Documentation Essentials- Proving Medical Necessity in Therapy Documentation

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What does “Reasonable” mean?

“Reasonable” (continued)

- Care that is “reasonable” is...
  - Safe.
  - has been proven effective.
  - not experimental or investigational, utilizing accepted standards of practice.
  - Appropriate frequency/intensity/duration for the given diagnosis/condition.
  - Furnished in an appropriate setting.
  - Ordered and furnished by qualified personnel.

“Reasonable” (continued)

- Care is safe...
  - “Practice two things in your dealings with disease: either help or do not harm the patient”. Dr. Thomas Inman, 19th century physician

“Reasonable” (continued)

- Has been proven effective/not experimental/utilizes accepted standards of practice.
  - The creative treatment story (scope of practice)
  - Evidence Based Practice (EBP)
“Reasonable” (continued)

• Scope of Practice- who defines:
  – Professional Advocacy Groups
  – State Boards
  – Medicare and other Third party payers

• Knowing what each entity defines as your scope of practice enhances your documentation!

“Reasonable” (continued)

• Care is given according to appropriate frequency/intensity/duration.
  – Frequency- times given/interval of time
  – Intensity- number of units of care/minutes provided
  – Duration- the episode of care- POC to D/C

• Determined by...
  – Research
  – Medicare and third party payers
  – You and your individual patient

“Reasonable” (continued)

• Care is provided in an appropriate setting.
  – Basically, meeting the patient’s healthcare needs with the least amount of resources, to meet the patient’s healthcare goals and maintain safety.
“Reasonable” (continued)

• Care is **ordered** by and **performed** by **qualified** individuals.
  – Orders- (regs)
  – Performed- those licensed to perform, and recognized to bill, appropriate interventions (CPT/HCPCS)
  – Qualified- those possessing evidence of licensure that covers a particular scope of practice

“Reasonable” (continued)

• Care is provided in such a way as to weigh cost vs. benefits:

![ROI](image)

Necessary

• The service of a physical, speech-language pathologist or occupational therapist is a skilled therapy service if the inherent **complexity of the service** is such that it can be performed **safely** and/or **effectively** only by or under the general supervision of a skilled therapist.
  (http://www.health.state.mn.us/divs/fpc/profinfo/ib03_2.htm)
“Necessary” (continued)

• Care must be “inherently complex...”
  – Is it clear that what you are doing took
    • Knowledge (book learning)?
    • Skills (hands on, use of equipment, etc)?

“Necessary” (continued)

• It is clear that you are the only one to be able to perform it safely...
  – “Don’t try this at home!”
  – Would someone be injured/die if someone outside of your scope/lack of training perform such an intervention?

“Necessary” (continued)

• Care is clearly only effective if you provided it, or someone with similar training...

\[
\text{Effectiveness} = \frac{\text{Achieved}}{\text{Desired}}
\]
“Necessary” (continued)

• “Sufficient” care explained

SOC ➔ LTG

PT...
MD...
Orthotist...
WG...

“The Basis for Documenting Reasonable and Necessary Care

• Functional Deficits (FD)
  – measurable (i.e., SBA, min assist, total assist)
  – Generally observable by all people, not just skilled practitioners, and alert people to a “problem” that must be “fixed.”
  – Addressed, depending upon the issue, by one or more practitioners (not necessarily discipline specific)- example- loss of upper extremity function
  – Are what the insurance companies are wanting to see addressed.
  – Must be compared to Prior Level Of Function (PLOF) before medical dx/treatment dx occurred that caused RFR
  – Answer “WHAT” is going on?
  – Answers, in part, the “reasonableness” of care.
Basis (continued)

• Underlying Impairments (UI)
  – **Measurable** (e.g.- special standardized tests, ROM, strength, balance, etc)
  – Are generally specific to a certain scope of practice of a skilled practitioner, and are **not inherently observable/measurable to a non-skilled professional**.
  – Addressed, depending upon the impairment, by one or more skilled practitioner scopes of practice (e.g.- PT and OT can both address ROM of an extremity)
  – **Cause the functional deficit, prove the need for skilled services, form the basis for goals and analysis, and demonstrate the need for chosen interventions (CPTs)**
  – Answer "**WHY**" is this going on?
  – Answers, in part, the "**Necessity**" of care

FD and UI comparison (examples)

• PT
  – Patient has a limp and cannot walk >100 ft before needing a break
    • Measurable
    • Observable by all people
    • Can be addressed by one or more skilled professionals (definitely within PT scope)
    • *This observation alone is not necessarily skilled, and therefore constitutes a FD only...*

PT FD vs. UI (continued)

  – What is causing the limp/limited walking distance?
    • Circumference of knee is 6 cm > than other side
    • Knee extension during heel strike is -25 degrees
    • Patient reports 4/10 pain at rest, 7/10 pain after 100 ft of ambulation, exacerbated by WB.
    • Quads demonstrate 3+/5 strength, with pain.
  – What makes these different from functional measures?
    • They are **not necessarily** readily observed by non-skilled personnel/non-therapists, and certainly not measurable by many, or make clinical sense to but a few.
OT FD vs. UI

- Patient cannot put on shirt unless it is button down. (functional impairment)
- Patient exhibits the following underlying impairments:
  - Right shoulder ROM is limited to 70 degrees scaption actively.
  - When pulling shirt over her head, she loses balance - therapist determines that patient has vestibular and/or proprioceptive issue due to 1) loss of visual input and 2) position change of head disorients patient.

