

Improving Your Documentation : Know What Is Expected By Medicare

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Or What We Could Have Titled:

Documentation: Now More Than Ever, Your Reimbursement Depends On It

Objectives

- Participants will gain a better understanding of Medicare guidelines and expectations regarding documentation.
- Participants will learn ways to improve the quality of their documentation (including goal writing).
- Participants will learn about Medicare’s plans regarding auditing/accountability.

Is It Important To Improve Your Documentation Skills?

- Skill in documentation is the hallmark of a professional approach to therapy and is one of the characteristics that distinguishes a professional from a technician.
- Not only is the logic of clinical reasoning reflected in documentation, but documentation itself shapes the process of clinical reasoning.

Taken from Functional Outcomes: Documentation for Rehabilitation – Quinn and Gordon

Is It Important To Improve Your Documentation Skills?

- Therapists should take pride in their professional writing; it is the window through which they are judged by other professionals.
- In fact, it could be argued that documentation of services rendered is just as important as the actual rendering of the services.

Taken from Functional Outcomes: Documentation for Rehabilitation – Quinn and Gordon

“Medicare reimbursement relies on documentation as its primary (if not only) source of determining whether a claim is paid or denied. Thus therapists must be very diligent about their documentation to appropriately reflect the patient’s status.”

-- Functional Outcomes Documentation for Rehabilitation

We All Know The
General Therapy Rules from Medicare

- You must have a doctor's order to evaluate
- You must have a supporting therapy diagnosis
- Services must be "reasonable" and "necessary"
- Must expect functional gains
- Services must be "skilled"
- No duplication of therapy services

SO... WHY ARE WE HERE?

A New Day in Therapy Documentation

History

Quality Control/Accountability

The Dreaded...
Audits

Lately, they have been increasing in frequency and intensity

Let's discuss a couple of types...

- RAC (Recovery Audit Contractors)
- ZPICS (Zone Program Integrity Contractors)

What are R.A.C. Audits and how are they going to impact my **documentation** efforts?

RAC = RECOVERY AUDIT CONTRACTORS

They are a systematic and concurrent operating process for insuring compliance with Medicare's coverage criteria and CMS documentation & billing requirements.

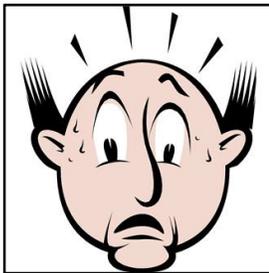
Which providers might be audited by RAC?

Health care providers that might be audited include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier that bills Medicare Parts A and B.

Are RAC audits designed to uncover and stop Medicare fraud?

The RAC audit program is more designed to address overpayments and curb perceived provider "abuse" of the program - not necessarily address enforcement issues around Medicare fraud. However, the RAC Statement of Work does require reporting of potential fraudulent activities to CMS / OIG for follow-up.

Therapists Auditing Therapists – Scary thought !



The array of audit tools available to CMS extends beyond RACs to the Medicare Administrative Contractors (MACs), the Medicaid Program Integrity Contractors (MPICs), and the Zone Program Integrity Contractors ("ZPICs"), which will replace the existing Program Safeguard Contractors ("PSCs").

ZPIC (Zone Program Integrity Program)

These are the fraud investigators.

ZPICs auditors are there to ensure the integrity of all Medicare-related claims for the providers in their assigned zones.

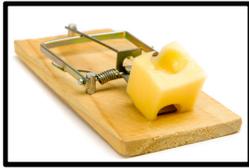
They work to identify, stop and prevent fraud and abuse. ZPICs are authorized to conduct audits, interview beneficiaries and providers, initiate administrative sanctions (including suspending payments, determining overpayments, and referring providers for exclusion from Medicare), and refer providers and beneficiaries to law enforcement.

The ZPICs are paid by CMS, but unlike the RACs, reimbursement to a ZPIC is not contingent upon any overpayment amounts recovered by the ZPIC.

So...

Now we know WHY we need to improve our documentation.

How would you rate YOUR documentation skills? Are you ready for that audit?



Many therapists fall into the trap of documenting like their peers at work.

Why don't we do what you've been taught to do?

You don't want to be a lazy documenter.
...and why are THEY lazy documenters?

Improving Documentation



- Responsibility
- Guidelines
- Skill
- Purpose
- Quality
- Accountability

Responsibility

You, as a therapist, have a professional responsibility to explain what has been done, what will be done, and why it was done in clear, unambiguous terms that will be understandable to all those authorized to read your note.

Taken from Functional Outcomes: Documentation for Rehabilitation - Quinn and Gordon

Purpose

To clearly justify the treatment you are implementing – in terms of the outcomes you will achieve.

Documentation is...

