Therapy Clinical Documentation and Regulations

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Purpose:

To provide a quick review of the purpose for skilled documentation, the steps to ensure proper documentation, and Regulations associated with therapy documentation. In its simplest form, documentation tells the story of what a Clinician did with a patient.

The 3 Purposes for Documentation

1. Communicates with other health care personnel

Documentation communicates what, why, and how of clinical care delivered to patients. These records allow other clinicians to understand the patient's history so they can continue to provide the best possible treatment for everyone. Proper documentation also serves to facilitate patient navigation and coordination along the continuum of care, from Emergency room, hospital and transitioning into the post-acute care setting.

2. Reduces risk management exposure

Thorough and accurate documentation mitigates risks and reduces the chance of a successful malpractice claim. A well-documented record serves as evidence of treatment and care, helping to alleviate liability concerns in the event of a claim. It is unlikely you will remember details of a particular case several years later when you are in the middle of a professional liability claim. Your documentation will be the tool you rely on in this situation. It protects the clinician and the patient to document properly

3. Ensures appropriate reimbursement

A well-documented medical record can facilitate effective payment and reduce denials associated with claims processing and ensure appropriate reimbursement. If it wasn't documented, it won't be paid.

The 3 Steps to Ensure Proper Documentation

1. Standardization

Use industry standards to create note-taking guidelines that work for your practice. Make sure that clinicians are focusing on clear and concise communications that will benefit other readers of the medical records.

2. Regular Peer Review

Review prior records and encounters; with current EMR's, this is often a simple process. No one understands the ins and outs of documentation quite like other clinicians. Pinpoint excellent documenters as go-to experts for questions and concerns. Peer-to-peer support of documentation will increase standardization and productivity.

3. Education

Clinicians never stop learning as they practice and that should be true when it comes to documentation as well.

Regulations

Remember the Golden Rule:

- If it isn't documented, then it wasn't performed. Reviewers do not know the services provided if there is no documentation.
- You are paid for what you document, not what you did
- Document, Document, Document
- More is always better when it comes to documentation

Reference: *Jurisdiction 11 Home Health and Hospice: Lack of Documentation Affects Provider Reimbursement*

Cloning:

The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). **While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.**

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Reference: *https://www.palmettogba.com*

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) and the skilled services applied on the current visit. **(Relevant medical history and or subjective)**
- The patient/caregiver's response to the skilled services provided **(Assessment)**
- The plan for the next visit based on the rationale of prior results **(Plan)**
- A detailed rationale that explains the need for the skilled service considering the patient's overall medical condition and experiences **(Assessment)**
- The complexity of the service(s) to be performed **(detailed treatments/objective)**

- Any other pertinent characteristics of the beneficiary or home **(home environment)**
- The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided **(Assessment)**

Documentation should justify:

- The individual is under the care of a physician or non-physician practitioner
- Services require the skills of a therapist
- Services are of the appropriate type, frequency, intensity, and duration for the individual needs of the patient.
- Avoid use of the following statements:
    - Continue with POC **(Be specific)**
    - Caregiver instructed in medication management **(What was instructed on specifically)**
    - Patient improving, less pain, increased ROM, increased strength, tolerated treatment well **(Vague Statements – be specific)**
- Include important details such as ROM in degrees, distance that can be walked, validated scales of functional independence, objective measurement scores, effects on progress such as reduced swelling, reduced spasticity, etc.
- Use statements which demonstrate the patient's response to the therapy such as:
    - Able to perform exercises as prescribed for 15 reps
    - Able to safely transfer from bed to toilet with standby assistance
    - Patient can now abduct shoulder 120 degrees
    - Able to don a pull over shirt with minimal assistance

Reference(s):

1. *Home Health LCD: PT (L34564), OT (L34560), and ST (L34563)*
2. *Reference: Medicare Chapter 7 Benefit Policy Manual 40.2.2*

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