Optimizing Your Documentation for Reimbursement

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Objectives

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Learning CMS Documentation Guidelines

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Common

Documentation Errors

3

How Documentation Impacts Reimbursement

4

The Importance of Medical Necessity

Professional Life

- Athletic Trainer in Wisconsin for 30+ years.
- VP, CAO Aspirus North WI Division.
- Manager of Rehabilitation Services.
- Implementation Lead and District 4 Regional Coordinator for the NATA Third Party Reimbursement Initiative.

Presentation Outline

- Importance of Documentation
- Common Documentation Errors
- Medical Necessity/Maintenance Therapy
- Common Misconceptions
- Evaluation, Plan of Care, Daily Notes
- Functional/Measurable Goals

What is the Purpose/Goal of Documentation?

- Communication
- Payment Justification
- Legal Protection

Medical Documentation

- Justifies the services you are billing for
- Complies with CMS guidelines
- Supports clinical decision making
- Ensures the provider and reviewer that you adhered to an agreed standard of practice
- Historical record of patient condition and response
- Records progression or lack of progress
- Determines of the service will be paid.

Medical Documentation-

Who is your audience and what are you documenting for?

- The Referral Source
- The Payor Source
- Our Colleagues (hand off care)
- Our Protection

What Does the Payor Want to See?

- What's wrong with the patient? (current/prior level of function, tests, measurement, and assessment)
- What is planned for the patient? (plan of care, treatment, duration of care, goals)
- What are the skills needed for care? (evidence of skilled services provided)
- What progress is being made? (updated plan of care, daily notes, paint a clear picture of where you were and where you are now)
- What is the result? (summary of services delivered, patient outcome data, status at discharge, compliance)
- Are you using OUTCOME TOOLS?

Why is YOUR documentation so Important?

- Documentation throughout the duration of rehabilitation, no matter the setting, is YOUR professional responsibility and a legal requirement.

- Documentation IS necessary for Reimbursement:
  - Insufficient or absent documentation is not going to justify to any payor source that the services were reasonable, ***medically necessary***, and appropriately billed to allow the claim to be processed for payment

The Top Five Errors in Documentation.

- Insufficient documentation
- Not documenting ***medical necessity***
- Incorrect coding; coding not matching your documentation
- No documentation
- Documenting the same thing each time – Repetition!

Insufficient Documentation

- **Insufficient Documentation does not mean documentation doesn’t exist, it means something was incomplete or missing from the documentation submitted with the claim.**
- **Failure to comply can set us up for failure...**

Insufficient Documentation – RISK!

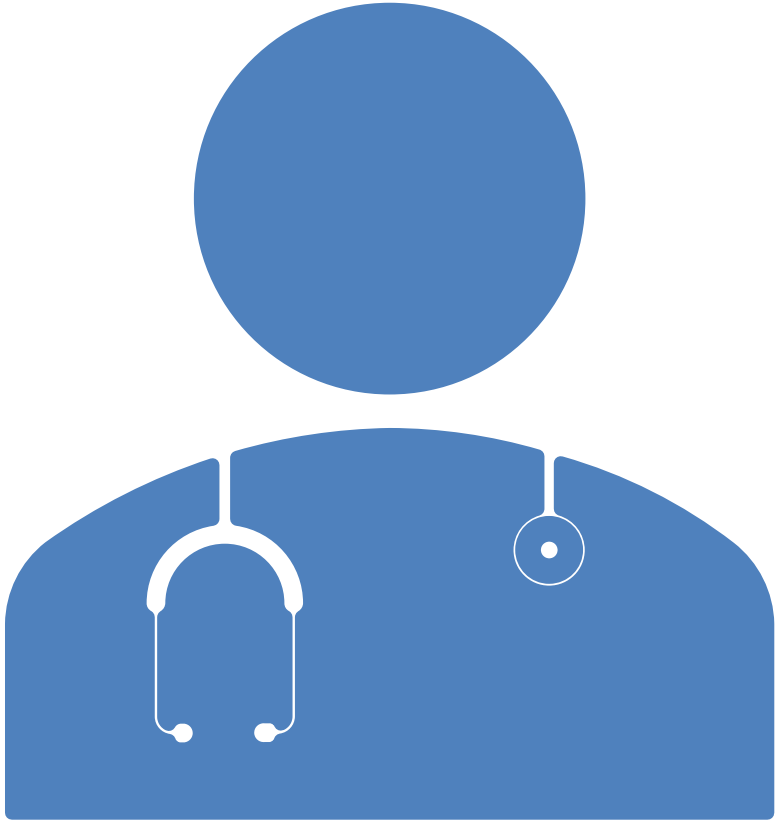
- ***"When a claim is denied for lack of supporting documentation, we the insurance company will request any additional documentation that might support the medical necessity and billing associated with the patient, and often "we" keep getting the exact same documentation, or the request for additional records goes unanswered. The concern is that IF this practice continues with insufficient or incomplete documentation and there is no indication of medical necessity, we (the insurance company) will just cut off coverage all together"***
- ***– Decision Maker within an Insurance Company.***

