Documenting Medical Necessity

Written and Presented by
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Quick Tips

1. Write legibly
2. No white-out for corrections – to make a correction, draw a SINGLE line through the incorrect statements, write “error” and date/initial
3. No blank spaces – if n/a, write “n/a” or “X”
4. Sign and date all of your documentation

What is Medical Necessity?

- **Medical necessity** is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
- **Appropriate Services and Supplies** are those that are neither more nor less than what the patient requires at a specific point in time.
1. Determinations of medical necessity must adhere to the standard of care that applies to the actual direct care and treatment of the patient.

2. Medical necessity is the standard terminology that all health care professionals and entities will use in the review process when determining if medical care is appropriate and essential.

3. Determinations of medical necessity must reflect the efficient and cost-effective application of patient care including, but not limited to, diagnostic testing, therapies (including activity restriction, after-care instructions and prescriptions), disability ratings, rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations, procedures, psychiatric care, levels of hospital care, extended care, long-term care, hospice care and home health care.

4. Determinations of medical necessity made in a concurrent review should include discussions with the attending provider as to the current medical condition of the patient whenever possible.
   A physician advisor/reviewer can make a positive determination regarding medical necessity without necessarily speaking with the treating provider if the advisor has enough available information to make an appropriate medical decision.
   A physician advisor cannot decide to deny care as not medically necessary without speaking to the treating provider and these discussions must be clearly documented.
• 5. Determinations of medical necessity must be unrelated to payers’ monetary benefit.

• 6. Determinations of medical necessity must always be made on a case-by-case basis consistent with the applicable standard of care and must be available for peer review.

7. Recommendations approving medical necessity may be made by a non-physician reviewer.
Negative determinations for the initial review regarding medical necessity must be made by a physician advisor who has the clinical training to review the particular clinical problem (clinically matched) under review.
A physician reviewer or advisor must not delegate his/her review decisions to a non-physician reviewer.

8. The process to be used in evaluating medical necessity should be made known to the patient.

9. All medical review organizations involved in determining medical necessity shall have uniform, written procedures for appeals of negative determinations that services or supplies are not medically necessary.
Reason for Referral

- When indicating the reason for referral, it must be functional.

- Good example: “Referred to OT due to decline in ADL performance.”

- Bad example: “Referred to OT due to re-admission.”

Reasons for referral may include:
- Decline in ADLs (be specific – dressing, toileting, bathing, etc.)
- Decline in mobility (be specific – gait, transfers, etc.)
- Due to recent weight loss
- Increased gait instability
- Due to recent weight loss
- Increased gait instability
- Decline in swallowing abilities
- Decreased tolerance of current ________
  (splinting, positioning, etc.) program

Always provide supportive documentation wherever applicable.

For example: Assessing pain.....
- Report your findings and resident statements
- Include any documentation from pain scale assessment, nursing notes, changes in medication, MD recommendations
• All documentation should be written using objective measures.

• When indicating WNL, WFL, IMP, Unable to assess, always provide a statement supporting this measurement.

• For example: “FMC = unable to assess DUE TO IMPAIRED COGNITION”

Goal Writing

• Each goal must be measurable through objective assessments, realistic to the resident’s rehab potential, and resident centered.

• The anticipated time frame must be included for all short-term and long-term goals.

• For example: “In 2 weeks, resident will....”

“If it isn’t documented, it didn’t happen!” Unknown Author
Key Components to Documentation

• 3 Key Components should be included at some point throughout the course of treatment.
  • What
  • Why
  • How

WHAT

– What are the treatment activities?
– What are the levels of complexity?
– What are the strategies, training, modifications and/or adaptations, etc.?
– What is the resident doing?

HOW

– How do these treatment approaches impact the resident’s need for skilled therapy?
– How is there a need for medical necessity?
– Does it require skilled interventions?
WHY

– Why are you recommending these treatment approaches?

– What is the therapeutic rationale and reason for continuing skilled therapy?

– Why are these treatment approaches relevant to the medical status, discharge goals, and rehab potential for this resident?

What, Why, and How?

• Always include the:
  • WHAT – The resident is doing what?
  • WHY – because why?
  • HOW – and is impacted how?

• For example: “The resident is using a sock aide and shoe horn for adaptive equipment training to increase independence with donning shoes and socks.”

Skilled vs. Non-Skilled

**Skilled Services**
• Services that require interventions provided by a qualified, licensed, health care professional.
• Skilled services include interventions requiring observation, assessment, and treatment approaches.

