



Medicare Therapy Documentation in a Skilled Nursing Facility

HARMONY UNIVERSITY
The Provider Unit of
Harmony Healthcare International, Inc. (HHI)
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Learning Objectives

- The learner will be able to summarize universal documentation guidelines
- The learner will be able to determine Medicare Coverage Criteria/Skilled Care
- The learner will be able to identify skilled care terminology
- The learner will be able to compose clinical documentation that supports Part A skilled care

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Universal Documentation Guidelines



- Create a complete picture of resident
- Guides MD
- Record physical, mental and emotional status

Basics of Documentation



- **Clarity:** Evidence of the need for further skilled care
- **Content:** Describe what you have done. There is beginning, middle and end of every good nursing note
- **Communication:**
 - Document any changes in the patient
 - Document what needs to be changed regarding the plan of care, current changes in the plan of care, medication changes and changes in therapy services

Basic Medicare Requirements



- The patient requires skilled Nursing Services or Skilled Rehabilitation Services i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§214.1 – 214.3)

Basic Medicare Requirements 

- The patient requires these skilled services on a daily basis (see §214.5)
 - Daily Nursing Notes
 - Treatment Sheets

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Basic Medicare Requirements 

- The patient requires these skilled services on a daily basis (see §214.5)
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF (see §214.6)
 - Services need to be provided at a SNF level of care

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Basic Medicare Requirements 

- If any one of these three factors is not supported by the documentation in the patient's record, the SNF stay, even though it might include the delivery of daily skilled services, will not be covered

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Skilled Rehabilitation Overview 

- Directly related to a written plan of treatment
- Requires knowledge/skills/judgment of qualified professional
- Services must be considered under acceptable standards of clinical practice
- Expectation of improvement of restorative potential in a reasonable and predictable amount of time...or...
- Establishment of a safe and effective maintenance program

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Medicare Benefit Policy 

- The 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 be safely and effectively performed only by a therapist

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Skilled Rehabilitation/ MD Involvement 

- The service must be ordered by a physician
- The therapy intervention must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional and must be reasonable and necessary to the treatment of the beneficiary's illness or injury necessary to the treatment of the beneficiary's illness or injury

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Skilled Rehabilitation/ MD Involvement



- MD involvement to prevent injuries
- Medicare allows the professional therapist to develop a suggested plan of treatment and to begin providing services based on the plan prior to MD signature
- MD signature required before facility bills Medicare
- MD Faxed signatures acceptable

Skilled Physical Therapy



EXAMPLE 1

An 80-year-old, previously ambulatory, post-surgical patient has been bedbound for one week and, as a result, has developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy services to restore lost functions, those services are reasonable and necessary.

Skilled Physical Therapy



EXAMPLE 2

A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary.

Medicare Benefit Policy 

- Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional

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Skilled Physical Therapy Application of Guidelines 

- **Assessment:** The skills of a physical therapist are required for the ongoing assessment of a patient’s rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient’s care plan include tests and measures of range of motion, strength, balance, coordination, endurance, and functional ability.

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Skilled Physical Therapy Application of Guidelines 

- **Therapeutic Exercises:** Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

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Skilled Physical Therapy Application of Guidelines



■ **Gait Training:** Gait evaluation and training furnished to a patient when ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy they reasonably can be expected to improve significantly the patient's ability to walk.

Repetitious exercises to improve gait, or to maintain strength and endurance, assistive walking are appropriately provided by supportive personnel (e.g., aides or nursing personnel), and **do not require the skills of a physical therapist.** Thus, such services are not skilled physical therapy.

Skilled Physical Therapy Application of Guidelines



■ **Range of Motion:** Only the qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy. Range of motion exercises constitute skilled physical therapy only if they are part of actual treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost to the degree to be restored).

