SPEAKER:
You are listening to the AOTA podcast. Here is your host, Matt Brandenburg.

Matt:

Alright. Today I'm joined by Kelsey Berg and Gina Braswell. Thank you both for being on the show today.

Kelsey:

Thanks for having us.

Gina:

Thank you very much.

Matt:

Yes, absolutely. And before we dive into our interview and I start asking you questions, I have a quick message from AOTA's regulatory affairs team. I almost feel like a kid like getting called onto reading class right now because I don't usually read alive on the show. So, this is going to be a good test of my reading skills and capabilities. But here we go. Carefully documenting occupational therapy services has become an integral part of the profession's work with clients. AOTAs regulatory affairs team has invited commercial insurance representatives, Kelsey and Gina, to join us for a discussion on documentation and coding issues. And why proper documentation is the key to a practitioner learning to tell their client's therapy story, including how we conduct an evaluation, develop a plan of care, set treatment goals, and identify the right interventions for the best client outcomes.

Assuring OT practitioners understand the importance of documentation will help the profession better describe the value of occupational therapy services and result in fair reimbursement for services. And that's the blurb, I think I made it through with just one or two mistakes. That's pretty good.

Kelsey:

That'll work. Yep.

Matt:

Awesome. Well, Kelsey, you are a clinical operations manager at Magellan Health, and Gina, you are the senior manager of provider relations also at Magellan Health. Can you tell us a little bit about your background and kind of introduce us to your roles at Magellan?

Gina:

Sure. I'll go ahead and start if that works. Kelsey and I both are involved in the utilization review process. I started out in clinical review. I was a therapy reviewer, reviewing therapy requests for medical necessity. I moved up a little bit in that team before moving over to provider relations. So, being an occupational therapist, along with my review experience, was a perfect combination in my mind in relaying the medical necessity information and what reviewers are looking for to relaying that information to therapy providers.

So, part of what my role entails is assisting providers with the program, the prior authorization details on a daily basis. And that might involve educating about the programs we manage, assisting with the intake process, creating educational documents or other materials on what is needed for medical necessity review. And also identifying trends for a facility and sharing information and resources to help address those trends with their authorizations. So, that's a little bit about how my role ties in.

Kelsey:

Yeah, I can go next. I, so prior to coming over to Magellan, I worked directly with patients in a pediatric clinic as an occupational therapist as well as in acute care at a hospital. And then after being introduced to this role and utilization management, I transitioned into the therapy review role on an intermittent basis and really just became passionate about the medical necessity review process and ensuring that patients were getting the therapy that they needed. It really became clear when I started this role that documentation can be challenging for therapists, and even when I was working in direct patient care, it was something that I, that was challenging for me as well.

So, especially knowing just how to document the skilled interventions was, is, can be challenging for practitioners. And over time, when I took on the management role, it really allowed me to focus on the quality of the medical necessity review process. So, currently in my current role, I oversee a team of occupational therapists, physical therapists and speech therapist that review therapy requests for prior authorization. And this team of therapy reviewers also works with physician reviewers, so they review therapy requests for medical necessity using clinical guidelines and their clinical expertise.

Matt:

Thank you both so much for that introduction. It's really interesting for me from a practitioner perspective to kind of get a peek into what this review process really looks like and what your roles are in, in going through that process. I did have a couple of follow up questions just about utilization management and review. Can we start just by kind of defining that? What really is utilization review and authorization review?

Gina:

As I mentioned a minute ago, Kelsey and I are both involved with the utilization review or the clinical review process, which is actually just one part of utilization management. I think oftentimes those terms, utilization management and utilization review are used interchangeably, but they're, they're two different things. And so, utilization management is where a facility or organization incorporates utilization review likely as part of a bigger plan to ensure, you know, that they're using their resources properly and that they are providing high quality care. So, that's the Utilization management is sort of an internal program that is critical in preventing denials and helping with successful appeals. And then the utilization review part that we're involved in is the process where organizations determine whether health care is medically necessary for a patient or an insured individual. And so, our, our roles revolve around medical necessity review for prior authorization purposes.

Matt:

Who, I guess, sorry, I'm just adding so many follow up questions here, but are you two making that decision of medical necessity?Like, say, a practitioner submits, you know, an evaluation report with a recommendation for frequency of services? Are you reviewing that report and that documentation and determining, yes, this is approved or no, it's not approved?

Kelsey:

I can answer that. That's a really good question. Personally, Gina and I are not involved with the direct review of the clinical documents that are submitted with prior authorization requests. But as I had mentioned, the team that I manage of OTs, PTs and speech therapists, when practitioners submit a request for prior authorization, we receive all the clinical documents and the background information on that patient. And then when that, when that therapy reviewer opens that, that case for review, they'll review the clinical documentations in addition to our own internal clinical guidelines. Utilizing our guidelines and their clinical expertise, they will review the clinical records for medical necessity and assess whether or not these specific requests for services meets the criteria.

