


HOME HEALTH SECTION  
AMERICAN PHYSICAL THERAPY ASSOCIATION



APTA  
American Physical Therapy Association

## Documenting Skilled Need in Therapy Notes

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### Objectives

- Review Medicare regulations related to documentation of skilled need
- Identify how to select the best qualifiers for meaningful documentation
- Identify documentation examples for quality of documentation
- Identify how to use patient goals to guide skilled documentation
- Review how documentation effects reimbursement



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### Skilled Need: why's it so important?

- Best Practice
- Compliance:
  - State surveys
  - Conditions of Participation review
  - Other surveying bodies
- Reimbursement
  - ADRs
  - RAC audits
  - ZPIC audits
  - CERT audits
  - Face-to-Face review
- Litigation protection

**Therapy is where the \$\$ is, they are looking at us TOO!**



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### Skilled Need: I document that, right?

- We know that to meet eligibility criteria for Home Health (HH), pt must be/have:
  - Homebound Status
  - Intermittent Needs
  - Reasonable and Necessary needs
  - Under the care of eligible MD
  - SKILLED NEED



Medicare Benefit Policy Manual – Chapter 7: Home Health [www.cms.gov/regulationsandguidance](http://www.cms.gov/regulationsandguidance), accessed 1/20/14

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### Skilled Need: I document that, right?

- But once the pt is on service...
- Does our documentation continue to support skilled need for EVERY visit??
- Do you paint the whole picture every time?



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## Skilled Need: Is there a Guide?

**YES!!!**



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## Skilled Need: Regulations

- 7/40.2.1-e
- "As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes... As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.



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## Skilled Need: Regulations

- Therefore the home health clinical notes must document as appropriate:
  - the history and physical exam pertinent to the day's visit
    - including the response or changes in behavior to previously administered skilled services
  - the skilled services applied on the current visit
  - the patient/caregiver's immediate response to the skilled services provided
  - the plan for the next visit based on the rationale of prior results.



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### Skilled Need: Regulations

- “Clinical notes should be written such that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as “next steps” to be taken. Vague or subjective descriptions of the patient’s care should not be used.”*
- “For example terminology such as the following would **NOT ADEQUATELY** describe the need for skilled care:*
  - Patient tolerated treatment well
  - Caregiver instructed in medication management
  - Continue with POC”


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### Skilled Need: Regulations

- “Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.”*
- “When the skilled service is being provided to either maintain the patient’s condition or prevent or slow further deterioration, the clinical notes must also describe:*
  - A detailed rationale that explains the need for the skilled service in light of the patient’s overall medical condition and experiences,
  - the complexity of the service to be performed, and
  - any other pertinent characteristics of the beneficiary or home.”


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### What does this mean for me?

- Every visit – not JUST the admit/eval
  - Document on objective test/measures related to a functional patient goal
  - Document how the patient needed a therapist vs a family member/other caregiver
  - Document how the pt responded to my **SKILLED** teaching/training immediately and how that effects the pt’s functional outcomes
  - Document the plan for the next visit and/or the progress towards goal, therefore discharge.
  - **Avoid vague references that mean nothing!**


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Now you know the SECRET!



**The Guideline are right there for us!**

**You don't have to document MORE, you just have to document SMARTER!**

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Let's break it down!


- Therapeutic Exercise




- ROM





- Gait /Transfer Training



- Modalities



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PT Evaluation for THR

- PT admit: L THR
- Strength: R LE: 5/5; L HIP FLEX: 3/5; HIP ABD:NT; HIP ADD: 3/5; KNEE EXT: 4/5; ANKLE DF: 5/5
- Strength Goals: INCREASE STRENGTH TO L LE BY 1/3 GRADE BY DISCHARGE
- Treatment:
  - PATIENT HAS A WRITTEN HEP FROM HOSPITAL, MADE ADJUSTMENTS ON HEP FOR PATIENT;
  - SUPINE EXS QUAD AND GLUT SETS X 10; HEEL SLIDES, SAQ, IR/ER, PASSIVE HIP ABD AND ACTIVE HIP ADD, LAQ X 10 WITH L LE;
  - STANDING TOE RISES, MARCHING IN PLACE, HIP EXT AND HAMSTRING CURLS X 10 WHILE HOLDING ONTO WALKER FOR SUPPORT.
  - INSTRUCTED TO DO EXS 2X/DAILY;
  - CRYOTHERAPY TO L HIP X 20 MINS WHILE SUPINE WITH L LE ELEVATED TO HELP WITH SWELLING.

