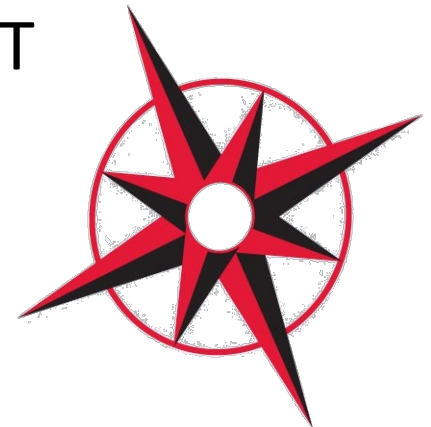




Update: Medical Necessity Documentation

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REMINDER

- Many claim denials occur because the providers or suppliers do not submit sufficient documentation to support the service or supply billed.
- Frequently, this documentation is insufficient to demonstrate medical necessity. In accordance with Section 1862(a)(1)(A) of the Social Security Act, CMS **must deny** an item or service if it is not reasonable and necessary.
- When determining the medical necessity of the item or service billed, Medicare's review contractors must rely on the medical documentation **submitted by the provider in support of a given claim.**

MLN MATTERS, SE1237

News

- Corporate Compliance **March 23, 2013**
 - OIG reports of 2000 and beyond
- QAPI **April 1, 2013**
- PEPPER – NOT for CAHS but review areas are:
 - Therapy completed with high ADLs
 - Non-Therapy admissions with high ADLs
 - Change of Therapy Assessment
 - % of Therapy days overall
 - Episodes of 90+ days of stay

Why Use CAH Swing Beds?

- Manage 96 hour rule
- Meant to be short term – two weeks or less
- Decreases barriers to discharge from acute
- Stabilizes staff scheduling and support fixed costs
- Depends on physician base – orthopedics?
- Increased patient/physician satisfaction
- Used for elderly with short term need for PT/OT
- Appropriate for wound care/IV antibiotics

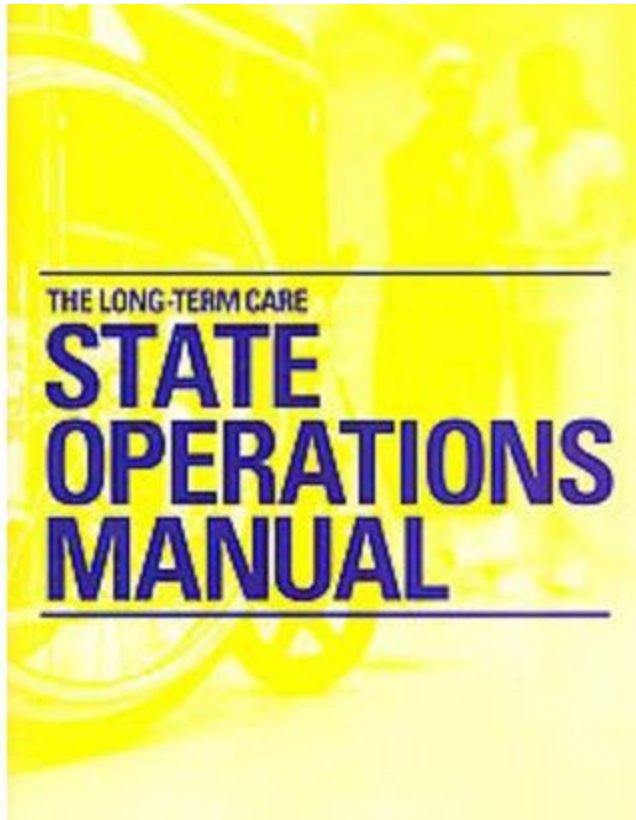
ACUTE CARE

- Can assist in managing the 96 hour rule BUT
 - This is not the level of care for testing and ruling out
 - This is not a level of care intended for “acute” procedures (i.e., telemetry)
 - Patients are expected to be “stable” to be in a skilled bed

