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Documentation and Reimbursement in Adult Health Care Settings

The chapters in Section I of this book provided the basics of documentation. Section II described documenting the different types of services, with the focus mostly on health care. Sections III and IV delve into the specifics of documentation and reimbursement in specific settings. Section III addresses the following settings in adult health care:

- Acute care
- Palliative and hospice
- Inpatient rehabilitation
- Skilled nursing facilities
- Home health
- Outpatient (e.g., hospital outpatient departments, clinics, private practices)

Each chapter in this section is authored by speech-language pathologists who have extensive experience practicing in those settings. I’ve written the chapters on acute care, palliative/hospice, and outpatient, having provided services in those settings through my private practice and then at the hospital for over 30 years. Although I’ve provided services in inpatient rehabilitation, skilled nursing, and home health, I haven’t done so recently, and therefore asked these experts to contribute these chapters.

The chapters will reinforce the basics from Section I and the types of services covered in Section II but will go more in-depth about the particular requirements in that setting. You will find information on the following:

- Documentation requirements in that setting (from evaluation to discharge)
- Tips on how to document efficiently
- Basics of reimbursement for clients/patients in that setting and how reimbursement rules impact documentation in that setting
- Any tips on coding (diagnostic and/or procedural)
- Examples of evaluations, treatment plans (including examples of long- and short-term goals for some typical disorders), progress notes, discharge summaries, and any specific outcomes tools or other forms that have to be filled out
- A case history example(s) from that setting to help you understand the coding, reimbursement, and documentation rules
Regardless of the third-party payer, the services in an acute care hospital are almost certainly done on a prospective payment methodology. The payer and the hospital have agreed to a methodology that dictates what amount the payer will reimburse the hospital, either per day of the patient’s stay or more likely per diagnosis of the patient. The payer does not assume any of the financial risk because the amount of reimbursement has been predetermined. If the hospital overutilizes services (e.g., performs four chest x-rays when two would suffice, prescribes an expensive drug when a generic drug would work), the hospital loses money.

Medicare Diagnosis-Related Groups: Part A

When a beneficiary with Medicare is admitted to a hospital, Medicare Part A is the payer. The patient has a deductible to meet, but then Medicare covers 100% (for the first 60 days). The beneficiary does not have to pay any coinsurance. When Medicare was originally established, hospitals were reimbursed on a retrospective, cost-based system. Whatever the hospital charged, called reasonable charges, Medicare reimbursed. In 1982, the first prospective payment system was established for acute care hospitals. Medicare determined it would pay a rate for a specific type of case, or diagnosis-related group (DRG). There are hundreds of these groups into which a patient can be classified. For example, there is a group for transient ischemia, several different groups for acute ischemic stroke, and several for intracranial hemorrhage or cerebral infarction (U.S. Department of Health & Human Services, 2001).

Therapy services are covered as a part of the payment the hospital receives. Medicare does not care how much therapy is provided because they are not going to reimburse the hospital any more for a patient who gets a lot of services. The hospital, however, may care a great deal. Out of the limited, preset amount the hospital receives, they have to pay for all the services they are providing. Thus, there might be pressure from hospital administration on the therapy departments to scale back the services they provide.

Medicare Part B in a Bed

This DRG-based prospective payment system is the way hospitals are reimbursed for inpatients under their Medicare Part A benefit. One might think that if a Medicare beneficiary is in a bed in a hospital, he or she is an inpatient. However, in order to qualify for inpatient status, the patient must meet two criteria: He or she must have a qualifying diagnosis and he or she must stay in the hospital two
1. Describe the payment methodology used most often for inpatients in acute care hospitals.
2. What are some challenges to completing charting on the computer during a session?
3. Explain a protocol order.
4. What are some advantages and disadvantages to the informal cognitive-communication evaluations that are completed in acute care?
5. Describe some differences between treatment plans developed in acute care and those developed in an outpatient setting.

**Activity A**

Look at each telephone order below. Note what is missing in each order.

