Compliance Efforts Lead to Process Improvements

by Shana Swope

After Medicare regulations and the accompanying paperwork threatened to overwhelm an outpatient rehabilitation center, staff took steps to simplify the recertification process. The result was improved efficiency plus increased commitment to the electronic medical record. Here's how they did it.

What happens when compliance issues meet head-on with operational procedures? At one outpatient rehabilitation center, Medicare regulations and surrounding paperwork were keeping patients from getting the therapy they needed. To address this problem, the center designed a collaborative, multidisciplinary process improvement project that has improved compliance, facilitated monitoring documentation, streamlined office procedures, reduced costs, and furthered the goal of an electronic medical record.

A Losing Battle with Paperwork

The rehabilitation center is part of a mid-sized, suburban, integrated delivery system with a 350+ bed acute care hospital and a full menu of outpatient services, including a department of the hospital that operates an outpatient rehabilitation center. Medicare regulations (42 CFR §424.11 and 42 CFR §424.24) require that the ordering physician recertify a patient's plan of outpatient therapy at 30-day intervals. The process used to comply with this regulation was tedious—lots of paperwork, many phone calls to physician offices, and canceled appointments because a recertification had not been received on time. In short, it was a recipe for compliance missteps, denied claims and reduced revenue, poor customer service, and physician and therapist frustration.

The decision to streamline the recertification process began when a patient account representative noticed that the scheduled recertification dates did not always match the actual physician's signature date logged onto the billing system. If the physician had not recertified subsequent treatment, the center could not bill for any therapies between the 30-day period and the eventual date of physician signature. The patient accounts department notified the outpatient rehab center office manager, who began to review the recertification process. Although the Health Care Financing Administration (HCFA) provides forms (HCFA-700 and HCFA-701) to use for outpatient rehabilitation plans of treatment and recertification, they are not required. Our facility used them to determine the data elements to include in the reports and certification forms.

To meet this requirement, the treating therapist electronically prepared a progress report with a suggested treatment plan and goals following the initial evaluation. Two to three weeks into the patient's treatment, the therapist prepared a progress report along with a recertification form. The report and form were then printed and mailed to each physician's office for signature with a request for return.

The due date was 30 days after the patient's initial evaluation visit, often only a week after the physician received the paperwork. Many times the therapist had to prepare a progress report after only a few therapy sessions so that the forms could be exchanged in time for the next 30-day period to be recertified. The amount of paperwork was staggering, especially because many patients require multiple disciplines of therapy, all requiring progress reports and physician recertification forms.

The office procedure for monitoring the status of recertification forms was even more tedious. An office clerk prepared a log from each therapist's outgoing reports listing the name of the physician, patient, therapist, and return due date. Returned recertification forms were then checked off against this log. The clerk had to call physician offices to check on the status of recertification forms not received. If there was an undue delay, the patient's appointments beyond the 30-day window had to be canceled and could not be rescheduled until the physician recertified the plan of treatment.

Room for Improvement

Results of an audit of the recertification process by the corporate compliance officer were discouraging: some physicians were prompt and cooperative, but some took weeks to sign and return the recertification forms. The scheduling process was a shambles, because patients usually scheduled their therapy sessions for regular time slots. When their sessions had to be canceled due to delayed receipt of recertification forms, they were unhappy about losing "their" time slot and often had to make alternate transportation arrangements. If a missing recertification was inadvertently overlooked, the billing for that therapy session usually ended up as a denied claim.

The rehab office manager and the compliance officer met several times to review the Medicare regulations and included the patient accounts department to ascertain the billing issues they were facing. In addition, the medical records manager was asked to evaluate the feasibility of moving from a paper-based system to an electronic system.

After reviewing the existing progress report and recertification formats, the documentation template programs were revised to meet the HCFA requirements and to prompt the therapists for needed data elements. It also standardized the format for the busy physician reading the progress report and recertification form. The use of template programs also reduced errors in transferring patient information to the reports, because it could simply be incorporated from the existing patient account information as it was prepared.

Adventures in Implementation

Most medical staff members already used a computer terminal connected to the hospital network to electronically sign physician documentation stored in the hospital medical record. The physicians have access from a number of locations in the hospital and at the rehab center, and many can access their patients' records from their offices or homes via the hospital's computer network. After enduring a few bumps on the road to implementation, we are now experiencing much improved compliance and timeliness and accuracy in billing. Further, any future projects will benefit from our implementation experiences.