Skilled Physical Therapy Application of Guidelines



■ **Range of Motion (Cont.)**
Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely by supportive personnel, such as aides or nursing personnel, and may not require the skills of a physical therapist. Passive exercises maintain range of motion in paralyzed extremities that can be carried out by aides nursing personnel would not be considered skilled care.

Skilled Physical Therapy Application of Guidelines



■ **Maintenance Therapy:** The repetitive services required to maintain function sometimes involve the use of complex and sophisticated therapy procedures and consequently, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services (see §214.1.B). The specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service.

Skilled Physical Therapy Application of Guidelines



EXAMPLE

A Parkinson's patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine which type of exercises are required for the maintenance of his present level of function. The initial evaluation of the patient's needs, the designing of the maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, and such infrequent reevaluations as may be required, would constitute skilled physical therapy.

Skilled Physical Therapy Application of Guidelines



EXAMPLE (Cont.)

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible; i.e., by the end of the last restorative session, the physical therapist will have already designed the maintenance program required and instructed the patient or support personnel in the carrying out of the program.

Skilled Physical Therapy Application of Guidelines



- **Ultrasound, Shortwave and Microwave Diathermy Treatments:** The modalities must always be performed by or under the supervision of qualified physical therapist and are skilled physical therapy

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Skilled Physical Therapy Application of Guidelines



- **Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths.** Heat treatments and baths of this type **ordinarily do not require the skills of a qualified physical therapist.** However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case; e.g., where the **patient's condition is complicated** by circulatory deficiency, areas desensitization, open wounds, fractures or other complications.

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Documentation Requirements



- CMS implemented clarifications and material regarding documentation requirements
 - Pub. 100-02 Medicare Benefit Policy Manual, transmittal 88

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Definitions



- **Treatment day:** A single calendar day in which treatment, evaluation or re-evaluation is provided. There could be multiple visits, treatment sessions/ encounters on a treatment day.

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Definitions



- **Visit/Treatment Session:** Sessions / visits begin at the time the patient enters the treatment area and continue until all services have been completed for that session and the patient leaves that area to participate in non-therapy activity
 - It is likely that not all minutes in the session are billable
 - Rest Periods
 - There may be two treatment sessions in a day
 - In the morning and in the afternoon
 - When there are two visits / treatment sessions in a day, plans of care indicate treatment amount of twice a day

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Definitions



- **Amount**
 - The amount of treatment must be specified on the Plan of Care for a patient
 - The amount of treatment refers to the number of times in a day the type of treatment will be provided
 - When the amount is not specified, one treatment session a day is assumed

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Definitions



- **Clinician**
 - A term used in Pub 100-04, chapter 5, section 10 or section 20, to refer to only a physician, non-physician practitioner or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law
 - Clinicians make clinical judgments and are responsible for all services they are permitted to supervise

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Definitions



- **QUALIFIED PROFESSIONAL**
 - A physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies
 - Qualified professionals may also include physical therapist assistants (PTA) and occupational therapy assistants (OTA) when working under the supervision of a qualified therapist, within the scope of practice allowed by state law
 - Assistants are limited in the services they may provide (see section 230.1 and 230.2) and may not supervise others

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Definitions



- **Frequency**
 - This is the number of times in a week the type of treatment will be provided
 - When frequency is not specified, one treatment is assumed
- **Holiday**
 - If a scheduled holiday occurs on a treatment day that is part of the plan, it is appropriate to omit that treatment day
 - A clinician overseeing the Plan of Care may determine that a brief, temporary pause in therapy sessions would adversely affect the patient's condition

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Definitions



■ Interval

● INTERVAL of *certified treatment (certification interval)* consists of 90 calendar days or less, based on an individual's needs. A physician/NPP may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report period.

