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Medical Review: Opportunities and Challenges

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View the entire course including any applicable handouts/resources. Complete a post-test assessment. You must score 80% or better on the post-test and complete the course evaluation to earn a certificate of completion for this activity. If required, Select Rehabilitation will report attendance to CE Broker.

ABOUT THE COURSE AUTHOR

Neely Tolbert Sullivan MPT, CLT-LANA, CDT, has worked with diverse client populations ranging from pediatric to geriatric in a variety of clinical settings. These experiences have allowed her to treat and develop effective client care programs. She has served in multiple levels of regional and corporate management positions. In these positions, Neely has developed policies and worked closely with interdisciplinary teams to ensure that all clients have the opportunity to attain their highest level of function and quality of life. She has most recently been responsible for the identification, implementation and evaluation of clinical programs in long-term care settings.

Neely currently provides educational support to 16,000+ therapists nationwide as the Director of Wellness and Education Specialist for Select Rehabilitation. Neely has lectured nationally and at the state level on a variety of clinical and regulatory topics. She has authored publications focusing on evidence-based practice and clinical care. Neely conducts audits, quality improvement planning, and clinical training to Select Rehabilitation employees and customers monthly. She is a member of the APTA including the Clinical Electrophysiology and Wound Management section and Geriatric section.

POST-TEST

1. What is one primary goal of the denial and appeals process in long term care communities?
 - a) To reduce therapy hours for patients
 - b) To increase therapy reimbursement rates
 - c) To ensure documentation justifies medical necessity and supports claims
 - d) To focus only on coding errors

2. Which section of the MDS affects the Physical Therapy (PT) and Occupational Therapy (OT) components under PDPM?
 - a) Section K
 - b) Section GG
 - c) Section J
 - d) Section I
3. What is the purpose of an Additional Development Request (ADR) in medical reviews?
 - a) To allow auditors to bypass reviewing medical records
 - b) To provide an opportunity to correct and resubmit claims
 - c) To gather further documentation to support the need for services
 - d) To delay payment until an appeal is submitted
4. According to the presentation, which documentation practice should be avoided?
 - a) Using objective data
 - b) Charting events in chronological order
 - c) Using unsanctioned abbreviations
 - d) Signing all entries with credentials
5. What is a key principle for successful appeals management?
 - a) Always submit appeals without evidence to save time
 - b) Appeal only when denials exceed 90 days
 - c) Include clear, evidence-based arguments and ensure timely submission
 - d) Focus appeals solely on coding errors

The post-test and corresponding course evaluation can be accessed at:
https://www.surveymonkey.com/r/Medical_Review_On_Demand

Or by using the following QR Code:



If all course requirements have been met, a certificate will be emailed from Select Rehabilitation to the email address reported in the course follow-up survey.

Any questions or issues related to this course should be directed to Dr. Kathleen Weissberg, National Director of Education for Select Rehabilitation at kweissberg@selectrehab.com

If accessibility of learning is required, please contact Kathleen Weissberg at kweissberg@selectrehab.com for appropriate accommodations.

Medical Review: Opportunities and Challenges

Neely Sullivan, MPT, CLT-LANA, CDP
National Director of Wellness and Education Specialist
Select Rehabilitation
nsullivan@selectrehab.com



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Objectives

- Explain an overview of the denial and appeals process
- Identify common errors and key elements to prevent denials
- Outline principles of effective documentation for nursing and therapy to support delivered services
- Describe successful strategies to employ in the denial and appeals process



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Overview



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Scope of the Problem

- FY 2023 improper payment 7.38 percent
- CMS has an increased focus on reducing improper payments
- CMS is using a variety of approaches to reduce improper payment include



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Audits Under PDPM

- SNFs are paid based on the characteristics of the patients they serve, rather than on the amount of therapy minutes they provide
- Denials are no longer focused so much on therapy.
- Each discipline, nursing and/or therapy, must justify the level of services provided and the patient's condition as coded within the medical record.



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Why is it Important to You?

- Volume of Medical Records Requests
 - Technical denials
 - Response time
- Lengthy and Costly Appeals Process
 - How many requests are in appeals?
 - Denials cost the facility both time and money



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Why is it Important to You?

