Patient Advocacy Through Documentation
Collaboration Between Nursing and Rehab
Barb Christensen, Clinical Director-Aegis Therapies

AGENDA
- Review Various Audit Types
- Brief Discussion of Implications of PEPPER Reports
- Components of Good Rehab Documentation
- Collaborative Documentation
- Examples/tools
- ADRs and Denials

Patient Advocacy??
- How is documentation, advocacy?

Patient Advocacy??
- How is documentation, advocacy?
- It’s ALL we have to validate that our services were skilled.
- Audit entities don’t see our patients.
- They only see what we write.
- What we write secures payment for our services today....
- And services for patients of the future!

Medicare Claims Review Entities
- Medicare Administrative Contractor (MAC)
- Recovery Audit Program (RAs-formerly the RAC)
- Comprehensive Error Rate Testing Contractors (CERT)
- Zone Program Integrity Contractor (ZPIC)

MAC (WPS for MO)
Goal: PREVENTION
How? Through Progressive Corrective Action (PCA)
- Pre and post-payment review
- Probe Review
- Targeted Medical Review
- Education
Recovery Audit Program (RA)

RA for Missouri: HealthDataInsights
Goal: DETECT AND CORRECT
How?
- Post-payment claims review
- Pre-payment in some states
- Widespread or Targeted review
- Therapy services over $3700 threshold
- *** Currently all TRA activity is on hold while CMS modifies RA contracts*** There is no clear indication of what will occur with Manual Medical Review.

Comprehensive Error Rate Testing (CERT) Program

Goal: MEASURE
How?
- Randomly select statistically valid sample of claims
- Post-payment review
- Publish results annually
  - Used to guide provider education

Top CERT Denial Reasons for SNF-Part A

- Insufficient documentation to support the RUG code billed resulting in a down code.
- No documentation of qualifying medically necessary three day inpatient hospital stay

Zone program Integrity Contractors (ZPIC)

Goal: IDENTIFY POTENTIAL FRAUD
- Perform data analysis and conduct medical review
- Conduct interviews
- Conduct onsite visits
- Investigate fraud and abuse
- Refer cases to law enforcement and OIG
- ZPIC in MO = AdvanceMed Corporation

ADRs and Denials Happen

More on this later....

PEPPER Reports

“Program for Evaluating Payment Patterns Electronic Report”
- Contains provider-specific data in categories identified by CMS as potentially vulnerable to improper Medicare payments.
- “Outlier” status identifies where billing practices differ from the majority of other SNFs in the nation.
Outliers

- It is very acceptable to be unique and away from the norm as long as the documentation tells the story of a patient’s condition that requires more than a typical amount of therapy or nursing services.
- CMS words “PEPPER cannot identify the presence of improper payments. These can only be confirmed through a review of medical record documentation...”

Back To Advocacy

- Regardless of who is looking or why....
- It is the documentation they will look at.
- Each patient comes to us with a history and a story.
- Our job is to tell that story.
- That’s the ONLY way to advocate for the services they deserve!
- As well as advocating for patients of the future.

What To Expect From Good Rehab Documentation (Applies To Nursing As Well)

- Each patient is an individual.
- Their medical record is their story.
- This story has 2 characters: The patient and the therapist/nurse.
- COVERAGE REQUIREMENTS
  - MEDICAL NECESSITY = the patient
  - SKILLED SERVICES = you
    - Denials occur when either Medical Necessity or Skilled Services is not convincingly described.
    - Or....when there are obvious conflicts in the story (such as discrepancies between what therapy says vs. what nursing says.

Medical Necessity

- The Patient’s Story explaining the need for skilled intervention at this time-whether it’s the SOC or at intervals throughout the episode.
  - The change in function related to the recent medical history.
  - The Medical Diagnosis
  - The co-morbidities and complexities
  - The Functional Deficits impacting daily life
  - The Underlying Impairments that are causing these Functional Deficits

Skilled Service

- Your Story explaining what you are doing during treatment sessions or nursing interventions.
  - Describes why you?

The services that only therapists or nurses are qualified to provide because of our specialized training and knowledge.
Analysis and Adjustments

Therapy MUST provide this in notes:
- Analysis
  - The thought process that goes on as the patient progresses through a task. What is observed, assessed, perceived and judged.
- Adjustments
  - The adaptations, changes, variations and progressions that are made during treatment. Changing the task, the environment, the cues etc according to the analysis.

Skilled Analysis-Must Be Described

SO WHAT?? TELL ME WHY??
- WHY did the patient progress? WHAT underlying impairment improved to cause the functional progress?
- WHAT are the current challenges?
- WHAT is so complex about this patient’s condition that they cannot continue on their own or with a caregiver?
- WHY is there a variation in the patient’s abilities throughout the day or over the past week?