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### PT Evaluation for THR

- **Assessment:** "PATIENT TOLERATED RX WELL, RELIEVED THAT SHE DID NOT HAVE TO DO 30 REPS WITH EXS, STATES IT WAS REALLY HARD YESTERDAY WHEN SHE DID IT WITH HUSBAND YESTERDAY."
- **Plan:** "PLAN TO SEE PATIENT TIW INITIALLY FOR GAIT AND EXS; PROGRESS AS TOLERATED"



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### What are the Learning Opportunities?

- **Strength:**
  - MMT is objective testing,
  - *What about UE for proper use of A.D.?*
- **Goal:**
  - Is it SKILLED to do strengthening exercise just to increase strength?
    - **NO**
    - *How do you measure a 1/3 muscle grade?*
  - Where is the FUNCTIONAL component that makes this skilled?
    - *What are the pt's goal? Does that make this goal functional?*



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### What are the Learning Opportunities?

- **Treatment:**
  - Just listed exercise, could an aide/caregiver have done this treatment?
    - *Was there verbal or tactile cues for proper recruitment*
    - *Maybe pt able to do 10 reps of QS, GS, AP, but only 8 reps of HS due to compensation*
  - Cryotherapy – where was the skill?
    - *20 min unless you see s/s of ...*
  - Why did a PT license need to be in the home instead of an aide? Or the family just doing the HEP from the hospital?



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### What are the Learning Opportunities?

- Assessment:
  - Did it give you any valuable information?
    - **NO**
      - How did the pt respond to the cueing?
      - What are the pt's deficits
      - What does the pt need to be able to perform in home
  - ***This is why pt needs Skilled HHPT***



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### What are the Learning Opportunities?

- Plan:
  - Did it give you any valuable information?
    - TIW is good
    - “..for gait/exer. Progress as Tolerated” Does that tell us much?
  - **NO**
    - ***What are you going to gait train with?***
    - ***What type of exercise?***
    - ***What functional and patient goals are you going to work towards?***



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### So let's do a re-write

- **Strength:** R LE: 5/5; L HIP FLEX: 3/5; HIP ABD:NT; HIP ADD: 3/5; KNEE EXT: 4/5; ANKLE DF: 5/5; **BUE 4+/5**
- **Strength Goals:** INCREASE STRENGTH TO L LE to 4+/5 BY DISCHARGE **IN ORDER TO TRANSITION SAFELY TO AMB WITHOUT A.D. WHILE PROTECTING NEW PROSTHESIS**



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### So let's try Take-2

- Treatment: patient has a written HEP from hospital, made adjustments on hep for patient; supine exs quad and glut sets x 10; heel slides, saq, ir/er, **TACTILE CUES WITH QS/HS/SAQ FOR QUAD RECRUITMENT, ONLY ABLE TO REPRODUCE 50% OF TIME WITHOUT CUES**; passive hip abd and active hip add, laq x 10 with l le; standing toe rises, marching in place, hip ext and hamstring curls x 10 while holding onto walker for support; **MAX V.C. FOR PROPER TECHNIQUE AND NO COMPENSATION ON HIPEXT/HAM CURLS.** instructed to do exs 2x/daily; cryotherapy to l hip x 20 mins while supine with l le elevated to help with swelling; **PT INSTRUCTED TO DISCONTINUE ICE IF NOTES NON-BLANCHABLE REDNESS/BLISTERS**



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### So let's try Take-2

- Assessment: **PATIENT UNABLE TO TOLERATE MORE THAN 10 REPS OF THE EXER BEFORE BEGINS TO COMPENSATE; EVEN w/10 REPS, PT REQUIRED, VERBAL/TACTILE CUES FOR PROPER TECHNIQUE AND QUAD RECRUITMENT; UNABLE TO SUSTAIN RECRUITMENT WITHOUT CUEING; WILL BENEFIT FROM FURTHER SKILLED HHPT FOR THER EX TO WORK ON STRENGTH OF AFFECTED LE. (PLUS "XYZ")**



