HOW DOES YOUR DOCUMENTATION SYSTEM MEASURE UP?

The role of the documentation system in operating “audit proof”.

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OBJECTIVES FOR THIS COURSE

• Identify traits of a Medicaid compliant documentation system.
• Identify HIPAA/FERPA documentation regulations.
• Determine if your documentation system is as user-friendly as it can be.
• Identify factors affecting development of software.

WHY A STANDARDIZED DOCUMENTATION SYSTEM?

Obviously,
To collect data for billing
WHAT ELSE CAN A STANDARDIZED DOCUMENTATION SYSTEM DO FOR YOU?

- When web based, can be accessed anywhere there is internet access
- Supervisor or Director has quick access to therapist work
- Document implementation of the IEP
- Easy access to records
- Easy transition for new or interim provider
- Provide consistency in documentation
- Track frequency of service delivery & missed visits

AUDIT PROOF DOCUMENTATION SYSTEM

- Is there such a thing?
- The technology is here… are we using it appropriately?
- Are we getting the all the benefits of technology?

STANDARDS FOR DOCUMENTATION SYSTEM

1. Must be secure and HIPAA/FERPA compliant.
2. Components of visit encounter notes need to be audit proof
3. Clinical components of encounter notes need to be audit proof
4. Technical Specifications
SECURITY & HIPAA/FERPA COMPLIANCE

- Secure site – SSL – easy to acquire
- Site shouldn’t allow browser to save passwords
- Users cannot log in from more than one browser/IP address – timed log out
- Set up for single user log ins, no shared log ins
- User agreement/training completed prior to use
- Frequency of password changes
- Permission levels

This is the easy part! Even older programs can meet these standards.

AUDIT SECTION: DOCUMENTATION OF SERVICE DELIVERY MEETS STANDARDS

Where do you start?
What are the standards?

- Your State’s Department of Special Education Manual
- Your State’s Health Licensure Laws/Rules
- Your State’s Medicaid Provider Manuals

Bonus Points:
- National organization’s guidelines (AOTA, APTA, ASHA, ANA)
- IDEA
- CMS
- OIG Reports (Federal Register)

AUDIT SECTION: DOCUMENTATION OF SERVICE DELIVERY MATCHES AMOUNT PAID

1. What’s required and why does it need to be in an encounter format?
2. Student Name (any other student identifiers)
3. Date of service provided including time in and time out
4. Service provided
5. Billing Code
6. Number of students when service is performed in a group setting
7. Therapeutic Intervention matches billing code
8. Name and credentials of service provider
9. Proof (usually signature) that documentation was created by the service provider
10. Log-in sheets/Attendance Records
FREQUENCY & DURATION

Sessions must exactly match the frequency in the IEP – no more, no less, because:

- The IEP is a legal document
- Your sessions completed should match the doctor’s order, for billing and liability reasons

System should compare each session against student’s IEP – not allow billing if not a match.

AUDIT SECTION: CLINICAL DOCUMENTATION GUIDELINES

- Goals and objectives are measurable
- Must include the medical condition or problem you are treating
  - Include therapeutic intervention
  - Must demonstrate measurable progress
  - Plan for follow up

The ideal documentation system will dictate user compliance.

- Sentence builders
- Multiple choice/drop down lists
- If/then comparisons
- Error Messages
- User prompts
- Banked/stored text
- Calculations
EXAMPLES

- System will not allow session to be saved without an intervention entered.
- System will recognize a date/time that is not reasonable.
- System uses prepopulated lists with acceptable verbiage
- System prompts user to choose a goal for the session.

TECHNICAL SPECIFICATIONS

- Must operate in all browsers
- User friendly – easy to move around and access records
- Pages must load quickly
- Direct Links within site for navigation – reduce clicks!
- Exportable reports in a variety of formats; i.e.; word, pdf, excel, csv
- Ability to attach documents
- Field-level Report Capability
- Pre-population wherever sensible
- Ability to work with other internal systems to monitor all necessary requirements are met before submission of claims take place

IS THERE AN APP FOR THAT?

- Document in real time
- Easy calculation of results, percentages
- Make the data collection part of the therapy
- Use of graphics and avatars made for the kids
- Our favorite: DocNow
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