FLEMING-AOD CONSULTING

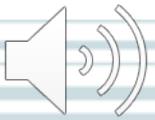
advanced outcomes design

Medical Necessity in Physician Documentation

Lisa Werner, MBA, MS, SLP
Director of Consulting Services

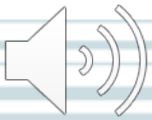
FLEMING-AOD advanced outcomes design CONSULTING

- **Medicare audits for post-acute stays are ongoing.**
  - Predominantly, Medicare Administrative Contractors (MACs) are conducting pre-payment and post-payment reviews.
- **We must prove that services were reasonable and necessary. What does that mean?**
  - The patient's needs required skilled intervention.
  - The patient required close medical and nursing supervision.
  - The patient could not make significant improvement without intervention.



FLEMING-AOD advanced outcomes design CONSULTING

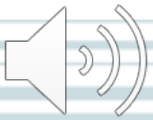
- **How Do We Document Medical Necessity?**
  - It is an effort, but the physician's documentation will make or break a claim.
  - Team has an ongoing opportunity to document medical necessity. This is achieved by documenting:
    - That services needed are of such a complex nature that they require a licensed clinician
    - Services need to be in an inpatient setting
    - Services are consistent with diagnosis, need, and medical condition
    - Services are consistent with the treatment plan
    - Services are reasonable and necessary
    - Patient is making progress towards reasonable goals



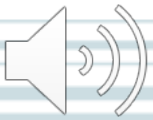
The Society for Post-Acute and Long-Term Care Medicine

FLEMING-AOD advanced outcomes design CONSULTING

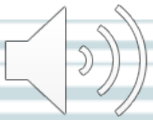
- From a paper published by the Society for Post-Acute and Long-Term Care Medicine entitled Determination and Documentation of Medical Necessity in Long-Term Care Facilities:
  - Although a final definition and determination of "medical necessity" still is an unrealized goal of the medical, insurance, regulatory, and legislative communities, the American Medical Directors Association believes that the attending physician's decision and documentation should be held paramount. A working definition of "medical necessity" that could be accepted is:
  - *Evaluation and management services, diagnostic tests and procedures, treatments, medical/surgical procedures, equipment or supplies that in the judgement of the attending physician (or physician extender [NP or PA] when permitted by federal and state statute) are required to professionally assess, plan, manage, and monitor the health care of a resident or patient in the facility within the parameters of generally accepted principles of medical practice.*



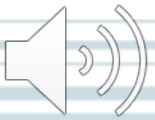
- Continued…
  - *The physician must be prepared to justify that the service or intervention is sound clinical practice and that it reflects reasonable and realistic goals and expected outcomes. The physician also must be willing to address and defend a rationale in relation to pre - morbid function, excess disability, and the expected positive outcome of any prescribed intervention. However, explanations of the above need not be explicitly documented in detail prospectively in the clinical record.*



- **One Medicare Administrative Contractor indicated the following regarding physician documentation in the skilled nursing facility:**
  - Records supporting skilled level of care must have:
    - History and physical exam pertinent to patient's care, including response of changes in behavior to previously administered skilled services
    - Skilled services provided
    - Patient's response to the skilled services provided during current visit
    - Plan for future care based on rationale of prior results
    - Complexity of service(s) to be performed

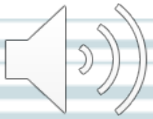


- **Role of the Rehabilitation Physician** (Cannot be resident/PA)
  - Approve admission within 48 hours prior to admit, via Pre-Admission Assessment
  - Verify appropriate for rehab within 24 hours, via Post-Admission Evaluation
  - Sign overall plan of care within 4 days (can be created by resident/PA but must be signed by rehab MD), via Interdisciplinary Overall Plan of Care
  - Assess medical and functional status at least 3x weekly, via Weekly Progress Notes
  - Lead the interdisciplinary team (through team conference)
- **The entire claim can be denied if required documentation is missing.**



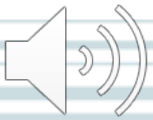
FLEMING-AOD advanced outcomes design CONSULTING

