January 26, 2018

Fast Facts Friday

RehabCare

Treatment/Documentation on Day of Evaluation

Daily Treatment Note narratives are not a Medicare required document. "The purpose of these [Daily Treatment] notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim. The treatment note is **not required to document the medical necessity or appropriateness of the ongoing therapy services**. Descriptions of skilled interventions should be included in the plan or the progress reports and are allowed, but not required daily." (***Medicare Benefit Policy Manual - Chapter 15 – Covered Medical and Other Health Services, 220.3 - Documentation Requirements for Therapy Services, E. Treatment Note***)

RehabCare policy, however, states that "daily documentation is required for all patients. Additional information is required for patients receiving wound care, use of modalities and when therapy services are provided in a group, co-treatment or concurrent setting. [In addition,] **a daily note is required on the day an evaluation is completed to support any skilled treatment provided.**" (***RehabCare Daily Treatment Note POL: 02.16***)

So why do we care about the Daily Treatment Notes on the day of the evaluation? What is the big deal?

A recent finding from our Independent Review Organization (IRO) stated the following:
"The documentation supports that the minutes were included in the evaluation. The OT documented "OT evaluation completed on this date with POC/goals established" treatment minutes coded under 97110 and 97535. It appears these services were part of the evaluation and time should not be recorded as treatment as it was already included in the evaluation. There is no indication that treatment was performed separate from the evaluation. The RAI manual indicates that "the therapist's **time spent on documentation** or on initial evaluation is not included [on the MDS.]" ***(CMS RAI Version 3.0 Manual CH 3: MDS Items [O], Minutes of Therapy)***

What does this mean?

Because the daily documentation only referenced the evaluation on the eval date, the auditors could not determine which minutes were spent in treatment AFTER the plan of care was established or WERE PART OF the evaluative process.
Part A reimbursement is based on a RUG category determined for therapy by the # of disciplines, # of minutes, # of visits and mode of therapy during an assessment period. In this case, the RUG decreased from an RU to an RV, and we indemnified the client for the financial adjustment. These adjustments can produce a lack of trust in our services and judgment in the eyes of the client.

OK, what about Part B?

Part B reimbursement is based on the # of units and the value of each CPT code. Although an evaluation is billable under Part B, it is still critical that the documentation of any treatment CPT code on the day of the evaluation clearly support that treatment minutes are not part of the evaluation. Even though daily documentation is not required, the content of the documentation should support that skilled treatment was provided to prevent over billing.

So how do we prevent these kinds of minute removals/denials when billing both treatment and evaluation on date of evaluation?

Always make sure that there is a narrative for the treatment codes billed that supports initiation of skilled services and not assessment/POC development. Use action verbs such as initiated, trained, cued, instructed for the skilled tasks you implemented. Describe those tasks to support this not assessment for goal development, but rather treatment tasks provided following the assessment portion of the treatment.