

Clinical Record Keeping in Speech-Language Pathology for Health Care and Third-Party Payers

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This document is intended to serve as a guide for speech-language pathology programs in establishing, revising, and maintaining accurate and appropriate clinical records. It encompasses American Speech-Language-Hearing Association (ASHA) standards, as well as those of outside organizations that develop documentation requirements, including the Centers for Medicare and Medicaid Services (CMS; www.cms.hhs.gov), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Commission on Accreditation of Rehabilitation Facilities (CARF). Regulations such as the Health Insurance Portability and Accountability Act (HIPAA) have been considered for those speech-language pathologists who are covered entities under this law (see www.hhs.gov/ocr/hipaa/ for more information). Additional concepts and practical suggestions from clinical facilities also are included. Readers are encouraged to confirm documentation requirements on an ongoing basis with employers, state and federal agencies, and professional organizations, as regulations and laws may change over time. This document does not address issues surrounding documentation in school settings or as related to the Individuals with Disabilities Education Act (IDEA). Information about IDEA and paperwork can be obtained through ASHA's Web site at www.asha.org.

Clear and comprehensive records are necessary to justify the need for treatment, to document the effectiveness of that treatment, and to have a legal record of events. According to the ASHA's *Code of Ethics*, Principle I, Rule K, "Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed and shall allow access to these records only when authorized or when required by law" (ASHA, 2003). Excellent record keeping does not guarantee good care, but poor record keeping poses an obstacle to clinical excellence (Kibbee & Lilly, 1989).

Clinical Record Keeping Process

I. The Documenter (Who)

- A. Usually the person who renders the assessment, care, or treatment.
- B. In emergency situations, the person designated to document a detailed account of the situation.

II. Components of Clinical Record Keeping (What)

- A. Identifying information.
 - 1. Facility name and client's clinic or medical record number.
 - 2. Client name and related identifying information (address, e-mail, telephone number(s), date of birth, language(s) spoken, and caregiver/legally responsible person to whom information can be released).
 - 3. Client Health Insurance Claim Number (HICN) or social security number.

4. Speech-language pathologist's (SLP) name, certification, licensure (as applicable), and related identifying information.
5. Referral source, related identifying information (e.g., Universal Physician Identification Number), reason for referral, and date (if applicable).
6. Date report prepared.
7. Evaluation date.
8. Treatment period covered by report.
9. Signed notice of privacy rights (HIPAA-covered entities).
10. Signed authorization to release information (as applicable).

B. Client history.

1. Medical diagnosis(es) (primary, secondary, including date[s] of onset).
2. Communication or swallowing disorder diagnosis(es) and onset date(s).
3. Medical history pertinent to speech, language, cognitive-communication, or swallowing treatment, including surgical procedures.
4. Educational status/occupational status (as appropriate).
5. Relevant history of language development, including language(s) spoken across various environments and age of onset of language(s) learned.
6. Prior functional communication status, considering the framework of the *International Classification of Functioning, Disability, and Health (ICF)*:
 - a. Body functions and structures
 - b. Activity and participation
 - c. Environmental factors
 - d. Personal factors
 - e. Contextual factors.
7. Prior speech, language, cognitive-communication, or swallowing treatment, outcome of that treatment, length of prior treatment.
8. Additional pertinent information (e.g., medical records, educational testing, observations).
9. Source(s) of client history.

C. Assessment of current client status.

1. Date of initial assessment or reassessment.
2. Initial functional status of client, considering the ICF framework, based on:
 - a. Baseline testing using standardized and nonstandardized measures.
 - b. Modifications of standardized assessment procedures utilized, including, but not limited to:
 - i. Use of interpreter
 - ii. Translated assessment

- iii. Use of gestures to elicit responses
 - iv. Other.
 - c. Interpretation of test scores/results.
 - d. Statement of severity.
 - e. Other clinical findings, including those from other specialists or team members.
3. Documentation that speech-language pathology evaluations consider a client's hearing, vision, motor, and cognitive status.
 4. Documentation that assessment tools were evaluated for ecological validity and determined to be appropriate for the client.
 5. The language(s) in which the assessment was conducted.
 6. Person(s) present during the evaluation (e.g. professional interpreter, family member, etc.).
 7. Statement of prognosis.
 8. Recommendations based on the client's functional needs and medical necessity, including referrals, as appropriate (see *Admission/Discharge Criteria in Speech-Language Pathology*; ASHA, 2004).
 9. Signature and title of qualified professional responsible for the assessment (and that of documenter, if different).