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### So let's try Take-2

- Plan: **PLAN TO SEE PATIENT TIW INITIALLY FOR GAIT AND EXS; WILL PROGRESS EXER PROGRAM, GAIT/TRANSFER TRAINING AS APPROPRIATE TO RETURN PT TO PRIOR LEVEL OF FUNCTION OF (I) WITH ALL TRANSFERS AND WALKING WITHOUT USING A.D. ON EVEN/UNEVEN SURFACE AND 8 STEPS TO ENTER/EXIT HOME.**



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## How do you start?

**Now you have the rules and some examples..**

**Where should you start?**



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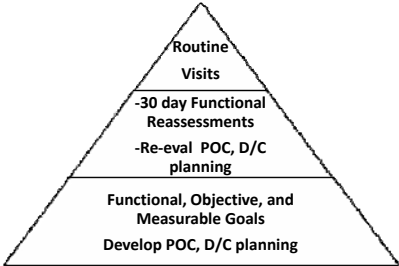
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## How do you start?



**Just like anything else – Start with a good foundation!**

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## How to write solid goals?

- When writing goals, remember to be objective and measurable but above all, be **FUNCTIONAL**
- Be **CLEAR** about what we are trying to accomplish
- Document towards a goal(s) on **EACH ROUTINE VISIT**, not just eval and re-assessments



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### Let's Try a Few Examples!

- Pt to walk again.
- Pt able to amb safely household distances
- *Pt to amb 1000' safely and independently with 4WW to enable them to safely go to meals and activities in facility.*




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### Let's Try a few Examples?

- Pt to increase R knee ROM by 10 degrees
- Pt to have 90 degrees AROM R knee by discharge.
- *Pt to achieve 105 degrees AROM in 3 weeks to tolerate car transfer in low car for MD appointment and 120 degrees by 6 weeks per MD protocol of maximum ROM.*




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### One More...

- Pt to have a home program
- Pt to be (I) with HP by discharge
- *Pt able to teach back use of ice/AP/elevation to combat pain/edema/DVT in 2 visits.*
- *Pt to demo (I) with R TKR supine exer program in 2 visits, seated program in 4 visits and standing program in 6 visits.*




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### Documenting Progress in Daily Notes

- Document progress toward goals in objective terms/measurements
  - Evidence based when possible
- AND, what does that mean functionally for pt?
  - “Pt can now perform bed mobility independently since quad/abd strength is increased”
  - “Pt can now tolerate sitting for 10-15 minutes with VSS for sponge bath performed by CG”
  - “Pt able to amb 65’ on level ground, with SPC and SBA, half the distance to the mailbox, before circumduction compensation begins.”



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### Documenting Progress in Daily Notes

- Examples:
  - Pt with COPD
  - PT who has had a stroke
  - Any others you are having difficulty with?
- It starts with you GOALS!!!



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### Uh...Oh... I can't put “Not met”

- What happens if we don't meet our goals?
  - **NOTHING!**
  - The world does not come to an end
- Another Documentation Challenge:
  - What if not meeting goals?
  - Can you justify continued therapy?



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## Documenting Lack of Progress

- What should you do?
  - First, make sure your goals are appropriate:
    - Set goals that are functional
    - Goal should be reasonable for condition
    - Goals should be patient-based and patient-centered.
    - Goals should be referred to often in daily documentation



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## Documenting Lack of Progress

- Document why goals not being met?
  - Medical conditions impacting patient progress—development of UTI or other illnesses
  - Social factors impeding progress—this is explainable but not if it isn't documented!
  - Perhaps pt. isn't responding as you had hoped/predicted.
    - It's ok to state this, but you have to show change in POC
    - Change of focus/approach with treatment
    - Change of clinician, if indicated



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## Pt is progressing well ...but needs more!

- When might this be?
  - **Anytime!!!**
- Okay to modify goals/advance them— **just make sure it is documented!**
- Focus on quality of their movement/mobility
  - Perhaps they can walk with the cane in their home but it is **unsafe to do so on their own**
  - Maybe they can do the TUG in less than 14 seconds but are **impulsive**



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### Pt is progressing..but needs more!