Insufficient Documentation

- *Accurate documentation is YOUR responsibility and documentation judges your credibility as a clinician.*
  - Anyone who reads your documentation is making a judgment about YOU and the quality of the rehabilitation services you provide, based off your documentation.
  - To say “We work hard, we don’t have time for complete or thorough documentation” is the WRONG way to think.

Insufficient Documentation

- We need to get beyond just documenting what we did!
- We need to use our documentation to guide us and the reviewer to ensure the treatment interventions will achieve the established goals.
- Quality not quantity!
  - Clear – concise – convincing.
  - Write smarter – the more a reviewer must read, the more you slow their productivity = denials.
  - Avoid repeating the same data within the same note.



Medical Necessity

- The definition of medical necessity allows for a lot of flexibility. For example, it's up you as a clinician to determine what constitutes a safe and effective treatment—or what duration and frequency are "appropriate" for each patient.
- ***At the end of the day, clinicians must defend their treatment decisions to the payor by offering proof of medical necessity.***

Medical Necessity

- Medical necessity is ultimately defined by who pays for the service:

- The definition is going to be largely influenced by the health insurance company or the vendor they use for therapy authorization.
- It most definitely is not “what the doctor says goes; OR just because you have a referral for it. That doesn’t mean it’s medically necessary.
- Be aware that some health plans may define medical necessity differently.

Medical Necessity: Insurance Definition

- **"Medical Necessity" refers to health care services that a health care provider, exercising prudent clinical judgment, would provide to a patient. The service must be:**

  - For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms.
  - In accordance with the generally accepted standards of medical practice.
  - Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease.
  - Not primarily for the convenience of the patient, health care provider, or other physicians or health care providers.

Medical Necessity

- Provide a brief assessment of patient's response to interventions at every visit.
- Show clinical decision-making processes used. Why did you change the exercise program, add or discontinue an exercise or modality?
- Avoid repetitive documentation.
- Re-read your documentation. Does it show the need for skilled care?
- Use your professional terminology.

Medical Necessity

- The reviewer of your documentation needs to clearly see what you were doing during the treatment sessions:
- What they are thinking…

What is wrong with the patient?
Did the treatment performed, address the injury or dysfunction?
Are the goals established for the patient addressing functional ADL's;

Not sport specific goals.