- Identifying Compliance Issues
 - What are your denial reasons?
- Financial Implications to the Facility
 - How much are the denials/appeals costing the facility in time and resources?
 - How are denials/appeals impacting cash flow?
 - How are denials/appeals impacting the facilities bottom line?



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Medicare Administrative Contractors (MACs)

- Converted from FIs and Carriers
- Responsible to monitor billing and utilization of services
- Each MAC has Local Coverage Determinations (LCDs) regarding requirements for documentation and billing



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CERT (Comprehensive Error Rate Testing) Program

- Randomly selects claims
- Review claims for compliance with Medicare coverage, coding and billing rules
- Annual report stating results of reviews



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Recovery Audit Contractor (RAC)

- Identify over & underpayments
- Review claims on a post-payment basis
- Use Medicare policies to review claims
- Two types of review:
 - Automated (no medical record needed)
 - Complex (medical record required)
- Able to look back 3 years
- All review issues are approved by CMS



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Program Safeguard Contractors (PSC)

- AKA Zone Integrity Contractors (ZPICs)
 - Coordinate with MACs
- 2 Major tasks
 - Benefit integrity/fraud and abuse
 - Specific projects



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Different Types of Audits

Type	Function
RAC	<ul style="list-style-type: none"> • Medicare Recovery Audit Contractors • Improper Payments • Goal is to recover money for Medicare
MAC	<ul style="list-style-type: none"> • Fiscal Intermediary/ Medicare Administrative Contractor (FI/MAC) • Administer payments • Do probe audits to correct and educate
CERT	<ul style="list-style-type: none"> • Comprehensive Error Rate Testing (CERT) • Measures Improper Rate for payments made by the MAC
Probe Audits	<ul style="list-style-type: none"> • MACs will do testing on claims to see if providers are implementing billing guidelines correctly
ZPIC	<ul style="list-style-type: none"> • Zone Program Integrity Contractors (ZPICs) • Also known as UPIC (Unified Program Integrity Contractors) Investigate Fraudulent activity



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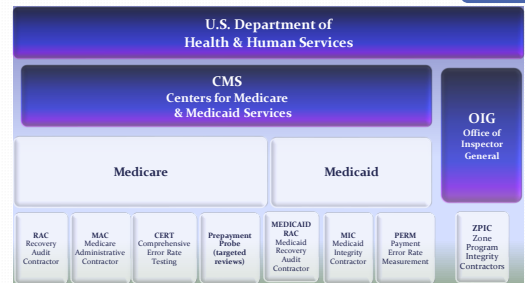
Different Types of Audits

Type	Function
Medicaid RAC	<ul style="list-style-type: none"> Medicaid Recovery Audit Contractors (RAC) Identify Improper Payments
MIC	<ul style="list-style-type: none"> Medicaid Integrity Contractor (MIC) Identify fraudulent patterns; appropriate utilization of Medicaid
PERM	<ul style="list-style-type: none"> Payment Error Measurement Testing (PERM) Establish Improper payment rate made by state Medicaid Once every 3 years per state
QIO	<ul style="list-style-type: none"> Quality Improvement Organizations (QIO) Investigate Quality of Care, DRG's and Medical Necessity complaints
Commercial Audits	<ul style="list-style-type: none"> Identify Improper payments Establish quality data



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State and Federal Auditors



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Types of Review

- Probe review
 - Provider-specific
 - Widespread probe
- Pre-pay review
- Post-pay review
- Targeted medical review (TMR)



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Billing Practices

- Know your state practice acts and survey guidelines
- Identify MAC; review LCDs and NCDs
- MAC diagnosis to treatment edits
- 30 days to respond to ADR
- Documentation **must** support services billed
- Following ADR, the claim may be paid, partially paid or denied



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Additional Development Request (ADR)

- Remember the medical reviewer cannot see & does not know your patient so need for treatment is based solely on documentation in the medical record
- A strong offense is your best defense