- **Requirement for a Post-Admission Physician Evaluation**
  - Must be completed by a rehabilitation physician within 24 hours of admission and must:
    - Document the patient's status upon admission to the IRF
    - Compare it to that noted in the pre-admission screening documentation
    - Begin development of the patient's expected course of treatment that will be carried out with input from all of the interdisciplinary team members in the overall plan of care
    - Identify any relevant changes that may have occurred since the pre-admission screening
    - Provide guidance as to whether it is safe to initiate the patient's therapy program
    - Support the medical necessity of the IRF admission
    - Include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities



FLEMING-AOD advanced outcomes design CONSULTING

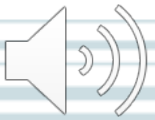
- **Requirement for a Post-Admission Physician Evaluation**
  - It would be useful for the post-admission physician evaluation to:
    - Describe the clinical rehabilitation complications for which the patient is at risk and the specific plan to avoid such complications
    - Describe the adverse medical conditions that might be created due to the patient's comorbidities and the rigors of the intensive rehabilitation program, as well as the methods that might be used to avoid them
    - Predict the functional goals to be achieved within the medical limitations of the patient
  - Serves as a combination medical/functional resource for all team members in the care of the patient as they prepare to contribute to the overall plan of care
  - Requires the unique training and experience of the rehabilitation physician as they perform a hands-on evaluation of the patient



Physician Documentation – Problem List and Plan

FLEMING-AOD advanced outcomes design CONSULTING

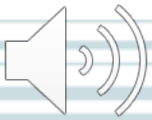
- **Recently, CMS clarified that the hospital can determine whether a physician has the adequate credentials or experience to be named a rehabilitation physician.**
- **A rehabilitation physician's documentation should:**
  - Combine into one Plan of Care
    - Medical treatments
    - Therapy treatments
  - Achieve high level of documentation quality
    - Documentation about therapy treatment status, plan, and goals in the same document as the medical treatment plan
    - The highest quality documentation links medical and therapy issues so it is clear how the two are interrelated



Ongoing IPR Physician Visits

FLEMING-AOD advanced outcomes design CONSULTING

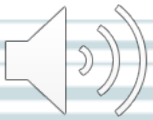
- **Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**
  - The patient requires physician supervision by a rehabilitation physician (defined as a licensed physician with specialized training and experience in inpatient rehabilitation).
    - The information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF, the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement.
    - The rehab physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to:
      - Assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as
      - Modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.



Physician Documentation

FLEMING-AOD advanced outcomes design CONSULTING

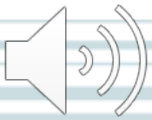
- **Three times a week progress notes should include:**
  - Face to face visits by rehab physician
  - Medical and functional assessment of the patient
  - Modification of the course of treatment as needed to maximize patient's capacity to benefit from intensive rehab
    - To reflect medical necessity, make sure the progress note reflects medical decision-making or change each day.
    - Early in the stay, medical issues will require management.
    - Later in the stay, the emphasis will be on family training and meeting the functional goals.
    - There is always something for the physician to comment on.



Medical Necessity in the Daily Note

FLEMING-AOD advanced outcomes design CONSULTING

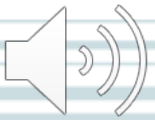
- **Make sure to document:**
  - CHANGES! Keep a chronological list of what you are doing to manage each condition on the problem list
  - Medication changes – document why a change was made
  - Lab results – document decisions made based on lab results
  - Orders for additional tests/labs – document reason why ordered, discuss risks, advantages, hasten rehab participation and discharge
  - Interaction with other professionals
  - Patient's functional gains as discussed with patient



Physician Documentation

FLEMING-AOD advanced outcomes design CONSULTING

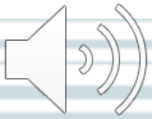
- **Medical Necessity**
  - Supersedes CPT Coding Requirements
  - Coverage Criteria
- **Coding**
  - Hospital Reimbursement/Length of stay
  - 60% Rule Compliance
- **Billing**
  - Professional Services
    - Evaluation and Management Service Codes (Medicare Part B)