Conditions of Participation

- Survey is to determine if the CAH is in compliance with the CoP set forth at 42 CFR Part 485 Subpart F
- Survey authority and compliance regulations can be found at 42 CFR Part 488 Subpart A
- **Here's what you need to know: If you cannot care (in total) for a patient's needs, you cannot admit them**

SOM, Appendix W



- Please review for CAH swing bed rules, when you have questions
- Medicare Benefits Manual, Chapter 8, also have significant review information

Skilled Care is Covered IF:

1. Patient requires **skilled services on a daily basis** (§30.6)
2. As a practical matter, considering economy and efficiency, the daily skilled services **can only be provided on an inpatient basis in a SNF** (§30.7)
3. The services must **be reasonable and necessary** for the treatment of a patient's illness or injury
4. The services must also be reasonable in terms of **duration and quantity**

These are REQUIRED



- If any one of these four factors is not met, a stay in a skilled level bed, even though it might include the delivery of some skilled services, is not covered

Basics



- Three day hospital stay
- Admission primary diagnosis must connect the treatment in the facility to the hospital stay

Importance of Skilled Stays



- 90% of Medicare A stay are skilled by therapy
 - Safety
 - PLOF
- Medically complex
 - Teaching
 - Safety

“Skilled”

- Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a “daily basis,” i.e., on essentially a 7-days-a-week basis.
- A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the “daily basis” requirement when they need and receive those services on at least 5 days a week.
 - If therapy services are provided less than 5 distinct calendar days, the “daily” requirement would not be met

MOST IMPORTANT

- Why is Medicare (any third party) paying for this patient to be in this setting on this day?



Chapter 8, 30.2.2.

- If the **inherent complexity of a service** prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service
 - Not only does Nursing NEED to be involved, the second question is can it be done by Home Health instead

Medicare Basics

- Skilled need that ties to 3 day hospital stay
- MSP
- Physician Certification
- Physician Supervision
 - Orders
 - Timely H&P
 - Diagnosis list
 - Rehab Potential
 - Oversight demonstrated
 - Signature requirements

MEDICARE IS NOT AUTOMATIC

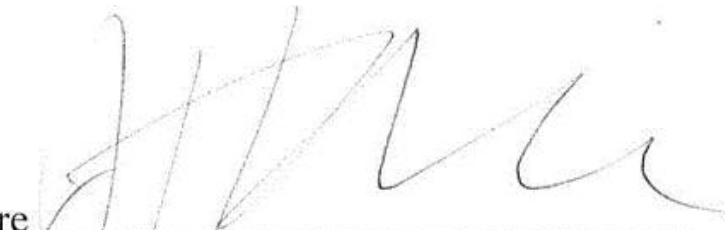
- Even though a recommended treatment is based on the determination of medical necessity
- OR the appropriateness of care for the patient
- OR even though the treatment falls within the scope of professionally accepted medical practice

IT DOES NOT MEAN THE SERVICE WILL BE COVERED

MEDICARE REQUIREMENTS

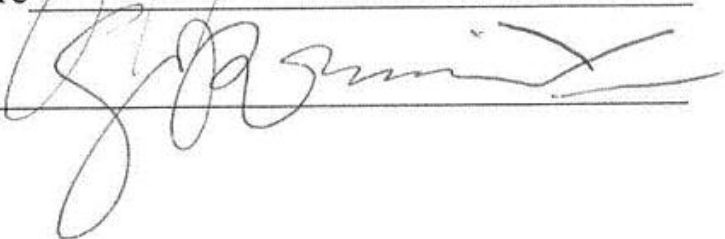
- Documentation is legible
- Signature is legible
- Treatment logs to identify therapy minutes
- Know your Local Coverage Determination

Licensed Clinician's Signature _____



Date: 5/10/10

Physician's Signature _____



Date: 5/10/10

MEDICAL NECESSITY =

- **DOCUMENTATION**
- From a coding and auditing perspective, nothing can be assumed
- The most clear cut way to support medical necessity in an audit is **documenting decision-making**



