I have 16 years experience as a speech pathologist.

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Fanatical football fan!
Disclosure Statement

Financial relationship:

- The New Mexico Speech-Language Hearing Association paid travel related expenses.
Framework for Today’s Presentation

- Define medical necessity
- Review best practices for documentation in the healthcare settings
- Practical Tips

**NOTE**: The framework for this presentation is based on ASHA’s Documentation in Healthcare Settings document located in their practice portal.

A Few Standards.....

If you didn’t document it, you didn’t do it.

and

The right service, in the right setting, for the right amount of time, to the right person.
Medical Necessity

Medicare:

- Medically necessary services are, “Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

- Services should be safe and effective, not experimental or investigational.
Medical Necessity

Medicare:

- Services should be provided with accepted standards of medical practice.
- Services should be delivered in the most appropriate setting.
- Services should be ordered and provided by qualified personnel.
Medical Necessity

Medicare:

- Services must be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist.
Medical Necessity

American Medical Association definition:

- “Healthcare services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider.”
The determination of whether a service is medically necessary must be made on a case-by-case basis taking into account the particular needs of the patient.

Insurers are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases, but those parameters may not contradict or be more restrictive than the federal statutory requirement.

In states where health care is delivered to enrolled patients through Medicaid managed care organizations (MCOs), the MCOs must make medical necessity determinations according to parameters set forth by the state as reflected in the state plan amendment or in accordance with federal statutory requirements in the absence of state parameters.
Medical Necessity

- All documentation in healthcare settings must prove medical necessity.
- Failure to document medical necessity may result in provider denials at the time of a prior authorization request.
- Failure to document medical necessity over the course of treatment may result in retrospective payment recoupment at the time of an audit.
The “look back” period varies, but insurers generally audit claims dating back as far as three to five years.

Providers have the right to appeal audit results.
Medical Necessity

Providers should address the following elements when submitting requests for and documenting speech therapy services rendered.

- **Is treatment reasonable**: provided with appropriate amount (number of times in a day that type of treatment will be provided), frequency (number of times in a week the type of treatment is provided), duration (number of weeks or total treatment sessions), and accepted standards of practice

- **Is treatment necessary**: appropriate treatment for the patient's medical and treatment diagnoses and prior level of function
Medical Necessity

- **Is the treatment specific**: targeted to a particular treatment goal
- **Is the treatment effective**: expectation for functional improvement within a reasonable time or maintenance of function in the case of degenerative conditions—patient’s prior level of function serves as the baseline
- **Does the patient require skilled intervention**: requires the knowledge, skills, and judgment of an SLP
Medical Necessity

Documentation to support medical necessity may include:

- Physician referral/order;
- Date the client was last seen by the physician;
- Date of the initial evaluation and name of the therapist(s) who participated in developing the comprehensive treatment plan;
- A medical/behavioral history – pertinent medical history that influences the speech-language treatment, concise description of functional status of the patient prior to the onset of the condition requiring services of an SLP, and documentation of any relevant prior speech-language treatment;
Medical Necessity

Documentation to support medical necessity may include:

- Date of onset – date of onset of speech, language, and related disorder diagnosis;
- The evaluation procedures used by the SLP to diagnose speech, language, swallowing, and related disorders;
- The diagnosis established by the SLP, such as expressive aphasia or dysarthria;
- Summary of relevant findings related to the diagnosis established and individualized plan of care;
- Impact on functional status;
- The amount, duration, and frequency of therapy requested;
- Rehabilitation potential of the client
Skilled Services

- Services submitted for reimbursement must be at a level of complexity and sophistication such that they require the specific expertise and judgment of a qualified provider.

- Documentation must prove that the services delivered required the expertise of a qualified provider.

- Thus, documentation must reflect the skilled services rendered.
SLPs use their knowledge and clinical reasoning to perform the following skilled services:

- analyze medical/behavioral data to select appropriate evaluation tools/protocols to determine communication/cognitive/swallowing diagnosis and prognosis;

- design a plan of care (POC) that includes length of treatment and establishes long- and short-term measurable functional goals and discharge criteria;

- develop and deliver treatment activities that follow a hierarchy of complexity to achieve the target skills for a functional goal;

- modify activities, based on skilled observation, during treatment sessions to maintain patient motivation and facilitate success;
Skilled Services

SLPs use their knowledge and clinical reasoning to perform the following skilled services:

- increase or decrease complexity of treatment task and increase or decrease amount or type of cuing needed;
- increase or decrease criteria for successful performance (accuracy, number of trials, response latency, etc.);
- introduce new tasks to assess the patient’s ability to generalize a skill;
- engage patients in practicing behaviors while explaining the rationale and expected results and/or providing reinforcement to help establish a new behavior or strengthen an emerging or inconsistently performed one;
- conduct ongoing assessment of patient response in order to modify intervention based on patient performance in treatment activities, patient report of functional limitations, and/or progress;
Skilled Services