ST FD vs. UI

- Patient cannot swallow without coughing (function)
- Patient exhibits the following findings to a SLP (underlying impairments)
  - Poor mastication due to loss of dentition
  - Decreased tongue strength and ROM, thus making bolus propulsion difficult
  - Rapid breathing, making airway closure coordination difficult

Recap- FD vs. UI

- Without a functional deficit, skilled care is not reasonable...
- Without assessment/analysis of underlying impairments causing functional deficits, we will not be able to prove our particular (discipline) services are necessary...
Reasonable and Necessary- proven through Diagnoses

• Choose appropriate and approved ICD-10s— not all allowed, dependent upon the service provided, and the discipline.

Reasonable and Necessary- Medical and Treatment Dx

• Must be Relevant
• Must be Current
• Must be Active
• Must be sufficiently explained in the “reason for referral”/“analysis/assessment” statement
• Medical diagnosis must have a cause-effect relationship with the treatment diagnosis
• Code to the highest level of specificity and complexity of the patient, as long as it is relevant to the patient’s therapy case/RFR.

Another thing to consider about your chosen Dx...

• Is it clear, within the body of your evaluation, that the objectively measurable functional deficits and underlying impairments point specifically to the treatment diagnosis that you have chosen?
• examples
As a recap...

• “Reasonable” - picture the scale
• “Necessary” - only you can provide services in a safe and effective manner
• Diagnoses - support your medical necessity
• Functional Deficits - answer the “what is going on with the patient?” question
• Underlying Impairments - answer the “why is this functional deficit occurring?” question

So, how do evals/progress notes show “reasonable and necessary” documentation?

• Documenting goals
• Documenting an assessment
• Documenting progress
• Documenting *skilled* services

**Documenting Goals**

- **SMART...**
  - **Specific** - area of function - be specific - allows for determination of
  - **Measurable** - if it is not measurable, you cannot address
  - **Attainable** - is it something we can achieve - ties into prognosis
  - **Relevant** - does it have bearing on patient rights? PLOF? Our scope of practice?
  - **Time-constrained** - There is an end in sight - may not impact “maintenance therapy” *per se*
Goals (continued)

• Good goals:
  – Functional Deficit
  – Underlying Impairment
  – Time Frame

• Bad goals:
  – Inclusion of the intervention/modality
  – Lack of specific and measurable descriptors
  – Vague markers of progress

Goals (continued)- examples of bad words in goals

➢ Least restrictive
➢ Maximize function
➢ Maximize level
➢ Highest level attainable
➢ “endurance” or “functional endurance” or “activity tolerance”

Goals (Continued)- good goals

• “Patient will perform sit to stand transfers with SBA due to right knee flexion ROM >=95 degrees to allow normalization of transfer dynamics in 2 weeks.”
• “Patient will demonstrate 3+ grade Kansas University sitting balance assessment to allow bilateral UE usage in seated dressing to allow donn/doff of shirt SBA in 2 weeks.”
• “Patient will demonstrate no anterior spillage on 9/10 trials as evidence of improved labial closure, to improve bolus cohesion, in 2 weeks.”
Goals (Continued)- Bad goals

- “Patient will ambulate 150 ft to allow improved ability to go from room <> dining room.”
- “Patient will increase UE strength to 5/5 to allow IND UB dressing.”
- “Patient will improve safety/judgment to 90% in order to function more safely in d/c environment.”

Goals (Continued)- “ICE” model of care

- **Improve Impairments** - improving the underlying impairment
  - Example: “Patient will have 3+/5 strength in right elbow flexion to allow IND self feeding/bringing food to mouth.”
- **Compensate for Impairments** - the patient makes up for an underlying impairment that he/she cannot improve
  - Example: “Patient will demonstrate IND feeding with left hand due to inability to bring right hand to mouth due to R UE weakness.”

“ICE” continued

- **Environmental adaptations** - the environment or caregiver’s behavior is modified to accommodate an underlying impairment for which the patient can neither improve or compensate for, thus improving function
  - Example: “Patient will be appropriately set up in wheelchair by caregiver 5/5 presentations, to allow patient to stay up for 2 hours, to allow patient to attend full meal and one activity, demonstrating proper alignment and report of pain <=3/10 by end of 2 hours.”
Why “ICE?”

• Why is ICE important to consider:
  – Not all patient underlying impairments are improvable, nor will all patients be able to compensate for the deficit.
  – If treatment focuses just on improvement goals, it limits the amount of acceptable therapeutic interventions that you can deliver to the patient.
  – It has a direct impact on patient prognosis.