Skilled Adjustments

- The skilled adjustments are the decisions made based upon skilled analysis.
- If we don’t describe the treatment decisions and adjustments, the intervention will appear repetitive.
- REPETITIVE SERVICES = DENIAL

Your Thoughts

MEDICAL NECESSITY and SKILLED SERVICES: Nursing perspective?

CMS Example

MEDICAL NECESSITY and SKILLED SERVICES: Nursing perspective
Example:
- Patient with pneumonia, chest congestion, confined to bed, confusion.
- Immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of relapse. Skilled overseeing of the non-skilled services (position changes and deep breathing) would be reasonable and necessary
  - “Documentation must illustrate the complexity…”

Your Thoughts

MEDICAL NECESSITY and SKILLED SERVICE: Rehab?
CMS Example

MEDICAL NECESSITY and SKILLED SERVICE: Rehab
CHF, diabetes, prior amputee both LE’s.
Training in bed mobility, transfer skills, functional activities at wheelchair level.

CMS Words-Benefit Policy Manual

- “...coverage of skilled nursing and skilled therapy services...does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care.”
- “...While the presence of appropriate documentation is not, in and of itself, an element of the definition of a “skilled” service, such documentation serves as the means by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case...”

Documentation Examples

Would this be a problem?
Therapy says: Gait training and strengthening exercises
Nursing note says: Patient walks ad lib.

Both statements are technically true. Medically necessary? Skilled need?

The REAL Story

Therapy: Patient has a low score on the Berg balance test, has difficulty with foot clearance during gait. In addition, O2 sats drop to 88 after 4 minutes of moderate activity. Hip flexors at 3/5 strength which impairs the ability to obtain good foot clearance.

On unit: Patient walks ad lib, but appears out of breath after a few minutes. Often reaches for rails or furniture to steady self. Gait is not fluid.

Is This Better?

Therapy says: High risk for falls due to results of Berg. Increasing balance challenges and leaving base of support. Focusing on hip flexor strength to improve foot clearance. Training in diaphragmatic breathing to improve O2 sats.

Nursing note: Patient able to walk independently but gait is impaired. Note breathlessness after short intervals.

Is medical necessity more obvious? How about skill?

Collaborative Documentation

- If discrepancy exists, nursing documentation will win.
- Medicare views nursing documentation to be representative of what is actually happening functionally on a day to day basis.
- Communication is fundamental – more on this later...
- Barriers to this:
  - MDS
  - 24/7 vs. 1 hour a day
  - Patient time for nurses vs. nurse aides vs. therapy staff
  - Time to talk/collaborate
A Word About ADLs

- Are you confident in ADL coding?
- Does it align with what rehab is saying?
- Patient may be more independent in rehab then on the MDS.
- What if MDS says they are MORE independent than rehab?
- Likely denial

ADL examples

- Patient rolls side to side in bed by using half rails. They do this independently. Coded as such on MDS
- Rehab has goals for bed mobility and rates them “mod assist”
- Both statements may be accurate.
- ADL may have been coded based upon only part of the description.
- Rehab may be focusing on supine to sit, not rolling.
- Bed Mobility MDS: “how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.”

ADL Example

- OT working on clothing adjustment while toileting. Focusing on balance and use of adaptive equipment to facilitate this action.
- On unit, patient transfers on and off toilet independently. Coded as such on MDS.
- MDS: Toilet Use: “how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination, changes pad, manages ostomy or catheter; and adjusts clothes.
- Discrepancy = denial

MDS

- Does not make collaboration easy!
- It is possible to make great gains in rehab (i.e. from max assist to min assist) but the MDS will remain the same at “extensive”
- “Extensive” on MDS equates to min/mod OR Max assist in rehab documentation. It implies nursing staff needs to actively guide and touch with more than “palms up” approach.
- “Limited” assist on MDS implies “palms up” only approach. It equates to CGA assist in rehab documentation.
- Good first step is to understand each others’ lingo

Rehab Lingo

- Independent: No assistance
- Modified I: No assistance but needs equipment or more time
- Supervision: Observe from a distance, may need cues or set up, no physical assist
- SBA: Close supervision, no physical assist
- CGA: Minor contact may be necessary. May be unsteady
- Min: Patient routinely needs 25% assist (can be physical or cognitive assist)
- Mod: Patient routinely needs 50% assist
- Max: Patient routinely needs 75% assist
- Dependent: Needs 100% assist
24 and 7 vs. 1 hour

- Patients belong to nursing. They are yours 24 and 7!
- Rehab sees them about 1 hour a day.
- Rehab needs to communicate what the patient is capable of and how.
- Nursing needs to communicate when/why it’s not possible.
- If the barriers to capability are related to underlying impairments rehab treats, (and this is documented), it all helps to tell that story. The story of skilled need.

