Gary Mertz, M.S., CCC-SLP, RAC-CT

Introduction

Many are familiar with the mantra, "If it isn't written, it didn't happen." Documentation of services is critical for ensuring continuity of care and reimbursement of services rendered. An often-quoted statement reminds us that, "Excellent record keeping does not guarantee good care, but poor record keeping poses an obstacle to clinical excellence" (Kibbee & Lilly, 1989, p. 16).

Maintaining and securing documentation are largely guided by state requirement as well as by the accrediting agency of the facility. The Medical Records department of a facility should be able to provide specific guidance about procedures and requirements. In general, however, documentation must be maintained as part of the patient's medical record and must be available to auditing bodies upon request. This article will highlight best practice in documentation and also current regulatory guidelines for documentation.

Best Practice

The American Speech-Language-Hearing Association Code of Ethics, to which all speech-language pathologists (SLPs) are bound, is critical to know. Principle of Ethics I, Sections F and K are pertinent to the discussion of documentation.

Principles of Ethics I, Section F specifies:

> *Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted. (American Speech-Language-Hearing Association, 2003b)*

This principle suggests that services rendered should be documented as part of the patient's medical record, as part of the evaluation/plan of treatment, or as a separate document, which is subsequently signed by the patient's responsible party.

Principles of Ethics I, Section K, further specifies:

> *Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed and shall allow access to these records only when authorized or when required by law. (American Speech-Language-Hearing Association, 2003b)*

This principle also suggests that services rendered should be documented as part of the patient's medical record. Documentation is considered best practice by the American Speech-Language-Hearing Association.

Regulatory Guidelines

Since different areas of the country are reviewed by different fiscal intermediaries (FIs), Medicare audit contractors (MACs), and recovery audit contractors (RACs), and states have different requirements based on licensure law, it is important to be familiar with specific guidelines issued by those regulatory bodies. However, among these agencies there are general guidelines to follow.

General Guidelines

The following general guidelines should be applied no matter the regulatory agency:

- Each form of documentation should include the facility name, the patient's name, and the medical record number. Room number is also helpful, particularly in instances when multiple speech-language pathologists (SLPs) are treating the same patient.

- It is critical to sign and date each item of documentation. A signature should always include your professional credentials and possibly your license number depending on state requirements.

- All documentation must be legible.

Remain objective in your documentation. Avoid using subjective statements; rather, ensure statements represent professionalism and objective information. Elaborate on your statements

when needed. The following are examples of subjective versus objective statements.

Subjective: "I think the patient will not benefit from treatment."
Objective: "Based upon objective findings of the evaluation, the resident is not a candidate for treatment."

Subjective: "It looked like the patient was frustrated."
Objective: "The resident presented with a reaction of frustration as evidenced by facial grimacing and rapid shaking of the head."

Subjective: "Jan told me that I shouldn't see the patient because he's worse today."
Objective: "Nursing recommended this SLP withhold treatment this date due to a decline in the patient's medical status."

Specific Guidelines

The *Centers for Medicare Services Manual Transmittal 88* (2008) has provided the most recent guidelines for documentation requirements and so the Medicare requirements will be discussed in this article. Each Medicare patient identified for treatment services must receive an evaluation. The actual format used for the evaluation is left to the provider's discretion; however, an outline of specific content that must be included in a treatment plan that is written as a result of the evaluation is provided by Medicare.

Plan of Treatment

According to the Centers for Medicare Services (CMS) guidelines, a Plan of Treatment (also referred to as a Plan of Care) must be established by the SLP who completed the evaluation. Note that an SLP can provide services under two separate Plans of Treatment. For example, one plan might cover dysphagia intervention while a second plan might cover communication/cognition intervention. Having two distinct plans for treatment is not a requirement, however, and the provider determines whether one or two Plans of Treatment are written to plan for services rendered. Although providing services under two Plans of Treatment may necessitate additional paperwork, it can be an easier method for tracking services distinctly.