Documenting Change in Function

• On eval- Important to distinguish between PLOF and CLOF to determine need for skilled services.
• On Progress reports- Important to demonstrate with consistent, specific, measurable functional deficits and underlying impairments.
• At discharge- important to document sweeping overview of functional gains and how you influenced underlying impairments.

What does documenting “change in function” answer?

• Reasonableness or Necessity???
• Reasonableness
Analysis

• Based upon data entered into goals
• Demonstrates critical thinking through functional deficits and underlying impairments comparison
• Gives opportunity to explain lack of progress
• Allows for further assessment of underlying impairments that may be impacting function
• If patient is on skilled maintenance, can discuss why continued skilled service is necessary
• Answers the “why?” progress/“why not?” progress.

Let’s take some change in function, and analyze it...

<table>
<thead>
<tr>
<th>Improve strength bilateral</th>
<th>Strength B LE 2+/5 Transfers sit&lt;&gt;stand max A</th>
<th>Strength B LE 3+/5 Transfers sit&lt;&gt;stand min A</th>
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Analysis Starter Phrases

– “Functional progress in ___ this past week/2 weeks/month has been significant due to improvement in ___.”
– “Patient accepts greater challenges in ____, thus allowing improved performance of _____ functional task.”
– “The patient did not make significant progress this note period due to ____. Please note update to plan of treatment to address this lack of progress. Skilled interventions have still been required during this time due to______.”
Analysis

Reasonable Necessary

Skilled Interventions

• Charges entered by therapist as CPTs CPT-
  Current Procedural Terminology (CPT) is a
  code set that is used to report medical
  procedures and services to entities such as
  physicians, health insurance companies and
  accreditation organizations.
  (http://searchhealthit.techtarget.com/definition/Current-Procedural-Terminology-CPT)

Skilled Interventions (continued)

• It is important that all CPTs have a clear relationship to the
  underlying impairments/functional deficits-
  – Example: manual therapy should have a clear relationship
    with objectively measured edema, joint and/or soft tissue
    play, etc.
• All CPTs that were billed during the interval between last to
current documentation should be explained. **Any that are not
explained should not be billed.**
Skilled Interventions (continued)

• It is not a description of what the patient did necessarily (though this may be part of it):
  – Example: “Patient performed 3 sets of 10 reps shoulder flexion with 3# weighted dowel.”

• It is a description of the special skills/techniques/analysis that you provided

Skilled Interventions (continued)

• “Therapist facilitated normalization of scapulothoracic rhythm during resisted shoulder exercises, to strengthen scapular plane abduction for functional tasks, by cuing for scapular retraction, to decrease risk of glenohumeral impingement.”

Skilled Interventions (continued)

• Use Action words...
  – Analyzed, assessed, adjusted, modified, adapted, instructed, upgraded, progressed, incorporated, inhibited, facilitated, modeled, normalized, facilitated, reduced (notice words lend themselves to therapist involvement as the initiator of the action, not the patient)
  – Avoid words/phrases such as continue(d,s), plateau, no change, little change, steady progress, little or no progress, patient not compliant, the same.
Skilled Interventions (samples)

• “PT has analyzed gait dysfunction over various surfaces, determining how strength gains improve cadence, which has necessitated adjustment to verbal cuing to achieve independent mobility.”

• “Electrical stimulation applied to knee extensors right LE due to terminal extension lag, at 50 Hz on symmetrical biphasic waveform, at pulse duration of 200 microseconds, 10 seconds on/50 off, with manual and verbal cues to facilitate >50% effort during on phase for increased motor recruitment.”

• “Application of short wave diathermy on thermal setting to iliopsoas muscle group, followed by low load stretching with manual cues to maintain appropriate alignment for effectiveness, which has led to additional 20 degrees hip extension, allowing patient to go from step-to gait to step-through gait.”

Skilled Interventions (samples)

– OT analyzed patient’s kinesthetic awareness of, and determined how postural and extremity weakness impact advanced bathing activities. OT applied PRE’s to develop triceps, upper and lower back strength for bathing due to poor postural control of thoracic kyphosis and scapular stabilization problems.

– OT determined most effective cueing strategies for grooming according to cognitive level and trained direct caregivers in application of these cues during routine care, to provide consistency in training and progress patient towards carryover, as evidenced by ACL level of 3.8.

Skilled Interventions (samples)

• Analysis of patient’s dentition indicates that improperly formed bolus is related to poor mastication, thus requiring at this time downgraded diet.

• Progressed patient to using calendar for self planning activities based upon A&O x 3 now, with minimal verbal cuing for proper use of calendar and clock concurrently to plan day with 3/5 days planned out appropriately.
Poor Examples

• “Patient performed ambulation 2 x 100 ft with FWW.”
• “Caregiver educated in proper transfer technique, but requires further training.”
• “Skilled interventions included double swallow, chin tucks, and lingual sweeps.”

Questions???

References

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