TIME

- Nurse aides often spend the most time with patients.
- They record information such as ADL statistics
- But who writes the notes??? Nurses.
- How confident are you that aides are passing on information that is detailed and accurate?
- Do they understand the full definitions in the ADL section of the MDS?

Example

Aide sees: Patient required assist with lowering legs out of bed for transfer. Needed limited assist for transfer from bed to w/c. Needed help to put shoes on. Loses balance when making the turn in to the bathroom. Cues to use walker correctly and safely. Drinks thin liquids but coughs when using a straw.

Medical record charting is accurate but says only: “Alert and verbal. Patient ambulates ad lib. Takes thin liquids.”

TIME – Rehab Perspective

- Often use assistants, but therapists see what they do, read/co-sign notes. Our barrier is not as great as the aide/nurse divide.
- But....therapists dislike documenting as much as nurses.
- Rehab departments have productivity standards just like most industries. It’s reality.
- Documentation time is NOT considered a billable service.
- Point of service is often an option.

Collaboration Strategies

- The Medicare Meeting:
  - All have one
  - Make it count
  - Ask: “What’s the need?” “What’s the skill?”
  - Write the note during the meeting
  - Function or problem oriented
  - Consider nurse aide in attendance
  - Tools to facilitate this conversation to follow

Collaboration Strategies

- Join a therapy session
  - Perfect opportunity to talk to patient and therapist about status and progress and continued needs
  - Perfect opportunity for point of service documentation
FUNCTIONAL ABILITY
Date: ____________________ Resident:

Medical Diagnosis:

Therapy/Treatment Diagnosis:

This checklist is designed to assist the charting nurse in describing the patient’s functional ability on the unit. The intent is to help facilitate nursing documentation that is functional in nature and reflects the patient’s performance as it relates to their rehab program. The rehab activity or program is checked and corresponds to suggested patient activities, or functional performances which might be noted in the nursing narrative.

**Rehab Activity**

**Suggested Nursing Observation/Documentation**

- Feeding
  - Describe patient’s ability to feed self. This comment should include any set up needed, as well as any assistive devices the patient is using. Is there any cueing required? (example: The patient feeds self 50% of meal using a built up spoon and plate guard.)

**Occupational Therapy**

**Documentation to support the need for PT**

- Resident requiring additional assistance to walk due to (loss of balance, falls, unsteadiness, weakness in legs, etc.)
- Resident has had episode(s) of near falls
- Resident demonstrates decreased walking distance with unsteady gait. (i.e. was walking to the dining room but now only walking in room)
- Resident appears fatigued or SOB with ambulation

**Documentation to support progress made with SLP**

- SLP provide training on use of external memory aid. Patient able to use to remember...
- SLP provide training on appropriate positioning to reduce patient specific swallowing issues. Less coughing noted during meals.
- SLP provided training on how to elicit yes/no responses from patient. Patient now able to select clothing for the day.
CHECKLIST FOR COLLABORATIVE DOCUMENTATION FOR THERAPY SERVICES

- Transfer ability
- Ambulation
- Assertive device needed—if so what
- Number of feet ambulated

Tools

- Easy to read
- Focus areas can be pre-checked by rehab.
- Can be left at nurse’s station.
- Useful reminder, but not very specific to each week’s status.
- How might you use this??

Nursing Supportive Documentation Tool

Problem

- Nursing Documentation examples to support PT, OT, ST

What to document

Tools

- Discipline specific.
- Identified functional areas.
- One page.
- Can be left at nurse’s station.
- Could become repetitive.
- How might you use this??
Additional Tips/Thoughts

- Does rehab audit their documentation?
  - Timeliness
  - Completeness
  - Quality audits
- Is there an opportunity to view nursing doc and rehab doc side by side?

Education

- Newer therapists (and older) often do not understand the importance of doc.
- Is this true for nurses as well?
- What education is provided to nursing staff?
- Education or “tip sheets” for aides on ADL definitions.
- Does your rehab provider mandate documentation training?

Denials And Appeals

- All claims pass through a series of computerized edits.
- If they pass all edits, they are usually paid.
- In many cases, documentation is never read, the claims simply passes through and is paid.