- Focus on areas of concern or part of the goal NOT being achieved
  - “Although pt has met goal of independent ambulation in the home, ***the patient continues to have dyspnea that is limiting functional activity tolerance and increasing risk of falls***”
  - “Patient is now pain free ***but quality of gait is poor and patient is a fall risk due to this. With continued focus on heel strike and gait pattern, the patient should reach the point where he is safe in his own home with device.***”



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### Review: Why is this discussion important?

- **Best practice:** for setting up your treatment for quality patient care ✓
- **Compliance:** with Federal/State rules/regs ✓
- **Reimbursement:** is based on your documentation. 💰
  - If it is not documented, it didn't happen!
- **Litigation:** may have to defend your care in court; will you remember 7 years from now? ✓



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### Why is this important? = \$\$

- Medical Review Process
  - ADR (Additional Documentation Request)
  - Step 1: Redetermination
  - Step 2: Reconsideration
  - Step 3: Hearing with the ALJ (Administrative Law Judge)
  - Step 4: Hearing with the Medicare Appeals Council
  - Step 5: Judicial Review



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### Medical Review Process

- If the ADR = denial, then agency can start the appeals process
- First 2 appeals are in writing
- To assist the appeal your documentation should:
  - Defend as you go – **do all that we have covered**
  - Show problem solving and individualization
  - Show change in POC as needed



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### Medical Review Process

- Written Appeals:
  - Focus only on the **REASON** provided in the letter
  - **BE SPECIFIC** about how your documentation refutes the reasons given for denial
  - Provide supporting documentation that is labeled and well referenced in you letter



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### Medical Review Process

- Common reasons for denial:
  - **Lack of Medical Necessity**: Why did this pt need your services
  - **Lack of skilled care provided**: Why was you skilled license required instead of the family/cg.
  - **Face-to-Face**: Technicality—also other technicalities—orders, consents are some examples
  - **Homebound status**: not supported



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### Medical Review Process

- If it gets to Step 4: ALJ
- Again, focus on the denial reasons
- Be prepared to defend:
  - Required skills of a therapists
  - Care reasonable for condition
  - Each visit was necessary
  - What was the functional goal?
- This could be >1 yr later




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### Medical Review Process

- If your documentation is too weak... your agency shouldn't appeal!
  - If medical necessity is not clear
  - If skilled need is not clear stated
  - If homebound is not supported
  - If visit frequency is out of compliance
  - If supervisory visits are out of compliance




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### FINAL REVIEW: WHY is skilled documentation important?

- Best practice** ✓
- Compliance** ✓
- Reimbursement** ✓
- Litigation** ✓




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### How do we accomplish quality documentation of skilled need?

- Solid foundation of goals that are:
  - OBJECTIVE
  - MEASURABLE
  - FUNCTIONAL
- Avoid vague verbiage that means **NOTHING**
- **Take credit for what you did and for the license that you have!!**


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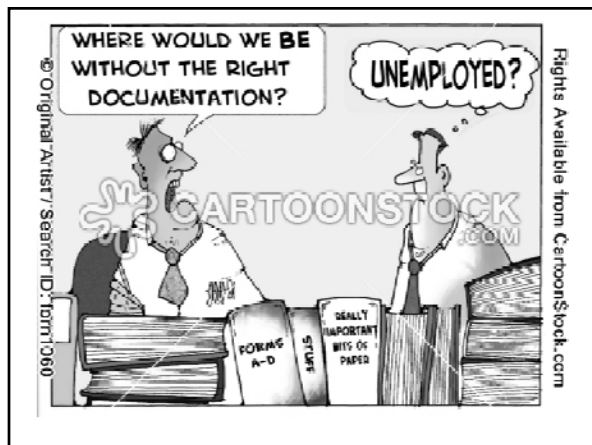
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### Questions?




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## References

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The Home Health Section:

- Keeps members informed of vital issues
- Shares current clinical and administrative knowledge and skills pertaining to home health
- Encourages research and development
- Monitors & actively participates in legislation related to HH documentation and reimbursement
- Acts as a liaison between Section members and the APTA
- Acts as a resource to other health care organizations

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