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Appeal Level	CMS Request Form Used	Provider Time to Respond	Reviewer Time to Respond	Minimum \$ Amount to Appeal
Redetermination-Appeal to A/B MAC	20027	120 days from date of denial	60 days	No minimum
Reconsideration-Appeal to Qualified Independent Contractor (QIC)	20033	180 days from date of FI's/A/B MAC response	60 days	No minimum
Administrative Law Judge Hearing (ALJ)	20034	60 days from date of QIC decision	90 days	\$130.00 (to change yearly)
Departmental Appeals Board (DAB) Review or Medicare Appeals Council	DAB-101	60 days from date of ALJ decision	90 days	No minimum
Federal Court or Judicial Review	N/A	60 days from date of DAB decision	N/A	\$1300.00 (to change yearly)

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Audit Risk Areas Under PDPM



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Accuracy of the MDS

- With the implementation of PDPM came the need for increased MDS accuracy and supportive documentation
- Issues tied to reimbursement must be validated in the documentation
 - Section GG – Function Score affecting PT, OT, Nursing Components
 - Section K – Swallowing Disorder and Mechanically Altered Diet affecting SLP Component
 - Sections I and J – SNF Admitting Diagnosis and Surgical Procedures affecting PT, OT, and SLP Components



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How do we Tell Our Resident's Story?

- Collaboration and communication are imperative
 - Pre-admission process: Thorough communication with the referring hospital &/or physician will be necessary to clearly understand the reasoning behind the resident's referral to the SNF
 - Determination of primary diagnosis: SNF teams will have to determine the primary diagnosis they will be treating together.
 - Describing all comorbidities and services: Teams must determine a strategic approach to understanding all of the comorbidities and related treatments & services that determine an individual's case mix.
 - Pre-bill Claim Review: Members of the IDT should review claims together, validate the information, and ensure that supporting documentation is in the medical record.



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ICD 10: Return to Provider Code

- If a "return to provider" code is used in I0020B of the MDS, the claim will be returned
- The "return to provider" codes include symptom codes that may be used by therapists as treatment diagnoses on their plans of care
- Symptom codes do not represent the primary reason for the SNF stay
 - Support the treatment provided to the patient and should be coded by therapy as treatment diagnoses



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Importance of Accurate ICD-10 Coding

Accuracy is critical to ensure:

- Medical records reflect resident
- MDS is accurate
- Quality Measure exclusions are identified
- Diagnosis codes are correct on the UB-04 claim



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Determining Primary Diagnosis

- PDPM requires facilities to code the diagnosis that corresponds most closely to the primary reason for SNF care
- CMS recognizes that in many cases, the primary reason for SNF care may not be the same as the primary reason for the prior inpatient stay



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Diagnosis Coding



- Only assign ICD-10-CM codes for active, physician documented diagnoses
- Always start with Index, followed by the Tabular
- Know the official guidelines for coding and reporting
- Claim order



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Do NOT ...



- Code from symptoms listed in licensed nursing notes
- Code diagnoses added by therapists unless signed by the physician
- Guess/assume or estimate what you think the physician meant without asking the physician to clarify the diagnosis



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Determining the ICD-10 Code



- Use a coding manual, do NOT code from the internet, your phone, or from a "most commonly used codes" list
- ICD-10 codes update every October 1st
- Identify the main term of the diagnosis
- If the diagnosis is not clear, query the physician



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Keys to Success



- Ensure staff have sufficient ICD-10-CM training to properly assign diagnoses codes
- Ensure your facility is receiving appropriate medical records to accurately assign diagnosis codes to the fullest specificity
- Make ICD-10 coding a priority for review at Triple Check
- Decide the Primary Diagnosis as a TEAM



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Importance of Clinical Documentation

- Under PDPM, accurate ICD-10-CM code assignment drives reimbursement for the entire Med A stay
- Must have the complete picture via medical records in order to capture accurate code assignment

PT	OT	SLP	Nursing	NTA
<ul style="list-style-type: none"> • Primary reason for SNF care • Functional status on admission 	<ul style="list-style-type: none"> • Primary reason for SNF care • Functional status on admission 	<ul style="list-style-type: none"> • Primary reason for SNF care • Cognitive status • Swallowing disorder or mechanically altered diet present • Additional SLP related comorbidities 	<ul style="list-style-type: none"> • Clinical information related to SNF stay • Functional status • Extensive services • Depression • Restorative Nursing 	<ul style="list-style-type: none"> • Comorbidities • Extensive Services



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Preparation is Key ...



