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Documentation: 3 WAYS TO IMPROVE THERAPY DOCUMENTATION

Don't throw away thousands of dollars--show how you earned them.

If you want to keep the $2000 extra that you earned for a high-therapy use episode, you'd better have excellent documentation.

Intermediaries are continuing their efforts to avoid paying the higher episode payment due when a claim includes 10 or more therapy visits. And they may have to deny only one or two visits to accomplish that, emphasizes physical therapist **Cindy Krafft**, director of rehabilitation for Peoria, IL-based **OSF Home Care**. So you need to continue focusing on improving your therapists' documentation skills.

You can preach "good documentation" until you're blue in the face, but this doesn't mean much to your therapists without specific examples to help guide them. Follow this expert instruction on what to do--and what not to do--so you can tell your therapists exactly what will bring in the reimbursement.

1. Keep your notes relevant. Think that filling pages of data will lock in your reimbursement? Think again. Many therapists don't realize that good documentation is more about quality than quantity.

The most common example of irrelevant documentation is the use of treatment "flow sheets," which list numerous data, such as a patient's number of repetitions, amounts of weight and distances of ambulation, among other things, remarks **Ken Mailly, PT** of **Mailly & Inglett Consulting** in Wayne, NJ.

"While all that information is very descriptive, it doesn't tell payers anything about why the treatment's being done," he adds.

Example: A physical therapist has been working with a 70-year-old woman who is recovering from a car accident and learning to walk again. The therapist diligently records in a flow chart the distances the woman ambulates at the beginning and end of each therapy session. By the end of her 7th therapy session, the therapist writes a progress report stating that the patient can walk 20 feet without assistance.

The problem: Although the information this therapist recorded is detailed and accurate, it is still not enough to convince an intermediary of medical necessity. Why? The therapist has not included any information on why the 20 feet is relevant.

The solution: The therapist should tie this accomplishment to a functional goal, says PT **Meredith Savage**, rehabilitation manager for **Forsyth Medical Center of Novant Health** in Winston-Salem, NC.

For example, the therapist might add that the woman can now walk 20 feet from her bedroom to her bathroom and that would present a case for medical necessity.

2. Focus on skilled services. If the intermediary sees documentation that reads as if your therapists' skills are no different from the person's next door, you can kiss your reimbursement goodbye--even if the documentation supports the relevance of your therapists' interventions.

Example: A patient who is recovering from a stroke has difficulty walking and is getting physical therapy to be able to safely climb the 10 stairs to his bedroom. The therapist notes this goal, which explains the relevance of his intervention, and keeps careful records on the minutes he "ambulates the patient" and the distances they cover.

The problem: A therapist who writes that he "ambulated the patient" does not show the intermediary a need for skilled services--because anyone can assist a person in walking. Plus, nowhere does the therapist distinguish "gait," which is the quality of ambulation, Mailly notes. Correcting gait deficiencies does require skilled intervention.

The solution: The therapist also should have noted the specific skilled interventions he gave to help improve the gait, such as verbal cues for the patient to increase his step height or step length, or to bear more weight on a particular side, offers PT **Kari Luther**, a staff therapist for **Mile Bluff Medical Center** in Mauston, WI. These notes don't have to be lengthy, but they're critical to prove to your intermediary that only a trained therapist would know how to provide this treatment.

3. Include the therapist's actions--not just the patient's. One common mistake many therapists make in their documentation is listing note after note of what their patient does--and only that. "You're not being paid for what the patient is doing, and if you list only what the patient does, you're implying that the patient is independent and doesn't need your skilled services," Mailly says.

Example: A therapist is working with a patient who is recovering from ACL surgery. After one session, the therapist writes, "Patient performed three sets of 10 straight leg raises."

The problem: The physical therapist has in no way noted her role, and an intermediary could assume that the therapist was in the other room and that the patient might as well be doing the same thing independently.

The solution: The therapist above would be much better off if she just mentioned her role in this process. For instance, she could say that she helped the patient maintain terminal knee extension during straight leg raises.

If the therapist can only say that she sat with the patient and counted off repetitions, then she has nothing to bill, Mailly says.