Required Elements

A Plan of Treatment must minimally include the following three elements: 1) a diagnosis; 2) long-

term treatment goals; and 3) type, amount, frequency, and duration of services.

1. **Diagnosis**A medical diagnosis and a treatment diagnosis must be included in the Plan of Treatment and must be relevant to the current episode of treatment. All diagnoses must correspond to the International Classification of Diseases code (ICD-9; World Health Organization, 2009). The ICD-9 is the international standard diagnostic classification system for health management and clinic use and is used to classify diseases and other health problems recorded on many types of health and vital records. Every agency should have a list of relevant ICD-9 codes available for review. The medical diagnosis used should be the cause of the treatment diagnosis or, conversely, the treatment diagnosis should be the result of the medical diagnosis. Examples of relevant medical diagnoses might be cerebral vascular accident (CVA) or Parkinson's disease and examples of treatment diagnoses might be dysphagia or symbolic dysfunction; in these examples, the CVA caused the dysphagia and the Parkinson's disease caused the symbolic function.

   Including prior level of function is also important information as it relates to treatment diagnosis. Although not required, Medicare recommends that the results of at least one of the following be included:

   - **ASHA NOMS Functional Communication Measures (FCM)**FCMs are based on the Adult National Outcomes Measurement System (NOMS) of the American Speech-Language-Hearing Association (2003a). FCMs are seven-point rating scales designed to describe the change in an individual's functional communication and/or swallowing ability over time. Based on an individual's treatment plan, FCMs are chosen and scored by a certified speech-language pathologist on admission and again at discharge to depict the amount of change in communication and/or swallowing abilities after speech and language intervention. By examining the scores from admission and discharge, clinicians can assess the amount of change and consequently the benefits of treatment. Further information may be acquired from: www.asha.org/members/research/NOMS/

   - **Patient Inquiry by Focus on Therapeutic Outcomes (FOTO?)**FOTO (2009) offers outcomes data collection services for orthopedic, industrial, pain management, neurologic, speech, cardiopulmonary, wound, and pediatric services. Further information can be acquired from: www.fotoinc.com

   - **Activity Measure-Post Acute Care** (AM-PAC)AM-PAC (CreCare, 2009) is a state-of-the-art outcome instrument that measures function in three domains: basic mobility, daily activities, and applied cognitive. AM-PAC can be used for quality improvement, outcomes monitoring, and research activities in inpatient and

outpatient rehabilitation, home care, nursing homes, and long-term acute care settings. AM-PAC is appropriate for functional assessment in adults with a wide range of diagnoses and functional abilities. Further information can be acquired from: **www.crecare.com**

- **Outpatient Physical Therapy Improvement in Movement Assessment Log** (OPTIMAL)OPTIMAL (American Physical Therapy Association, 2009) is an instrument that measures difficulty and self-confidence in performing 21 movements that a patient/client needs to accomplish in order to do various functional activities. Further information can be acquired from: **www.apta.org/AM/Template.cfm?Section=Research&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=36879**

When these measurement systems are not used, Medicare recommends that one of the following be included:

- Individual item and summary scores of functional assessment (and comparisons to prior assessment scores) from commercially available treatment outcomes instruments other than those listed above; or

- Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or

- Other measurable progress towards identified goals for functioning in the home environment at the conclusion of treatment.

It is important that the above information be included in Plans of Treatment to protect claims from denials of coverage.

2. **Long-Term Treatment Goals**Per Medicare regulation, long-term goals should be specified for the certification period covered by the Plan of Treatment document. Goals should be measurable via objective means.

   A goal written simply as *"Increase swallow function"* does not allow an auditor or fellow SLP to determine the end target for the goal nor does it allow for measurement. A measurable goal might read, *"Within 4 weeks, the patient will independently consume at least 75% of a soft diet of nectar liquid consistency without signs or symptoms of penetration or aspiration."* In this example, the end target is stated and the goal is measurable.

