in therapy (examples of how the therapy is making a difference for the resident on the unit.)
  - Resident only needs assist with her bath now and can dress herself completely since working with OT this month
  - Resident is out of her room and attending activities now that her w/c positioning has improved
  - Resident has not requested PRN tylenol x 3 days since shoulder pain significantly reduced due to recent modality treatments with Diathermy in PT
  - Transfers no longer requiring assist of 2 caregivers.

- The remaining functional problems that still need to improve through therapy.
  - She is improving on her toilet transfers, but still needs help to keep her balance in standing in the bathroom, especially when tired in the evening
  - Her LE positioning is better with the new orthotics provided by PT, but she is still guarding her left shoulder and doesn’t want staff to move her arm during care.
  - Pt doesn’t always use her walker appropriately (carrying it in the hallway) and seems to be unsteady when walking with other people nearby or if she is distracted.

- How therapy goals are being reinforced outside of rehab (nursing follow through with suggested techniques etc. to improve function.)
  - Using transfer board this week to assist with transfers after training with PT
  - OT trained staff on application of hand splints and new wear schedule began this shift.
  - OT provided self release seat belt to replace lap buddy. Patient seems to be tolerating the seat belt well and has had no incident of attempting to rise without assist. When assisting to toilet earlier this shift, she was able to release the seat belt upon request prior to transfer.
An excerpt from a sample denial letter below demonstrates how a nursing documentation entry that conflicts with the rehab related service needs can lead to non-payment under medical review.

A panel of licensed healthcare professionals reviewed this case and determined that the physical, occupational, and speech therapy services were not reasonable and medically necessary. According to the documentation in her medical file, the beneficiary was an 84-year-old female whose diagnoses included Alzheimer's disease, dementia, osteopenia, and abnormality of gait. She was admitted to the memory unit of the provider’s assisted-living facility on April 20, 2009, from home. She was referred to comprehensive rehabilitation due to decreased balance, strength, and safety awareness.

A physical therapy plan of treatment and initial evaluation dated April 20, 2009, documented the beneficiary’s prior level of function as independence in the home environment. Upon admission, lower-extremity strength was assessed at 4- to 4/5, dynamic standing balance was poor, and the beneficiary scored 13/28 on the Tinetti Assessment Tool. She was independent for bed mobility and required minimal assistance with sit-to-stand transfers and standby assistance for ambulation up to 100 feet without an assistive device. Physical therapy services were provided twice weekly and the beneficiary was discharged on May 14, 2009.

Medicare coverage criteria were not met for physical therapy. According to the documentation submitted, the beneficiary sustained a significant decline relative to balance and ambulation, and skilled physical therapy services were needed to return her to her prior level of function. In May 2009, most skilled activity was needed to increase balance and objective Tinetti scores significantly increased during treatment. However, this documentation conflicts with nurse’s notes covering April 21, 2009 to April 27, 2009, which indicate that the beneficiary was walking at will and was steady while doing so. Other nurse’s notes did not indicate difficulty walking. Physician documentation on April 24, 2009, indicated that, while some weakness of thigh muscles was noted, the beneficiary was walking in a coordinated and smooth manner. Given the conflicting documentation, a significant functional decline could not be substantiated. Thus, we have determined that the physical therapy services were not reasonable and medically necessary and, therefore, not covered under Medicare.

SAMPLE HTS FORMS ARE INCLUDED ON THE FOLLOWING PAGES FOR YOUR REFERENCE:

Significant change form---------------------- used to document functional change in current resident warranting therapy referral

Admission/PLOF form------------------------used to show significant change in new admission/readmission warranting therapy referral & provides basic info needed to initiate therapy services. Also used for outpatients/ALF patients etc. coming to rehab
Please document the following change in the nursing notes if you feel therapy is warranted:

Resident __________________________________ Rm ___________________

Appears to have demonstrated a change in the following:

☐ Transfers____________________________________________________
☐ Ambulation___________________________________________________
☐ ADLs_______________________________________________________
☐ Toileting safety_______________________________________________
☐ Fall risk/balance______________________________________________
☐ Positioning___________________________________________________
☐ Swallowing___________________________________________________
☐ Communication_______________________________________________
☐ ___________________________________________________________________

This change is compared to his/her prior level of function of:

________________________________________________________________________

Skilled therapy is medically necessary because:

________________________________________________________________________

______________________________________________________ ___/___/___
Signature of person completing form date
Resident: ____________________  MR #: _______
Physician: ____________________
Room: _______
Admit Date: ________

Transfer from  
☐ hospital  ☐ home  ☐ nursing facility  ☐ rehab center  ☐ other

Payor  
☐ Medicare A  ☐ Medicare B  ☐ Advantage Plan
Number: ____________________

☐ Primary / ☐ Supplemental Insurance

☐ Medicaid  ☐ current applicant  ☐ will apply ___/___/____

Current Diagnoses:

Therapy orders  
☐ PT  ☐ OT  ☐ ST

Height____  Weight____ lbs  Equipment Needs  ☐ W/C  ☐ Walker  ☐ _________

Diet__________________________

Activity restrictions  ☐ no  ☐ yes  detail_______________________________

Weight bearing restrictions:  ☐ none  ☐ WBAT  ☐ NWB  ☐ PWB  if restricted, give detail_______________________________