Matt:

Thank you so much for that clarification. This really is a side of occupational therapy practice that I haven't seen too much or don't have too much exposure to. So, I'm very excited to, to continue this interview. And I want to ask each of you, why do you think it's so important for practitioners to, to understand all of this information we're going to discuss about documentation, billing and coding and utilization review or utilization management?

Gina:

Yeah, it's a good question and a good point, too. It is a completely different role. It's not your traditional role as an occupational therapy practitioner. And I'll just say it did take a little time for adjustment, to be honest. But the three things that I think are important, why it's important to know and understand documentation, billing and coding, I think the prominent our most recognizable answer would be to optimize reimbursement. Our providers should have a good understanding of the procedure codes that are needed to run their practice efficiently and then billed properly for the services that they provide.

And of course, ultimately that's going to avoid claims denials. It'll maximize profits, you know, and that's successful in any practice, important to be successful in any practice. So, a failure to follow the proper protocols could cause significant loss in revenue for an occupational therapy practice. And the not so well-known answer of why it's important to know those things is, you know, coding is essential not only for the proper reimbursement, but it's used as a tracking tool by CMS and other agencies to inform how occupational therapy is practiced. They track the health care utilization for all specialties. So, I think that's an important aspect to keep in mind and be knowledgeable of. So, those are the two business answers, but I think we all know, of course, the OT is more than just a business. The most important part of what we do involves the patients and maximizing their functional independence. So, the other reason that it's important to understand documentation, billing and coding and utilization review as well, is the quality of care, being able to provide that maximum value of therapy services.

When you have an understanding of medical necessity, what's required in the documentation, it helps ensure that the services that are being provided are in accordance with best practices. And that the patients who need therapy are getting that appropriate therapy quality services that they need at the right time. I think that's, you know, those are three of the reasons I think it's important to know.

Matt:

Absolutely. Yeah. And that's a really beautiful answer. It really paints a picture clearly and is really encouraging to, to hear about that focus on, on improving quality of care, which is something, you know, all OT practitioners are going to be striving for. And what about you, Kelsey? Was there anything you wanted to add onto that question?

Kelsey:

Well, like you said, Gina provided a really great response and really just hitting home that the intention of utilization management is really for the best interest of the patients and the members and to make sure that they're getting that quality care.

In my experience, especially in the pediatric clinics, wait lists are months long. There's a waiting list to get in to see therapists, and it's very important to make sure that all of the patients that are waiting for services can get in and get the therapy that they need. And utilization management is just a part of that process where we are making sure that skilled therapy is being provided for the right patients at the right time, like Gina mentioned.

Matt:

I love that. And we mentioned this a little bit beforehand, but billing and coding and documentation are kind of two separate roles within kind of this, this big theme of utilization management. Is there any clarification you wanted to provide on kind of a difference there or your roles in regards to, to those two topics?

Gina:

I think they are definitely two different aspects. The part that we are more heavily involved in is that documentation and medical necessity review. As a provider relations manager, I do hear and have discussions with providers about claims, but not so much coding and billing typically from our role and vantage.

That's something that is handled by the health plans where we are contracted to do the prior authorization part component.

Matt:

Awesome. Thank you so much. And you both have experience in rehabilitative practice. How does that approach differ from a rehabilitative practice and is there really a difference between habilitative versus rehabilitative documentation, would you say?

Kelsey:

 Yeah. So habilitative and rehabilitative practice are really quite different. Habilitative services really focus on helping a person learn to improve functional skills that they have, that they've not yet even developed, which is why this is really common in the pediatric population with those that either have a developmental delay or other medical diagnosis that for whatever reason is impacting typical development. And then with on the opposite side of that, rehabilitative practice focuses on helping a person restore or improve skills that they've either lost or that became impaired due to an illness or an injury like a stroke or a car accident.

And when it comes to documentation for those two different approaches, there are, there are really only just some differences between the two. Habilitative plans of care tend to be longer term. They can range from six to 12 months or even longer for some patients. So, because they tend to be longer, it's really important for practitioners to document the active management of that plan of care. So, important components to include would be like, how are you adjusting the frequency of visits over time? Are you taking therapeutic breaks? What's happening during those times of frequency adjustments or breaks in care? Did your patient regress? Did they maintain or were they able to succeed with a lesser visit in, in addition to that home program? These are just some really essential components that we would expect to see or that practitioners should really include in that habilitative documentation. And then for rehabilitative services, the plan of care does tend to be short term, sometimes ranging from just a handful of visits and other times maybe up to two to three months of care.