MEDICAL NECESSITY

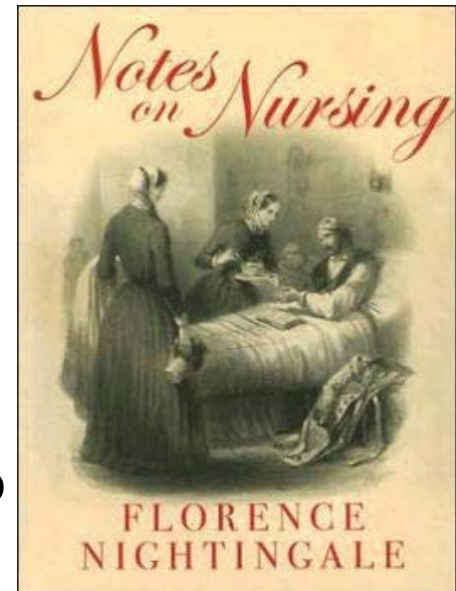
- Consistent with the symptoms or diagnoses of the illness or injury under treatment
- Necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational)
- **Not furnished primarily for the convenience of the patient, the attending physician, or the family**
- Furnished at the most appropriate level that can be provided safely and effectively to the patient

DAILY DOCUMENTATION

- Daily Documentation is required to reflect the skilled services being provided.
 - **Objective measures** of the current level of assistance required for functional tasks
 - A **description of the skilled services** provided
 - **Assessment** of the patient's response to the services.
 - **Progress** towards the treatment goals
 - Documentation of any **treatment variations** with the associated rationale
 - Accurate documentation of **treatment time** in minutes, to be recorded on the MDS

What Would Nursing Document?

- Skilled nursing can include the following:
 - Initiation of intravenous (TPN) feeding, or when documented difficulties or complications exist
 - Initiation of nasogastric tube feeding, gastrostomy and jejunostomy feeding, or when documented difficulties or complications exist
- What needs to be documented?



MDS definitions

- What are the four late loss ADLs?



MANY DENIALS START WITH:

- A large percentage of claim denials is due to diagnosis codes that do not match up with the procedure codes on the claim
 - With therapy one of the main issues are the treatment codes NOT making it to the UB-04
 - V codes ARE USED in a skilled setting
 - V54.81 (aftercare following joint replacement)
 - V57 series (care involving use of rehab procedures)

THERAPY ORDERS

- The medical record must be documented to support compliance with the physician order

A handwritten signature in black ink, appearing to be 'J. W.', written in a cursive style.

- **Without adequate documentation and/or legible orders and signatures** and/or following of that order, the services may be considered non-rendered, or not provided at the level at which they were billed

Skilled Therapy

- The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to “daily” skilled services.
 - Arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a “daily basis.”
 - To meet this requirement, the patient must actually need skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.
- It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is furnished each day, unless the patient's medical needs indicate that daily therapy is required.
 - For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the “daily basis” requirement would be satisfied **only if there is a valid medical reason why both cannot be furnished on the same day.**