- Ensure your facility is receiving appropriate medical records to accurately assign diagnosis codes to the fullest specificity
- Practice coding on tough areas such as fractures
- Ensure that the proper Primary ICD-10 CM is assigned
- ICD-10 CM codes to support Comorbidities



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Section GG: Functional Status

- Ten (10) items
- Points are assigned based on performance of each item
- “Resident refused,” “Not applicable,” “Not attempted due to medical condition or safety concerns” “not attempted due to environmental limitations” are grouped with “dependent”
- Additional response level to reflect residents who skip the walking assessment due to their inability to walk
- Multiple items are averaged together



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Section GG: Coding Tips and Definitions

- Residents should be allowed to perform activities as independently as possible, as long as they are safe
- Activities may be completed with or without assistive device(s)
 - Assistive device should not affect coding
- Code based on “usual performance”
- Not the most independent or dependent



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Section GG: Coding Tips and Definitions

- If a helper is required (i.e., resident is unsafe), only consider staff assistance when scoring
- A “helper” is facility staff who are direct employees and facility-contracted employees



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Section GG: Coding Tips and Definitions

- Residents with cognitive impairments may need physical or verbal assistance
- Code based on the resident's need for assistance to perform the activity



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Section GG: Activity Not Attempted

- 07, 09, 88, 10 should not be used if you did not directly assess the item during your evaluation
 - All attempts should be made to obtain the information from other sources
- 09 should be a rare score for eating, toileting, and bed mobility items
 - This essentially says the person did not eat, eliminate, or move in/out of bed at all prior to hospitalization
- Do not score dashes
 - A dash will impact the facility's annual payment update and result in a 2% reduction



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Medical Necessity: What to Document?

- Assessment information
 - A collection of objective data and details about resident's current condition
- Action
 - What did the nurse or therapist do with the findings?
- Response
 - How did the resident react?
 - What did you communicate to others about the resident's condition?
- Evaluation
 - Was the action taken effective?
 - Does the plan need to be re-evaluated?



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Medical Necessity: How to Document

- Always follow facility policy
- Document events in chronological order
- Document the facts
- Do not chart in advance or prior to providing care/treatment
- Make sure documentation is in keeping with acceptable standards of practice
- Document only what you are qualified to do
- Date and time all entries using AM/PM unless military time is used
- Sign all of your entries with your credentials
- Avoid using abbreviations or only used acceptable abbreviations approved by your facility



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Medical Necessity: How to Document

- Documentation should include correct anatomical terms
- Know your medical terminology
- ICD-10 is very specific; documentation must support accuracy and specificity
- Keep your documentation concise, objective and professional



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Medical Necessity: Principles of Skilled Care

- The service must inherently complex
- Nature of the services requires the skill of licensed personnel
- Skilled service provided directly or under supervision of a licensed nurse or therapist
- Diagnosis and prognosis DO NOT determine what is skilled care



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Medical Necessity: Reasonable and Necessary

- Skilled care may be necessary to either:
 - Improve a resident's current condition, or;
 - Prevent/slow further deterioration of the resident's condition
- Skilled documentation must:
 - Substantiate daily skilled care was delivered
 - Record treatments, therapy and resident's response to same
 - Communicate between the disciplines and serve to facilitate continuity of care



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Medical Necessity

- The resident's medical record must document as appropriate:
 - The history and physical exam
 - The skilled services provided
 - The resident's response to the skilled services
 - Plans for future care
 - Detailed rationale explaining the continued need for skilled care
 - Complexity of the services to be performed
 - Any other pertinent characteristics of the resident
- Whatever code your team chooses, the documentation must be supported by all three disciplines and nursing



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Medical Necessity: Facts and Details