That's kind of the main differences between the two. But otherwise, for the most part, the documentation should be quite similar. Both should have functional smart goals. The skilled interventions should be well documented as well as the functional deficits through either standardized testing or just a functional report of the deficits for their patients.

Matt:

 Absolutely. Thank you for explaining that so clearly. It makes a lot of sense now, Gina, was there anything you wanted to add there?

Gina:

No, I thought that was a great answer. The only small thing is that, you know, your different populations might require different assessments, but overall, it is the same components. And Kelsey went into detail on what components are needed. And those documents, that all of that should be documented in as very similar as well. Like you should be able to locate all of that information with the initial evaluation. Any re-evaluations, the most recent progress notes, even daily notes are important as far as demonstrating skilled interventions as well.

But a lot of similarities for those basic components. But Kelsey did a great job covering what would be different on the rehabilitative documentation.

Matt:

I love how you brought up skilled intervention. I think a lot of us know a primary requirement for reimbursement is that the service provided must require the unique skill of a licensed OT practitioner. How do you really define skill and how does OT practitioner do what you just described and demonstrate that skill within their documentation?

Kelsey:

That really is the million dollar question. I would say that skill interventions are such an important part of practice and documentation, like you said, really focusing on, you know, what are you doing during therapy sessions that a layperson or a caregiver cannot be done at home, like do at home, that it truly requires the skills of a therapist. And oftentimes, especially in habilitative documentation, it can become challenging to document what you're doing during sessions that really requires your skills as an occupational therapist, making sure that we're not, you know, doing repeated activities.

Or, you know, low complexity exercises that a caregiver could, you know, complete at home with the patient or that the patient themselves can complete at home. And then another big part of it is, you know, recognizing that during the initial parts of care, some goals can be scaled initially, but over time no longer require the skills of a therapist. For example, working on activities of daily living with patients, addressing a skill such as buttoning or teeth brushing. While that may be scaled in the initial parts of care over time, it would be expected for that patient to take over or that caregiver to take over addressing that specific goal. Given that it may just be low complexity and no longer required the skilled expertise of a therapist. And I'll let Gina add to that as well.

Gina:

Yeah. One, one thing I did want to add is, as I know and Kelsey, I'm sure you would agree as a practitioner, you manage so much in your head. That's where your clinical reasoning is going on. You know why you're doing what you're doing in treatment.

Sometimes it's just a matter of a gap in the black and white notes rather than a matter of skilled intervention is not occurring. So, it's important to always make sure that it does get into those black and white notes as that, you know, is all that we have as opposed to the therapist, fuller clinical picture that they are managing. But as Kelsey mentioned over time, some goals, you know, may require skill in the beginning when you get down to where you're providing those verbal cues from session to session, it would be critical for those notes to show what is it with the verbal cues that requires those skills of the therapist. Being able to distinguish that from what could be provided at home or in a home exercise program is, is important. There really is so much that, that an OT practitioner is, is doing. When they provide skilled intervention, they have this, you know, large clinical picture like, like you mentioned in figuring out, you know, what to include and what not to include in documentation can, can be difficult to do.

Matt:

What would you say are some of the most common documentation issues that you encounter?

Kelsey:

 There are three that stick out in my mind when it comes to the medical necessity review process where we see, a big one is that we see in the prior off as over requesting whether that means the duration or frequency. So, sometimes we see therapists over requests rather than requesting what is actually needed for that patient. So, really having therapists use best practice to determine, you know, what does my patient need, what frequency they need to be seen at, and how do I expect this to change over time? Do I expect them to need two times a week indefinitely? Or it can be extremely helpful to include kind of that, that plan between you and that patient. If you plan to taper that frequency or, you know, what is the discharge plan with that family to transition over to a home exercise program. It's also common for us to see documentation that lacking clear progress towards goals. I know as a busy practitioner and we're all very busy a lot of the times in progress notes, sometimes therapists will document that goals are just progressing.

And that's really the only, that's the only term that they'll put underneath each goal. How are they progressing? That can be helpful to include so that from the prior authorization standpoint, we can see how the patient has progressed for that reporting period. And then lastly, we, we see that lacking the, the evidence of the skilled intervention. So, like we mentioned prior, that just a lot of the times when practitioners send in their notes, those skilled interventions are not documented. So, that is a large portion of the conversations that we have with practitioners over the phone and peer to peer conversations or, you know, that Gina has with providers over the phone of really helping them understand the importance and how to document those skilled interventions that are really working towards those deficit areas to help that, that patient achieve the goals in the plan of care.