Certification



■ Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due

Documentation Requirements



- The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation
- The contractor may request otherwise



Medicare Benefit Policy

- Required Documentation:
 - Evaluation/and Plan of Care (may be one or two documents)
 - Treatment Notes for each treatment day
 - Progress Notes (including Discharge Notes, if applicable)

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Skilled Rehabilitation Overview

- Evaluations should reflect:
 - Why these services require the skills of a therapist
- Progress notes should reflect:
 - That the patient is making improvements...or...
 - That a safe maintenance program continues to be developed

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Evaluations

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Prior Level of Function

- Medicare supports skilled intervention to assist the patient to attain their highest/prior level of function
- Gather as much information regarding the patient's functional level prior to recent illnesses
- PLOF is vital to supporting medical necessity for skilled rehabilitation and support the intensity of services rendered

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Prior Level of Function Example

- Prior to hospitalization this patient resided in an assisted living apartment. The patient ambulated independently with a walker with extended time required to climb stairs. The patient performed her self-care daily at an independently level. The patient was not responsible for meal preparation or house hold tasks. The patient reportedly obtained cold snacks independently.

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Prior Level of Function Example

- Prior to admission to the SNF the patient resided at home with his wife who provided assistance for self care, meal prep and house keeping activities. The patient was independent for all mobility tasks in and out of the home.

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Prior Level of Function



Example

- This long-term care resident was performing toilet transfers with supervision, and contact guard assistance for hygienic care two months prior to this evaluation
- This patient is admitted after a long acute hospitalization where the staff report the patient improved from a maximum assistance level to function at a minimum assistance level upon discharge. Prior to the hospitalization this patient was independent with all mobility and self care tasks.

Non-Supportive Documentation



- "Return to PLOF is questionable secondary to 30-year history of Muscular Dystrophy"
- "Consistently confused"
- "Severely impaired problem solving related to cognitive deficits. Even though patient is at baseline in ADLs, cognition, will continue therapy on a daily basis."

Medical Necessity



- Avoid:
 - Pt is appropriate for skilled PT/OT services due to decreased functional abilities
- The above statement does not convey why these services need to be performed by a qualified professional
- Safety Issues Related To:
 - Poor posture
 - Improper gait
 - Weak grip, arthritis
 - Dysphagia
 - Poor communication skills
 - Paralysis/paresis
 - Perceptual deficits
 - Vestibular disorder
 - Cognitive disorder
 - COPD, emphysema

Medical Necessity 

- The patient will benefit from skilled OT, PT, ST on a daily basis following surgical intervention for repair of her fractured shoulder **to restore independence with bathing, dressing, and toileting tasks**
- Skilled OT, PT, ST are indicated on a daily basis to **establish an individualized functional maintenance program** which addresses gait, transfers and lower extremity strength

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Medical Necessity 

- The patient is non-weight bearing on the right lower extremity; therefore, skilled PT services are indicated on a daily basis to **address transfer training, therapeutic exercises and strengthening of the upper and lower body to decrease the risk of falls during non-weight bearing mobility tasks**

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Supportive Documentation 

- MD certification
- "Fair" rehabilitation potential. How is this tested and what does it mean?
- Good for stated goals

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Medical Diagnosis



- Identify medical diagnosis and resulting rehabilitation diagnosis.
 - Medical diagnosis:
 - This is the primary diagnosis that has resulted in the therapy disorder and which is most closely related to the current plan of care for therapy
 - If more than one diagnosis is treated concurrently, the therapist enters the diagnosis that represents the most intensive services (over 50% of rehab effort for the therapy modalities provided)

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Treatment Diagnosis



- Identify medical diagnosis and resulting rehabilitation diagnosis
 - Rehabilitation diagnosis:
 - This is the treatment diagnosis; the diagnosis for which rehabilitative services are being furnished
 - For Example: While CVA may be the primary medical diagnosis, aphasia might be the SLP treatment diagnosis

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Goal Writing



- Long-Term Goals
 - Level you expect patient to be at discharge (or in 4 wks)
- Short-Term Goals
 - Incremental steps toward the long term goals
 - Think beyond transfers, ambulation, and ADLs