Claim Edits

- If over the cap, is there a KX modifier.
- Are there any CCI code edits? If so, is there a 59 modifier?
- Have we followed rules of the particular MAC/LCD?
- Are any of the services billed part of a Probe Review?
- Are there issues with Functional Limitation Codes/G-codes?
  - The denial may be appropriate
  - If not, may be able to re-submit with corrections

Probe Selection

- A probe review occurs when an insurer or oversight review entity determines that medical review (auditing) of a sampling of claims is necessary to determine if any issues are present.
  - Two types of Probes
    - Service-Wide
    - Provider-Specific

Service-Wide Probe

- Claims samples are taken from a broad base of providers.
- Typically a specific service is involved in the probe such as
  - Upper RUGs in state of Iowa
  - Manual e-stim in the state of Wisconsin
- Probes may be posted on the Insurer’s web site.
- If you bill a service that is part of a Service-Wide probe, there is a potential you'll have a claim that is ADR'd.
  - Typically only a percentage is looked at
Provider-Specific Probe

- A specific provider is selected for medical review of a sampling of their claims.
- Most common type of probe review.
- Typically, before the review takes place, facility Administrator will receive a Probe Notification Letter.
- MACs are required to notify you.
- ZPICs are not

Provider-Specific Probe - Selection

- Data analysis
- Used to detect outliers and trends in billing of certain services as compared to local and national patterns. Outliers may be subject to probe review.
- Example: SNF Part A lengths of stay outside the industry norm.
- Complaints
- Follow up to complaints made to the insurer could result in a probe review.
- Referrals from an insurer to an oversight agency could result in a probe review.

Provider-Specific Probe

- Typically 20-40 claims are sampled
- Probe may be pre-pay or post-pay
  - Pre-pay: as a claim is submitted to the insurer an edit stops/suspends the claim and will not allow payment until medical review is completed of the medical records associated with that claim.
  - Post-pay: the claim has already been paid. The claim is now being selected for medical review to determine if the claim was paid appropriately.

ADR

- When a claim has been selected for medical review, the request for the associated medical records will be made through an “Additional Development Request” = ADR
- It’s not a denial
- You may be notified by the insurer.
- Providers are encouraged to use FISS Option 12 (claim inquiry) to check for ADRs once a week.
- In most cases, ADR packet is due within 30 days.

A Word About Dates Of Service

- Claim Dates of Service (DOS)
- The from and through dates will align with a specific claim billed.
- May not align with SOC and EOC dates of a Part A stay or therapy episode of care.
- In many cases, medical records from prior to or after this date may need to be sent.

Claim Denial

- Denials can occur at the line level or at the claim level
- Line level: specific claim lines are denied, but not the whole claim.
- “Partial” denial
  - For example:
    - 3 lines of CPT code 97110 are denied, but the rest of the claim is paid
    - All SLP is denied, but OT and PT are paid
- Claim level: The entire claim is denied
  - “Full” denial
    - Keep in mind that the claim is tied to specific DOS and does not necessarily mean that an entire episode of care is denied.
### Common Computerized Edit Denials
- Over the therapy cap without KX modifier
- CCI edit without a modifier 59
- Claim does not contain a covered ICD code form an applicable LCD.
- Medical records requested but not received timely

### Computerized Generated Denials
- Some MACs allow the computer generated denials to be re-billed with the appropriate modifiers/codes added.
- Others require that these denials be appealed.

### Why Do We Get Denials From Medical Review?
- 2 main reasons
  - Medical Necessity: We have not convinced the MAC of the need for our services in the first place or the continued need.
  - Skilled Service: We have not convinced the MAC why the skills provided could only have been performed by a nurse or a therapist.
- Very few denials occur because of lack of progress
  - Is this sounding familiar???

### Timelines
- The process is identical for Part A and Part B
- The entire process is about 300 days (on paper)
  - We MUST follow out timelines
  - MACs don't necessarily have to
  - Recent communication from CMS: ALJs will not even be SCHEDULING hearings for 2 years.

### Level 1: Appeal Letter
**Level 1 Appeal = REDETERMINATION**
- Conducted by the MAC
- Appeal packet must be to the MAC within 120 days of the RA date
- MAC has 60 days to issue a decision

### Level 2: Reconsideration
**Level 2 – RECONSIDERATION (if we did not get the denial overturned in level 1)**
- Conducted by a new entity – Qualified Independent Contractor (QIC)
- Appeal packet must be in their hands with 180 days of the redetermination decision.
- QIC has 60 days to issue reconsideration.
Level 3: ALJ

- Level 3 Appeal – Administrative Law Judge
- Appellant has 60 days from receipt of reconsideration to request ALJ
- NOW: It will be at least 2 years before ALJs are scheduled
- ALL THE MORE REASON WHY THE BEST OFFENSE IS A GOOD DEFENSE

QUESTIONS??

THANK YOU