Physician documentation Tips

Lisa Werner, MBA, MS, CCC-SLP
We must prove that an inpatient rehabilitation stay is reasonable and necessary. What does that mean?

- That patient’s needs could only be met through the services provided in an IRF/U.
- The patient required a hospital level of care that provides close medical and nursing supervision.
- The patient could not make significant improvement without an intensive rehabilitation program.
7 Criteria of Medical Necessity – No longer the regulation, but still useful!

1. Medical Supervision
2. 24 Hour Rehab Nursing
3. Relatively Intense Level of Services
4. Interdisciplinary Approach
5. Coordinated Care Plan
6. Significant Practical Improvement
7. Realistic Goals
**How Do We Document Medical Necessity?**

- Team has an ongoing opportunity to document medical necessity. This is achieved by documenting:
  - That services needed are of 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
Documenting Medical Necessity

**Key Areas**

- **Pre-admission screening**
  - Document needs to stand alone and justify admission
- **Physician documentation**
  - Establishes the justification for admission through post-admission assessment
- **Nursing documentation**
  - The rehab nursing plan of care ties the medical condition established by the physician and the rehabilitation goals set by therapy
- **Therapy documentation**
  - The therapy plan of care ties the functional deficits to the medical condition and notes progress and barriers
January 1, 2010

- **Role of the Rehabilitation Physician** – Cannot be resident/PA
  - Approves admission within 48 hours prior to admit – *Preadmission Assessment*
  - Verifies appropriate for rehab within 24 hours – via *Post Admission Evaluation*
  - Signs 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*
  - Assesses medical and functional status at least 3 x weekly – via *Weekly Progress Notes*
  - Leads the interdisciplinary team (through team conference)
- **The entire claim can be denied if required documentation is missing**
• **Requirement for a Post-Admission Physician Evaluation**
  
  - To be completed by a rehabilitation physician within 24 hours of admission to
    
    - Document the patient’s status on 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 completed 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 or not 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
• **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 them
    - 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
• **Requirement for a Post-Admission Physician Evaluation**
  - 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 he or she performs a hands-on evaluation of the patient
  - Does not require the physician to obtain input from the interdisciplinary team prior to completing, although it would be in the best interest of the patient if team member input were provided
  - The document must be retained in the medical record.
• **Requirement for a Post-Admission Physician Evaluation**
  - The conclusion of a post-admission evaluation may disagree with the pre-admission conclusion that the patient is an appropriate IRF admission. It is important to document the differences and identify when those differences result in a change to the admission decision.
  - The rehabilitation physician must note the discrepancy and document any deviations from the pre-admission screening.
  - For example, patient believed to be able to tolerate 3 hours per day, but only tolerates 2 hours on day one due to pain from the ambulance trip to the IRF. In this case the reason for the temporary change must be noted in the patient’s medical record – no need to discharge.
Another example, pre-admission indicates IRF is appropriate, but post-admission assessment indicates there is a marked improvement in the patient’s functional ability since the time of the pre-admission screen OR an inability to meet the demands of the IRF rehab program.

- IRF must immediately begin the process of discharging to another setting of care
- It may take a day or more for the IRF to find placement for the patient in another setting of care so Medicare contractors will allow the patient to continue to receive treatment in the IRF until placement in another setting can be found,
- However, anything after the 3rd day of the patient’s admission to the IRF is not considered reasonable and necessary
- In these cases the IRF claims should be down coded to the appropriate CMG for IRF patient stays of 3 days or less
The Interpretation

• **CMS Provider Education call stated:**
  
  - The rehabilitation physician must conduct and document the post-admission assessment.
  