...a written record of therapeutic intervention with your client

...a legal document

...is a tool used by auditors to determine if guidelines were met

Documentation is...

Evidenc
e!q6UC

Guidelines

What is Reasonable and Necessary?

- **What is Reasonable?**
The services delivered to a beneficiary must be *considered under accepted standards of practice to be a specific and effective treatment for the patient's condition*. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. This means services provided must be within the scope of practice.
- **What is Reasonable Time?**
Simply...
Your documentation must verify functional progress over a reasonable period of time.

Medicare doesn't want to pay for 4 months of therapy only to find that the patient's only progress is that she can finally get her right arm into the sleeve of her shirt...
That's just not reasonable.

Medical Necessity

- **What is Necessary? (Why should they pay for a therapist to do this?)**
The services must be of such a *level of complexity and sophistication*, or the patient's condition must be such that the *services required can be safely and effectively performed only by or under the supervision of a qualified therapist*.

Criteria:

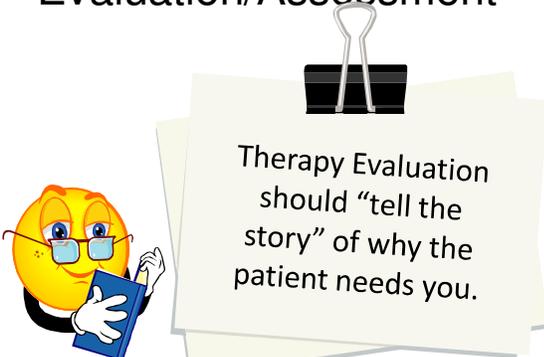
- When the treatment is designed to restore, improve, or compensate for lost or impaired functions, particularly those impacting activities of daily living, resulting from illness, injury, congenital defect, or surgery.
- When the treatment is expected to result in significant therapeutic improvement over a clearly defined period of time.
- When the treatment is individualized and there is documentation outlining quantifiable, attainable treatment goals.

Documenting Skill

Write like a therapist!!!!

Why are YOU there?
Let the reviewer know that, clearly, in every note.

Evaluation/Assessment



Therapy Evaluation should "tell the story" of why the patient needs you.

Evaluation/Assessment

Should be:

- Concise
- Complete
- Objective
- Legible
- Quantitative
- Timely

...and should include a clear plan

Evaluation/Assessment

- All spaces completed and legible
 - Diagnosis
 - Referring Physician
- Need for skilled intervention (why is therapy involved?)
 - Prior level of functioning
 - What deficits do you find?
 - Tell the patient's story
 - Establish the plan of care
- Establish objective and measurable goals with timeframes
 - Establish frequency (patient specific)
 - Physician's signature

Goal Writing – Remember This?

- Willard & Spackman's 'Occupational Therapy', 11th Edition (2008)

RUMBA Test: -

Relevant: functional goals and achievement
Understandable: legible and avoid jargon
Measurable: includes frequency and duration, how long it occurred or how many times
Behavioral: measurable occurrences
Achievable: reasonable

Goal Writing Guidelines

Goals Should Include:

- WHO
- WHAT
- UNDER WHAT CONDITIONS
- HOW WELL
- BY WHEN

WHO?

Remember to focus on the person receiving therapy! The "WHO" should be the patient.

If family members or caregivers are involved, the goals can refer to them or involve them, but they are not the focus of the goal.

And the goal is NOT to begin with "O.T. will..." (you are writing the goal for the patient, not the therapist)

Example: "Pt. will support enough of her weight in the standing pivot transfer from her wheelchair to her bedside commode so that her daughter can transfer her by herself using learned skills at mod. assist level by May 1."

WHAT?

"What" is the activity the patient will be performing if the goal is achieved. Your "What" should be observable and repeatable.

Side Note: It is generally the third word in your goal.

Example: "Patient will _____"

UNDER WHAT CONDITIONS?

This would be the conditions under which the patient's achievement of the goal is measured.

Example: "Pt. will retrieve her mail from her mailbox at mod. independent level, walking across her porch, down/up 4 steps, and across uneven grassy lawn (100 ft), using her single point cane to by discharge."

How Well?

Descriptions that provide details necessary to measure goal achievement. This is the criteria for performing the activity (ie., level of assistance required, quality of the task performance, consistency and/or efficiency).

Examples: "within 10 minutes", "with contact guard assistance at the trunk to maintain balance", "with only 1 rest break required",

BY WHEN?

This is your target time period. You are projecting that the patient will achieve his goal by THIS TIME.

Does it need to be a date on the calendar?

Progress Note

Simply Put >> This is to summarize your **intervention** process for that visit and document patient's progress towards his/her goals.