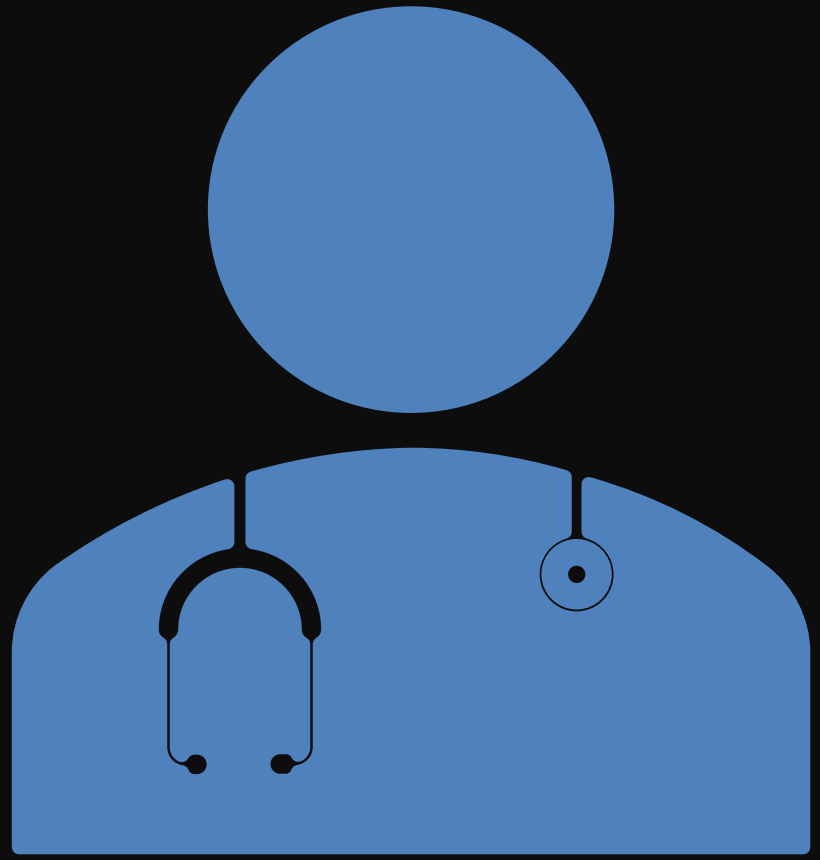
What skilled service are you providing that deserves payment?
WHAT AM I PAYING FOR?

Maintenance Therapy

- General exercises to **promote overall fitness and flexibility** and activities to provide diversion or general motivation, do not constitute therapy services for CMS purposes.
- Remember, payors follow CMS guidelines.
- We need to be careful around maintenance therapy as athletic trainers.

Maintenance Therapy Example #1

- Patient was 6 months post-op from an ACL reconstruction with allograft tissue: patient was in therapy still having some knee pain.
  - ***In an updated plan of care - Patient functional limitations: "Patient fearful of re-injury with high level activities such as jogging, resistance training, work-out classes, snow skiing, water skiing, and hiking."***
  - **THERAPY SERVICES DENIED BY PAYOR, NOT ADL FUNCTIONAL LIMITATIONS**



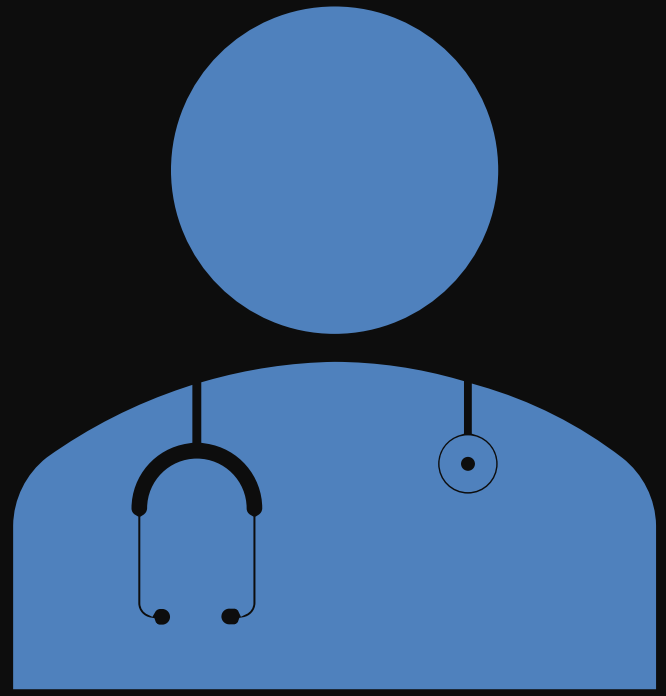
Maintenance Therapy Example #2

- The Payor **denied** further visits stating:
- ***Notes show that the patient has good strength and normal movement. Therapy is working on advanced skills, return to activities beyond normal active daily living. This is not covered; benefits do not cover "return to sports" related rehabilitation. You can call if you wish to request a peer-to-peer review.***

