Function Based Documentation: Learn to Document with Care

Course Instructor: Dr. Jose R. Rafols
OTD, MHSA, OTR/L
Length of Instruction: 90 Minutes
To comply with professional boards/associations standards, I declare that I do not have any financial relationship in any amount, occurring in the last 12 months with a commercial interest whose products or services are discussed in my presentation.

Function Based Documentation: Learn to Document with Care

Jose R. Rafols, OTD, MHSA, OTR/L, CEAS
Clinical Instructor

Cross Country Education
Leading the Way in Professional Development.
www.CrossCountryEducation.com
Function Based Documentation: Learn to Document with Care

Course Objectives:

1. Review specific content & purpose of clinical documentation.
2. Become familiar with the various documentation requirements mandated by Medicare and Medicaid, as well as, the general guidelines for concise, accurate documentation.
3. Review common documentation styles and contrast & compare them.
4. Become familiar with what function-based documentation is.
5. Learn to document with C.A.R.E. and understand how to avoid documentation pitfalls.
Function Based Documentation: Learn to Document with Care

What is CYA?

CYA... means:
C = Concise
Y = Yet
A = Accurate information

What is CYA?

CYA...could also mean:
C = Cover
Y = you’re
A = ***????!!!

Always treat clinical documentation serious and make sure it is function based...
Function Based Documentation: Learn to Document with Care

Clinical Documentation Content & Purpose
Function Based Documentation: Learn to Document with Care

Clinical Documentation (What is it?):

Serves as a historical document that is used in real-time to capture & record clinical (e.g. physical, psychological, and social) findings on the client/patient being treated.

This historical document is archived for future references in the event legal proceedings are called for (How long)???
Function Based Documentation: Learn to Document with Care

Definition of Documentation:

A factual entry ascribed or written into a medical record which is considered legal and binding in a court of law.

Documentation can take the form of initial assessments, progress notes or summaries, clinical check-lists, flow-charts, patient-care instructions, and discharge summaries.

Screenings [??] are not considered part of the medical record, as per MC regulations.
Function Based Documentation: Learn to Document with Care

There are many things to keep in mind, with regards to clinical documentation:

- Timeliness
- Accuracy
- Relevancy
- Generally acceptance by peers w/in the profession or clinical community
- Skilled one-on-one therapy verses a maintenance program
- Frequency, duration, no. of visits etc...
Function Based Documentation: Learn to Document with Care

However, the **two** most important points to keep in mind are:

(a) Is the (therapy) or intervention justifiable [?]? and...

(b) Is the (therapy) or intervention a reimbursable event...[?].

If you cannot answer these two questions in your evaluation or progress notes, then you need to reevaluate what your are doing.
Function Based Documentation: Learn to Document with Care

Justifiable verses Reimbursable:

The clinician still has great autonomy over whether the patient receives therapy or not...

Sometimes therapy is justifiable, but is not reimbursed:
- Slow progress
- Chronic conditions
- Diagnosis which cause progressive decline
- Experimental Treatments

Sometimes therapy is reimbursed but not justified:
- Poor compliance
- Poor motivation
- Reached Max Medical Benefit (MMB)
- Safety Concerns = cognitive awareness
Function Based Documentation: Learn to Document with Care

Clinical Documentation (Contents):

1. Script or a physician’s order (referral for service)
2. A summary evaluation/assessment (baseline measurement)
3. Intervention plans (Plan of Care) = POC
4. Daily, weekly, monthly documentation of patient progress
5. Attendance records
6. Discontinuation summaries
7. Follow-up documentation if needed
Function Based Documentation: Learn to Document with Care

Clinical Documentation (heads up):

8. **The physician’s script (written orders) will be assessed by case management** on whether the patient’s injury is considered **appropriate** (R/N) for skilled and professional intervention.

   a. Significant practical improvement is key for justification of services (Not optimum).
   
   b. **[U-R will Ask]** Can the patient make practical improvement w/in a reasonable amount of time with this therapeutic intervention?
Function Based Documentation: Learn to Document with Care

Clinical Documentation
Medicare Requirements
Function Based Documentation: Learn to Document with Care

Clinical Documentation (Requirements):

Medicare requirements for clinical documentation:

1. **Identify which service is required** (OT, PT, SLP, Cardiac rehab, Voc-Rehab etc.); this becomes important with pediatric therapy, as well as, co-therapy [or] co-treatments.
2. **Types of intervention** or **modalities** (Tx’s)
3. **Amount of service** (e.g. frequency, duration, number of visits = *MC edits*)
Function Based Documentation: Learn to Document with Care