Essentials of Progress Notes

- Must match plan of care
- Must be informative
- Must describe the 'Treatment Encounter' (date of tx, each procedure or modality provided, reference to goal you were addressing, total time of tx, etc.)
- Must be signed by patient and therapist

If signed by someone other than the patient:

Jane Smith for John Doe

Essentials of Progress Notes

FORMAT

Most of our notes are loosely based on the SOAP note format.

"S"

NOTE: For Subjective Quote – Asking the right questions will help elicit a response from your patient that is not automatically forthcoming.

S
O
A
P

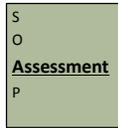
Essentials of Progress Notes

S
Objective
A
P

- Outline treatments that were performed, including patient education, equipment provided, etc.
- Indicate changes in patient's status or any observed changes during or after treatment.
- Report any communication with providers or family members.

Common pitfall: Not enough detail provided about specific interventions

Essentials of Progress Notes



- 'Assessment' - is the most important part of the note!
- It answers to "WHY" we are involved.
- Addresses how patient is progressing toward set goals.
- Increases and Decreases in measurements are shown.
- Modify goals or set new goals.
- And NOTE:

You Should NOT just say ...
 "PATIENT PROGRESSING WELL."
 Or "PATIENT IS IMPROVING"

Essentials of Progress Notes



PLAN – The final section of the note that outlines the plan. Any specific interventions for upcoming sessions should be documented, including any changes in the intervention strategy.

Avoid using just . . . "Continue established treatment plan".
 CONTINUE is not a plan!

Some people have gotten away with...

- S – No complaints
- O – ADL Training
- A – Tolerated Well
- P – Continue plan of care.

Am I right?

Reports of Specific Problems Relating to Therapy Documentation

- Poor Assessment (lacking prior level of functioning)
- Lack of goals that include functional measurements
- Poorly written orders
- Documentation that doesn't clearly indicate the reason for therapy (medical necessity/skill required)
- Notes that do not refer to specific goals
- Documentation that does not indicate

Work on Quality of Documentation

Examples

If you are saying...

"Applied hot packs"

(Why is this a skilled service?)

Maybe you could have said something more specific like...

"Moist heat to cervical spine to promote relaxation and improve cervical spine flexibility so that the patient can _____."



Work on Quality of Documentation

Examples

Gait: 100ft, RW, slow

(WHAT WAS THE THERAPIST DOING? WAS IT P.T.?)

Assisted ambulation with ADLS

(WHICH ADLS; WHAT KIND OF ASSIST?)

Improve ROM and strength.

(“IMPROVE” TO WHAT?...AND FOR WHAT?)

Pt. progressing towards goals.

(WHICH GOALS?...AND PROGRESSING HOW?)

Work on Quality of Documentation

**“Independent”
is a red flag word**



“Independent” with HEP was particularly looked at in recent audits. If you are still progressing the patient, don’t use “independent” quite yet. Consider...are they REALLY independent? Because independence implies ‘safely’, ‘effectively’, and ‘efficiently’. It’s not a one time thing.

And be careful even using mod independent. Auditors take it literally. State what you mean.

Work on Characteristics of Good Documentation

- **CONCISE** – Brief and to the point; length of narrative or volume of material is not necessarily indicative of quality of care rendered.
- **SPECIFIC** – Use adequate detail and descriptions; use adjectives and clear descriptions; include specific procedures, medications, teaching, etc.

Work on Characteristics of Good Documentation

- **COMPLETE** – Include all applicable observations, services, and responses; give yourself credit for all services performed to support coverage and for legal protection.
- **FOCUSED** – Concentrate on problems and purpose of care being rendered; it is important to clarify why the care is needed and that the care being provided is meeting those needs; avoid superfluous information which may lead the reviewer to conclude that the care is not necessary.

Work on Characteristics of Good Documentation

- **OBJECTIVE** – Information is in verifiable terms; evaluate compliance objectively and provide specific data to support care.
- **ACCURATE** – Information is valid and reflects the client’s condition and services provided.
- **CONSISTENT WITH ORDERS** – All orders implemented; all services covered by orders.

Work on Characteristics of Good Documentation

- **COORDINATED** – Various parts of the record are consistent; information from all disciplines is consistent; i.e. the nurse, therapist, aide notes reflect the same client status and limitations. Discrepancies raise questions of coverage and quality of assessments.
- **PROFESSIONAL** – Spelling, grammar, abbreviations, and terminology are appropriate.

Remember



- If it was NOT documented, how can you show that it was or was not done.
- Bad documentation can make good care look bad.
- One questionable entry in the record can harm the integrity of the entire record.
- The record is your only defense 2 to 5 years (or longer) down the road.

Documentation Exercises

Thank You!