Matt:

Thank you. And how about you, Gina? Are there any other common documentation, billing or coding pitfalls that, that you would see?

Gina:

I think those three are the main trends that we do see. And as Kelsey mentioned, we do have those conversations with providers to assist in those areas. But overall, if you could narrow it down, those would be the three most common trends.

Matt:

Awesome. And thank you both so much for the information. I'm excited to hear more about your process when you are reviewing documentation. I do want to plug real quick, AOTA is going to be following up this podcast with the four part webinar series detailing documentation that will go over key topics for documentation, starting with documentation, starting with documenting for payer compliance. This is going to be on January 12th at 2 PM Eastern time. Kelsey and Gina, along with Christine Kroll, will be presenting that. So, if our listeners are interested in finding more, make sure you're aware of that webinar. But what, what are you two looking for when you review OT documentation? We've touched on some of this, but kind of how, how does your process go? Is it via the electronic health record? When are you doing this throughout the year? Is it because something was flagged? Sorry to ask you a quadruple barreled question.

Gina:

That's actually a good question and it does vary a little bit. So, with prior authorization, it does require that providers submit these requests before the services are performed. With our process, we don't require authorization for that initial evaluation. So, providers will go ahead and complete that initial evaluation, develop the intervention plan, and then submit for that prior authorization for the requested frequency and duration. And that can come to us. We have an online portal, so usually it's a digital format. We also have a call center where they can just initiate the request and then upload or fax documents in. And then that starts that prior authorization review process. So, it's, it's not like some of the Medicare plans where that is a, it's a medical review that occurs afterward, more of an auditing process.

But this occurs before treatment is rendered. I think that answers the first question. (LAUGH)

Matt:

 Yeah, I think, I think you answered a couple of them, is just general about your process. You covered when it's kind of occurring on the timeline after that, that initial evaluation, you have your online portal. Do things ever come in like already, you know, flagged? Are you aware of, of documentation that may have concerns before you see it?

Kelsey:

That would usually come out probably during a re-review or the appeals process, as I think what would be the best way to answer that question. So, if there are issues with the documentation, meaning that medical necessity was either not met entirely or maybe partially met because sometimes we receive requests where part of their requests will be approved and part of it will be denied based on the documentation that the practitioner submitted. And then from there, if they, if the occupational therapist wanted to appeal that decision, then they would review the denial reason.

And then submit additional documentation to have reviewed a second time or a third time by a therapy reviewer and sometimes a physician reviewer.

Matt:

Wonderful. And you mentioned medical necessity. How is medical necessity established and what is really needed in documentation to support a therapy request?

Kelsey:

Again, that's a question I think that we hear often as well. And what I would recommend is, of course, checking the policies of the health plan that you're submitting for or, you know, if it's a specific vendor performing clinical reviews, always make sure you look into what those policies are. What we recommend keeping in mind as far as medical necessity, it's more, it's a bigger picture that encompasses several things. I would love to say that it's, you know, you have this checklist and once you check off each box, you're good to go. That would be wonderful to have it so black and white. But it is a little bit more of a bigger picture where what is needed is the overall clinical picture.

You know, where was the patient when treatment started? How has therapy helped so far and where are they headed? What's the finish line there? And that information can be supported in your initial evaluation if there's a re-evaluation, any previous discharge notes, knowing if there's been any previous, previous therapy, your most recent progress notes and daily notes all kind of help form that bigger picture of medical necessity.

Gina:

And if I could narrow it down, I think we'll kind of discuss these more as we go. But if you could narrow it down to, say, four main things that would be first, demonstrating delays that would warrant skilled therapy. The second one would be showing overall functional progress toward the goals. The third would be documenting evidence of skilled interventions during those treatment sessions. You know, what is specific for that individual's treatment, not necessarily how is occupational therapy skill, but making sure it includes what's skilled with that individual patient.

And then the active management, as Kelsey has mentioned in some of the previous questions, showing that that intervention plan is being actively managed based on the patient's response to treatment. Is it being modified and updated as you go? I think those would probably be the four things that I think comprise the idea of what medical necessity is. I love that and it makes a lot of sense that there's kind of these guidelines without having a black and white checklist like, like you mentioned earlier, because every individual is, is going to be different and have unique needs. So, there is no one checklist that can apply to everyone.

Matt:

That definitely makes sense. Where does standardized testing come into play here? And and also, if standardized testing can't be completed, what would you recommend a practitioner do?

Kelsey:

And this is a question that we get asked commonly. You know, if, if, can they submit a prior authorization request without testing? And the short answer is yes. And it's not uncommon for, for standardized assessments to not be appropriate for whatever reason to measure deficits for a specific patient, especially in habilitative therapy or even in the adult population, you know, depending on cognitive functioning, post-op status.