1. **#1**
   
   0915  
   Telephone order Paul Munology, MD to Sam Speech  
   Evaluate for swallowing problems  
   Read back and verified  
   Sam E. Speech, MA, CCC-SLP

2. **#2**
   
   7-01-17  
   Telephone order Paul Munology, MD to Sam Speech  
   Evaluate for use of tracheostomy speaking valve when patient is on trach collar trial.  
   Sam E. Speech, MA, CCC-SLP

3. **#3**
   
   7-01-17 0915  
   Paul Munology, MD  
   Videofluoroscopic swallow evaluation in the morning  
   Read back and verified

4. **#4**
   
   7-01-17 0915  
   Telephone to Sam Speech  
   Clinical swallow evaluation  
   Read back and verified  
   Sam E. Speech, MA, CCC-SLP

5. **#5**
   
   7-01-17  
   Telephone order Paul Munology, MD to Sam Speech  
   Evaluate for confusion  
   Sue Swallow, MA, CCC-SLP
and quality at periodic intervals post-discharge. In Sally’s case, the IRF was able to share with Sally and her family the percentage of patients who indicated they are able to manage their own care needs 3 months after discharge, despite a majority of patients continuing to need some level of assistance at the end of their IRF stay.

**Additional Considerations**

**Efficiency**

Efficiency in completion of documentation is an important component of work-life balance, work satisfaction, and effectiveness (U.S. Department of Health & Human Services, 2014). Over the years, clinicians have developed several tools to help them manage the challenges of completing paperwork.

Productivity requirements for therapists in an IRF are estimated to be an average of 6 billable hours in an 8-hour work day. Although completion of clinical records is necessary, the time spent with one’s patient aiding her in behavioral change is the most important activity a clinician provides.

There are currently three types of medical records used in an IRF setting:

1. Paper-only medical charts
2. Electronic medical records (EMRs) and electronic health records (EHRs)
3. EHR with some paper records preserved, such as billing or patient-signed forms

Speech-language pathology departments should have adequate training and orientation for all new staff members to help them successfully navigate which forms and what parts of the medical record must be completed and

<table>
<thead>
<tr>
<th>REASON FOR MISSED TREATMENT</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient refused</td>
<td>No specified reason for refusal given by the patient. Despite education and encouragement, patient refuses to engage in treatment session.</td>
</tr>
<tr>
<td>Patient refused due to fatigue</td>
<td>Patient refused to participate due to fatigue despite efforts to modify treatment session or schedule.</td>
</tr>
<tr>
<td>Nursing care required</td>
<td>Patient is requiring intervention from nursing staff that is not able to be rescheduled.</td>
</tr>
<tr>
<td>Conflict with scheduling due to outside appointment</td>
<td>Patient requires follow-up outside of IRF unit and, due to travel and/or wait times at appointment, has missed part or all of session.</td>
</tr>
<tr>
<td>Patient placed on medical hold</td>
<td>Medical staff have deemed that patient is not safe for treatment and have placed on a medical hold.</td>
</tr>
<tr>
<td>Patient refusing and reporting feeling unwell</td>
<td>Patient presents with specific or non-specific complaints regarding illness and not agreeable to modification to treatment.</td>
</tr>
<tr>
<td>Patient demonstrating a change in mental status</td>
<td>Patient is showing a change in baseline status observed since admission.</td>
</tr>
<tr>
<td>Patient is showing decreased arousal or is unarousable</td>
<td>Patient is showing known or increased difficulty in maintaining arousal and/or attention, either inhibiting participation in treatment session or requiring medical assessment and intervention.</td>
</tr>
<tr>
<td>Conflict with scheduling due to inside appointment</td>
<td>Patient is requiring an intervention in the IRF by a member of the treatment team that was not scheduled.</td>
</tr>
<tr>
<td>Patient missed all or part of session due to toileting needs</td>
<td>Patient has immediate toileting needs that prohibit participation in scheduled session and that cannot be incorporated into treatment session.</td>
</tr>
<tr>
<td>Patient not safe for treatment due to an increase or demonstration of new agitation</td>
<td>Patient is demonstrating unsafe behaviors toward self or others that limit ability to safely participate in treatment session at the scheduled time, possibly requiring medical assessment and intervention.</td>
</tr>
<tr>
<td>Patient refusing treatment due to increased or new pain</td>
<td>Patient is refusing to participate in treatment session due to pain despite efforts to intervene with medications or other modalities to alleviate pain.</td>
</tr>
<tr>
<td>Other</td>
<td>Any interruption that limits the patient’s ability to participate in treatment must be specified by clinician in documentation.</td>
</tr>
</tbody>
</table>
**Table 15-4**

**Graphing Progress**

**Gestural Request of Familiar Objects and Actions**

- Spontaneous
- Imitation

**Identification of Familiar Objects from Field of 3**

- Spontaneous
- 1 gestural