

QualityWISE NEWSLETTER

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FEBRUARY 2017

With the ever-evolving changes to Medicare policy, it is extremely important that, as clinicians, we are documenting the medical necessity of the services we are providing. Our services must be based on best clinical practices and research and evidenced by strong documentation.

This edition of QualityWISE provides tips and guidelines on how to use progress notes to effectively document the skilled services we provide to patients.

Using Progress Notes to Document Skilled Service

Medicare and other insurance companies ask several questions of providers to ensure the services provided to a patient are medically necessary. Their questions include the following:

1. Does the clinician have the appropriate education and license to treat the patient's medical need?
2. Why is it that only a licensed therapist can provide skilled therapy to the patient to achieve his/her long-term goal?
3. What frequency and duration of treatment is required for a patient to achieve his/her long-term goal?

In order to ensure we are in compliance with all rules and regulations, it is essential that our progress reports and updated plans of care demonstrate continued medical necessity.

Below are some guidelines to keep in mind when completing progress reports:

- **Demographics:** Complete the note in its entirety, ensuring the correct diagnoses are listed and that those diagnoses are included in the Local Coverage Determination (LCD) for the contractor governing payment of the claim.

- **Goals:** Short-term goals should be specific to functional deficits/impairments and should be measurable, attainable, relevant and time-constrained. The goals should relate to the patient's level the previous week and be reasonably obtainable. Long-term goals also should be measurable and relate to the patient's goal at the end of care. Skilled Interventions should not be in the goal, as the way in which we achieve the desired goal will likely change from week to week.
- **Continued Skilled Services Required:** List LCD-approved interventions to address functional deficits with a rationale.
- **Daily Treatment Minutes:** Duration of treatment should always be based on clinical reasoning to achieve the patient's desired goals.
- **Analysis of Functionl Outcome/Clinical Impression:** Each progress note should demonstrate objective and timely improvement or explain the lack of functional progress. Provide skilled analysis of the patient's performance for the week, using critical thinking and assessment of underlying impairments that may impact function. Explain the patient's performance and why he/she did or did not make progress.
- **Skilled Services Provided Since Last Report:** Skilled intervention is not a description of what the patient did. Skilled intervention is a description of special skills, techniques and analysis that the therapist provided. We must demonstrate through our documentation that what we do as licensed therapists is improving the impairment, compensating for the impairment, or adapting the environment to accommodate for the impairment. Use action words that lend themselves to therapist involvement as the initiator of the action, not the patient. For example, words like analyzed, assessed, adjusted, administered, modified, adapted, instructed, upgraded, progressed, incorporated, facilitated, modeled, normalized, or reduced.

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- **Patient/Caregiver Training:**

Document techniques on which you are training the patient or caregiver that will impact the patient's burden of care inclusive of patient/caregiver outcome or level of understanding.

- **Remaining Functional Deficits/Underlying Impairments:** Discuss challenges the patient faces that require continued skilled services.

- **Impact on Burden of Care/Daily Life:** This is your chance to emphasize the impact the therapy provided has made on the patient's daily life. This should demonstrate how therapy services provided have benefited the patient and, where appropriate, demonstrate that continued therapy is needed.

- **Updates to Treatment Approach:** Make adjustments to care, reflecting how the patient has responded to each goal. Do not use non-descriptive statements like "continue goals" or "no change," as these may be seen as services capable of being trained to a caregiver and/or the patient.

- **Prognosis of Therapy Intervention:** The prognosis should reflect the patient's expected prognosis (Excellent, Good, Fair) and describe why that level was selected. Documentation should reflect the clinician's reasoning that there is an expectation that goals are reasonable and will be achieved. Even if the patient does not have "excellent" or "good" potential to return to his/her prior level of function, keep in mind that sometimes our goal is to teach compensatory strategies, adapt the environment, or maintain current status and teach caregivers so that the highest functional outcome is achieved. **For example, "Prognosis is excellent due to strong patient motivation and compliance to environmental modifications."**

Remember, every issue of the *QualityWISE Newsletter* is archived at <http://www.rehabcare.com/employees/qualitywise/>, along with helpful FAQs. If you have any questions or concerns related to quality, compliance or the CIA, you can email RehabCareQualityWISE@rehabcare.com or contact Kindred's Compliance Department at compliance@kindred.com. And you can always contact the Compliance Hotline at 800.359.7412 to report suspected violations of any federal healthcare program requirements or Kindred's policies and procedures.

Thank you for everything you do
to ensure exceptional outcomes for our patients
and partners.