SLPs use their knowledge and clinical reasoning to perform the following skilled services:

- ensure patient/caregiver participation and understanding of diagnosis, treatment plan, strategies, precautions, and activities through verbalization and/or return demonstration;
- train and provide feedback to patients/caregivers in use of compensatory skills and strategies (e.g., feeding and swallowing strategies, cognitive strategies for memory, and executive function);
- develop, program, and modify augmentative and alternative communication systems (low tech or high tech);
- train in the use and care of communication system
Skilled Services

SLPs use their knowledge and clinical reasoning to perform the following skilled services:

- instruct patient and caregiver in use and care across communication levels (word-conversation) as appropriate, based on patient’s prior level of function or desired long-term goal;
- develop maintenance program to be carried out by patient and caregiver and train caregivers to facilitate carryover to ensure optimal performance of trained skills and/or to generalize use of skills;
- evaluate patient’s current functional performance for patients with chronic or degenerative conditions and provide treatment to optimize current functional ability, prevent deterioration, and establish and/or modify maintenance program;
- determine when discharge from treatment is appropriate.
Documenting Skilled Services

Recommendations for documenting skilled services:

- Use terminology that reflects the clinician's technical knowledge.
- Indicate the rationale (how the service relates to the functional goal), type, and complexity of activity. For example
  - "To address word retrieval skills, patient names five items within a category. A limit of 12 seconds made the activity more complex than that tried in the last session."
  - "Skilled observation and assessment indicates the patient has residue in the oral cavity with solids, increasing the risk of aspiration of that material; therefore, the clinician instructed the patient in the performance of tongue sweeps of the buccal cavity with minimal cues, which were successfully performed on 80% of solid boluses."
Recommendations for documenting skilled services:

- Report objective data showing progress toward goal, such as
  - accuracy of task performance (e.g., 50% accuracy in word retrieval in sentence completion tasks);
  - speed of response/response latency (e.g., patient demonstrated 7-10 seconds of delay for auditory processing of sentence-level information; delay reduced to 3 seconds with supplemental written cues);
  - frequency/number of responses or occurrences (e.g., patient swallowed 6/10 PO trials of ½ tsp boluses of puree textures with no delay in swallow initiation);
  - decreased number/type of cues (e.g., initial phoneme cues provided on half of the trials); level of independence in task completion (e.g., patient verbally described all compensatory strategies to maximize swallow safety independently, but required minimal verbal cues from SLP/caregiver to safely implement them at mealtimes);
  - physiological variations in the activity (e.g., patient demonstrated increased fatigue characterized by increasingly longer pauses between utterances).
Documenting Skilled Services

Recommendations for documenting skilled services:

• Specify feedback provided to patient/caregiver about performance (e.g., SLP provided feedback on the accuracy of consonant production; SLP provided feedback to caregiver on how to use gestures to facilitate a response).

• Explain decision making that results in modifications to treatment activities or the POC and how modifications resulted in a functional change (e.g., patient's attention is enhanced by environmental cues and restructuring during mealtime, allowing her to consume at least 50% of meal without redirection).

• Explain advances based on functional change (e.g., patient able to express basic needs in 2- to 3-word phrases consistently; introduced more complex topics to be used in therapy).
Recommendations for documenting skilled services:

- Indicate additional goals or activities (e.g., speech intelligibility remains impaired due to flexed neck and trunk posture and reduced volume; goals for diaphragmatic breathing will be added to POC to encourage improved respiratory support for verbal communication and increased volume of phonation).

- Indicate dropped or reduced activities (e.g., cuing hierarchy was modified to limit tactile cues to enable greater independence in patient's use of compensatory strategies at mealtimes).

- Evaluate patient's/caregiver's response to training (e.g., after demonstration of cuing techniques, caregiver was able to use similar cuing techniques on the next five stimuli), and elaborate on patient/caregiver education or training (e.g., trained spouse to present two-step instructions in the home and to provide feedback to this clinician on patient's performance).
Clinical Documentation

Essential components include justification of:

- **Medical necessity**: are the services provided reasonable and necessary?
- **Skilled service**: are services ones that can only be provided by a qualified professional?
- **Functional**: do the services address goals that are relevant to patients’ educational/vocational needs, safety, and independence in their respective environments and to their specific communication needs and partners?
- **Value**: as payment models evolve away from fee-for-service to bundled care and efficiency, SLPs in healthcare must justify the value of their contribution to the coordinated care of the interdisciplinary team and to the patient’s functional outcomes.
  - Do the services improve care and save costs through prevention (e.g., aspiration pneumonia, g-tube feedings),
  - Do the services increase safety (e.g., compensatory strategies to communicate emergency information),
  - Do the services increase independence to minimize resources for supervision or institutional care (e.g., improved attention, problem solving)?
Components of Clinical Documentation

- Documentation requirements vary by payer source and setting.
- All documentation should be signed and dated. Do not use a stamp.
- Documentation must be completed in a timely manner.
- Documentation should reflect what you did.
  - Document all interactions – direct and indirect
Components of Clinical Documentation

- Don’t document something you didn’t do.
- Don’t copy and paste notes from session to session – this lacks individualization.
- Don’t use too many abbreviations.
Purpose of the evaluation:

- Determine the type and severity of a speech and language / swallowing disorder
- Establish baseline
- Determine habilitative / rehabilitative potential
- Set Goals
The evaluation report includes a summary of the evaluation process, any resulting diagnosis, and a plan for service and may include the following elements:

- reasons for referral;
- case history, including prior level of function, medical complexities, co-morbidities, barriers, and functional limitations;
- review of auditory, visual, motor, and cognitive status;
- standardized and/or non-standardized methods of evaluation. If using non-standardized methods include the justification why;
The evaluation report includes a summary of the evaluation process, any resulting diagnosis, and a plan for service and may include the following elements:

- diagnosis;
- analysis and integration of information to develop prognosis, including outcomes measures and projected outcomes;
- recommendations, including
  - referrals to other professionals as needed,
  - plan of care—
    - treatment amount, frequency, and duration;
    - long- and short-term FUNCTIONAL goals
Plan of Care

Amount, Frequency and Duration:

- **Amount**: Total number of sessions / units requested
- **Frequency**: The number of times per week / month you intend to provide intervention
- **Duration**: The number of weeks / months included in the plan of care

**NOTE**: The frequency and duration should be specific to the patient’s needs. It should not be a preset formula you use for all your patients.
Plan of Care

Short- and long-term treatment goals:

- Short- and long-term goals must focus on FUNCTION
- Goals must be measurable
- Goals should be developed in conjunction with the patient / family.

**NOTE:** Goals should be specific to the patient's needs, not a preset group of goals used with all your patients.
Plan of Care

Functional Goals:

- Are your goals
  - Specific – who, what, where, when, and why
  - Measurable – What is the criteria for mastery?
  - Attainable – Can the patient master the goal?
  - Realistic - Is the family willing to assist with the goal?
  - Timely – What is the timeframe for achievement?

NOTE: If prior authorization is required for continued services, reviewers will look to see if the patient mastered his/her goals. Set goals the patient can reasonably accomplish.
Writing functional short-term goals

- Short-term goals should state why you are working on the skill
- Key phrases:
  - ____________ in order to
  - ____________ so that
  - ____________ to prevent
  - ____________ to reduce
Modifying the Plan of Care (POC)

- A POC should only be modified when there is a significant change in the patient’s medical condition. (AKA – Is there a need to change the long-term goals)
- When there is a need to modify the POC, it should be modified in conjunction with the PCP

**NOTE:** Do not modify the POC if there is a need to change a short-term goal or if deleting a goal due to mastery of a skill.
Evaluation or Assessment?

Per Medicare:

- **Evaluation**: Comprehensive, used to determine diagnosis in a new setting. Uses formal and informal measures to establish measurable goals. Evaluations are payable.

- **Assessment**: Occurs on an on-going basis, even daily. Assessments are brief and are used to report on progress towards established goals. May use formal or informal measures. Assessments are non-payable.
A treatment note is a record of the treatment session and should include the following information:

- date;
- location;
- patient response;
- objective data on progress toward functional goals with comparison to prior sessions;
- skilled services provided (e.g., materials and strategies, patient/family education, analysis and assessment of patient performance, modification for progression of treatment);
- session length and/or start and stop time, as required.
Goal: Improve speech intelligibility of functional phrases to 50% with minimal verbal cues from listener.

- **Unskilled treatment note**: Pt continues to present with unintelligible speech. Treatment included conversational practice. Recommend continue POC.

- **Comment**: This treatment note does not provide objective details regarding patient’s performance.

- **Skilled treatment note**: Pt continues to have unintelligible speech production; unable to consistently make needs known. Intelligibility at single-word level: 60%; phrase level: 30%. Pt benefits from SLP’s verbal cues to reduce rate of speech and limit MLU to 1-2 words. Listener has better understanding if pt points to 1st letter of word first. Pt demonstrated improved self-awareness of intelligibility relative to last week’s session.
Goal: Pt will produce one-word responses to functional wh-questions x 60% with min cues.