  - The assessment could not be documented by a physician extender or resident.
The Interpretation

**CMS Q&As:**

- The history and physical can be used as the post-admission physician evaluation if it is expanded to include all of the required items.
- It is not required, but is suggested, that it be renamed to make it clear that the H&P includes the PAPE.
- The H&P associated with the PAPE cannot be completed by a physician affiliated with the acute care hospital.
- The same physician is not required to complete the H&P and PAPE.
- If a patient is seen by a rehab physician in acute care prior to his admission to rehab, an update is required to support the facility’s decision to admit the patient.
- It is required that a PAPE be completed within 24 hours of admission regardless of when the patient was seen by the rehab physician in acute care.
• What’s so special about Physical Medicine and Rehabilitation?

  - Combining into one Plan of Care
    - Medical treatments
    - Therapy treatments
  - Levels of documentation quality
    - Documentation about therapy treatment status, plan and goals in the same document as the medical treatment plan
    - Exemplary: Links medical and therapy issues so it is clear how the two are interrelated
• **Assessment / Problem List should include:**
  - Primary rehabilitation diagnosis (primary functional limitation, primary impairment and cause)
  - Complications and coexisting conditions (including chronic conditions)
  - Symptoms requiring treatment
  - Precautions
  - Additional rehab impairments/diagnoses
  - At risk conditions and preventative measures
• **What is the plan?:**
  - The preliminary plan supports medical necessity by describing the “treatment for the condition”
  - Indicates the decision to admit the patient
  - Provides evidence of the complexity of the interdisciplinary program
  - Lists the interventions to be provided by each team member
  - Implies the skill level required to provide such services
The Plan is the most important piece of the post-admission assessment because it sets the interdisciplinary care plan.

It defines the medical, nursing, and therapy needs of the patient.

Suggested Goals:

- It is safe to begin the intense interdisciplinary rehabilitation program as follows:
  - Will consult physical therapy for...
  - Will order occupational therapy for...
  - Will order speech/swallowing therapy for...
  - Rehabilitation nursing is required for the following specific duties –
  - Will consult Dr. () with internal medicine.
- Will consult Dr. () with rehab psychology to work on maximizing interactions with therapy, to decrease stress, to work on pain management issues and adjustment issues as necessary.
- Medical issues being managed closely and require the 24 hour availability of a physician specializing in physical medicine and rehabilitation are as follows –
- Goals – The patient is currently () with ADL's, ambulation, and transfers. We would like the patient to be modified independent with ADL's, ambulation, and transfers by discharge.
• Inadequate Plan of Care –

1) left hemiparesis – restart therapy
2) MM – check with Dr X on the timing of his stem cell infusion
3) recurrent aspiration – monitor and initiate speech
4) history of esophageal hemorrhage – monitor
5) dysphagia – per speech
6) hypotension - resolved
7) neurogenic bowel
8) neurogenic bladder
9) hypertension - monitor
10) cardioembolic CVA - engage Dr. X in follow-up
11) gait abnormality - therapy initiated
12) debility - therapy
1. TBI secondary to fall on 12/27/05 – with diffuse SAH and IVH- repeat Cranial CT scan during rehab stay
2. Bilateral hemiparesis – PT, OT, and rehab nursing to facilitate use of limbs in functional activities, focus on strengthening and conditioning
3. Severe cognitive deficits – Using neurostim – Amantadine 100 mg TID- Neuropsych and SLP working with rehab nursing will eval and treat safety issues; develop compensatory strategies for deficits; focus on facilitating expression of basic needs and wants
4. Communication deficits – SLP will eval pt – Apraxia may be compounding communication deficits, but may have aphasia secondary to left hemisphere involvement
5. Gait Abnormality – PT will address balance issues, strengthening for pregait activities, analyze gait deviations and develop progress gait training program using assistive devices as progress permits; patient may benefit from aquatic program if continence will permit.
6. Hyponatremia – cerebral salt wasting – will continue fluid restrictions to 1000 ml daily; monitor strict I/O’s; give salt tabs 4 grams q 6 hours and check Sodium q 12 hours- consider endocrinology consult
7. Hypothyroidism – Continue Synthroid – check TSH and free T4
8. Impaired Self Care Skills – OT evaluation and treatment for ADL training working with rehab nursing to provide training opportunities
9. Neurogenic bladder – continue foley for now to facilitate monitoring of I/O's- after sodium's stable, will remove foley and begin timed void trials with rehab nursing while monitoring post void residuals; check baseline UA/ Urine culture
10. Neurogenic bowel – Miralax daily; will add Mylicon and daily dulcolax suppository
11. Post-traumatic Headache – consider Elavil at HS if persists; Tylenol for now
12. Hypophosphatemia – monitor renal panels
13. LUL Lung nodule – patient to F/U with Dr. X in ~ 4 weeks
14. Anxiety Disorder – avoid Thiothixene; Neuropsych to address via counseling; provide safe/structured environment via third floor rehab nursing
15. Paroxysmal Supraventricular Tachycardia – Continue medication management; monitor HR via Rehab Nursing and during therapies; Continue Dig – check level
16. Hyperlipidemia – Monitor Lipid panel
17. H/O remote Stroke – Plavix and ASA
18. Osteoporosis – Fosamax and exercise program
Composing a Plan
Example #2