- Documenting "Condition improved" or "wound appears to be healing" is not enough
 - State the facts
 - Provide comparison over time
 - Give exact measurements and provide your observations in support of your clinical opinion
 - Indicate "As evidenced by"
 - Document the continued risks and concerns
 - Document what you are planning next and why
 - Incorporate all things that contribute to goal achievement



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Examples of Nursing Documentation

- Left lateral calf wound healing as evidenced by decrease in size and amount of drainage from last week. Wound measures 0.2 cm x 0.5 cm. No drainage observed on dressing or in wound bed at time of scheduled dressing change. Oral intake has been optimal with resident consuming at least 75% at every meal in the last week.
- Resident's condition is improving since admission as evidenced by resident is now able to ambulate entire distance from room to dining room for meals without requiring a rest break and without evidence or complaints of shortness of breath.



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Supportive Therapy Documentation

- Necessary documentation that the skilled therapy interventions are required
 - What services does therapy provide that restorative nursing cannot address?
 - Assessment and changes to the treatment regime
 - Medical complexity



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Example: Skilled Gait Training

- PT performed gait training with client to normalize gait pattern, training in correct sequencing of gait using verbal and tactile cues with AD to increase safety, gait training w/ emphasis on stair climbing activating gluteal musculature and safety training w/ larger steps (using metronome) and changing directions.



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Supportive Nursing Documentation



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Supportive Nursing Documentation

- Reflects coordinated efforts between nursing and interdisciplinary team
- Supports therapy's plan of care
- May impact reimbursement for skilled therapy services



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Supportive Nursing Documentation

- Good nursing documentation
 - Minimizes loss risk for a facility
 - Avoids subjective terms
 - Essential for anyone
 - Skilled by Medicare
 - Treated in therapy
 - Referred to therapy for a decline in function
 - Receiving Part B therapy service



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Communication Between Nursing and Therapy

- Essential part of identifying appropriate candidates for therapy and supporting interventions
- Make it a habit
 - Always be looking for residents who have skilled needs
- Document what you see
 - Look for a pattern of change



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Supportive Nursing Documentation

- Prior to therapy evaluation
 - Supports prior level of function
 - Supports need for evaluation
- During therapy
 - Changes in function must be documented to show progress and carryover



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Phrases to Avoid

- | | |
|---------------------------------------|-----------------------|
| • Custodial care | • Chronic condition |
| • Maintaining | • Not motivated |
| • Poor/fair rehab potential | • Extreme depression |
| • Inability to follow directions | • Little change |
| • Refused to participate in treatment | • Status quo |
| | • Plateau |
| | • Ambulating "ad lib" |



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Supportive Nursing Documentation

- | | |
|---------------------------------|---------------------------|
| • Assistance required | • Compensatory strategies |
| • Safety awareness | • Communication |
| • Adaptive equipment | • Dysphagia |
| • Cognitive issues | • Positioning |
| • Functional activity tolerance | • Pain |



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Supportive Nursing Documentation

Grooming and/or Dressing

- Does the resident express desire to participate but cannot?
- Does it take more effort from nursing staff than in recent past?
- Are assistive devices used?
- Are gestures, verbal or visual cues used?



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Supportive Nursing Documentation

Oral Hygiene

- Is the resident performing activities in bed vs. at the sink?
- Are noticeable odors present even though resident performs oral hygiene?
- Are cues or gestures needed?



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Supportive Nursing Documentation

Bathing

- Does it take more nursing staff to perform?
- Does it take a long time?
- Does client clean themselves adequately?
- Does resident exhibit frustration?
- Are assistive devices used?
- Are gestures or cues needed?
- Are there safety concerns?



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Supportive Nursing Documentation

Toilet Hygiene

- Does the resident require extra assistance?
- Is there loss of balance?
- Can resident sequence steps to complete task?
- Is the resident as clean as he used to be?
- Are there safety concerns?



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Supportive Nursing Documentation

Feeding and Eating

- Are cues or gestures needed?
- How much food actually gets into the mouth?
- Coughing during or after meals?
- Is the vocal quality wet and gurgly?
- Can the resident sit up straight to eat?
- Is an altered diet consumed?
- Any pocketing?