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Performance Skills 

- **Motor skills:** moving and interacting with task, objects, and environment
 - Posture
 - Mobility
 - Coordination
 - Strength
 - Effort
 - Energy

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Performance Skills 

- **Process Skills:** managing and modifying action when completing tasks
 - Energy
 - Knowledge
 - Temporal organization
 - Organizing space and objects
 - Adaptation

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Performance Skills 

- **Communication Skills:** Conveying intention and need and coordinating social behaviors
 - Physicality
 - Information exchange
 - Relations

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Level of Cueing

- Constant (max)
- Frequent (mod)
- Occasional (mod)
- Rare (min)

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Causes of Cueing

- Technique
- Sequencing
- Pacing
- Initiation

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Types of Cueing

- Verbal
- Tactile
- Visual

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Bed Mobility



- Patient will roll side to side with min verbal cuing to bend knees first
- Patient will roll side to side with min verbal cuing to use side rails
- Patient will roll to one side and hold the position for 1 minute
- Patient will roll to one side and then to another without signs/symptoms of fatigue
 - Could also use O2 sats, heart rate, or recovery time
- Patient will ask for the side rail to be put up prior to rolling side to side 90% of the time

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Bed Mobility



- Patient will coordinate pulling legs up onto the bed at the same time the upper body lowers to the mattress with mod verbal cueing
- Patient will coordinate moving legs off the edge of the bed at the same time the upper body rises with mod verbal cueing
- Patient will roll to side prior to supine to sit with mod verbal cueing
- Patient will initiate positioning himself in middle of the bed with max assist prior to rolling onto back

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Sitting Balance



- Patient will maintain good posture while sitting on edge of mat table (with head up and shoulders back) 50% of the time
 - Could also set this goal with min or mod verbal cueing
- Patient will self-correct losses of balance 25% of the time
 - This could include putting hands out to the side, etc.

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Sitting Balance



- Patient will maintain fair + sitting balance for 2 minutes (then progress goal by 2 minute increments)
- Patient will ensure feet are well supported and ask for foot rest 80% of the time
 - Can use this goal if patient's feet do not reach the floor

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What Is a "Functional Goal?"



- **Necessary Components of Functional Goals:**
 - Related to a functional activity that is measurable
 - Must have a qualifier to define when the goal is met. **Be Specific!**
 - Must be patient centered/patient oriented
 - Needs to answer *who* will do *what* with *how much assistance* and *why* is this important

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Example of a Functional Goal



- The patient will ambulate 100 feet with a rolling walker independently in two weeks to allow safe gait to the dining room in the resident's senior housing complex

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Cognitive Goal Setting



- **Attention:** "Patient will attend to ADL tasks for a 30-minute session with rare cues to regain attention"
- **Sequencing:** "Patient will properly sequence bathing and dressing tasks 3 out of 5 trials with supervision only, using visual aide provided by OT"
- **Memory:** "Patient will demonstrate recall of AM self-care schedule when prompted by OT 60 minutes following completion of session"

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Impaired Cognition



- Transmittal AB-01-136, 09/25/2001 states that contractors *may not* install edits that result in the automatic denial of services based solely on the ICD-9-CM codes for Dementia

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Impaired Cognition



- **Establishing Medical Necessity:**
 - Primary Diagnosis
 - Secondary Diagnosis
 - Objective findings to support services in MR
 - Specific details as to why these services are medically necessary based on the therapist's objective that will be supported by the functional goal attainment as outlined in the treatment plan and progress notes

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Duplication of Services 

- Rehab goals can appear to be demonstrating a duplication of services. High risk of denial
- Commonly seen goal areas:
 - Independence with bed mobility
 - Transfers
 - Ambulation

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Duplication of Services 

- The goals must be written to differentiate the skilled area to be addressed by each discipline
- Careful review of what the patient must be able to do to return home safely to formulate goals
- Goals can then be broken down into subsets of what tasks the patient must complete on a daily basis to be successful at home