Subsequent Hospital E/M Service Codes

FLEMING-AOD CONSULTING
advanced outcomes design

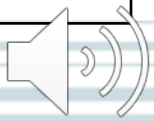
E/M Service Level Code	History	Physical Exam	Medical Decision Making
99231 (15 minutes)*	**Problem focused** *(CC, Brief HPI=1 to 3 elements)*	**Problem focused** *(1 body area and/or organ system)*	**Straightforward or low complexity** (minimal/low diagnosis and management, minimal or no data review, minimal to low risk)
99232 (24 minutes)*	**Expanded problem focused** *(CC, Brief HPI=1 to 3 elements, problem-pertinent ROS)*	**Expanded problem focused** *(2-7 body areas and/or organ system)*	**Moderate Complexity** (multiple diagnosis and management, moderate data review, or moderate risk)
99233 (35 minutes)*	**Detailed** *(CC, extended HPI=4+elements, extended ROS= problem+2-9 systems, pertinent PFSH=1 item from P, F, and S)*	**Detailed** *(2-7 body areas and/or organ systems with at least 1 being of detailed nature)*	**High Complexity** (extensive amount of diagnosis and management, extensive data review, or high risk)



Subsequent SNF E/M Service Coding

FLEMING-AOD CONSULTING
advanced outcomes design

E/M Service Level Code	History	Physical Exam	Medical Decision-Making
99307 (10 min)	**Problem focused** *(no specifications)*	**Problem focused** *(1 body area of system)*	**Straightforward or low complexity**
99308 (15 min)	**Problem focused** *(no specifications)*	**Problem focused** *(1 body area of system)*	**Low Complexity** *(minimal/low diagnosis and management, min/no data review, min to low risk)*
99309 (25 min)	**Expanded problem focused** *(Status of 1-2 chronic conditions, brief 1-3 areas)*	**Expanded problem focused** *(up to 7 systems)*	**Moderate Complexity** *(multiple diagnosis and management, moderate data review, or moderate risk)*
99310 (35 min)	**Detailed** *(2-3 systems, pertinent history)*	**Detailed** *(up to 7 systems)*	**High Complexity** *(extensive amount of diagnosis and management, extensive data review, or high risk)*

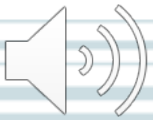


Medical Decision-Making

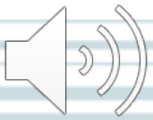
FLEMING-AOD CONSULTING
advanced outcomes design

- **Supports the need for close medical supervision**

- **Supports active medical management**
  - Connects the subjective and objective to the assessment
  - Connects the assessment to the plan
  - Describes the “why this” and the “why not that”
  - It’s the “this is how I got from here to there”

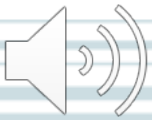


- **Medical Decision-Making**
  - When calculating your level of medical decision-making, do not overlook the complexity of the encounter's data. This includes the following classes of data:
    - **Review of clinical lab services such as WBC tests**
    - **Review/order of radiology services such as x-rays**
    - **Review/order of medicine services such as EKG**
    - **Discussing results with test-performing physician**
    - **Independent review of image, tracing, and specimen, such as reading a CT scan**
    - **Decision to obtain old records/obtain history from someone other than patient**
    - **Reviewing and summarizing old patient records from an outside source**



FLEMING-AOD CONSULTING
advanced outcomes design

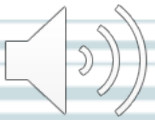
- **Medical Decision-Making**
  - Per the 2016 Coding Institute Evaluation and Management Coding Handbook, when data is reviewed, it is considered to add to the complexity of the visit.
  - Make sure to indicate if you completed a review of old patient records from an outside source, which is likely a common practice during the admission process.
  - Consider the review of the data sent from the referring hospital as part of the patient assessment. This is an opportunity to potentially increase reimbursement derived from coding initial encounters.



