Codify
BY AAPC

Eli's Rehab Report

Practice Pointers: Take Your Documentation to the Next Level, Part 2: Follow-Up Visits

If you're not meeting these key standards, your reimbursement could be on the chopping block.

In Part 1 of this article, you learned ways to strengthen your initial evaluation. Now, it's time to find out how you can pack a punch with your existing patient treatment notes.

Strengthen Your Language

Denials are usually dealt because the documentation missed key points not because the therapist didn't do his or her job. However, you don't have to write a book; what you say is more important than how much you say.

Here are a few weaknesses experts repeatedly notice in therapy documentation:

- **Leaving out your professional lingo.** "Simple changes in language make a world of a difference," says **Pauline Franko, PT, CEEAA,** president and owner of **Encompass Consulting & Education** in Tamarac, FL. She encourages using skilled therapy words often to describe what you did.
- **Example:** "Using [insert specific technique], patient was educated in [insert specific task]. Patient performed return demonstration with __% of accuracy for 2/5 reps. Treatment was modified, patient demonstrating significant improvement in pain level: now 4/10 from 7/10 in 3 treatments."
- **Being too vague.** An example of an inadequate vs. adequate note, according to Franko, might be, "patient was given transfer training," versus, "instructed patient in transfer training through forward scooting in chair utilizing alternating hip hiking and contralateral weight shift." Another example: "Patient performed balance training activities," versus, "Instructed and trained patient in stepping strategies to self-correct balance."
- **Relying too much on CPT® codes.** Don't let a CPT® code describe what you did; instead, describe your skilled services to support the codes, Franko says. Her example is therapeutic exercise (97110). This code encompasses a lot of different techniques, so just naming the code isn't enough. You'd be better off saying something like, "guided progressive resisted exercises to (L) quads with emphasis on vastus medialis," she says.

Track Measurable Changes Like a Pro

Payers are quick to scrutinize your claims when a patient has slow progress or your therapy has a longer timeframe than usual. So, be one step ahead with ways to justify your decisions in these cases. Franko suggests addressing questions such as,

- If the patient is not showing reasonable improvement, what parts of the treatment are you changing?
- Is the patient's level of improvement appropriate based on other identified co-morbidities and complexities?
- Are you having the same length of time for achieving the patient goals, or are you customizing the plan to each patient?

"Repetitive, canned notes are not convincing evidence that treatment choices were individual to the patient," says **Donna Thiel, JD,** partner with **King & Spaulding** in Washington, D.C.

Good idea: "Document progress relative to the prior note," Thiel says. For example,

Today we continued work to restore function following hip replacement (3/15). With patient having made substantial progress on distances walked, today we focused on improving balance,as well as reinforcing progress to date on ambulation.

"The note should reflect measurable, objective changes in performance on the short-term goals addressed during the session," says **Nancy Swigert, MA, CCC/SLP, BRS-S,** ASHA Fellow and director of respiratory care and speech-language pathology for **Central Baptist Hospital** in Lexington, KY. For example, "last session the patient could only name 50 percent of common foods when maximum cues were used. Today, the patient's accuracy was at 70 percent with moderate cues."

Noting other pieces of the puzzle can help justify your case when progress is slow. You want to paint a picture of the whole situation. "Discuss any new medications, treatments, or services that are provided and then document the patient's reaction to the new therapy," Thiel says. For example:

Post CVA (in March 2015), Mr. Ford was unable to walk. In the first eight weeks he regained ambulation through gait and strength training so can now walk, with cane 100 feet, but continues to struggle with getting in and out of a car due to loss of function in his left arm and contractures in right hand. Fitting his hand with a splint today has enabled him to grip the car door and secure his safety belt.

Good to know: Often when a payer can shoot holes through your documentation it's because there already are holes in the record. Figure out what those blank spots are and connect the dots. "The entire patient record should reflect factors that justify the treatment continuously," Thiel says. However, "requests for medical records often do not include all dates of service, so critical points in a course of therapy might not be in the notes requested.

"For example, records of prior trauma or chronic conditions might not be in the DOS record requested in ADRs. For that reason, it may be helpful to harken back to the initial assessment/diagnosis in progress notes," Thiel suggests.

Don't Sell Yourself Short

Acknowledge the teaching skills that only you can provide, not just the actual time performing the hands-on part, Franko says, using ultrasound as an example. Instead of just saying you applied ultrasound, you could say:

I obtained information on how the patient felt after the last treatment and how long that improvement was maintained, observed the actual treatment area as a safety precaution and determined what treatment will be provided that day, i.e. increasing time, intensity, etc.

In other words: "In addition to documenting objective, measurable changes using percent correct, level and amount of cueing needed, and improved performance over previous session, the clinician's progress note should reflect that the therapist's skill was needed for the patient to achieve that level of performance," Swigert says, offering the following phrases as ways of demonstrating skilled therapy:

- Based on analysis of performance, therapist made adjustments to tasks during the session.
- As a result of analysis of performance and adjustments made, patient's performance improved.
- Feedback and cues were provided by the therapist on a consistent/inconsistent basis on some/all tasks and resulted in improved performance.
- Patient required minimum/moderate/maximum verbal/visual cueing by the therapist throughout the session.

Example: "Last session, accuracy on naming was 50 percent with maximum cues. Based on analysis of that performance, the therapist adjusted the task by using objects instead of line drawings and consistently provided gestural cues, and, as a result of these adjustments, the patient's performance improved to 75 percent."

Editor's note: For more information on the documentation requirements, especially in light of the imminent ICD-10 transition, please see "Take Your Documentation to the Next Level, Part 1: The Initial Evaluation" in Eli's Rehab Report, vol. 22, no. 7.