Although not a Medicare requirement, patient-initiated goals (e.g., "I want to be able to eat regular foods again") might be considered and included if appropriate. If the patient is unable to voice a goal, the family, nursing staff, social services, etc. could be consulted to determine other goals to address.

3. **Type, Amount, Frequency, and Duration of Services**These elements must also be specified in the Treatment Plan. The *type* of service is specific to the service provided (e.g., speech services=. The *amount* of service refers to the number of times per day the treatment will be provided (e.g., once per day). Medicare states that the amount of services provided should be once daily unless otherwise specified. *Frequency* refers to the number of times per week services are rendered (e.g., 5 times per week). The *duration* of treatment refers to the number of weeks or the number of treatment sessions the patient will receive (e.g., for 4 weeks). Although not required, Medicare states that if the duration of the entire course of treatment is anticipated to be longer than 90 days, the projected overall duration for the course of treatment might also be documented.

Recommended Items for Inclusion

In addition to the above requirements, Medicare states that providers may make their plans more specific as part of best practice. More specific information might include short-term goals; specific treatment interventions; and procedures, modalities, or techniques. Also the following items are recommended for inclusion in the Plan of Treatment:

1. Medical history that is pertinent to the current treatment diagnosis. For example, a medical history that is positive for left knee replacement is not pertinent to the treatment diagnosis of dysphagia but a history of esophageal dysmotility is pertinent and should be included.

2. The specific reason for the referral. The more information provided the better because the reason for referral may not necessarily be evident. For example, the reason for referral of a patient post CVA newly admitted to a facility with a diagnoses of severe oro-pharyngeal dysphagia and aphasia might be obvious. However, a patient referral with a simple notation of "nursing referral" would not be specific enough. "Nursing referral secondary to increased coughing while drinking thin liquids" would be a more informative referral statement.

3. Precautions for the patient (e.g., aspiration precautions, food allergy information).

4. Prognosis documentation. Prognosis should be stated using terms "fair," "good," or "excellent." A prognosis of less than fair does not support the medical necessity for the pending services (e.g., "Prognosis to regain independent cognitive function is good as

evidenced by recent onset date, patient motivation, and low severity of deficit").

5. Barriers to meeting goals. Barriers are referred to as negative prognostic indicators and include anything presented by the patient that may interfere with progress in treatment (e.g., the severity of the deficit, lack of motivation, significant patient confusion).

6. The projected discharge location. Since the discharge location may impact the type, duration, and intensity of treatment the patient receives, the location should be addressed in the plan of treatment. For example, a discharge location that includes transfer to an independent living setting supports the need for aggressive treatment to ensure the patient's success in transferring and remaining in the new environment.

Changes in the Plan of Treatment

Routine changes to the Plan of Treatment do not require the approval of the Attending Physician unless the physician requests that he or she be notified of the changes. However, significant changes in the patient's status that necessitate an adjustment to the long-term goal(s) do require a physician's signature.

Progress Report

Medicare Part B (outpatient) states that the minimum Progress Report period is once every 10 treatment visits or at least once every 30 calendar days, whichever is less. This frequency, however, can cause problems if a denial of coverage should arise. As an example, based on the Medicare requirements, a month of treatment that occurred at a frequency of three times per week would have only one single Progress Report available to explain the medical necessity of the treatment provided and challenging a denial of coverage might be difficult. Best practice would be to write a weekly Progress Report, which more easily tracks progress throughout the course of treatment. In fact, Medicare specifies: "Clinicians are encouraged, but not required to write Progress Reports more frequently than the minimum required in order to allow anyone who reviews the records to easily determine that the services provided are appropriate, covered and payable" (Centers for Medicare Services, 2008, p. 32).

Outside the frame of protection for the claim, a more frequent Progress Report becomes very helpful in a situation where the SLP who is providing primary treatment varies from week to week. (Although this situation is not considered a best practice for continuity of care, it is the reality of staffing situations of some facilities.)