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Duplication of Services 

- PT Goal:
Patient will demonstrate independent bed mobility
 - Better Stated As:
Patient will be able to scoot up in bed independently with use of both side rails

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Duplication of Services 

- **OT Goal:**
Patient will demonstrate independent bed mobility
- **Better Stated As:**
Patient will transfer from supine-to-sit independently to facilitate ambulation to the bathroom

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Duplication of Services 

- **PT Goal:**
Patient will demonstrate independent transfers using the rolling walker
- **Better Stated As:**
Patient will demonstrate 4/5 lower extremity strength to transfer from sit-to-standing to prepare for ambulation

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Duplication of Services 

- **OT Goal:**
Patient will demonstrate independent transfers using the rolling walker
- **Better Stated As:**
Patient will transfer from the bed to commode to facilitate independent toileting

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Re-Evaluations



- Re-evaluation provides additional objective information not included in other documentation
- Re-evaluations are separately payable and are periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, decline or change in the patient's condition or functional status that was not anticipated in the plan of care for that interval

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Re-Evaluations



- Documentation must support the need for re-evaluation to be covered and payable
- Re-evaluations planned prior to discharge to determine whether goals have been met may be indicated
- Re-evaluation may be necessary to provide additional information, beyond that required to be included in the discharge summary
- The re-evaluation is used to provide the physician or treatment site at which treatment will be continued with additional data

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Treatment Notes



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Medicare Benefit Policy 

- The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim
- Documentation is required for every treatment day and every therapy service

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Medicare Benefit Policy 

- Treatment Notes need to include:
 - Date of treatment
 - Identification of each specific intervention/modality provided
 - Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment.
 - Signature and professional identification

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Medicare Benefit Policy 

- To further support services, consider also documenting
 - Patient self-report
 - Adverse reaction to intervention
 - Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.)

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Medicare Benefit Policy 

- Significant, unusual or unexpected changes in clinical status
- Equipment provided
- Any additional relevant information the qualified professional finds appropriate

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Documentation Requirements Treatment Notes 

- Documentation is required for every treatment day and every therapy service
- Treatment notes are not required to document medical necessity or appropriateness of the ongoing therapy services

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Documentation Requirements Treatment Notes 

- The purpose of the Treatment Note is simply to create a record of all treatments and skilled interventions that are provided
- Record of the time of each service is required to justify the use of billing codes on the claim

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Documentation Requirements Treatment Notes



- The signature and identification of the supervisor is not required to be on each Treatment Note, unless the supervisor actively participated in the treatment
- The supervisors identification must be clear in the Plan of Care or Progress Report

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Documentation Requirements Treatment Notes



- It is not required to document in the Treatment note the amount of time for each specific intervention/modality
 - Pub. 100-02, chap. 15, section 230.3B
 - This may be recorded voluntarily, but this will be indicated in the billing

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Skilled Interventions



- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> ■ Skilled: <ul style="list-style-type: none"> ● Trained in use of one-handed dressing techniques to facilitate upper body dressing ● Educated in use of core body exercises to increase trunk strength and stability during ADLs ● Instructed in scanning techniques to help locate food on their plate | <ul style="list-style-type: none"> ■ Non-Skilled: <ul style="list-style-type: none"> ● Encouraged patient to perform ADLs at sink ● Helped patient ambulate from smooth to inclined surfaces ● Observed patient attempting to get out of bed without the side rail |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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Progress Notes

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Medicare Benefit Policy

- Progress Notes need to include:
 - Assessment of improvement and extent of progress (or lack thereof) toward each goal
 - Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions

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Medicare Benefit Policy

- Changes to long-term or short-term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment
- That the patient's condition has the potential to improve or is improving in response to therapy

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Medicare Benefit Policy 

- That maximum improvement is yet to be attained
- That there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time

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Documentation Requirements Progress Report 

- Each report should compare and contrast the prior level of function and describe specific areas which reflect improvement
- Within each level of function, include specific performance tasks that the patient can demonstrate as a result of skilled intervention