**Non-Skilled Services**
• Services that are routine and do not require specialized knowledge of a qualified health care professional.
• Non-skilled services include ongoing implementation and maintenance of established programs.
Tips for Avoiding Denials

1. Complete every space – leave no blanks
2. Use skilled terminology
3. Always include the reason for continuing skilled therapy based on medical necessity
   – if no longer medically necessary, there is no longer a skilled need
4. Be consistent – when billing CPT codes, make sure your documentation reflects these; when selecting ICD-9 codes, make sure it relates to the plan of care

Skilled vs. Un-Skilled

Skilled Terminology

1. Independent Carry-Over
2. Gait Training
3. Gradual Progress due to...
4. Maximum Functional Potential with performing...
5. Resident presents with decreased participation due to...

Un-skilled Terminology

1. Maintain
2. Walked
3. Little Change
4. Plateau
5. Unmotivated

Skilled Terminology

6. Resident was assessed/measured/analyzed for...
7. Resident was provided with verbal/tactile/etc. cueing
8. Resident was instructed and rec'd training for... (activity)
9. Activity Tolerance
10. Decreased Cognition

Un-skilled Terminology

6. Monitored/Observed
7. Reminders/Reminded
8. Practiced/Helped
9. Endurance
10. Confused
How to document objectively

• The objective evaluation data or score must be documented with interpretation or analysis of it’s meaning for the resident.
• Documenting various references throughout a resident’s chart will demonstrate increased objective data.
  – For example, resident presents with a wound, eval should document from nurses notes, wound notes, dietary notes, MD orders/meds, MDS comparison, pain scale, Braden scale, etc.

Avoiding Red Flags

• Skilled interventions are documented using language and terminology that reflect the technical skill of the healthcare professional.
• They describe the treatment process and the reasons for the procedures and/or modalities used to service the resident.
• The resident’s goals and functional deficits are included when documenting skilled interventions.

Activity Two

Identifying Skilled Terminology
Instructions

Read the sample statements and construct a progress note based on using the skilled terminology.

Physical Therapy

1. Resident is doing better.
2. Transfers have improved from minimal assistance to stand-by assistance with verbal cues.
3. The resident has progressed from a moderate assisted gait of 15-feet with a hemi-walker to a minimal assisted gait of 50-feet with a quad cane.
4. Exercises are going well and the resident is walking farther.
5. The resident performs weight-shifting exercises independently.
6. Resident is able to get in and out of bed with less help.
7. The resident is demonstrating increased endurance with all treatment approaches.
**Occupational Therapy**

1. The resident is demonstrating increased activity tolerance with performing AM ADLs.

2. The resident is making gains in all areas.

3. Strength in the R UE has increased from 3-/5 to 3+/5, enabling the resident to complete UB bathing tasks with moderate assistance.

4. The resident is continuing to do better.

5. The resident is able to participate in ADL's more often.

6. The resident completes R UE PREs with minimal verbal cues.

7. The resident is demonstrating increased endurance with all treatment approaches.

**Speech Therapy**

1. The resident is hard to understand and runs out of breath when they speak.

2. Slowing down helps them talk better.

3. The resident’s articulation is severely unintelligible during connected speech.
4. Rapid rate and shallow breathing interfere with speech prosody.

5. The resident is alert and attentive and can follow directions with 75% accuracy.

6. The resident follows instructions well.

7. The resident is able to imitate a spoken model and use visual and tactile pacing cues to produce intelligible 3-word phrases.

**PT – Answer Key**

- Should use statements: 2, 3, and 5:
  - “The resident performs weight-shifting exercises independently. The resident has progressed from a moderate assisted gait of 15-feet with a hemi-walker to a minimal assisted gait of 50-feet with a quad cane. Transfers have improved from minimal assistance to stand-by assistance with verbal cues.”
  
  *(The statements can occur in any order)*

**OT – Answer Key**

- Should use statements: 1, 3, and 6:
  - “The resident is demonstrating increased activity tolerance with performing AM ADLs. The resident completes R UE PREs with minimal verbal cues. Strength in the R UE has increased from 3-/5 to 3+/5, enabling the resident to complete UB bathing tasks with moderate assistance.”
  
  *(The statements can occur in any order)*
ST – Answer Key

• Should use statements: 3, 4, 5, and 7:
  – “The resident’s articulation is severely unintelligible during connected speech. Rapid rate and shallow breathing interfere with speech prosody. The resident is alert and attentive and can follow directions with 75% accuracy. The resident is able to imitate a spoken model and use visual and tactile pacing cues to produce intelligible 3-word phrases.”

(The statements can occur in any order)

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THANK YOU! 😊