- **Documentation about therapy treatment status, goals and plan in the same document as the medical treatment plan**
  - H&P – lists therapy goals and interventions as well as medical goals and interventions
    - We will initiate comprehensive rehabilitation program with physical therapy, occupational therapy, recreational therapy, 24 hour rehabilitation nursing and physicians. She will benefit from this comprehensive rehabilitation program to address ADLs and mobility status post surgery as she is currently requiring moderate assistance for ADLS and mobility
    - Hypertension – will monitor and adjust dosing of Norvasc and hydrochlorothiazide due to recent uncontrolled pressures
    - Postop anemia. Hemoglobin has been stable at 9, will continue to monitor and consider adding iron supplementation if this continues to be an issue. Will hold off for now as patient has constipation and iron can be constipating
    - Rehabilitation therapies. Goals to manage pain, increase ambulation and ADLs to goal of independent level and to work on range of motion with CPM machine. Assess for equipment needs and home safety

Better outcomes for everyone.
• Links medical and therapy issues so it is clear how the two are interrelated.
  - H&P – lists how medical impairments will impact therapy progress
    • A 72-year old female, previously modified independent, following cerebellar infarct – decreased balance, coordination, unable to return to prior level of function. Needs inpatient rehab, physical/occupational therapies for function as well as decreased cognition, in need of speech therapies. Rehab physician care management for therapy plan of care, management of pain control with non-narcotic use, management of chest pain and monitoring for complications following stroke. Rehab nursing care to work on bowel and bladder training, transfers, education.
    • Physical therapy to work towards improvement of bed mobility, transfer training, balance/coordination with gait to a modified independent level
    • Rehab nursing to support therapy goals, return to modified independent with bowel/bladder, educate on prevention of stroke
  - Occupational therapy . . .
  - Speech therapy . . .
• **Review your post-admission physician evaluation for:**
  - Document the patient’s status on 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 completed 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 or not it is safe to initiate the patient’s therapy program
• **Review your post-admission physician evaluation for:**
  - 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
  - Describe the clinical rehabilitation complications for which the patient is at risk and the specific plan to avoid them
  - Describe the adverse medical conditions that might be created due to the patient’s comorbidities and the rigors of the intensive rehabilitation program and the methods that might be used to avoid them
  - Predict the functional goals to be achieved within the medical limitations of the patient