There are many reasons why if a practitioner is unable to complete any sort of standardized testing, it's really important for them to document the reason why. Whether that be the patient being noncompliant or just simply that it's just not appropriate due to that level of deficit. So, instead, a practitioner should have just some sort of objective report of functional deficits in their documentation that demonstrates delay. So, it's additionally, it is beneficial to document clinical observations. If you're working in the pediatric population, a parent report of concerns or any deficits that are observed at home and in the community, we don't always need to see the standardized testing or percentiles to justify a delay.

Matt:

Absolutely. Thank you. What would you say is important information for you when you are looking at reviewing goals? What are you looking for? And how can practitioners establish and document the goals well?

Gina:

I think as far as goals, there's a couple of formats, actually, you're probably familiar with the smart goal format.

One I recently learned about was the Coast goals. I wasn't familiar with that, but they both include a lot of the same things. And what that would be is the specific task, and is it measurable, Is it attainable? Is it realistic? And what is the timeline for accomplishing that? As far as the cost format, I did want to actually just quickly touch on that, because I did find it almost more descriptive, but it includes, what is the client expectation or the client action? What is the functional occupation? What is the assist level? What is the specific condition? And then what is the timeline again? I think both of those, whether you use either format, you want to make sure that the goals are functional and actually measuring the progress of the functional activity. So, sometimes you might see a goal for a functional activity, but it's measuring the active range of motion. So, you want your your goal to be measuring the functional activity needs to be attainable. How long has it been in the plan of care?

Are the notes still demonstrating a skill need to address that task? If there has been a low complexity goal that's in the plan of care for an extended period of time, that appears to just require something such as verbal cues. You know, as I mentioned earlier, making sure that the notes demonstrate what the therapist is doing that couldn't be completed by a non skilled person and why that skill is still needed at that point and care. Also, modifying the plan of care is important. The goals in particular, I should clarify, is there a evolution toward more complex goals? So, if in rehabilitative care in particular, you may start with the goals and that are of lower complexity. But as they meet those goals, ensuring as a practitioner that they do progress to a higher complexity so that it does also demonstrate that need for skill. And then the timeline, you know, always working toward a finish line that shows the clinical reasoning that comes from the specific training as a licensed therapist that we received and the experience that couldn't be performed by a non skilled person.

And of course, it's, you know, being able to assess when discharge might be. It's not a rigid thing. So it might require adjustments, you know, based on the response to therapy or unexpected things that could come up. But making sure that finish line is also part of the plan of care. And the goals in particular, I think is important when reviewers are looking at those goals.

Matt:

 Goals are so key to documentation and intervention and the whole OT process really. What would you say are some efficient ways for practitioners to indicate progress over time through their documentation?

Kelsey:

 And I think the key word in that question is efficient, right? Because as far as occupational therapists working in clinics or hospitals or whatever setting that they're working in, we don't have a ton of time for documentation. And I think that that's that is something that I've heard from many practitioners, is just wanting more time for documentation, but we don't always have it. So, just some some tips for documenting that progress over time efficiently, tracking it on daily notes as you go can be really helpful.

That will help you once you get to completing your progress notes at those regular intervals. It can help avoid using those free phrases of just saying progressing under each goal. It can be really hard to understand what that feeling means. So being able to have, you know, your daily notes to reference what progress is really being made during those sessions can help you write an effective progress note when it comes time to completing that. It's also important to include, you know, like Gina mentioned, that updated progress on goals, and it's not expected that patients meet all goals at each progress interval. So, even using quick statements such as, you know, goal has been met 50% of opportunities as evidenced by. And then completing that statement for each of those goals can be really efficient way just to show progress over time.

Matt:

I love that. I love that. Those are excellent tips and good tricks. Because you're right, documentation can sometimes be seen as as a burden when especially when there is kind of a time crunch. And so it's always good to have some some efficient ways to do it. What would you say if a patient really is not progressing or is progressing at a at a very slow rate?

Gina:

And, you know, that is another question we hear a lot, because unexpected events and conditions can always occur that impact that progress. Right? The patient may have a fall that really sets them back. So, as long as the documentation clearly indicates why there might be a lack of progress. And then also say there is the slower rate of progress or again, lack of progress with ability of care, making sure that the plan of care is modified accordingly. It's not useful to continue with the plan of care if it's not working. So, whatever that reason might be, making sure that there are updates if appropriate. And if there whether there is complete lack of progress or slow progress, being sure that the documentation still clearly indicates those skilled interventions because if there is slow progress, that would imply that the goals are in that plan of care for a longer period of time.

So just making sure there is a clear indication of what is still skilled, even though it's taking a little bit longer to accomplish that goal.