Prior Level of Function (Prior level of function is what the patient has done within the last 3-6 months)

Assistive devices:  ☐ Walker  ☐ Cane  ☐ W/C  ☐ Scooter/powered mobility  ☐ Other_______________________________

Prior Skills performed:  check if independent or required assist, include estimated % of assist

<table>
<thead>
<tr>
<th>Task</th>
<th>Independent (V)</th>
<th>Assisted (%)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td></td>
<td>__ %</td>
<td>Note any special accomodations</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Household walking</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Community mobility</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Meal prep</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
<tr>
<td>Meds &amp; Health Management</td>
<td></td>
<td>__ %</td>
<td></td>
</tr>
</tbody>
</table>

Prior restrictions (if any):

<table>
<thead>
<tr>
<th>DC Plan</th>
<th>DC setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Home Independently</td>
<td>Home Situation</td>
</tr>
<tr>
<td>☐ Home with assistance</td>
<td>1 level home</td>
</tr>
<tr>
<td>☐ Assisted Living</td>
<td>2 level home</td>
</tr>
<tr>
<td>☐ Nursing home</td>
<td></td>
</tr>
<tr>
<td>☐ To Family Member’s Home:</td>
<td>Who?_____________</td>
</tr>
</tbody>
</table>

 DOES RESIDENT REQUIRE SKILLED THERAPY SERVICES TO ACHIEVE DC PLAN?  
 Yes  No  TBA

Signature: __________________________________________  Date: ____________________
Transfer from □ hospital □ home □ nursing facility □ rehab center □ other

Payor □ Medicare A □ Medicare B □ Advantage Plan Number 111-11-1111A
□ Primary / □ Supplemental Insurance
□ Medicaid □ current applicant □ will apply __ / __

Current Diagnoses: HTN, DM, OA, n/o cataract remoral surgery, Parkinson's Dis, with recent frequent falls at home. Admitted from ER with facial laceration, left shoulder pain from fall 1/15/11

Therapy orders □ PT □ OT □ ST

Height 5'11" Weight 180 lbs Equipment Needs □W/C □ Walker to be assessed by Diet
Activity restrictions □ no □ yes detail Fall precautions
Weight bearing restrictions: □ none □ WBAT □ NBW □ PWB if restricted, give detail

Prior Level of Function (Prior level of function is what the patient has done within the last 3-6 months)

Assistive devices: □ Walker □ Cane □ W/C □ Scooter/powered mobility □ Other

Prior Skills performed: check if independent or required assist, include estimated % of assist

<table>
<thead>
<tr>
<th>Task</th>
<th>Independent (✓)</th>
<th>Assisted (✓)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td>✓</td>
<td>✔%</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>✓</td>
<td>✔%</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>✓</td>
<td>✔%</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>✓</td>
<td>10%</td>
<td>Spouse washed back with provided supervision</td>
</tr>
<tr>
<td>Household walking</td>
<td>✓</td>
<td>✔%</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td>✓</td>
<td>✔%</td>
<td></td>
</tr>
<tr>
<td>Community mobility</td>
<td>✓ MI</td>
<td>✔%</td>
<td>used cane on occasion for community distance</td>
</tr>
<tr>
<td>Meal prep</td>
<td>✓</td>
<td>60%</td>
<td>Wife prepares meals. He was (✓) to get</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>basic snacks, drinks etc.</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>✓</td>
<td>75%</td>
<td>Wife manages housework.</td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td>5%</td>
<td>No longer driving.</td>
</tr>
<tr>
<td>Meds &amp; Health</td>
<td></td>
<td>25%</td>
<td>Wife sets up pill box &amp; keeps appt calendar</td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prior restrictions (if any):

DC Plan | DC setting
---------|----------------|
□ Home Independently | Home Situation
☑ Home with assistance | ✓ 1 level home 3 steps to entry ☐ Apartment
□ Assisted Living | ☐ 2 level home ☐ Senior Citizen Apartment
□ Nursing home | ☐
□ To Family Member's Home: Who? Home spouse Do they Work? No - retired

DOES RESIDENT REQUIRE SKILLED THERAPY SERVICES TO ACHIEVE DC PLAN? ☐ Yes □ No TBA

Signature: Greta Caregiver RN Date: 1/15/11
Resident  Betty White  Rm  100

Appears to have demonstrated a change in the following:

☐ Transfers
☐ Ambulation
☐ ADLs
☐ Toileting safety
☐ Fall risk/balance
☐ Positioning
☒ Swallowing Coughing with liquids and choking on meds
☐ Communication

This change is compared to his/her prior level of function of:

Safety swallowed liquids & meds whole without any coughing/choking or signs of difficulty up until last week.

Skilled therapy is medically necessary because:

Nursing interventions attempted (see nsg notes) but continues to have swallowing problems that are not improving. Dysphagia eval required to r/o potential aspiration risk.

Marta Caregiver RN  1/15/11
Signature of person completing form  date