OASIS Alert

Reimbursement: 3 STEPS STANDARDIZE YOUR REHAB DOCUMENTATION AND STOP DENIALS IN THEIR TRACKS

Painting a complete therapy picture could prevent $1,100 losses -- and more.

If you poorly document therapy visits,your intermediary will deny your claim and smile all the way to the bank. Spare yourself headaches and time by following this expert advice.

To secure adequate reimbursement for therapy you provide, you must be able to justify your home health patient visits, said physical therapist **Craig Moore**, speaking at an Oct. 13 session of the **National Association for Home Care & Hospice's** 2009 Annual Meeting in Los Angeles. To support your visit "your documentation must be objective, consistent, and defensible," said Moore, with the **Florida Hospital Rehabilitation & Sports Medicine Center** in Celebration, Fla.

Step 1: Here's What You Must Show

More agencies than ever are getting denials of therapy visits because of poor documentation, reported Peoria. Ill.-based physical therapist and consultant **Cindy Krafft** with **Fazzi Associates**, speaking at the same session, "Improve Rehabilitation Clinician Documentation for Reimbursement." Documentation that is subjective, not standardized and reliable, or used only at the beginning of the episode is unlikely to support many visits, she said.

Reality: If you provided 14 therapy visits in an episode and your intermediary denies two of them, your agency loses more than $400 for just that episode, Krafft illustrated. If you provided 23 visits and five are denied, your agency loses more than $1,100 for that episode.

Documentation must show why you are making the visit, what you are doing, how your actions make a difference for the patient, and sound rationale for timing the patient's discharge or referral to another discipline, Moore emphasized.

Use standard measures at the start of care and throughout the episode to show a patient's progress along the care continuum, Moore suggested. Therapists are taught to use a great variety of tests and measures, he said, but they need to repeat the ones they are using to demonstrate what has changed during the episode and how the patient performs at the end of the episode, not just at the beginning.

Step 2: Decide What Instrument To Use

Think about why you want to use a specific measure, how you plan to use it, what information are you looking for, what barriers you may encounter, and how to break through those barriers, Moore said.

Example: As part of a clinical trial at his facility, Moore evaluated post-stroke patients to determine their ability to walk. The study was attempting to determine when to best begin rehabilitation after a stroke, and whether to provide the therapy in an outpatient setting or in the patient's home. The therapists used many measures to evaluate the study patients. Among these were:

• the "Ten Meter Walk Test" to measure the patient's walking speed;

• the "Six Minute Walk Test" to measure the patient's endurance;

• the "Functional Ambulation Classification" (FAC) to categorize the patient depending on how independently he performed the first two tests;

• the "Fugl-Meyer Assessment of Physical Performance" to measure upper and lower extremity motor and sensory impairment;

• the "Berg Balance Scale" to assess static and dynamic sitting balance; and

• the "Stroke Impact Scale" to assess changes over time in impairments, disabilities, and handicaps following a stroke.

Strategy: Look for measures that are easy for people to understand, that show change over time, and that provide information to support the therapy you plan to provide. "The Ten Meter Walk Test together with the FAC can be a powerful indicator of functional prognosis after a stroke," Moore said.

Step 3: Include Clear Descriptions Of Goals

Once you decide what tests or measures to use for a specific patient, document the results and how those results help determine your goals, Krafft advised. Include clear descriptions of the goals and your time frame for achieving them.

Other documentation to include in the medical record:

• The patient's previous functional status compared to the current test results to help define and support therapy goals.

• Measurements of the patient's progress toward goals throughout the episode.

• How the therapy activity you are providing is connected to specific functions and goals.

• The patient's response to interventions.

• Plans for the next visit, including interventions, parameters, and precautions.

Note: For extensive discussion of the tests, copies of the tests, and instructions on how to use them, as well as more on documentation, order a recording and handouts from the session from NAHC at www.dcprovidersonline.com/nahc. For more on defensible documentation,check out the **American Physical Therapy Association** at www.apta.org.