Treatment Notes

A treatment note is daily documentation of the services provided and is written in the patient's record of treatment. A treatment note is comprised of:

1. The date of treatment

2. Identification of the specific service provided (worded to correlate to billing and coding)

3. Total timed code treatment minutes (i.e., minutes of treatment relating to the diagnostic code) and total treatment time in minutes.

4. Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment.

Examples of treatment notes:

10/29/09ST services, 50 minutes. Performed thermal gustatory stimulation x 10 with patient presenting with swallow within 4 seconds 90% of the time. Followed-through with chin tuck independently 75% of the time and 90% of the time with minimal cues.

Gary C. Mertz, M.S., CCC-SLP

1/25/10ST, 45 minutes. Named 3 items to a category with 85% accuracy given minimal cues.

Gary C. Mertz, M.S., CCC-SLP

2/6/10ST, 50 minutes. Answered complex yes/no questions with 90% accuracy given minimal cues. Response latency averaged 5 seconds.

Gary C. Mertz, M.S., CCC-SLP

Medicare stipulates that the following elements are optional, however, including the following information meets best practice:

- Patient self-reportThese are patient responses to questions such as, "How do you think you did today?" Or, "Do you think this therapy is helping?" If the patient is not able to adequately respond, the family and/or nursing staff could be consulted.

- Adverse reaction to interventionInclude any issues of a physical nature, such as pain, or behavioral issues, such as increased agitation or aggression. (Nursing staff should be notified immediately of such situations and notification should be documented in the Treatment Notes.)

- Communication/consultation with other providers (e.g., supervising clinician, attending physician, nurse, another therapist, etc.). As an example, when working in a skilled nursing facility, it is critical to communicate with the nursing staff on a daily basis to provide basic feedback on the patient's performance and status during the course of treatment. Not only does such communication assist the nursing staff in understanding the patient's situation but it also establishes and strengthens your relationship with nursing personnel.

- Significant, unusual or unexpected changes in the clinical status of the patientAny significant changes should be immediately communicated to nursing staff and subsequently documented. Changes in clinical status can very well be a sign of a far larger problem.

- Equipment provided; and/or

- Any additional relevant information the qualified professional finds appropriate. This may include information such as subjective observations regarding the patient's mood or motivation that may have impacted performance for the day (e.g., Patient appeared tired today which may explain lower response accuracy rates for cognitive tasks). Other relevant information might include comparisons of the session with prior sessions (e.g.,Patient presented with notably lower fatigue this session in comparison to prior sessions).

Discharge Note

A Discharge Note (also referred to as a Discharge Summary) is a Medicare requirement for each episode of treatment. The discharge documentation is a progress report covering the period from the last progress report to the date of discharge. The purpose is to justify the medical necessity of services rendered during that period.

It is optional to include additional information in the Discharge Report that might summarize the treatment for the episode or that might justify services that extended beyond those that would be expected for the patient's condition. However, inclusion of these optional elements constitutes best practice and it is the last opportunity to justify the need for the services; these elements protect the claim in the event it is reviewed for coverage.

It is best practice to also include information specific to any equipment the SLP recommends that the patient acquire for home use. The specific vessel for ultimately communicating this information to the patient and/or his/her caregivers is largely dependent upon facility process. It is therefore critical that the SLP seek out this process as soon as possible upon beginning work in a given facility.

Finally, the SLP should always provide input as to whether the anticipated discharge of a patient from the facility to another place of residence is safe and appropriate. The ultimate decision for the location of discharge lies with the patient and/or his/her responsible party.

Tips

Given all of the requirements, it is sometimes difficult to determine what exactly should be documented. In general, insurance carriers and Medicare Services are looking for functional outcomes. All documentation you write should relate the patient's treatment session to a functional goal. As an example, Medicare is not interested in a patient's tongue becoming stronger but the agency is interested in the resulting decrease in risk of aspiration.

