



Documentation – Effective Goal Writing: How To's



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Are you a patient **ADVOCATE**?

“One who pleads the cause of another”



LCDs / MACs / FI.... HELP....what do these mean?

FI – Fiscal Intermediaries
MAC – Medicare Administrative Contractors
LCD – Local Coverage Determinations

A/B MACs will be expected to consolidate LCDs in a jurisdiction and educate providers.

RAC.... What is this??? Recovery Audit Contractors

- o Began with a Demo Project in CA, FL, NY and expanded to AZ, MA, SC
- o RACs found over \$1B in “overpayments”
- o Still <1% of reviewed claims and only 2% from SNFs
- o 2009....RACs went “national” and there are 4 RAC contractors

What do RACs do?

- o Review claims on POST PAYMENT basis
- o Use the same policies as FI/MACs
- o Can't review claims prior to 10/1/07
- o Must employ nurses, therapists, coders and a physician

The MDS is changing

MDS 3.0

- o CMS plans to implement in a budget neutral way
- o Plans to adjust computation of ADLs to mke it more sensitive to differences in functional levels
- o Section T of MDS will be eliminated
- o OMRAs will be completed 1-3 days after discharge from therapy

And the RUGs are changing too...

RUGs IV


- o New system is based on 66 RUG categories
- o Will modify the hospital "look-back"
- o CMS will be updating the nursing and therapy case-mix weights
- o Changes in the way we code therapy minutes on the MDS

Does this effect how we document?

TRANSMITTAL 63 (12/29/06)

- o "Documentation required to indicate measurable beneficiary physical functioning"
- o Asks for "functional assessment scores"


OBRA SUMMARIES:
483.45 PROVIDE REHAB SERV.



PASSED IN 1987 TO IMPROVE THE QOL IN NURSING HOMES TO ENSURE EACH RESIDENT RECEIVED THE HIGHEST QUALITY OF CARE WHILE NOT IMPOSING A SAFETY RISK TO SELF OR OTHERS.

- o THAT A FACILITY MUST PROVIDE OR OBTAIN **REHABILITATION SERVICES** FOR EVERY RESIDENT IT ADMITS, IF THE COMPREHENSIVE RESIDENT **ASSESSMENT** AND **POC** IDENTIFY A NEED/ POTENTIAL IMPROVEMENT IN LOF WITH REHABILITATION INTERVENTION.

LEGAL COMMITMENT to our THERAPY RENDERED.....




<u>Fox vs. Bowen (1987):</u>	<u>Transmittal #262 (1988):</u>
<ul style="list-style-type: none"> o SNF's sued intermediary on behalf of their beneficiaries. o Intermediary was denying claims based on arbitrary rules of thumb. 	<ul style="list-style-type: none"> o Revised and expanded guidelines to present more clearly the requirements of Medicare coverage. o Is a more detailed explanation of 3 requirements (eligibility) that MUST be met: ordered by a Md.; 'skilled' service, daily basis, 'reasonable and necessary'.

i.e.: no dementia; no greater than 50 ft.

Transmittal 262


It is what opened the box for us...to treat pts to their highest practicable level....



And we need to fight to keep outside the box!

Documentation is all about YOU!

- o What did **YOU DO?**
- o What did **YOU** / will **YOU ANALYZE?**
- o What will **YOU ADJUST** in the next session?
- o Why are **YOUR** skills needed rather than the CNA?



What must your documentation do?

PROVE

- o Medical Necessity
 - Evaluations essentially PROVE medical necessity...if you can't prove WHY on the eval... it's a NO GO.
- o Skilled Services
 - If payer isn't convinced that only YOU can provide this service, why do they need YOU?

WHY YOU ???

Thinking Outside the Box



I could be treating other patients...



How do you help someone get someone to get out of the box...
WHEN they don't know they are in the box?

WIIFM

- o From PATIENT perspective
- o From CAREGIVER perspective
- o From THERAPIST perspective



Qualities of a *GOOD* therapist

Describe a therapist....



Qualities of *GOOD* documentation


Describe documentation



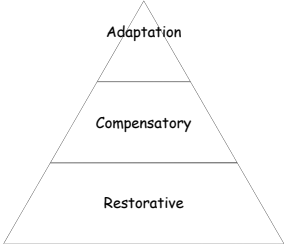
Consider the PATIENT'S GOAL

- Expectations from therapy
- Prior level of function and interests
- Co-morbidities
- Discharge environment/ expectations
- How about the caregiver's goals?

These need to be incorporated into the treatment plan




Thinking outside the box ... to our therapeutic approaches




Bag of tricks

- Test and measures
 - Evidence based
- Therapeutic use of self
- Medically necessary treatment plan
- Therapy interventions
 - Individual vs group treatment
 - Alternative approaches (ie: Vital Stim)
 - Caregiver/patient educatio



What is "defensive documentation"

- History and chart review
- Systems review
- Tests and measures
- Comprehensive evaluation
- Diagnosis
- Prognosis
- Plan of Care



GENERAL THINGS TO THINK ABOUT WHEN TREATING *and then* DOCUMENTING...