- **THERAPY SERVICES DENIED BY PAYOR**

Maintenance Therapy Example #3

- Physical therapy is care that aims to help improve function. More PT can be done when you are making progress that addresses **daily function**. In addition, your progress must be objectively measured. This means you should check your progress using special tests and tools. We reviewed the documentation. It does not show that progress is objectively measured. It also does not show that you are making progress towards ADL's. Based on the records we have; more therapy is not approved.
- -**THERAPY SERVICES DENIED**



Maintenance Therapy/Performance Progression

- Medical necessity is NOT return to play.
- Don’t confuse the common phrase “return to prior level of function” with return to sport participation.
- Prior level of function is return to functional activities of daily living.
- If your rehabilitation is starting to look like this…you need to think cash-based services:

Medical Necessity – Common Misconceptions

- **Rehabilitation may be continued if**;
  - There is a provider order/referral.
  - There has been a change of function documented.
  - It's important to the patient/athlete.
  - The patient/athlete is making progress.
  - Goals have not been met yet.
  - They still have pain with high level activities.
  - They haven't returned to prior level of function.
  - **Medical Necessity is return to ADL prior level of function – not high level of sport participation.**

Coding and Billing – Daily Notes

- **Daily Notes Must Include**:
  - Date of treatment.
  - Intervention, or activity.
  - Each individual CPT code needs total minutes.
  - In/out time for a total treatment session length.
  - Outcome/Assessment – patient response to treatment.
  - Change or modify your plan after each treatment session.
  - Document home programs.
  - Signature and professional identity.

Coding and Billing – CMS 8 Minute Rule

- **97000 series CPT codes.**
  - **“Qualified health care professional.”**
- **Only codes specific to a discipline are the evaluation/re-evaluation codes.**
- **0951 revenue codes.**
- **CPT Timed codes: CMS 8-minute rule to coding.**
  - 1 unit ≥ 8 minutes to < 23 minutes
  - 2 units ≥ 23 minutes to < 38 minutes
  - 3 units ≥ 38 minutes to < 53 minutes
  - 4 units ≥ 53 minutes to < 68 minutes
  - 5 units ≥ 68 minutes to < 83 minutes

Coding and Billing

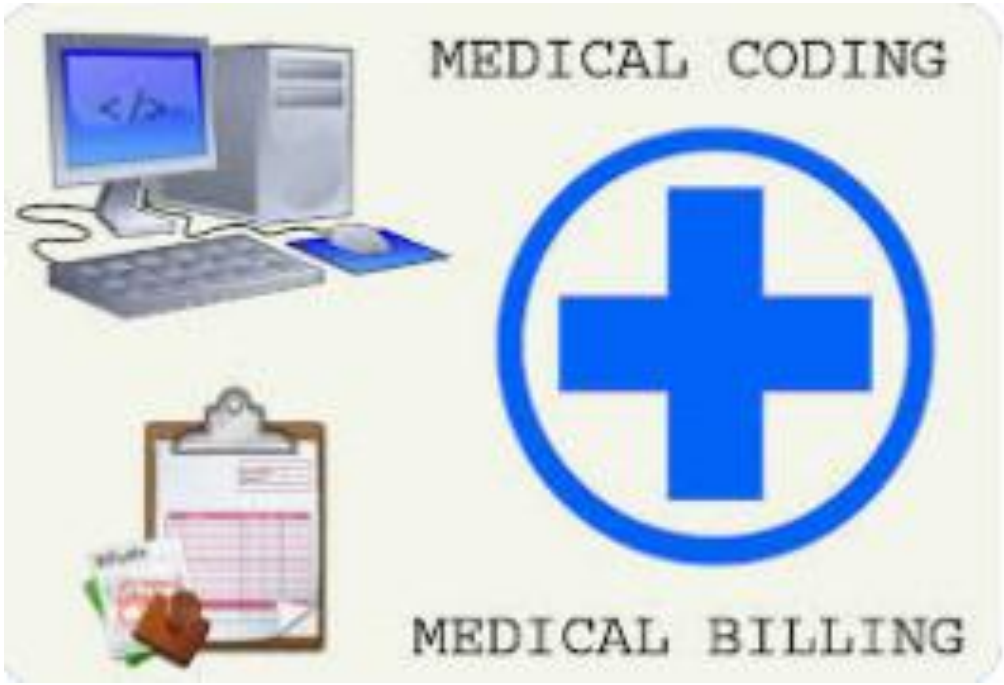
- **Services should be appropriate type, frequency, intensity and duration for the individual needs of the patient.**
  - The fact that services are billed is NOT evidence that they were appropriate.
    - Document OBJECTIVE measures.
    - Address the needs of the patient.