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Documentation Requirements Progress Report 

- The minimum Progress Report Period is at least once every 10 days or at least once during each certification interval, whichever is less
- The beginning of the first reporting period is the first day of the episode of treatment
 - Service provided on the first day of treatment is the evaluation, re-evaluation or treatment
- The Progress Report Period requirements are met when both the Progress Report and the clinician's active participation in treatment have been documented

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Documentation Requirements
Progress Report

- The end of the Progress Report Period is either a date chosen by the clinician, the 10th treatment day or the last day of the certification interval, whichever is shorter

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Documentation Requirements
Progress Report

- Clinicians are required to participate in treatment during the Progress Report Period
- Documentation/proof of the clinician's participation in treatment is required in the Treatment Note or in the Progress Report via the clinician's signature

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Documentation Requirements
Progress Report

- Elements of Progress Reports may be written in the Treatment Notes per discretion of the clinician
- If each element required in a Progress Report is included in the Treatment Notes at least once during the Progress Report Period, then a separate Progress Report is not required

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Supportive Skilled Documentation

- Patient at high risk for
- Skilled assessment of
- Reasonable probability
- Potential for recurrence
- Monitoring for consistency
- The medical regimen is not essentially stabilized
- Patient continues to require daily skilled rehab for
- Patient requires daily skilled evaluation of the plan of care

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Non-Supportive Skilled Documentation

- Plateau in progress
- Still requires
- Patient is unable to follow directions
- Patient has poor rehab potential
- Patient refuses to participate in therapy (without documentation of root of refusal)
- Within normal limits

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Non-Supportive Skilled Documentation

- First progress note to support skilled therapy services is 4 weeks after therapy began
- Quoted statements from patient refusing therapy and asking to end the therapy sessions/program, yet services continued without documented improvement

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Non-Supportive Skilled Documentation



- "Slow, steady gains" described in Progress Notes, but comparison of function is without change from one week to the next
- When a plateau is suspected, therapy goals should be adjusted and progress documented more frequently to justify treatment

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Patient is Minimal Assist Upper Body Bathing



- On evaluation, patient required max verbal and tactile cueing for **initiation** of upper-body bathing while seated at the sink. At this time, the patient only requires mod verbal cueing and no tactile cueing to initiate upper body bathing

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Patient is Moderate Assist Sit-to-Stand



- At the time of the last progress note, the patient required mod verbal cueing for sequencing of transfer technique. At this time, the patient no longer requires verbal cueing to lock wheelchair breaks and only requires min verbal cueing to push up from the armrests in order to transfer safely.

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Patient Can Donn Pants with Supervision



- Patient required mod verbal cueing to use adaptive equipment at the time of the last progress note. At this time, the visual cue of the adaptive equipment next to the clothing prompts the patient to use it without verbal cueing. Patient would benefit from continued skilled services to work on use of the adaptive equipment without the visual prompt.

Patient is CGA Ambulation with Wheeled Walker – Week One



- This week the patient was able to ambulate 45 – 50 feet with CGA with the w/w. Patient required mod verbal cueing to keep walker close to the body while ambulating and to leave walker on the ground when turning corners.

Week Two



- This week patient was able to ambulate 50 feet with CGA and w/w. Patient only required verbal cueing to keep walker close to the body on 3 out of 10 trials. The patient kept the walker on the floor when turning corners on 4 out of 10 trials.

Week Three 

- Patient requires CGA with w/w when ambulating. Patient was able to ambulate 50 – 60 feet this week and did not require verbal cueing to keep walker close to body. Patient only required verbal cues 2 out of 10 trials to keep the walker on the ground when turning.