WEEKLY PROGRESS

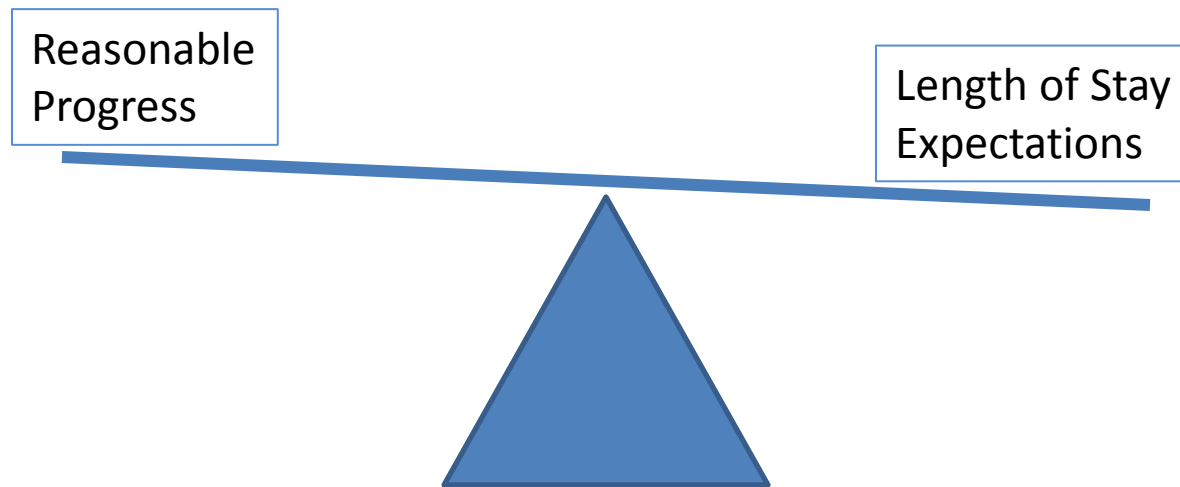
- Document the **current level of assistance required** for functional tasks and compare it to the previous week's status to evaluate the patient's progress
- Determine if **progress towards goals** has occurred
- If progress towards goals has not occurred, **document the possible reasons contributing to the lack of progress**. The goals should be revised or the patient should be evaluated for possible discontinuation of therapy services. Determine if a functional maintenance program would be indicated
- Document the **need for continued services** by a skilled therapist verses the use of restorative nursing
- Document **evidence of carryover of the skills learned** in therapy to the functional tasks
- Identify the **expectation for further progress**
- Identify the **resident's risk factors** that may be eliminated by receiving the therapy
- **Justify the frequency, duration and intensity of the treatment**

MDS Definitions

- Must be 15 minutes minimum a day to “count” – that is “hands on” time
- Needs to be a minimum of 150 minutes per week? Where’s your log?

Date																									
Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
OT Ind																									
OT Conc																									
OT Group																									
PT Ind																									
PT Conc																									
PT Group																									
ST Ind																									
ST Conc																									
ST Group																									
Total for day																									
Running Total																									

Balance the Care Choices



Therapy Challenges

- Missing Treatment
 - Change in Patient condition or status (rehab or clinical)
 - Psychological challenges; patient depressed
 - Patient Complaints of Pain
 - Insufficient nutrition
 - Refusal of any skilled services or request for delayed treatment
 - Appointments or LOAs (dialysis, doctors)
 - With Family / Family & Friends Visiting
 - Plan of action for Holidays
 - Discharge plans
 - Facility Activities

Therapy Challenges

- Staffing
 - Therapist change treatment day (e.g.. moved to Saturday)
 - Therapy Staffing Shortage
 - Staffing (Full time, Part time, PRN Pool)
 - Weekend Staffing
 - Daily Staggered Hours
 - 3 day holiday weekend
 - Therapist time involved in non-patient care activities

Legal/Audit Cases in Audits:

- Medically Unnecessary Services
 - Rendering services that simply are not needed by the patient; i.e. unnecessary stent cases.
- Medically Excessive Services
 - Services that may be needed by the patient but are delivered excessively, in a quantity that is not in accord with standards of care. i.e., pediatric dental cases.
- Failure of Care
 - Medically necessary services that are not delivered

SELF-AUDIT



Q&A



RESOURCES

- **State Operations Manual, Appendix W**
http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf
- **Medicare Benefits Manual, Chapter 8**
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>
- **Colorado Rural Health Center: Critical Access Hospital Swing Bed Manual**
<http://www.coruralhealth.org/programs/cah/documents/coswingbed.pdf>
- **CMS "Medicare Program Integrity Manual" Section 3.6.2.1 - Coverage Determinations**
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>

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