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Supportive Nursing Documentation

Functional Communication

- Can a listener understand the resident's words? Gestures?
- Is there a change from normal communication?
- Are any devices used?
- Are wants and needs known?
- Can the resident follow directions?
- Is the resident oriented?



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Supportive Nursing Documentation

Bed Mobility/Transfers

- How much assistance to sit up in bed? Roll? Scoot?
- How much assistance for transfers?
- Is assistance more or less than usual?
- Is there loss of balance?
- Are there safety concerns?
- Any assistive devices used?



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Supportive Nursing Documentation

Functional Mobility

- How much assistance to walk to the bathroom?
- If you left the resident's side, would he fall?
- Any assistive devices needed?
- How far can the resident walk?
- Is this distance more or less than usual?
- Is assistance more or less than usual?
- Are there safety concerns?



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Supportive Nursing Documentation

Positioning

- Less comfortable than before?
- Leaning?
- Sliding?
- Falls?
- Safety concerns?



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Supportive Nursing Documentation

Range of Motion

- Joints tighter than usual?
- Range of motion less than normal?
- Do splints or positioning devices fit?



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Documentation Examples

- Dressed and bathed resident at bedside, no c/o
 - Resident requires limited assist w/ upper body dressing & bathing at bedside; requires extensive assist with lower body



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Documentation Examples

- Resident answers “no” to every question
 - Inconsistent responses with yes/no questions – answers “no” to every question. Difficulty making needs known.



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Documentation Examples

- Amb ad lib
 - Walks in corridors with RW, able to go to/from activities and dining room with cues only



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Successful Appeal Strategies



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What can you do to lessen the impact?

- Review denials
- Monitor state and federal auditor websites for targeted issues
- Follow up on repayments for successful appeals
- Improve documentation
- Have a system to track audits/appeals



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Communication is Key

- Need communication between business office and therapy manager about payer plans.
- Documentation workflows are triggered by the payer.
- Documentation requirements could fall short to the adjusted payer.



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Mistakes in Audit Management

- Not centralizing the audit management program
- Not understanding your auditors
- Not following up on key audit trends
- Failing to respond to denials timely
- Too many dabblers
- Not taking Ownership



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Successful Appeal Strategies: Identify

- Why?
- Remark and reason codes help explain the insurer's reasons for the denial
- Correct and resubmit the claim
 - Do not resubmit the original claim without any alterations



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Act

- Set a goal of creating and submitting appeals quickly
- Delaying your response just keeps that unpaid claim on your accounts receivable and raises your risks of missing the insurer's timely filing deadline



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Investigate

- An effective appeal is an argument backed by evidence
- Examine the insurance company's rationale for denial
- Make a list of the reasons that you disagree with the denial
- This may require detective work



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Respond

- Don't let your appeal get lost by submitting it to the wrong place or the wrong way
- Understand the insurer's processes
- Do not hesitate to take your case to a higher level if you are turned down



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Respond: Arguing the Merits

- Merit-based arguments
 - Medical necessity of the services provided
 - Appropriateness of the codes billed
- Use of past Medicare Appeals Council cases
 - http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_decisions.html
 - <http://www.hhs.gov/dab/macdecision/>



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Incorporate Evidence

- An effective appeal is accompanied by supportive references
- To refute a denial based on the necessity of a service ask clinician to write a short description of the specific benefit of the service to the patient



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Set a Reminder

- Set a reminder in your calendar to follow up in 30 days by calling the insurer
- If they claim not to have received your appeal, ask to speak to a supervisor and get his or her fax number so you can resubmit your appeal that day
- Document the details of all of your conversations



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Log It

- Keep a log of all denials you receive and the appeals you file
- For each denial, capture the amount in question, the reason for the denial, and the important dates associated with each situation
- Document the result
- Look for trends
- Rely on a management system to track and report this data



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What Have We Learned?

- Audits are costly and constantly changing
- State and federal audits are here to stay
- Denials and appeals impact our cash flow and profitability
- Reviewing data, education and documentation are key
- An audit management system is a necessity
- Be prepared!



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Thank You!

Neely Sullivan, MPT, CLT-LANA,
CDP
Education Specialist
Select Rehabilitation
nsullivan@selectrehab.com

