>90% of Medicare Part A stays are skilled by rehab

Some of the Medical Review Types

<table>
<thead>
<tr>
<th>Review Entity</th>
<th>Pre-pay</th>
<th>Post Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAC  Recovery Audit Contractors*</td>
<td>(pending)</td>
<td>☑</td>
</tr>
<tr>
<td>CERT  Comprehensive Error Rate Testing</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>MAC  Medicare Administrative Contractors</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>MICs  Medicaid Integrity Contractors</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>QIO  Quality Improvement Organization</td>
<td></td>
<td>☑</td>
</tr>
<tr>
<td>ZPIC  Zone Program Integrity Contractors (formerly PSC)</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>State Auditors (may re-RUG)</td>
<td></td>
<td>☑</td>
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Medical Review Preparation

- Review contractors request claim samples to make sure that the entire medical record cohesively supports:
  - Services rendered
  - Intensity of those services
  - Duration of care as billed
- Documentation inconsistencies, conflicts or lack of clearly defined skilled service needs result in claim denials and recoupment of overpayments

Success under medical review

SUPPORTING SKILLED SERVICES
ADMISSION

Where have they been?
Where are they going?
Starting baselines.

Medicare Admission Basics

Certification
• Skilled need ties to 3 day hospital stay
• Diagnoses codes
• Timely signatures cert/recert

Billing
• Payment status/days available verified

Physician Supervision
• Orders
• Timely H&P/ medical eval timely
• Protocols
• Progress reports
• Rehab Potential
• Oversight demonstrated
• Legible identifier

Prior level of Function (PLOF)

• Best documented function within last 3 months. Any available prior MDS should corroborate PLOF statement. Reviewers want proof of PLOF outside of therapy notes
• Functional level with detailed % assist levels for each goal area

Clarify activity level & involvement
• Were they going to the dining room independently?
• Managing housework?
• Involved in the community? (driving, shopping, church, social/leisure activities, work?)

Set goals for tasks w/an established recent change from PLOF to current level of function.

Medical Necessity of Rehab

Describe changes in condition that prompted skilled therapy need

• Changes in condition from a medical review perspective must be shown as a contrast between the prior level of function - PLOF and current function.
• Changes must be significant enough to warrant skilled therapy services beyond the scope of what nursing staff could manage without rehab’s help.

Mr. Jones was transferring independently last month, but has consistently required moderate/extensive assist this month due to knee pain and instability.

Objective baseline data

• Summarize objective findings that apply to key problem areas such as level of assist with mobility, ADLs, level of pain, cognitive status, etc.
• Objective data at evaluation is cornerstone to proving measurable progress later
Diagnosis Codes

Therapy plans, MDS and UB-04 must include relevant diagnosis codes to describe the medical condition(s) and symptoms that have prompted rehab services.

- SNF stay extension of hospitalization
- Diagnoses should be physician approved & added to the master diagnosis list
- Rehab diagnosis codes should be on the UB04 to support billed services under automated review

Skilled Criteria for Therapy

- Therapy at least 5 days/week
- As a practical matter, daily skilled services can only be provided in a SNF
- Services directly related to an active written treatment plan based on evaluation
- Services must require the skill of a therapist (complex, sophisticated, judgment & knowledge)
- Services must be accepted standards of practice, reasonable & necessary and be provided with the expectation of material progress

Showing Sophistication

- Formal testing with interpretations of results
- Review & management of complexities
- Plan adjustments in response to progress
- Skilled terminology & clinical reasoning

Skilled Entry Example: Plan Adjustment

Modification of OT approaches based on current complexity of memory deficits:

Plan Adjustments:

- Added goal: Pt will respond to striking visual cues in room to comply with walker use with bed to BSC transfers 100% of the time 3 of 3 days.
- OT to analyze functional vision for reading posted reminders this week and will incorporate environmental compensations including consistent placement of AD, arrangement of bed position in relation to bathroom door and striking visual contrast adaptations to walker, call light mechanism and mobility aids.

Skilled Entry Example: Reflecting Knowledge

Non-skilled:
Pt tolerating 25 reps of LE exercise all planes with red T-band

Skilled:
Promoting improved postural-core stability for dynamic functional activity through progressive balance, proprioceptive, and bilateral integration challenges via reciprocal movement patterns based on PNF guidelines within limits of prescribed cardiac precautions.