D. Treatment plan.

1. Date that plan of treatment was established.
 - a. For Medicare patients, the plan of care must be established and certified by a physician before treatment begins. Plan of treatment must be recertified by the physician on a regular schedule (every 30 or 60 days, depending on the setting).
2. Short- and long-term functional communication or swallowing goals.
 - a. Should reflect desired client outcomes: the level of communication independence the client is expected to achieve based on input from the client and/or family.
 - b. Should reflect culturally and linguistically appropriate services. Reimbursable, functional communication goals should not include features that are due to communication differences.
3. Treatment objectives.
4. Recommended type and expected amount (e.g., 1 hour sessions, individual or group), frequency (e.g., three times per week), and duration (e.g., 3 months) of treatment.
5. Follow-up activities.
6. Statement of prognosis specific to long-term goal(s).
7. Date treatment plan was discussed with client and/or family.
8. Date interdisciplinary conferences were held, if applicable.
9. Statement of schedule for review of the plan.

10. Signature and title of qualified professional responsible for treatment plan.

E. Documentation of treatment.

1. Date client began treatment at present facility.
2. Time period covered by report (date of treatment[s]).
 - a. Frequency of documentation is determined by facility guidelines, payer requirements, and professional preference. In some cases, documenting each session may be valuable, such as when appealing an insurance denial.
3. Summaries of assessment and treatment plan in treatment reports.
4. Current client status.
 - a. Communication or swallowing diagnosis.
 - b. Objective measures of client communication or swallowing performance in functional terms that relate to treatment goals.
 - c. Use of consistent reporting (use same method during each treatment session to track progress toward short- and long-term goals or explain rationale for changing method).
5. Any changes in prognosis (include significant developments).
6. Any changes in plan of treatment.
7. Description of the need for continued intervention, if applicable.
8. Signature and title of qualified professional responsible for treatment services (and that of documenter, if different). Note: The supervisor of noncertified personnel, including persons in their Clinical Fellowship (CF), should sign all records, unless other requirements are stated. For example, Medicare recognizes ASHA's standards for supervision of CFs, and co-signatures by the supervisor are required only when direct supervision of care has occurred. (Refer to Medicare guidelines regarding the use of students in therapy—information available at www.asha.org). The supervisor should also sign all evaluation reports and discharge summaries.

F. Discharge summary.

1. Follow-up recommendations (see *Admission/Discharge Criteria in Speech-Language Pathology*; ASHA, 2004).
2. Establishment of a maintenance program, if applicable.

G. Record of consultation.

1. Consultation with other professionals.
2. Consultation with client and caregivers or legally responsible parties.

H. Correspondence pertinent to individual client.

III. Storage (Where)

A. General information.

1. In secure place, to be accessed only by authorized personnel.
2. Safeguarded against loss or destruction.

3. Refer to HIPAA Privacy and Security rules, as applicable.
- B. Historical clinical records.

1. Maintained through computer storage.
2. In secure yet less accessible place (away from current files).

IV. Time Frame for Recording, Sending, and Retaining Client Information (When)

A. Recording.

1. According to time frame set by:
 - a. National, state, and accrediting body standards.
 - b. Facility.
 - c. Department.