Matt:

 It's it's it's very encouraging for me, too, to hear how documentation and and documenting patient progress can be fluid because, you know, patients are living, breathing, changing, experiencing different circumstances throughout their their development and their life. So it's it's encouraging to hear how documentation has kind of these built in systems and processes to to understand that ebb and flow of of patient progress. Could both of you shared a personal example of how you've seen quality documentation lead to positive outcomes?

Kelsey:

I have an example, one that comes to mind. Recently, there was a case where the documentation indicated that the patient had been in care for three years at two times a week. This was habilitation of care. So, those are those episodes of care do tend to be a little bit longer. This one in particular was over 250 visits, which is is a lot.

And they were requesting another six months at two times a week. And at the time of this request for additional visits, we had just began managing care. A prior authorization, I should say, for this particular health plan. And there were two goals addressing grasp and writing skills and then hand strengthening, which had been targeted in the initial plan of care. Three years ago, there was a goal for the first step of a hygiene (UNKNOWN) process that was addressed for the previous six months in the plan of care as well. So, it wasn't clear why these goals were not attainable. They had changed slightly, yet they were still low complexity goals, addressing the same skills over time. And the notes only showed that cues were needed for grasp and attention to task. It wasn't clear why a non skilled person could not give those cues for attention and grasp. And then it wasn't clear why another six months at two times a week was medically necessary at that point and care. But the provider received an additional information request to have the opportunity to support what skilled interventions were occurring during those treatment sessions.

And then also asking for the documentation to support that requested frequency as well. That provider did participate in a peer to peer discussion, which is a therapist to therapist discussion addressing, you know, clinical questions that they may have regarding what information was needed. And so during that discussion, there was...they addressed the skilled interventions that were lacking that would be helpful for the review. Also discussed the evolution of the plan of care, as we previously discussed and what happened was this provider went back. There was a new intervention plan that was developed that addressed the current functional deficits, a little bit higher level that had not been previously addressed, and it did demonstrate the need for the specific clinical skills as opposed to something that could be practiced at home. And so that authorization request number one, it supported the higher quality of care and it did support the need for that skilled intervention and it led to a positive outcome.

So the provider and the patient, I think, benefited from that process and that care was authorized in that instance.

Matt:

 And I love that example and I love the connection that it illustrates between high quality documentation and high quality care. And I think that's something that that all of us want to provide is the highest quality care as possible. And sometimes, spending a little bit extra focus and maybe a little extra time on our documentation to ensure it's quality can can help to do that and lead to some more positive outcomes for patients. Kelsey how about you as a personal example you'd like to share?

Kesley:

Yes. So and what Gina provided is really it's not it's not uncommon that we see the results of just that further discussion between a therapy reviewer and a therapist result in a positive outcome. You know, when we're able to have those peer to peer conversations and be able to gain that additional information, and then as a result of those conversations being sent in that additional clinical documentation, we oftentimes do see that that does have a positive outcome for the practitioner and the member.

One specific case that I can recall that occurred recently was the original, and this was a habilitative request for two times a week for six months. And this was for a member that had been in care for a significant amount of time. And the original documentation that was submitted was very minimal. There wasn't a lot reported and the goal section, there was not a lot of evidence of progress over that reporting period. The deficits were apparent, but overall it was just not clear that medical necessity was met based on what was submitted. So after that, requesting additional information or clarifying information, that could help us better understand why an additional two times a week for six months of care was needed. The provider submitted a very detailed narrative notes and a letter of medical necessity that further that really explain that recently a break in care had occurred after they had trial the lower frequency, and ultimately did discharge to a home exercise program and that that had led to resulted in a regression.

That nformation was not included in the original documentation. So, after they submitted a quality letter explaining the recent occurrences that have had happen with that patient. It did result in a positive outcome and it really showed that they were actively managing that plan of care that they were trialing different frequencies, that they were helping facilitate that home exercise program with the family. And they ultimately had a great outcome for that member. I loved that, that's a wonderful example as well. And I think it really highlights some of those important or key features to include in in documentation and authorization requests.

Matt:

I want to ask you what evidence or data are used to establish the documentation and billing criteria that you're using when you when you review all the documentation and and reports?

Gina:

Very good question. Our clinical guidelines are based on the best practice guidelines or standards of practice that are promoted by the national organizations.

And they also are based on evidence based research and in some cases generally accepted industry wide standards. When you are discussing the criteria for delay, that is one of those components as well. As far as the testing, it falls into that category of the industry wide standards.

Matt:

Absolutely. And I think that just kind of reiterates the importance for practitioners to, you know, stay informed about those clinical practice guidelines and strive to to provide evidence based intervention. Do you ever see skilled maintenance therapy claims? And if so, what do you see in the records that supports skilled maintenance therapy? And what do you see that kind of does it?