Skilled Entry Example: Sophistication

- Gait summary: Gait cadence currently is 40 steps/min with rolling walker (55 steps/min appropriate for unit/hallway locomotion) compared to 38 steps/min initially. Improved bilateral knee flexion ROM during preswing phase gait to 25 degrees (norm 35 degrees) which is reducing risk of tripping through improved foot/toe clearance during swing phase.
- Modification of PT approaches: Sensorimotor stimulation to maximize sequencing hip/pelvis in turning & backing activities from rolling walker level in preparation for sitting
Justify intensity of services

- Clinical complexity
- Physician protocol
- High level DC expectation
- Planned short stay
- Split treatments/BID
- Every session skilled—shifting non-skilled activities to HEP/RNP

Finding Balance

- Length of stay expectations
- Reasonable progress

Safe Discharge Transition

- Treatment should evolve in a step wise fashion based on resident performance, goal progress, and successful compensations learned in therapy
- Documentation of treatment interventions, service intensity, and billing patterns should reflect this evolution
- Start caregiver training early—not just last days on therapy

NURSING DOCUMENTATION

- Management & Evaluation of Care Plan
- Observation & Assessment of Condition
- Teaching & Training
- Direct Skilled Nursing Services
Clarify the significant changes

- Document clear PLOF details and summary of problems hindering return to PLOF that require therapy intervention

Mr. Stevens was living home alone with regular visits from daughter who helped with shopping, bill paying and setting up pill box. He is currently unable to self toileting or complete dressing, bathing or meal preparation without physical assist of 1. PT and OT are actively addressing these and other significant deficits that are currently obstacles to achievement of the patient, physician and family goal of return to home in 6-8 weeks.

Support ongoing therapy

- Document:
  - to show daily skilled need
  - the functional impact of gains made in therapy
  - remaining functional problems
  - how therapy goals are being reinforced outside of rehab

Mrs. Smith only needs assist with her bath this week 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. Staff are incorporating PT recommendations for transfers including counting aloud to initiate, consistent walker placement and cues to scan left visual field when pivoting toward side of visual neglect.

MDS Documentation

- MDS data should accurately reflect functional levels and relevant changes throughout the rehabilitation course. Discrepancies between rehab documented status and MDS coding should be clarified in the documentation.

Resident required more assist 3rd shift during night time toileting than is typical during the day.

Decoding assist levels

<table>
<thead>
<tr>
<th>MDS terminology</th>
<th>Therapy terminology</th>
<th>Therapy Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0/Independent</td>
<td>Independent</td>
<td>No physical or cognitive assist required</td>
</tr>
<tr>
<td>1/Supervision</td>
<td>Supervision (S)/Standby Assist (SBA)</td>
<td>Safety &amp;/or cognition require therapist to facilitate task</td>
</tr>
<tr>
<td>2/Limited</td>
<td>Contact Guard Assist</td>
<td>Guided maneuvering or other non-weight bearing assist. (Therapist is in contact just in case physical assist is needed.)</td>
</tr>
<tr>
<td>3/Extensive</td>
<td>Minimal Assist</td>
<td>1-25% physical assist and/or weight bearing support</td>
</tr>
<tr>
<td>3/Extensive</td>
<td>Moderate Assist</td>
<td>26-50% physical assist and/or weight bearing support</td>
</tr>
<tr>
<td>3/Extensive</td>
<td>Maximal Assist</td>
<td>51-75% physical assist and/or weight bearing support</td>
</tr>
<tr>
<td>4/Total Dependence</td>
<td>Dependent/Total Assist</td>
<td>76-100% physical assist and/or weight bearing support</td>
</tr>
</tbody>
</table>

Justify RUG level /service intensity

1. Therapy days/minutes are reasonable & necessary for condition
2. Progress is in line with the intensity of service
3. Treatment is evolving based on patient’s response
**Communication**

_Solution: Medicare Meeting_

- Weekly Medicare Meeting or daily "stand up" recommended to:
  - Discuss therapy progress, interdisciplinary care coordination, skilled need criteria and transition plans.
  - Review RUG level—still appropriate?
  - MDS assessment planning
  - Problem solve issues (e.g. therapy refusals)
  - Complete a strong weekly documentation entry in the nursing notes supporting the past week's rehab services and detailing ongoing medical necessity and continued therapy needs when applicable, especially if rehab is the primary skilled service for a Part A stay.
  - Check for errors, omissions, contradictory statements

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**Technical Issues**

- Legibility
- Lack of signature keys
- Therapy minutes/days discrepancies
- MDS transmission
- Late/missing documentation
- Certification errors
- Undated signatures
- Order errors
- UB04-MDS errors
- Medical records filing errors

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**Prepare for Medical Review**

- Complete a risk assessment
- Develop a facility medical review plan _BEFORE_ medical review.
- Involve rehab when an ADR involving therapy services is received.
- Follow the directions on the ADR exactly
- Review all documentation for accuracy prior to sending.
- Keep copies of everything sent along with records of dates mailed, etc.
- Investigate appeal & recoupment regulations

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**Policies & Procedures**

- Documentation standards & practices that speak to meeting skilled criteria
- Claims submission (review False Claims Act)
- Self disclosure
- Medical records & records retention
- Quality Assurance plan, implementation, results review
Training, Auditing & Monitoring

Training
• Compliance program philosophy & ethical practice standards; reporting
• Medicare Billing & Coding
• Clinical programs that meet skilled standards
• Documentation of Skilled Services

QA & Audits
• QA systems (e.g. triple check meeting)
• Periodic audits of documentation

Amie Martin OTR/L
(812)431-4804
amartin@proactivemedicalreview.com

Proactive Medical Review & Consulting, LLC    www.proactivemedicalreview.com