Clinical Documentation (Requirements):

Medicare requirements for clinical documentation:

4. **Treating Diagnosis** (*hint)*... if the MD (attending physician) writes a script of “debilitation, generalized weakness, CVA X 7yrs ago” ... you need to seek clarification.
   
   a. Long standing CVA *(bad)*
   b. Frequent subluxation of shldr *(better)*
   c. Acute shldr subluxation and radiating pain, secondary to hemiplegia *(best)*

5. **Objectives** that are client centered (STG/LTG’s)
Function Based Documentation: Learn to Document with Care

Clinical Documentation (Requirements):

Medicare requirements for clinical documentation:

6. **All handwritten entries** must be made in Blue/Black ink...and all entries must be legible.

7. **All electronic signatures** must comply with appropriate security safeguards and meet electronic health information protocols.

8. All electronic or handwritten entries must include the **date the services** were **rendered**.
Function Based Documentation: Learn to Document with Care

Documentation: General Guidelines
Function Based Documentation: Learn to Document with Care

General Guidelines:

2. Must identify **current status** of the patient.
3. Must **describe** the **services** being rendered.
4. Must **describe the patient’s response** to therapy or treatment.
5. Must describe the **physical and mental demeanor** of the patient.
6. Must “**JUSTIFY**” why the patient requires **skilled professional services**.
Function Based Documentation: Learn to Document with Care

General Guidelines:

7. **Must be specific** and must objectively describe what was done to the patient.

8. **Must have patient identifiers** on each and every page of the patient’s document (*Name, DOB, Age, Med-Record Number, Attn MD or therapist).

9. **Must** include the clinician’s or professional’s signature and personal credentials on the document.

**A stamped physician or licensed therapist signature is **not acceptable** under MC guidelines.**
General Guidelines:

10. **Must include where the patient has been since the onset** of the illness or injury (e.g. acute-care center, PM&R, Home-bound therapy, or previous surgeries).

11. **Must include a HEP on the first week** and acknowledge the patient’s or caregiver’s understanding of the instructions.

12. **[You Should]**...include the patient’s comorbidities (e.g. other medical illness/diagnosis), as this will allow you to leverage case-management for additional visits, should the need arise.
Function Based Documentation: Learn to Document with Care

General Guidelines:

13. **MC-documentation**, in many states, require the therapist’s (e.g. C.I.) co-signature on any notes written by an occupational/physical therapy student, as well as, an occupational/physical therapy assistant student.

14. **MC, HMO’s and Private Insurers require that plans of care (POC) be completed and signed by the referring (attending) physician or PCP-surrogate before initiating patient treatment.**
Function Based Documentation: Learn to Document with Care

General Guidelines:

15. Must include the patient’s past medical history (PMHx) in the initial evaluation.
16. Must include the patient’s prior level of function (PLOF); ADL status.
17. Must include the patient’s rehabilitative potential in the Plan of Care (POC).
   [  ] Excellent, [  ] Good, [  ] fair.
18. Must include the need for assistive devices or DME’s (*Canes, Walker, 3-in-one commode chair, AFO’s, Electric Wheelchairs, etc.)
Function Based Documentation: Learn to Document with Care

General Guidelines:

19. What Medical Reviewers look for:

- Good plan of care (e.g. POC = Tx plan)
- Previous therapy provided
- Chronic conditions/Dx
- Rehab potential
- Progress notes matching up with super-bills (*irregularities with billing)
- Limitations affecting strength, ROM, ADL’s
- Start date, frequency & duration
Function Based Documentation: Learn to Document with Care

General Guidelines: (Food for thought)

(WAC-PAC): All documentation should be ...

[W]...Well written
[A]....Accurate
[C]....Clearly understandable

[P]...Paints (illustrate) a clinical picture
[A]...Allow transference of care
[C]...Consistent with established protocols

Function Based Documentation: Learn to Document with Care

General Guidelines: (Food for thought)

(*RUMBA):

- **Relevant** = is the information in the note relevant?
- **Understandable** = is the information in the note understandable?
- **Measurable** = is the information in the note measurable?
- **Behavioral** = does the note describe observable behaviors?
- **Achievable** = is the outcome outlined by the clinician achievable?

*Perinchief, JM. (2003) Willard & Spackman’s Occupational Therapy*
Function Based Documentation: Learn to Document with Care

Documentation Formats (Styles)

Currently there is a plethora of documentation styles
Function Based Documentation: Learn to Document with Care

Documentation Styles:

I. SOAP Note
II. DAP Note
III. Expanded SOOOAP Note
IV. HCFA 700/701 Forms
V. Narrative Note
VI. Daily Check-List
VII. E-documentation
Function Based Documentation: Learn to Document with Care

I. SOAP Style:

- **S.O.A.P style** = was originally developed by Dr. Lawrence Weed in the early 1960’s in an effort to make patient documentation more client centered.