To help you decide what information to document, the following tips are provided.

- Ask the following when deciding what to write: "Why" and "So what?" Answer these questions pre-emptively.

  Example:

  You want the patient to be able to better retrieve words. Why? So that he or she can more easily communicate wants and needs. So what? If he or she cannot communicate then he or she risks becoming socially withdrawn and unable to communicate critical information (e.g., if the patient is experiencing pain, etc.).

- Include tag lines at the ends of sentences to elaborate on the functional outcomes of services provided.

  Example:

  (Original) Patient is now able to complete 5 sets of oral-motor exercises and is allowing 3 minutes of thermal gustatory stimulation.

  (Adding tag line) Patient is now able to complete five sets of oral-motor exercises resulting in increased bolus management and decreased pocketing of food in the buccal cavity. Patient also allows 3 minutes of thermal gustatory stimulation with a resulting decrease of swallow latency from 4 seconds to 3 seconds. These improvements are decreasing the risk of choking/aspiration.

- Thoroughly explain any lack of progress. Provide reasons for the lack of progress and

explain what procedures have been implemented to remedy the situation. Explain that a goal has not been met because prerequisites necessary to obtain the goal are not yet in place.

Example:

Patient not consuming PO trials at this time because prerequisite of consistent laryngeal elevation has not yet been attained.

- Explain ongoing barriers to meeting the goals.

  Example:

  Resident not yet able to fluently communicate verbally secondary to ongoing anxiety and agitation associated with verbal apraxia. Ongoing counseling and anger management techniques are assisting the resident to cope with these issues.

- Choose words carefully when a challenging situation, such as a heated discussion about patient care or recommendations, arises. Stay objective and focus on the facts. Do not allow emotions to enter the documentation.

  Example:

  (Subjective wording) Mr. Smith's wife was unreasonable and got angry, started yelling at me, telling me I was wrong and that I should know better.

  (Objective wording) Mr. Smith's wife disagreed with this SLP's recommendations adamantly.

When a Mistake Is Made

Mistakes in written communication are not uncommon but if mistakes happen, proper error correction is necessary. To properly correct an error, ensure that the original entry remains legible while inserting the corrected information. This process is referred to as the "line-out error" procedure. Ensuring that the original entry remains legible is critical. Obscuring or otherwise rendering the original entry illegible can place the provider at a high legal risk should the medical record ever be used in court. In such a case, a legal entity could conclude that there is something that the provider is trying to hide versus simply an error correction. Therefore, do not "scribble" over an error and never use correction fluid.

The line-out error procedure is as follows:

1. Identify the need for correction.

2. Place a single line through the error.

3. Create a notation next to the error that states "error" or "void" and initial the correction. (Note that it is not advisable to correct someone else's error.)

4. Document the correct information as close to the original entry as possible.

Some Words about Fraud

Fraud is absolutely unacceptable regardless of the reason it occurred. An extensive discussion of fraud is not the purpose of this article, but the following are examples of fraudulent behavior pertinent to documentation:

1. Billing and/or documenting services that were not provided.

2. Performing inappropriate or unnecessary procedures, that is, documenting services that are not necessary. In a time when productivity is are expected to be met within the constraints of a budget, it is all too easy to feel pressured into keeping a larger caseload even though the services being rendered are not ethically appropriate. If such a situation occurs it is important to remember that avoiding fraud is absolutely a requirement on multiple levels. It is your sole responsibility as the SLP to ensure compliance.

3. Post-dating documentation. It is necessary to document "late entry" if such an entry is made.

Conclusion

Documenting details in an organized, objective fashion allows for continuity of care for patients and helps to protect SLPs against the claim of denial. In a busy environment, quality documentation also allows recollection of details that may otherwise have been forgotten. Documentation allows the SLP to take credit for the quality services provided and enables him or her to share details of interventions in a clear and concise manner.

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