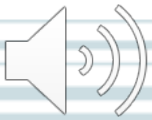
Coding Based on Time

FLEMING-AOD CONSULTING
advanced outcomes design

- **Coding Based on Time Alone**
  - In both the inpatient rehabilitation and skilled nursing facility settings, billing may be based on the amount of time spent during the encounter if the provider's documentation does not meet the optimal history, exam, or medical decision-making levels for the high-level code the provider feels is warranted. Evaluation and Management (E/M) service may be based on time alone if at least 50 percent of the visit was spent on counseling or coordination of care (CoC), and this fact must be stated in the documentation.
  - The documentation must contain the following three elements:
    - **Notation of the total time spent on the encounter**
    - **Notation of the total time spent on counseling and/or CoC or the percentage of the visit spent on counseling/ counseling and/or CoC**
    - **The reason for/topic of the counseling/CoC.**
    - (2016 Coding Institute, Evaluation and Management Coding Handbook)



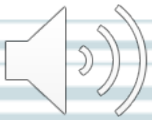
- **Discharge Codes**
  - In the inpatient acute rehabilitation setting, physicians who are the **attending** on record can use discharge management codes to report the total duration of time spent by a physician for final discharge of a patient.
  - Service may include examining the patient, discussing the stay, instructing caregivers on continuous care and the referral paperwork, such as the discharge records, prescriptions, and referral forms.
  - When calculating the time involved on discharge day, the time does not have to be continuous. If there is no time notation in the discharge service documentation, you must code 99315/99238 rather than 99316/99239.
    - **99315/99238- Discharge day management; 30 minutes or less**
    - **99316/99239- Discharge day management; more than 30 minutes**
  - Recognize the total time spent in the discharge process and document the amount of time in the discharge summary.



Common Errors

FLEMING-AOD advanced outcomes design CONSULTING

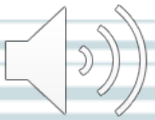
- **Make sure to include:**
  - All documentation must include a date and time with the signature.
  - Describe that decision-making in detail to reflect medical decision-making.
  - When coding based on time rather than the elements of each component of the note, state "more than 50% of time spent," followed by the reason for/topic of the counseling/coordination of care.
  - When stating 'see additional note and new orders in paper chart' in the chief complaint section, remember that the additional documentation may not be sent to an external auditor. Therefore, there may be evidence of more complex decision-making than that reflected in the subsequent progress notes. Best practice is to document the medical decision-making in the note.



Common Errors

FLEMING-AOD advanced outcomes design CONSULTING

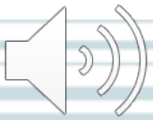
- **Make sure to include:**
  - Initial notes must contain all three components: History (history of present illness, review of systems, & past medical/family/social history), Physical Exam, and Medical Decision-Making.
  - Do not interchange Review of Systems (ROS) & Physical Examination. Review of systems of the history typically comes from discussing the issue with the patient, whereas the physician exam comes from the physician's first-hand observations.
  - For ROS, it is now appropriate to state 'no change from prior review.' Ensure that the initial review is present in the records. If you are referring to something that does not exist, this item cannot be counted toward your billing code.
  - When assessed, include documentation noted during a physical exam in order to bill at a higher level. Indicate regular findings by body area or organ systems.



Common Errors

FLEMING-AOD advanced outcomes design CONSULTING

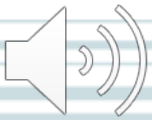
- **Make sure to include:**
  - Notes should include information on the patient's functional status, but you should recognize they do not contribute to the CPT code billing. Billing relies on ROS, physical exam, and medical decision-making.
  - Recognize changes in medications, ordered tests, or consulting with other physicians as moderately complex, which would allow billing a higher level code (when considered in addition to the history/review of systems.)



Discharge Transition

FLEMING-AOD advanced outcomes design CONSULTING

- **Day before discharge notes:**
  - Transition is one of the most important elements of a successful discharge without readmission to a hospital.
  - Make sure that notes on the day before discharge reflect what is expected of you:
    - Review medications with the patient/caregiver
    - Review therapy gains and ongoing needs and plans with the patient/caregiver
    - Review any follow-up visits planned
    - Report questions that the patient/caregiver asked
    - Report that you provided your contact information
  - Consider billing this type of note based on time by including the amount of time spent in counseling with the patient and/or family.



FLEMING-AOD CONSULTING

advanced outcomes design

Questions?

Lisa Werner, MBA, MS, SLP

lwerner@flemingaod.com