- **SOAP Notes** are used by a great range of health care providers and in many HC-settings.
I: SOAP Style (Cont):

S = **Subjective:** Use direct quotes when possible; may paraphrase or summarize what the patient said; make sure what you write is clinically relevant.

O = **Objective:** Specific, factual, and observable clinical occurrences; it is what you said and did in the treatment session; also what the client said and did throughout the session; quantifiable measurements and results are documented here, as well.
Function Based Documentation: Learn to Document with Care

I: SOAP Style (Cont):

A = Assessment: here you will use your “clinical” judgment and synthesize objective and subjective information; you will also comment on how the patient responded towards your intervention; clinical assessments of treatment intervention is a skilled process and is what differentiates you from non-professionals.

P = Plan: is where you document what your next step is with the client; here you will comment on what you will be focusing on, or what, if any, equipment the pt. may need.
Function Based Documentation: Learn to Document with Care

II. DAP Style: (Description, Assessment and Plan)

- **DAP Notes**: are also known as = FIP Notes = findings, interpretations and plan.
- **DAP Notes**: are slightly different than SOAP notes where in the “D” section you commingle the “subjective & objective” information in one section.
- **DAP Notes**: under the “A” section you would assess & document accordingly, just as you would in a standard SOAP note.
- **DAP Notes**: under the “P” section you would state your plan, just as you would in a standard SOAP note.
Function Based Documentation: Learn to Document with Care

III. Expanded SOAP Style (SOO00AAP):

S = **Subjective:** contains the patient’s recent or primary concern (Pt’s comments).

O = **Objective:** measurable, reproducible, data.

O = **Opinion:** builds onto the “O-objective” section, similar to the standard SOAP note, and provides opinions regarding the signs/symptoms/injury; it offers opinions of a given test or assessment.

O = **Options:** in line with the “O” section; the options section offers the patient options towards available treatment approaches.
Function Based Documentation: Learn to Document with Care

III. Expanded SOAP Style (SOOOAAP):

A = **Advice:** here you would collaborate w/the client/patient and offer advice and encouragement towards the treatment being offered (e.g. decrease or stop smoking after a flexor tendon laceration to promote healing).

A = **Agreed Plan:** document any special instructions issued, as well as, when the patient is to RTC.

P = **Plan:** much like the standard SOAP note, you would document your future course of action and what the focus of Tx will be.
IV. HCFA 700-&-701

- **HCFA 700 & HCFA 701**: are an amalgamation (combination) of a medical review form, a plan of care form, a certification form and a recertification form that was once mandated by CMS for OT, PT, SLP services to use.

- Although the SF-700/701’s are no longer mandated by CMS, any other form(s) that substitutes them must include the same information.
V. Narrative Note:

- **Narrative notes** may be used to document patient services; however, they lack structure, and as such, may cause clinicians to inadvertently omit important information.

- **Narrative notes** are often used with electronic documentation styles.
Function Based Documentation: Learn to Document with Care

VI. Daily Check-List:

- **Daily check-lists**: these are considered forms of summary documentation and can be used in lieu of daily notes.
- **Daily check-lists**: are often overused and therapists tend to be careless when using them (e.g. omitting important information).
- **Daily check-lists**: if used throughout the week...you need to write at least one weekly note that is detailed & outlines progress, lack of progress, or sentinel events.
Function Based Documentation: Learn to Document with Care

VII. E-documentation

- **E-documentation**: is any form of documentation that is done electronically (*through any digital medium).
- **E-documentation**: has been the fastest growing style of patient documentation in the past 10 yrs; it allows clinicians to capture data in real-time.
- **E-documentation**: dramatically reduces data-entry error, increases billing accuracy, and enhances productivity & oversight (*big brother is watching you).*
Function Based Documentation: Learn to Document with Care

Function Based Documentation I
“Think-Functionally”
Function Based Documentation: Think Functionally (FAST)

Functional, Accurate, and Simple Terminology:

[FAST-1] Documentation is meant to describe what, when, where why and how you did what you did to the client; however, the use of measurements alone to describe how the client progresses clinically is not enough to justify skilled intervention (e.g. therapy).