*Better outcomes for everyone.*
• **Requirement for an Individualized Overall Plan of Care**
  - Essential to providing high-quality care in IRFs, since comprehensive planning of the patient’s course of treatment early on leads to a more coordinated delivery of services to the patient. Such coordinated care is a critical aspect of the care provided in IRFs.
  - Requires that an individualized overall plan of care be developed for each IRF admission by a rehabilitation physician with input from the interdisciplinary team by the end of the fourth day following the patient’s admission to the IRF.
  - Must support the determination that the IRF admission is reasonable and necessary.
  - Must be maintained in the medical record.
• **Requirement for an Individualized Overall Plan of Care**
  - Synthesized by a rehabilitation physician from:
    - Pre-admission screening
    - Post-admission physician evaluation
    - Information garnered from the assessments of all therapy disciplines
    - Information from the assessments of other pertinent clinicians
• **Requirement for an Individualized Overall Plan of Care**
  - Purpose is to support a documented overall plan of care. The overall plan of care must detail:
    - Estimated length of stay
    - Patient’s medical prognosis
    - Anticipated functional outcomes
    - Anticipated discharge destination from the IRF stay
    - Anticipated interventions that support the medical necessity of the admission
      - Based on patient’s impairments, functional status, complicating conditions, and any other contributing factors. Should include these details about the PT, OT, SLP, P/O therapies expected:
        - Intensity (# of hours/day)
        - Frequency (# of days/week)
        - Duration (total # of days during IRF stay)
• **Requirement for an Individualized Overall Plan of Care**

  - Individual clinicians will contribute, but it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient’s medical record.

  - If the overall plan of care differs from the actual length of stay and/or expected intensity, frequency and duration, then the reasons for the discrepancies must be documented in detail in the patient’s medical record.

  - Good practice to conduct the first interdisciplinary team meeting within 4 days of admission to develop the overall individualized plan of care. It is the IRF’s choice to develop the internal process.
CMS Provider Education call stated:

- The physician is responsible for documenting the information that pulls the overall plan of care together.

- Signing the plan of care is not equivalent to synthesizing a plan of care completed by the clinicians.
The Interpretation

**CMS Q&As:**

- Rehab physician has to synthesize the plans of care, but he does not have to write it out himself.
- The purpose of the overall plan of care is to provide general direction for the team and to establish broad goals for the patient’s treatment. The team members are responsible for setting their specific plan.
- The intensity of therapy should be stated, but since treatment is adjusted for the patient’s individual need consider adding a statement that reflects the times stated are an average that will be varied based on the patient’s daily needs.
- Physician extenders can complete and sign the form.
• **Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**
  - Must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehab therapy program.
  - This occurs when the patient’s condition and functional status are such that:
    - The patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient’s functional capacity or adaptation to impairments) as a result of the rehabilitation treatment and
    - If such improvement can be expected to be made within a prescribed period of time.
The Rule

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.
  - Means that 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.

Better outcomes for everyone.
• **Requirement for Evaluating the Appropriateness of an IRF Admission / Inpatient Rehabilitation Facility Medical Necessity Criteria**

  • Candidates for IRF admission should be assessed to ascertain the presence of risk factors requiring a level of physician supervision similar to the physician involvement generally expected in an acute inpatient environment, as compared with other settings of care (proposed rule).

  • Per CMS, during the past 25 years, it was often assumed that “close medical supervision” was demonstrated by frequent changes in orders due to a patient’s fluctuating medical status. Currently, however, patients’ medical conditions can be more effectively managed so that they are less likely to fluctuate and interfere with the rigorous program of therapies provided in an IRF.

  • All IRFs may increase the frequency of the physician visits as they believe best serves their patient populations.
The face-to-face visits and the resulting documentation must be completed by the rehabilitation physician rather than by a physician extender.
• **CMS Q&As:**
  - The physician must see the patient and document progress with medical and functional issues at least 3 times per week.
  - The team conference does not count as one of the 3 required visits.
Three times a week progress notes should address:

- Face to face visits by rehab physician
- Assess the patient medically and functionally
- Modify the course of treatment as needed to maximize patient’s capacity to benefit from intensive rehab.
Components of the Daily Note

SUBJECTIVE:

OBJECTIVE:

Vitals: BP, T, P, R, Pulse ox

LUNGS: clear to auscultation bilaterally __, rhonchi __,
rales __, wheezes __, crackles __