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Monthly Progress Report 

- These are completed every 30 days and include components of weekly progress noted while also requiring:
 - Updated goals and treatment plan with **identification of significant improvement in functional skills**
 - "Significant" means a generally measurable and substantial increase in the patient's present level of functional independence, and competence compared to the level of function at the time treatment was initiated. HIM 12, 544

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Monthly Progress Report 

- Any change in treatment plan would require physician clarification orders
- The completion of clarification orders to communicate the expected treatment plan with the physician and receive verbal approval for the treatment to continue

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Discharge Notes

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Discharge

- Upon completion of each program, a discharge summary should be entered on the same form for which weekly and or daily notations on the patient's progress were made
- It is important to give a thorough synopsis beginning with a comparison between the initial level of function and discharge status

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Discharge

- List all techniques and methods trialed even failed attempts
- Discharge setting with cues for re-referral for skilled therapy

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Documentation Requirements Discharge Note



- A discharge note is required for each episode of treatment
- The discharge note is a Progress Report written by the clinician
- The discharge note covers the reporting period from the last Progress Report to the date of discharge

Documentation Requirements Discharge Note



- Unanticipated discharge:
 - Data related to discharge not noted in the previous Progress Report will require the clinician writing the final note to rely on treatment notes and verbal reports of the assistant or qualified personnel

Documentation Requirements Discharge Note



- Discharge anticipated within 3 treatment days of Progress Report:
 - Clinician may provide objective goals, when met will authorize the assistant or qualified personnel to discharge the patient
 - The clinician must verify services provided prior to discharge required the skills of a therapist
 - Services were provided or supervised by a clinician

Documentation Requirements
Discharge Note

- The clinician should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode for review purposes
- The discharge note includes all the treatment provided since the last Progress Report

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Documentation Requirements
Discharge Note

- The discharge note needs to indicate that the therapist reviewed the notes and agrees to the discharge
- The clinician may include additional information:
 - Summarize the entire episode of treatment
 - Justify services that may be extended beyond those usually expected for the patient's condition

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Medicare Part B

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Skilled Therapy under Medicare Part B



- Entitled to Part B: Beneficiaries pay additional to have Part B
- Services must be skilled, reasonable and necessary
- Part B reimburses 80% of fee screen. Additional insurance may cover the additional 20% (Medicaid, Medex).

Skilled Therapy under Medicare Part B



- Therapeutic interventions are mandated (LTC survey, OBRA, Transmittal 262) with condition changes
- Condition change - Improvement or decline in function documented by: Nursing, Therapy, Dietary, Activities, Social Services
- Condition change communicated at:
 - Care Plan Meeting
 - Beneficiary Review Meeting
 - Rounds

Skilled Therapy under Medicare Part B



- The Medicare cap on outpatient rehabilitation therapy services was instituted under the Balanced Budget Act of 1997 as a combined cap on speech-language pathology (SLP) and physical therapy (PT) services to Medicare beneficiaries
- Separate cap on occupational therapy (OT)

Skilled Therapy under Medicare Part B



- Current therapy cap for Physical and Speech Therapy combined is \$1,880 for calendar year 2012
- Services that meet the exceptions criteria and report the KX modifier on billing log will be paid beyond this limit with **clinical justification**

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Rules & Regulations Part B Service Delivery



- Local Medical Review Policy (LMRP) are published by each Intermediary
- Review to understand intermediary's specific requirements and expectations related to Medicare B therapy billing
- Therapy documentation should reflect the wording and terminology used in the LMRP in order to support our claim

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Skilled Rehabilitation MD orders



- The service must be ordered by a physician
- Frequency and duration are required
 - Minutes are not required (PRI)
- Must be current for entire time services are required
- "Evaluation and treatment as indicated" must be clarified

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Onset Date



- Date of the primary or treatment diagnosis for which therapy services are being rendered. Must be of a recent onset. Chronic conditions greater than 3 months are at risk for denial.
- Emergency matters: Choking, falling, etc. Require immediate attention and there is no need to "wait" for documentation.
- For chronic diagnoses, indicate the date of the change or deterioration in the patients condition that now necessitates therapy services (acute exacerbation date)