[FAST-2] You need to describe patient progress in “FUNCTIONAL TERMS” to the clinical case-managers...this helps illustrate how the client has or has-not improved.
Function Based Documentation: Think Functionally (FAST)

Functional Accurate & Simple Terminology:

[FAST-3] Simple terminology works well in helping case managers understand when their client can resume their BADL’s (basic ADL’s) or return to their previous living environment.

[FAST-4] Simple terminology also assists the case manager in understanding when and if their client can reintegrate into the workforce.

[FAST-5] Simple terminology will alert the case manager if the patient needs custom orthotics, home modifications, and adaptive equipment.
Function Based Documentation:
Think Functionally (FAST)

Functional Accurate & Simple Terminology:

[FAST-6] Collaborating and building rapport with case managers is paramount; they yield great power and if you explain in simple “layman's” terms what the client needs, you are more apt to get their approval.

[FAST-7] Functional documentation may be easier for some clinicians than others; nevertheless, [all] clinicians need to be well versed in functional terminology.
Function Based Documentation: Think Functionally (FAST)

Functional Accurate & Simple Terminology:

[FAST-8] Keep in mind the reviewer of your clinical notes will rarely be an allied health professional (OT, PT, SLP) ... 95% of the time they will come from the nursing profession.

[FAST-9] These reviewers are interested in whether their client can bath him/herself, can obtain sufficient nutrition-able to feed him/herself, drive to the MD’s office, can administer their own medication, is safe at home, and most importantly will stay out of the hospital ($$$).
Function Based Documentation: Learn to Document with Care

Function Based Documentation II

The Good..
The Bad..
The Ugly..
**Function Based Documentation: Learn to Document with Care**

- In the next three slides we will assess three “common” clinical entries; then we will “tweak” the statements to make them more “function based”.

- Finally we’ll look at the functional words/phrases that help the reviewer “connect the dots”, in terms of, how therapy will assist their client in regaining lost function.

- Remember case-management’s function is to save $$$; their other mandate is to insure their patient gets the appropriate level of care at the right time.

- Functional documentation allows the case manager to view the patient’s treatment milieu as a necessary step towards functional recovery.
Objective Clinical Notes

[1] The patient demonstrates increased forward Flexion of 28 degrees in his right shoulder today, when measured with an 180 degree goniometer.

[2] The patient demonstrated a four pound increase of grip strength in his right dominant hand, as measured with a standard Jammar Dynamometer.

[3] Ms Lister presented with a 50% decrease in dorsal swelling of her left wrist; her left wrist extension was assessed and demonstrated an improvement of 17 degrees since last Friday.
Function Based Documentation: Learn to Document with Care

Functional Translation:
(function based documentation)

[1] The patient’s forward flexion has improved by 28 degrees, as observed by his ability to reach overhead, grasp the T-shirt’s collar and remove the garment independently, after set up.

[2] The patient’s right dominant hand strength showed significant improvement this week, as he can now hold his car keys in his hand, insert it into the ignition switch, and start the car’s engine independently without modification.

[3] Ms. Lister presents with increased wrist extension in her left wrist, as per today’s reassessment. Ms. Lister reported that she was able to push the heavy fire door open in her apartment building using her left hand. Ms Lister also reported that she was unable to do this last week.
### Function Based Documentation: Learn to Document with Care

<table>
<thead>
<tr>
<th>Clinical Observation</th>
<th>ADL Component(s)</th>
<th>Key functional words</th>
</tr>
</thead>
<tbody>
<tr>
<td>[3] Increase in Left wrist mobility and strength</td>
<td>Wt. bearing act’s, opening doors, securing and holding heavy objects in Left hand.</td>
<td>Push doors open...which means the patient can safely egress from a burning Building (*Life safety measures-important).</td>
</tr>
</tbody>
</table>
Function Based Documentation: Learn to Document with Care

Documentation Terms to Avoid:

- Doing well ......................(*so what!!)
- It seems like......................(*so what!!)
- Patient improving .................(*so what!!)
- Has less pain ........................(*so what!!)
- Increased ROM or Strength ......(*so what!!)
- Tolerated treatment well.........(*so what!!)
- Patient appears to be..............(*so what!!)
- Patient arrived for therapy.......(*so what!!)

- When you use documentation that is vague or nebulous you convey to the reviewer that you are clinically uncommitted or unsure of what you are doing (*please don’t use these).
Function Based Documentation: Learn to Document with Care

I: Terminology that conveys unskilled treatment or intervention: (*refrain from using these terms)

- Maintain, help, watch
- Observe, practice, monitor

II: Terminology that conveys skilled treatment or intervention (* try using these words instead)

- Assess, analyze, interpret, modify
- Facilitate, inhibit, instruct
- Fabricate, design, adapt, perform environmental modifications
- Determine, establish
Function Based Documentation: Learn to Document with Care

Document in Functional Terms
Document with C.A.R.E!