Coding and Billing – Timed Codes

- **What constitutes a timed code?**
  - Time spent in formal/informal assessment of related functional impairments.
  - Time spent educating client/caregiver related to intervention with the client present.
  - Time spent in face-to-face intervention.

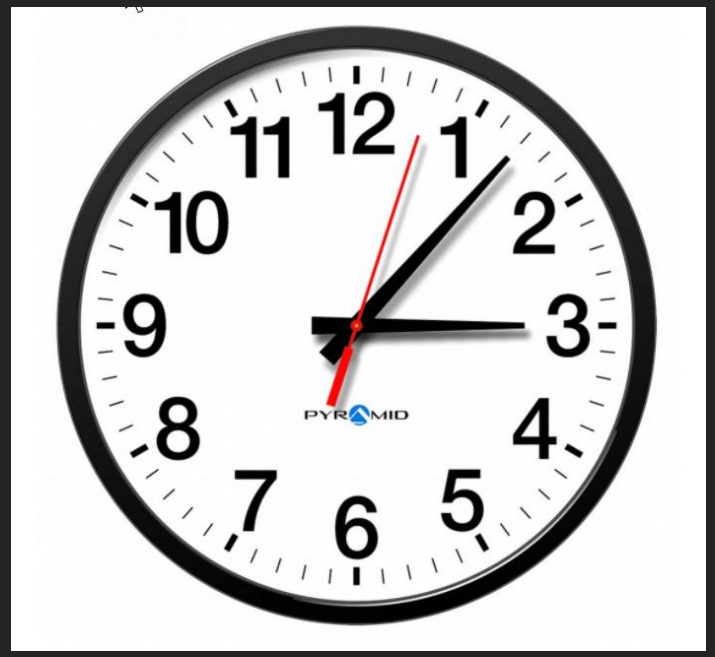
Coding and Billing

- Total number of units cannot exceed total treatment time.
- Add all minutes of timed CPT codes per date of service.
- Assign minutes per timed code: 1 unit = $\geq$8 min $\leq$ 23 min.
- Greater than 5 units billed in one treatment session can be subject to audit/review. (red flag)
- Cannot provide a billable services for two patients, but only bill the one who will reimburse you. UNETHICAL BILLING!!



Coding and Billing

- With any 15-minute timed code, it is important to understand that a substantial portion of the 15 minutes must be spent performing the ***intention*** of that code.



Coding and Billing – 8 Minute Rule

- Ther Ex: 20 min.
- Ultrasound: 8 min.
- Manual Therapy: 15 min.
- Total Time (timed codes)= 43 min.

- Equals 3 units of billing.
- **3 units (≥ 38 minutes to ≤ 53 minutes)**

Coding and Billing – Know your Codes

97530 Therapeutic Activities the “ing” code.

Use of dynamic activities to improve functional performance, transfers, lifting, throwing, catching, etc.