Onset Date



- Nursing notes should support a change in condition requiring a skilled therapy services
- Nursing needs to clearly outline the precipitating event(s) to Rehab referral
- There is no federal requirement for 3 days of nursing documentation to initiate Part B services

Diagnosis



- Medical diagnosis **supports** deficits identified on evaluation being treated
- Be reported on the UB-04. What is the process between therapy and billing?
- Ensure chronic codes that are not related are not used
 - Dementia
 - UTI

Diagnosis



- Indicate the Medical DX that has resulted in the therapy disorder
- Relate to the current plan of care for therapy
- Represent the most intensive services (over 50% of the revenue code billed)
- Relevant to the problem to be treated (e.g., O.A. with treatment diagnosis of "pain in the joint" or "difficulty walking")

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Reason for Referral



- Avoid statement such as *"to purchase private wheelchair" or "New admission"*
- Provide the reason for the referral as it relates to the primary or treating diagnosis or condition and the mechanism of injury
- For chronic conditions, an objective description of the changes in function (acute exacerbation) that now necessitate skilled therapy should be indicated

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Reason for Referral Examples



- *"falls x 3 in the last 2 weeks"*
- *"no longer ambulating to the dining room"*
- *"...decline in their transfer ability, this is supported through staff interview"*
- *"developed stage 2 pressure ulcer on coccyx"*
- *"exacerbation of M.S. and is now having difficulty with*
- *"unable to sit upright in current chair and requires frequent repositioning from staff."*
- *"5 %weight loss and is currently p.o. intake is 50%"*

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Physician Certification



- The therapy intervention must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional and must be reasonable and necessary to the treatment of the beneficiary's illness or injury necessary to the treatment of the beneficiary's illness or injury

Physician Certification



- Minimally required every 90 days
 - Recommend every 30 days
 - Continued physician oversight
 - Ensure plan continues appropriate
 - Summarize progress every 30 days
- 700 or 701 no longer required
- Any format

Method of Service Delivery



- Individual therapy – one on one intervention
- Group therapy (97150)
- Concurrent therapy should be billed as group treatment under Med B
- Co-treatment time needs to be split between the therapists

Program Development 

- Successful development and implementation of a Part B therapy program
 - Identify all patients in-house who have access to Part B benefits
 - Implement process to get patient/family approval for Part B therapy services prior to delivery
 - Educate nursing on appropriate patient referrals for Part B therapy services
 - Therapy to initiate routine review of key facility reports to address resident needs in a timely fashion (e.g., falls, weight loss, skin, etc.)

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Denial Management 

Skilled Interventions 

- Medicare will support continued services when the patient is not making progress if there is documentation that multiple skilled interventions have been trialed
- It is appropriate to give each trial an adequate amount of time to determine if the patient will progress

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Skilled Rehabilitation Risk for Denial



- If the expected results are insignificant in relation to the extent and duration of the therapy services required to achieve the results, the services would not be reasonable and necessary
- In general, when a resident reaches a level of function equal to his or her status prior to the acute hospital condition, or when the resident's progress plateaus, skilled therapy no longer is considered to be reasonable and necessary

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Common Mistakes That Affect Reimbursement



- Therapy minutes are not tracked and documented consistently between therapy notes and logs and what was recorded on Section P of the MDS
- Documentation between therapy and nursing is not consistent
- Goals are not functional
- Goals are not measurable

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Common Mistakes That Affect Reimbursement



- Goals are not patient centered
- Prior level of function not appropriately addressed
- Change in functional status not sufficiently addressed
- Duplication of services

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Common Mistakes That Affect Reimbursement



- Documentation is not filed in the medical record for all disciplines to review for clinical decision making and reimbursement tool completion (24 hours)
- Documentation within evaluation and treatment plan does not specifically address number of people required to assist patient to complete ADL safely. (Measurable)
- Illegible documentation

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Questions/Answers



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