- Use objective data like percentages
- Describe level of functioning
- Speed of response/response latency
- Appropriateness of response
- Describe successive approximations
- Number of episodes/occurrences
- Physiological variations in the activity
- What happened when you did what you did with the patient?
- Why is that change significant from a functional point of view?
- Knowing that change occurred, what will you do now?
- What would you do more of?
- What would you do less of?
- What would you do differently?

Statements/terms to avoid

- "Patient tolerated treatment well"
- "Continue per plan of care"
- "As above"
- "Good" or "well"
- "Tolerating puree diet"
- "Cognition interferes with therapy"

Medical and skilled necessity....


OK- you have those credentials – prove your stuff!



If you can't write these....
You can't play in the game

Let's look at "Medical Necessity"

Patient had a CVA.....



SO WHAT?

- ❖ Is every CVA the same?
- ❖ What are we doing for the patient?

Medical Diagnosis doesn't mean anything without the **SO WHAT?**

Medical Necessity



RULES:

- o Be specific
- o Level & complexity to require skills of a therapist
- o Expectation of improvement
- o Be delivered in a time frame that is reasonable

What changed and WHY?


Our therapy documentation must...

Color your picture with details and colors, not fluff and fillers that offer no content... doesn't paint the picture


Example #1
Speech - Medical Necessity.....

Patient's speech is unintelligible;
He continues to need therapy services




Better example.....

Pt has dysarthria, continues to have unintelligible speech production and unable to consistently make needs known. Intelligible at single word level has improved to 30%. He responds to SLP cues to use slow rate of speech and limiting responses to 1-2 words. Listener has better understanding if pt points to 1st letter of word first.




Ex # 2
Swallowing- medical necessity

Progress is slowed due to patient's poor recall during meals.



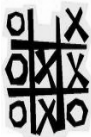
Better example

Patient was successful 6 of 10x in using a cue card for safe swallowing technique. If cue card is not used, her success rate drops to 40%. Pt's attention is enhanced by environmental cues during mealtime, allowing her to consume 50% of meal without redirection.



Let's look at "Skilled Services"

The strategy of what we do...
 What are we doing with the
SO WHAT?
 We strategize and
 plan our attack....



Skilled Services


RULES:

- o Therapist has the specialized knowledge and training necessary to treat patient
- o Assess
- o Analyze
- o Rehab, compensate or adapt
- o Educate

Our documentation must support our skills!


Example #1
Swallowing- Skilled Services:

Advance plan of care to thin liquids.



Better example....


Through instruction and oral motor exercises, the patient has improved oral bolus control with oral motor strengthening to decrease premature swallow and subsequent penetration. Coughing has decreased to < 2x/ 4oz drink. Liquid consistency is advanced from nectar to thin.



Example #2
SLP Cognitive pt

"Weekly summary"

Confusion throughout, often losing train of thought. Unsure of why she is here. Significant memory deficit. Pt should continue in skilled ST.




Better documentation

- o Focus of therapy has been to establish compensatory strategies to assist with safe return to ALF. Pt able to recall (via spaced retrieval cue) to use pill box to take meds per schedule. Pt is now using the wall calendar with < 1 cue to per day to recall daily and upcoming appointments. Pt performs best in tx using visual cues, especially when distracted. Met with family to educate....

Group Therapy

Why are we putting a pt in a group?
What is the desired outcome?



We need to reflect the medical necessity and skilled services that were provided in the group

Group Therapy


- o Patient participated in a "Safety Bingo Group"
- o Patient participated in a Safety Bingo Group that addressed problem solving and safety awareness, improved ability to generate solutions for safety in the home.

*Do we really need to talk about **GOALS** ?*

- o Goals are the basis of our plan of attack...attacking the deficits.
- o **STG** are the stepping stones to **LTG** and discharge from therapy...
What does the patient need to do to achieve the long terms goals?
- o **UNIQUE to the specific patient!**

GOALS: Painting a mental picture

- Who?
- What?
- Quality of Action
- Under what circumstances
- By when



Thinking Outside the Box

MUST CHANGE OUR MINDSET....

Why should YOU be involved?
What did YOU do?
Did YOU analyze & adjust?
Did YOU say that?



Ways to improve documentation

- o Peer review
- o Continuing education
- o Cue cards / checklists
- o Brainstorming as a TEAM
- o Never ending process...



Pulling it together

Tools of good documentation

- Therapist qualities
- Qualities of good documentation
- Consider different perspectives
- Words to avoid
- Carryover effect
- Medical Necessity
- Skilled services



End with Success!

Barriers without solutions are just excuses

Survival... document like our JOBS depend on it