CV: regular rate and rhythm __ murmurs __, rubs __, gallops __

Abd: soft __, non-tender __, normal active bowel sounds __, obese __

Ext: cyanosis __, clubbing __, edema __,
calf tenderness __ (Right __ Left __)

Neuro:

Labs:

PLAN: 1. Justification for continued stay –
2. Medical issues being followed closely –
3. Issues that 24 hours rehabilitation nursing is following –
4. Rehab progress since last note –
5. Continue current care and rehab
Components of the Daily Note

Make sure to document:
- Medication changes – document why changed
- Lab results – document decisions made based on lab results
- Ordering additional tests/labs – document reason why ordered, discuss risks, advantages, hasten rehab participation and discharge
- Document interaction with other professionals
- Document patient’s functional gains as discussed with patient
• **Links medical and therapy issues so it is clear how the two are interrelated**
  - Assessment/Plan – medical comorbidities impact on therapy is considered
    - Hypertension remains uncontrolled despite adjustment in Norvasc. This has resulted in fatigue and discomfort that have caused the patient progress slowly with PT and OT. Will consult cardiology to assist with control of hypertension and remove this barrier to intensive therapy participation.
    - Missed 1 hour of therapy due to nausea and vomiting per PT, will add Phenergan PRN for reoccurrence and monitor participation in intensive rehab via conversations with therapy.
“Seen and Agree” comments by the attending when working with a physician extender or resident must reflect both functional and medical issues warranting continued inpatient rehab (need a more detailed addendum on these days) as well as modifications to the treatment plan to maximize the patient’s capacity to benefit from rehab.

Five examples for seen and agree statements:

- Example 1: Saw patient face to face along with PA/resident. Agree with medical assessment – nausea is currently limiting rehab. Agree with functional assessment – transfer gain from max to min assist is significant. No treatment modifications to further maximize capacity to benefit from rehab needed at this time.

- Example 2: Examined patient along with PA/Resident. Agree with medical and functional assessment as written. Modified treatment prescribing Phenergan for nausea/vomiting to maximize capacity to benefit from rehab.
• Example 3: Please see Mr. Wiggins note for further details, briefly the patient is having less pain today and is tolerating the Fentanyl lollipops well.
  • CV: RR S1, S2 no murmur
    ▪ Resp: CTAB
    ▪ Abdomen: + BS, soft
    ▪ Ext: no change of edema
    ▪ Integument: neck draining purulent exudate
  • A/P: 52 year male who was shot in the neck by wife – consulting WCON today, improving functionally, otherwise discussed and agree with Mr. Wiggins A/P.”

• Example 4: Patient was seen and examined with Dr. or Mr....... I agree with the exam and assessment and plan. Due to continued need for medical management of HTN, DM, neurogenic bladder etc... we will continue our daily physician management. Persistent functional deficits in mobility and ADL’s with the patient at a overall Moderate assistance level for ADL’s and requiring min assistance for mobility with a walker will continue daily PT/OT and full therapy program at a minimum of 3 hours a day.

• Example 5: “Patient seen and evaluated with team. Agree with dictation. The patient is making slow/great progress due to...”X”. It remains necessary for the patient to remain in acute rehab to manage/maximize “X”. Plans are outlined to optimize patient’s functional recovery.”
• **Review your progress notes for:**
  - Notes written by the rehab physician at least 3 times per week.
  - Notes that reflect the patient’s medical status and needs.
    - Were labs, x-rays, or tests results completed and was a plan evident
    - Were conversations with consulting physicians noted
    - Were suggestions for the team present
  - Notes that reflect the patient’s functional status and needs.
  - Notes that clearly indicate the interaction between the medical issues and the functional presentation.
  - The rehab physician’s assessment and decision-making were clear when notes are written by a resident or physician extender.
Questions?

Lisa Werner
Lwerner@erehabdata.com
(202) 588-1766

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