ADL’s: basic personal everyday activities including, but not limited to, eating, toileting, grooming, dressing, bathing, and transferring.

Specific exercises performed to address ADL function.

97530 should focus tasks such as carrying, lifting, handling, reaching, transferring, catching, lunging, throwing to improve FUNCTION. Choosing 97530 vs 97110 depends on intent of task.

- Squatting can be used for 97110 strengthening, unless squatting is used to practice retrieving an item from the floor, then can be used as 97530 therapeutic activities.

No Documentation

- Too often charges are dropped to the payor and do not have the needed documentation support the charges.
- The documentation IS there, it just doesn’t justify what was charged to the patient.
- If you performed it and it was skilled: DOCUMENT IT.
- Bill ONLY for what your treatment and documentation supports.

Repetitive Documentation

Reviewers expect to see documentation of adjustments, progressions and/or modifications to your treatment interventions:

Lack of description of adjustments, progressions and modifications

Doing the same thing everyday assumption

- Repetitive Services Denial

The Evaluation

- **The Initial Evaluation: The most important document in your medical record keeping…**
- Establish need - why is skilled therapy needed NOW?
- Establish that there's been a change in ADL function AND that it is within your scope of practice.
  - -What is wrong?
- Give the basis for your treatment plan.
- Reason for referral and summary of your plan.

The Evaluation

Treatment and History Summary (Reason for Referral):

- A brief paragraph: Why is the patient needing to be evaluated?
  - What are the patient problems (use medical diagnosis) and how it is impacting their function?
  - Describe how it affects their functional ADL's.
  - What was their prior level of function? Describe what they use to be able to do, and now why now they can't.
  - Set your measurable and functional ADL related goals based on their problem list.
  - Assure the provider/reviewer that the condition/deficits are within your scope of practice.

A well-written treatment and history summary is crucial to paint the entire picture for the provider/reviewer

Evaluation Components

- Name and diagnosis
- Reason for referral
- Medical history
- Prior level of function
- Functional limitations
- Examination AND use of objective measurements/tests
- Clinical presentation (stable, evolving, unstable)
- Objective data of impairments including pain if it is affecting function
- Clinical decision making: your skilled interventions to treat – involved clinical judgement. Reasonable plan with interventions, frequency, duration and rehab potential
- Measurable functional goals with a time frame attached

Plan of Care Components

- Every 10 visits or 90 days (CMS guidelines).
- List all ongoing and any new treatment interventions.
- Document/comment on current interventions. What has been added and/or eliminated….and why.
  - -Explain why you think they made progress. If they didn’t make progress, explain what you are going to do differently to achieve progress.
  - -Reviewer wants to see that what you are doing is skilled.
- Update frequency and duration.
- Update existing goals, comment on new goals, interventions and strategies of continued care.
- Talk about compliance to HEP.

The Daily Note

- The date of service.
- What was performed in the session (services provided).
- How much time was spent performing each services…and total time of session.
- What are your treatment interventions and why.
- Observations/assessment by the clinician.
  - Do not write “Patient tolerated treatment well”.
- Anticipated plan for next session.
- Most still follow the SOAP format.

Goal Writing – Long Term

Build functional goals based off your patient problem list created at the evaluation:

Have an end date for the LTG's: typically, 2-3 months (based on anticipated duration).

Example:

- Problem List: Patient with shoulder pain states he/she has difficulty reaching overhead into cabinets.

GOAL: *The patient will demonstrate increased Right shoulder flexion AROM to greater than 110 degrees within 4 weeks in order to improve the patient's ability to reach into overhead cabinets at home.*

Goal Writing – Short Term

Short-Term Goals should be written as a steppingstone to your long-term goal, measurable by you and anyone else who might be involved.

Short-Term Goals are good for use with post-op patients, to address protocol guidelines.

Short-Term Goals are usually 1-4 weeks based on the duration of care.

Summary

- Health care providers,... generally speaking, do not enjoy the compliant documentation process. However, it is a necessary component IF you want to be compensated for the services you provide.

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