- **Unskilled treatment note**: Pt produced word-level responses with 70% accuracy in treatment session with verbal cues.

- **Comment**: This note does not include modification of the plan of care based on patient performance and does not detail skilled treatment activities.

- **Skilled treatment note**: Word level responses to wh-questions to: self and ADLs: 70% accuracy semantically abstract questions: 50% accuracy. Benefits from phonological (initial syllable) cues but unable to self-cue successfully. Naming nouns is better than verbs. Performance improves when pt attempts written response to augment verbal output to facilitate phonographeme associations.
Goal: Pt will use compensatory strategies for orientation to time to reduce agitation with 80% accuracy when cued by staff.

- **Unskilled treatment note:** Pt recalled events that occurred earlier today with 50% accuracy.
- **Comment:** This treatment note does not support the short-term goal in the plan of care.
- **Skilled treatment note:** Spaced retrieval techniques were used to train pt to locate calendar, check clock, and look on whiteboard for daily schedule. Pt responded to temporal orientation questions relating to personal history (x 50% accuracy) and schedule at current living environment (x 60% accuracy) with mod verbal cues provided by SLP/caregiver. Pt benefitted from verbal rehearsals to improve independence in use of compensatory strategies.
**Goal:** Pt will communicate with a speaking valve in place at phrase level x 10 utterances with appropriate vocal quality, pitch, and loudness to indicate wants/needs.

- **Unskilled treatment note:** Pt tolerated speaking valve for 30 minutes.
- **Comment:** There is no clear connection between the daily note and the short-term goal.
- **Skilled treatment note:** Speaking valve was placed to help facilitate verbal communication. Pt repeated 10 phrases without visible signs or symptoms of respiratory distress for 30 minutes. Pt’s SPO2 level maintained 99%-100% during the entire session.
Progress Notes

Progress notes are written at intervals that may be stipulated by the payer or the facility and report progress on long- and short-term goals. These notes typically include

- number of sessions, location, attendance;
- patient response, including home programming;
- skilled services provided (see above, Skilled Services);
- objective measures of progress toward functional goals;
- changes to the goals or plan of care, if appropriate.
**Short-term goal:** Pt will use compensatory strategies to record upcoming appointments with 90% accuracy.

- **Unskilled progress note:** Pt was given an appointment book for recording upcoming appointments. Continue established POC.

- **Comment:** This note does not report the patient's performance and provides no description of modification or feedback.

- **Skilled progress note:** A 3-step process was provided in writing to help Mrs. J go through the steps of recording appointments in her pocket calendar. She practiced with trial appointments until she replicated the 3 steps with 100% accuracy with minimal verbal cues.
**Short-term goal:** Pt will safely consume mechanical soft diet with thin liquids x 3 meals per day with = 1 overt s/s of aspiration to meet all nutrition/hydration needs.

- **Unskilled progress note:** Pt has been tolerating mechanical soft/thin liquid diet well.
- **Comment:** This progress note does not reflect change in status as a result of skilled intervention.
- **Skilled progress note:** Pt has been seen for 8 treatment sessions during this period. Pt's diet was upgraded from puree/nectar thick liquids to mechanical soft/thin liquid diet. Pt safely consumed 3 trial meals at lunch with no overt signs and symptoms of aspiration. Pt requires mod verbal cues to safely implement compensatory strategies. The short-term goal has been updated to include trials of regular texture foods. Plan of care includes caregiver education prior to discharge.
Discharge summaries are prepared at the conclusion of treatment and typically include:

- dates of treatment;
- goals and progress toward goals;
- treatment provided;
- objective measures (e.g., pre- and post-treatment evaluation results, outcomes measures);
- functional status (see ICF framework above);
- patient/caregiver education provided;
- reason for discharge;
- recommendations for follow-up.
Practical Tips

Don’t underestimate the importance of formatting:

- Use Headings
- Organize information in a logical sequence
- Don’t make the doctor/insurer hunt for information
- Spell and grammar check reports
Practical Tips

Work Efficiently

- Use templates when possible
- Develop standardized descriptions for each assessment you use.
- Use pre-designed tables to insert standardized assessment results
  - Raw scores
  - Standard scores
  - Age equivalents
  - Percentile Ranks
Practical Tips

Know the requirements of your payer source

- Medicare Part B typically guides documentation BUT
- Each payer source can establish its own documentation requirements.
- Make sure your EMR has enough flexibility to meet the individual requirements of the payer.
Time to Practice!

- Medical necessity
- Functional Short-term goals
- Treatment notes