One of the first complications was that the therapist's report became separated from the accompanying recertification form. The doctor would read the therapist's report on his or her computer, exit that menu, enter another, and search for the recertification form to "e-sign." If the doctor only had a few patients, this was manageable, but orthopedists with a large number of patients found the new process unwieldy.

The office manager suggested that each therapist review the procedure with the physician individually, and this was more successful. The doctors quickly learned how to match up the progress report and attached treatment plan with the proper recertification form. The medical record now stores all rehab center reports, including treatment progress notes in one area in date sequence, so normally the progress report is immediately followed by a draft of the recertification form.

Further, we decided to specifically identify the recertification reports on the physician's e-signature menu as "rehab center reports," so they could be easily distinguished from other forms in the queue, such as history and physicals, operative reports, and discharge summaries. This made the process even simpler for physicians, especially those whose patients had multiple disciplines of treatment. One "file" held all reports for those patients, and the doctors didn't have to search "PT," "OT," and "SP" for all the necessary forms.

We soon realized we had not made it clear that the recertification process only applied to Medicare patients. We were preparing recertification forms for all patients and monitoring the process as well. After a few weeks of making more work than necessary, we were able to limit the process to Medicare fee-for-service accounts. But this step was not eliminated until the rehab center reviewed its process for obtaining the necessary approvals and documentation from commercial insurers and managed care organizations—a process, fortunately, that was already working well.

Part of our intention in streamlining the recertification process was to put the responsibility of managing paperwork on the ordering physicians. We felt that we had simplified the process as much as possible and did not want to be in the uncomfortable position of telling a patient that his or her daily appointment was canceled because a physician had not completed the paperwork. But treating the patient was a compliance risk, because the billing would be unallowable without a properly dated recertification. Therapists strongly objected to turning away patients at the front desk because of a paperwork

error, and we didn't want to jeopardize good relationships with physicians by blaming them and irritating the patient in the process.

Ultimately, we felt that patients could best motivate physicians to sign the recertification forms. If a patient appeared for a scheduled therapy session and the recertification form had not been e-signed, we would call the physician's office while the patient waited briefly. If the physician was unable to e-sign the form immediately, we agreed to treat the patient at that visit, pending receipt of the e-signed recertification. We knew that we could not bill for that visit and used the occasion to notify both the physician and the patient that Medicare regulations require the paperwork requested and that we could not provide further therapy without complete forms. We believe that this process will keep the patient from becoming angry at being turned away unexpectedly. At the same time, patients are advised to check with their physician to verify that they have prepared the recertification.

Ongoing Progress

While the customer service and billing issues were being addressed, the medical records department was hard at work modifing the existing monitoring processes. Previously, physicians were subjected to loss of staff privileges if their records were not completed on a timely basis, but only a few of the various electronic records in this process were monitored. The medical records department wanted to pull all records into the process, because the chart is comprised of many records at least as important as the history and physical and discharge summary, but there was no easy way to monitor whether all documents requiring electronic signature had been completed.

The information services department designed a report that could be sorted in two ways—by physician or by type of report. The physician report identifies the physician and lists all outstanding reports by type, patient account number, and date transcribed. This is invaluable to the medical staff office and medical information management department in reviewing which physicians are delinquent in completing their records.

As of summer 2000, physicians' staff privileges are restricted when records are 30 days past due. This addition to the privileging process also has been extended to cover all types of medical records requiring physician signature, including home health and our skilled nursing facility. It should be noted that the 30-day limit is the outer limit—many types of records, such as verbal orders, require physician signature in a much shorter time frame.

The report specifically for the rehab center is helpful in monitoring the status of recertification reports. After generating the report, rehab center clerical staff can follow up on its status. They can quickly identify which calls need to be made first, based on scheduled therapy visits. The report can also identify each physician so that the staff can easily tell which one may need a refresher visit from a therapist.

This process is still being fine-tuned by staff on an ongoing basis, and a follow-up review is scheduled for this month. The initial success may lead to the implementation of a similar process on the skilled nursing facility floors so that therapists and physicians alike can benefit from the streamlined process. Because the organization has been committed to electronic medical records for quite some time, the process did not require major training and orientation efforts, nor did it require extensive commitments of time from the information services staff.

The entire process, from the discovery and evaluation of system gaps through testing and full implementation, took less than six months. It gave the compliance officer a valuable view of the operational side of patient care and made the therapists and rehab center staff more aware of Medicare requirements. The medical information management department and the medical staff have been able to use the new procedures as well, both to eliminate unnecessary and burdensome paperwork and to manage the electronic medical records and accompanying monitoring reports.

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