Letterhead

Date

Address to Send Documentation:
Sample: Prepay Review
Performant Recovery, INC
2815 southwest Blvd
San Angelo, TX 76904
Fax 925-373-5888

RE: *Recovery audit Pre Payment Review*
Resident Name
Medical Rec. No. / DCN:
HIC Number:
Claim Period:
Total Charges: $
(all above info comes from audit request form)

To Whom It May Concern:

The medical records for the above referenced claim period are enclosed for review. For your convenience, a summary of the medically necessary skilled services provided is as follows:

General Information, Hospital Transfer Summary, Physician Orders and Progress Notes: Pages G1-Gxxx
Physical, Occupational and Speech Therapy Services: Pages T1-Txxx
Nursing Assessments, Progress Notes, Care Plan Info: Pages N1-Nxxx
MDS Assessments: Pages MDS1-MDS xxx
*All pages are labeled in the bottom right corner. *(staff will need to organize all documentation in sections as designated above and number all pages in bottom right corner using G,P,N or M followed by page number for easy reference)*

Admission Information:
(Resident's name) was admitted to our facility on (date) following a ( ) day hospitalization stay for: *(list primary reasons for hospital stay from transfer summary; Sample: progressive weakness and confusion attributed to diagnosis of progression of Parkinson's Disease and dysautonomia with orthostatic hypotension.)* Co-morbidities complicating acute diagnoses above include: *(list any pre-existing conditions that contributed to illness and recovery, ie: severe OA, tremors, bradykinesia and dementia.)*

Please refer to the hospital transfer summary for hospital course specifics. (Page *G xx list page number*)
Main diagnoses for which skilled care was provided at our facility are listed here:
1- *Example: Gait dysfunction and movement disorder due to progression of Parkinson's Disease*

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2- *Example: Observation and assessment of the residents treatment regimen due to medication changes and changes with physical function*
3- *Example: Management and Evaluation of the residents care plan due to progression of Parkinson's Disease*

The physician signed the Certification for skilled nursing care and admission orders on (*date)(Page Gxxx)*

Prior Level of Function:
Prior to the hospital admission, this resident was living *(where? at home)* and functioning at an (*list level of function; Sample: independent level using a wheeled walker for mobility*. See Occupational Therapy Evaluation (Page Txxxxx) for prior level of function status.

Physical Therapy: *(If PT was not provided, indicate so and remove information below:*
Physical Therapy documentation: (Page T1-Txxxx)
Physical Therapy Evaluation ( ) : (Page T1-xxxx)
Evaluation identified _____ (*Sample: " a significant decline in functional status from the above prior level of independence recommending skilled services 5 days per week for a minimum of 35 minutes daily for 4 weeks.*) The physician signed the physical therapy plan of care on ( ).
Physical Therapy Progress Report on ( ) (Page Txxxx). *Comment if progress made.*
Sample:
Physical Therapy Progress Report 11/26/13: (Page T8-9) Report identified overall progress with goals, with new long term goal for stairs added. Continued need for skilled therapy services was indicated.
Physical Therapy Discharge Summary ( ) (Page Txxxx)
Sample:
Physical Therapy Discharge Summary 2/11/13 with noted achievement of all long term goals.(T10-12)

Daily Treatment Encounter Notes with Treatment Minutes detail the daily skilled therapy provided, adjustments to plan of care, as well as the response to treatment. (Pages Txxxx)

Repeat above format for OT and Speech if on program:

Skilled Nursing Intervention for Audit Period : (Page N1-xxxx)

This resident received skilled monitoring and nursing interventions for the conditions below during the above referenced claim period as follows: *(include page numbers for items; include any relevant nursing information to establish skilled services were being furnished)*
Sample:
**Debility: Inability to ambulate due to compression fracture, chronic back pain, multi-level degenerative changes in cervical spine and new onset of knee pain post fall.*
**Diabetes: Insulin dependent with blood sugars BID without coverage*
**Chronic Kidney Disease*
**Depression / Bi-Polar Disorder with flat affect and impaired communication*
**Malnutrition and elevated liver enzymes*

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MDS Assessments Completed:
5 day ARD *(date)* Score ( ) *ie:RVA* (Page MDS 1-xxx)
14 day ARD *(date)* Score ( ) *ie:RVA* (Page MDS xxxxxxx)
30 day ARD *(date)* Score ( ) *ie:RHA* (Page MDS xxxxxxx)

Thank you for your consideration of the above information. Supporting documentation for the above is enclosed.

Sincerely,

Administrator and/or Medicare Nurse or other designated representative

It is highly recommended to highlight the information in the medical record that corresponds to the citations in the cover letter so the reviewer can flip to the page and find the info quickly

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