Therapy utilization is under scrutiny by the federal government, making defensive and accurate therapy documentation crucial to home health agencies. In fact, high therapy utilization is one of six target areas for the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The Handbook to Home Health Therapy Documentation, sold in convenient packs of 10, is your tool for frontline therapist education. Through clear and practical scenarios, and the know-how of expert author Cindy Krafft, PT, MS, therapists will be able to integrate complete documentation to avoid claim denial, fraud, or compliance issues.

**THIS HANDBOOK WILL TEACH YOU HOW TO:**
- Understand the theory and purpose of documentation to avoid incidents of claim denial, fraud, or noncompliance
- Coordinate documentation between therapists and other members of the clinical team to improve patient care
- Develop measurable and meaningful goals
- Conduct and document assessments that show medical necessity
- Set appropriate visit frequencies and durations
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Cindy Krafft, PT, MS

Cindy Krafft PT, MS, HCS-O, brings more than 20 years of home health expertise that ranges from direct patient care to operational and management issues. Years spent in the homes of patients proved to Cindy that this was the best setting in which to focus on functionality and the specific challenges faced by each patient. Providing care in the home environment is different than any other setting, which is clearly evident in both training and consultation activities.

For the past 15 years, Cindy has been a nationally recognized educator in the areas of documentation, regulation, therapy utilization, and OASIS. She has served in several national projects as well as an expert resource for OASIS updates. She focuses on providing the knowledge and tools to operationalize external requirements while keeping the needs of each home health the driver of care. Cindy has been involved at the senior leadership level for the Home Health Section of the American Physical Therapy Association and is its immediate Past President. She works with APTA and CMS to clarify regulatory expectations and addresses proposed payment methodologies to ensure the long-term participation of therapy services in home health. She has written two books, The How-to Guide to Therapy Documentation and An Interdisciplinary Approach to Home Care, and co-authored her third, The Post-Acute Care Guide to Maintenance Therapy.

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Many therapists have had little or no exposure to home health as part of their education. Once they accept a position with an agency or contract company, they may become frustrated because they do not understand the unique expectations that surround this area of practice. The documentation challenges in this setting are significant, and there have been limited sources of information to guide the home health therapist in meeting the demands of payer sources and agencies—until now.

**Home Health PPS**

Prior to 2000, Medicare paid home health agencies on a per-visit basis. There was a set dollar amount for each discipline, and as long as “skilled” issues were present, care could continue unabated. In order to gather standardized and consistent data, The Centers for Medicare & Medicaid Services (CMS) created the Outcome and Assessment Information Set (OASIS) instrument, with nationwide implementation in agencies effective January 1, 2000. The tool focuses on outcome measurement, as the name implies, but it was selected for a secondary purpose as well: Because every agency in the country was going to use it, CMS decided to use some of the questions to determine what payment would be made for the care provided. Thus, the relationship between the number of therapy visits and reimbursement was born. References to Medicare may appear a narrow focus at first glance, but the key concepts apply to home health regardless of the payment source.

Along with OASIS came the model of the 60-day episode for home health. As long as patients qualified for services, they were allowed to continue those services, but formal reassessments were now expected if care was going to extend beyond 60 days. Essentially, the industry was placed on a budget, with OASIS used to calculate the dollar amount associated with each individual patient, and the Home Health Prospective Payment System (HHPPS) era began.
‘Fixing’ Therapy Documentation

It wouldn’t take much effort to simply create a list of words or phrases that therapists could use to improve their documentation. Although some have tried this route, they’ve had only limited success, because content tends to become repetitive quickly and lacks both patient specificity and a clear picture of therapist involvement. Therefore, before getting into the details of documentation content, it is important for therapists to get a broader perspective on this unique practice setting, to understand the “why” behind the expectations, and to empower them with a working knowledge of how to document the necessary information clearly.

Time to Make a Choice

Some might argue that therapists’ practice decisions were never influenced by the reimbursement model. This argument is true in the majority of agencies, which consider the patient’s needs to be the driving force for decision-making. Nevertheless, therapists struggle with documentation and how it affects reimbursement. Therapists know that patients need their services, but they often feel overwhelmed and frustrated with getting these services written down on paper or into a computer. In desperation, they say, “Just tell me what you want me to put down.”

The time has come to change how therapy documentation and care delivery are viewed in the home health setting. Therapists must take back control of their documentation, with a clear orientation on how to create meaningful content efficiently while keeping the focus on the patient. At the end of the day, the patient is the primary reason that any therapist stays in the home health setting, and they must embrace effective documentation as a critical element of excellent patient care.
People generally choose to enter healthcare professions based on their desire to help others. Regardless of practice setting, documentation is often seen as a necessary evil. Any discussion of documentation tends to provoke feelings of frustration as well as the assumption that high-quality content requires a large volume of detail and time. In order to better understand these concerns, consider how therapists learn to document the care that they provide.

**Documentation in Home Health**

**Documentation tools**

There are issues with documentation tools no matter what the format. Thus, gaps in documentation cannot be blamed on any specific tool: The responsibility for providing documentation that clearly supports medical necessity falls squarely on the shoulders of therapists. Each therapist must be diligent in creating appropriate detail that is a balance of “check boxes” and narrative content to show each patient’s individuality.

**Completing documentation**

A frequent strategy for managing paperwork in home health is to defer documentation until the end of the day or the following day. Doing so can allow therapists to be home at a reasonable time and be available for personal events. On its face, this plan seems like a good one, but it raises questions about the accuracy of the information being recorded. Meaningful key details can be lost between care delivery and the time that the note is generated, especially when multiple visits have occurred in the interim. As an example, think about the first person you encountered yesterday: Can you provide a detailed description of what that person was wearing, his or her hair and eye color, and the first words spoken? Without a plan to remember all of that information, some aspects of the
description are likely to be omitted. Jotting down a few cues to refer to later is a good way to ensure accuracy and clarity.

**Making Peace**

No one would suggest that documentation is delightful and that therapists will learn to love it, but therapists must reach some level of acceptance in order to move past the current environment of confusing and conflicting information that is leading to content that is insufficient to support medical necessity. High quality in assessments, visit notes, and clinical summaries is not about the amount of information they contain but rather about the focus of the content. Mythical lists of the correct statements to use to ensure payment are not the answer. The level of detail needed to support the ongoing inclusion of physical therapy, occupational therapy, and speech-language pathology as integral parts of home health care requires that therapists reclaim ownership of this important issue and revisit what they know to be skilled care.
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