Function Based Documentation: Learn to Document with Care

- **C = Clarity** ...can the reader understand what you have written in the chart?

- **A = Accuracy** ...does the documentation reflect what actually happened?

- **R = Relevance** ...does the document relate to the identified needs and purpose of the treatment or intervention being provided?

- **E = Exceptions** ...are there any unusual occurrences, patient-compliance issues, or any changes in the pt’s medical condition that need to be included in your document?
Function Based Documentation: Learn to Document with Care

Clarity...

- Make sure the document uses very little **medical jargon**.
- **Spell-out** most **abbreviations**; be aware that other clinicians are reviewing your assessments & notes.
- Only use **abbreviations that are authorized** by your facility, your professional organization or the AMA.
- Make sure the **documentation** in the medical record is **legible (**)**.
Function Based Documentation: Learn to Document with Care

Clarity... (Continued)

- **Illegible** documentation is one of the most common reasons for rejection of service(s).
- **MC/HMO reviewers** do not have the personnel to call-back the provider (e.g. the clinician) and clarify a statement made in the patient’s medical record.
- **Illegible documentation** will therefore, go un-reviewed and unpaid.
- **Recommendations:** have your staff with poor penmanship dictate their notes or use a word processor. (*or help them find another place of employment*).
Function Based Documentation: Learn to Document with Care

Accuracy...

- Documentation should be **short & concise**.
- Documentation should be **chronologically, technically and functionally correct**.
- Documentation should include **instructions on HEP’s** & medical terminology should be used consistently throughout.
- Insures **patient confidentiality** according to HIPAA regulations.
- Adheres to **industry-wide protocols**.
Function Based Documentation: Learn to Document with Care

Relevance…

- Documentation clearly identifies why your particular service are needed, why it would need to continue, or why the services need to be discharged.
- Documentation is consistent with M.D. referral, evaluation, follow-up visits, and D/C summaries (**).
- Documentation reflects stated goals and Tx’s (**).
- Documentation establishes a reasonable time-line for care.
Function Based Documentation: Learn to Document with Care

Relevance… (Continued)

- Documentation & MD’s referral … you “must” do what the doctor’s script calls for, and no more; unless you call, clarify, and document that you received T.O. or V.O. (telephone orders or verbal orders).
- Stated Goals & Tx’s … another reason that patient services are not reimbursed (paid for) is because documentation is not consistent with stated STG/LTG or plan of care.
Function Based Documentation: Learn to Document with Care

Exceptions…

- Documentation provides **justification on why you deviated** from the treatment plan.
- Documentation also justifies why you **chose a particular evaluation methodology** or treatment approach over another.
- Documentation reports any **unusual occurrences or outcomes**.
- **Medical complications are also documented** (e.g. lethargy, fatigue, infection, dislocation, irritation, loss of sensory-motor function, etc.).
Function Based Documentation: Learn to Document with Care

Document in Functional Terms
Avoid these Pit-falls
Function Based Documentation: Learn to Document with Care

Things to keep in mind:

- Date all entries for proper sequencing of events (*if dates, signatures or charges are not included with note... chances are you will not get reimbursed).
- Document the time the Tx was rendered; also document whether the patient refused Tx, missed Tx, or was ill & could not attend therapy.
- Document specific facts not general ones.
- Never blame other HCP’s for treatment shortcomings (*avoid finger pointing).
Function Based Documentation: Learn to Document with Care

Things to keep in mind:

- Treat **late entries as late**… write “addendum” or “late entry” and continue with the portion of your note that you omitted.
- Do not engage in “micro-scribbling”…meaning trying to squeeze one more note into the chart’s margin.
- One-line through any documented error; followed by the word “error”, your initials, and the date.
- Never use white-out, liquid paper or white strips to correct a documented error (*looks like you are hiding something).
Function Based Documentation: Learn to Document with Care

- Be “careful” when scheduling patients and avoid overlapping treatments:

I. **Overlapping treatments** are viewed by MC-and-HMO’s as group treatments (Therapy).

II. **Overlapping treatments** are being scrutinized, more so than ever, & many stand-alone OP rehab centers are fraudulently billing group therapy as on-on-one therapy.

III. **Skilled one-on-one care** means you can only intervene or treat one patient during that “billable” encounter.
Function Based Documentation: Learn to Wrap-up

QUESTIONS?

COMMENTS?

“The pen is mightier than the sword”

Thank You