Kesley:

You know, that's a good question. We on our end, we don't see a lot of the maintenance therapy request. We do see some, but I think what is needed for a maintenance program to support an adequate medical necessity. The biggest difference for a maintenance program is that medical necessity doesn't depend on the presence or absence of the patient's potential for improvement from skilled intervention.

So in that instance, what what we're looking for is a intervention plan written to maintain or prevent deterioration rather than expect progress. And then procedures needed to maintain that member's current function or prevent further deterioration must be of that complexity, or, as some guidelines indicate, sophistication that require the clinical reasoning of a licensed therapist. So, they need to require skill. So it can't be a maintenance program for passive range of motion, that is typically something you can pass on, but make sure that it illustrates the need for skilled intervention. And then also it must demonstrate why those skills are needed. The specialized judgment, the knowledge of a licensed there, a licensed therapist. Why is that reasonable for the safe and effective delivery of those service services? So, it must show the skill and that must require the skill, if that makes sense. So, it boils down to on a maintenance program, there's there's basically two deciding factors of whether services are considered reasonable, effective treatments for the condition.

And then does it require the skills of a therapist on whether they can be safely carried out to, number one, maintain or prevent deterioration rather than expect progress. Just to add to that to something that we that we see in records that supports our skilled maintenance therapy request is definitely the frequency of care is delivered at a much lower rates. It is it is typically rare that we see skilled maintenance therapy being requested for two times a week or sometimes even weekly is inappropriate. It's it tends to be a lot less frequent visits just given the nature of the of the approach with those types of maintenance therapy plans of care.

Matt:

Absolutely. And do you see kind of a place or an area where where maintenance therapy can grow into or fill or take on a larger scope?

Gina:

You know, I think that as long as it does, you know, any with any plan of care, as long as it is demonstrating that need for skilled intervention, I don't know if there's an absolute area, I could say where there's room for growth or an area to fill.

I think it does just come down to whether or not, you know, it is skilled intervention. And as Kelsey mentioned, sometimes, you know, it's a lower frequency. It may be a frequency just to re-evaluate maybe even once a month to reevaluate where that patient is at at that point. I think more it might be something that may be providers are not aware of as much. And maybe if with awareness and being informed, that might be something they could utilize more. Potentially even in habilitative, habilitative patients, because a lot of the times with members and patients that have been in therapy for an extended period of time, we see periods of time where a therapy break may be appropriate, but for whatever reason, it may be beneficial to switch more towards a maintenance approach or a lower frequency of checking in monthly to make sure that there isn't a significant regression before fully discharging.

Kelsey:

I do see that as a possible area for more maintenance plans of care is to be utilized potentially in the pediatric population where those those patients that have significant deficits.

And that we would expect them to have significant deficits for lifelong potentially, that those maintenance plan of care is may be beneficial to use with that population.

Matt:

I love that that makes a lot of sense. Well, what are some kind of final recommendations that you would give the practitioners to help them ensure quality care and documentation? Maybe a couple, you know, action steps that some practitioners could do.

Gina:

 I would say, keeping in mind, as I mentioned before, you know, we recognize that practitioners have that full clinical picture, and that's where our clinical reviewer has to rely on those black and white notes to get that best clinical picture. So, be sure that any details impacting the clinical picture, the overall clinical picture are captured. And even as briefly as possible, you mentioned earlier it can definitely be difficult determining what needs to be included and what doesn't. And one thing I do remind providers that it's more about quality than quantity. Sometimes we do see practitioners include a very lengthy narrative which takes more time for the therapist, and then it also takes more time to review and get that decision back as well.

But many of those long narratives are more describing the child's performance level rather than the skilled interventions that are used to address those delays. So, honing it in to those prominent deficits and what was done to address them is helpful. And then, you know, was there any modifications to activities addressing the underlying impairments? You know, what was the response to that? Was there a specific type of assistance provided to elicit a specific response? That's something that helps to show that skill. Are there new strategies being tried that require the skill for maybe a goal that's been in the plan of care for a while with little progress? You know, are you trialing new strategies? Those things are helpful, you know, as far as ensuring the quality of the documentation in regards to medical necessity. And I would say it's important as a therapist to ask yourself questions. What did I do with the patient that could not be practiced in a home program? You know, as I mentioned earlier, I know I used to manage so much in my head.

It didn't always get to the notes when it was happening. So, how is the patient progressing? Rather than, are they progressing? And then what is that finish line? You know, can I, as a therapist logically reason that the patient will attain the current goals and then be ready for a decreased frequency or discharge at the end of this current authorization request?Those are some of the things that I would recommend as far as the documentation.

Matt:

And same for you, Kelsey. What recommendations would you give?

 Yes, very well said, Gina. In addition to everything that Gina said, I would also just recommend looking into specific CEU's on documentation. They are they are coming out at a higher rate and there are a few on occupational therapy dotcom, that that would be really helpful for occupational therapists. One specifically on skilled OT documentation and medical necessity. There is another one on Summit Education and the CEO is titled Documentation Bootcamp Skill Therapy Services.

And just continue to complete, know that continue learning on this topic can be really helpful for practitioners to just achieve the ultimate goal of documenting skill therapy and ultimately achieving the best outcomes for their patients.

Matt:

I love that. And thank you for mentioning those those continuing ed resources. Another reminder that there will be that four part webinar series detailing documentation coming out on January 12th that you two will be presenting at. Are there additional resources that you would recommend to listeners who want to learn more about what we've discussed today?

Kelsey:

 in addition to those CEUs, the center of Medicare and Medicaid Services website has many areas on their webpage with just specific compliance information. And then, as always utilize AOTA if they have great resources on their website, including content on coding and billing as well as continuing education article on the OT practice framework foundation for documentation. Utilize those resources and that can really help us improve our overall documentation.

Matt:

Absolutely. Gina, are there additional resources you would recommend?

The same as Kesley, I think AOTA has great resources including the American Journal of Occupational Therapy. Great articles that are helpful in understanding the current trends, the evidence based practices reviews of,you know, current are new treatments that we might hear about. It's always good to fall back on AOTA for sure. And then I have agreed with all those when she mentioned we had discussed some of that before and definitely some good resources available out there.

Matt:

Absolutely, and earlier in the interview, you mentioned checking policies. Do you have any resources to to help check policies and then kind of for practitioners to learn what policymakers and insurance companies are looking for?

Kelsey:

 I think, you know, just you could do a search. I think, as mentioned earlier, you've got your Medicaid and Medicare policies and Medicare especially. It's sort of the golden rule that most other entities follow.

But being aware of those, I think they update those annually and just doing research, seeing, you know, for your specific state. I know in Texas we just had a House bill that passed that that had a big impact on therapy providers and just being aware, know, maybe searching what's going on in your state regarding therapy, being updated with your local state organizations is important as well. I think we're staying on top of that information. Right, when you are seeing a patient and making sure you're aware of the exact insurance that they have, immediately, I would recommend going to the health insurance website. And most often they have tip sheets available to assist with what you need to submit, as well as clinical guidelines that are used in the review process and that can help assist practitioners with submitting what is needed for that medical necessity review. I love that. And thank you so much for those recommendations. And a couple of things there that as a practitioner I just wouldn't have thought to do but think will be extremely helpful moving forward.

Matt:

It is now Golden nugget time, this is our concluding segment, the Golden nugget segment. I want to thank you both so much for sharing your knowledge and your expertise and so much valuable insight with us today. And my last question for you is, if you could recommend one thing to practitioners, what would it be?

Gina:

 I think my golden nugget. I like that, by the way, my golden nugget, I would recommend building your own personal foundation in which you can grow as a therapist. Be informed, be accountable, stay abreast of the current evidence based research, the changing policies medical necessity requirements. Don't rely on others to keep you informed, but take time every week even if it's just 30 minutes, maybe an hour. Do do your own research. Knowledge is power and we are in a world with constantly changing health care. And more and more, I feel like we need to, as occupational therapists, be able to validate and support the care that we provide and show that it is improving outcomes in those reasonable time frames.

Kelsey:

So, my golden nugget is always work on growing as a therapist and being informed, being accountable for all of those things that that you're working on daily. I couldn't agree more with what Gina said. And so I'm going to piggyback off that a little bit and and really encourage occupational therapists to be just extremely intentional with your with the time you're spending on completing things like continuing education. I know that each state has different requirements for how many hours that we need to maintain our licenses. But again, be intentional and if and if there are certain areas that you feel you are lacking in or that you really have a passion for learning more about, capitalize on those CEO opportunities. Take the time during the week to collaborate with colleagues and discuss those journal articles and making sure that everything that we're doing in our practice is evidence based, because that is that is really the most important part of providing that quality care is making sure we're utilizing our current evidence that we have to provide that skill therapy to the patients that need us the most.

Matt:

Those are fabulous golden nuggets. Thank you both so much for sharing. And again, thank you so much for being on the show today. It's been a real pleasure to speak with you and to learn from you about this really important topic.

Gina:

Thank you for the opportunity.

Kelsey:

Thank you so much. Yeah.

Speaker:

Thanks for listening to the AOTA podcast. Tune in again next time.