B. Sending reports and information to other professionals and client and/or family.

1. According to a specified time frame as discussed above.

C. Storage and maintenance of historical clinical records.

1. According to schedule for filing and transferring historical files for archival storage.
2. According to state and federal law or, when no law exists, a created policy that reflects client/patient and program needs.
 - a. States may have differing regulations (refer to state Department of Health regulations regarding medical record retention).
 - b. Various Medicare regulations stipulate that, in the absence of a state statute, medical records must be kept for a minimum of 5 years after date of discharge. HIPAA regulations require that records be retained for a minimum of 6 years after discharge or 2 years after a patient's death (see www.hipaadvisory.com/regs/recordretention.htm for more information).
 - c. Records for minors may need to be kept longer, possibly until the minor reaches the age of 21.
 - d. Professionals should abide by the most stringent regulations regarding record retention.
3. Client or caregiver permission or notification does not permit earlier destruction of medical records.
4. Record keeping procedures may vary by facility or program.
5. Disposal of obsolete records should be in a manner that protects the confidentiality of client information.

V. Rationale for Documentation (Why)

A. Reasons for appropriate documentation.

1. Justify initiation and continuation of treatment.
2. Support the diagnosis and treatment (including medical necessity and need for skilled services).
3. Describe client progress.
4. Describe client response to interventions.
5. Justify discharge from care.

6. Support reimbursement.
7. Communicate with other practitioners.
8. Facilitate quality improvement.
9. Justify clinical decisions.
10. Document communication between involved parties (practitioners, client, caregivers, or legally responsible parties).
11. Protect legal interests of client, service provider, and facility.
12. Serve as evidence in a court of law.
13. Provide data for continuing education.
14. Provide data for research (i.e., efficacy).

VI. Methods (How)

- A. Clinical record keeping should:
 1. Conform to federal, state, and local laws.
 2. Adhere to facility's standards and regulations.
- B. Electronic documentation systems (paperless) are acceptable if supported with appropriate technology to ensure accessibility, usability, and privacy.
- C. Writing should be clearly understood by the reader; that is, content should be:
 1. Accurate, concise, and informative.
 2. Adapted for a potentially large readership.
 3. Useful and relevant to other staff.
 4. Neat and legible, if handwritten.
- D. Clinical records should be consistent in format and style.
 1. As established by facility (e.g., SOAP note format—Subjective, Objective, Assessment, Plan [Miller & Groher, 1990]).
 - a. Preprinted forms or standard formats for reports should be established.
 - b. Use of checklists versus narrative accounts is at the discretion of the clinician and facility.
 - c. No universal documentation template exists.
 2. Using appropriate *International Classification of Diseases and Related Health Problems* (ICD) codes, current revision (U.S. Department of Health and Human Services).
 3. Using appropriate Current Procedural Terminology (CPT) codes, current revision (American Medical Association).
 4. Using appropriate terminology per ASHA policies and currently accepted terms.
 5. Using appropriate and acceptable abbreviations (see JCAHO patient safety goals regarding the use of abbreviations in medical records).
 6. Individual payers may have different documentation requirements. Typically, health plans are instructed by law to request only the minimum information necessary to pay the claim.
- E. Clinical records need to be organized with entries recorded chronologically.

- F. The documenter must assure accuracy by:
 - 1. Proofreading documentation to verify that the meaning is clear.
 - 2. Appropriately correcting an entry (i.e., crossing out incorrect material with one line, writing reason for change, entering the correct information, and dating and initialing the correction; no use of “white out”).
- G. The documenter should provide rationale for such clinical decisions as test selection (including sensitivity to the population to which it was administered), diagnosis, prognosis, treatment goals, and recommendations.
- H. The documenter must be sensitive to client rights by:
 - 1. Including signed documentation about consultation with client, caregiver, and/or legally responsible parties.
 - 2. Obtaining signed and dated release of information forms or authorizations in compliance with state and federal policy whenever documents are released or information is disclosed.
- I. Clinical records must be treated as a legal document by:
 - 1. Ensuring that records are written in ink or computer-generated for permanence.
 - 2. Signing all record entries with name and professional title of primary service provider and all appropriate professionals.
 - 3. Dating and initialing materials from other facilities before entering them into permanent record. Note: for legal purposes, records need to be thorough, accurate, and include all necessary signatures and release authorizations.
- J. A quality improvement process for record maintenance should be instituted, such as:
 - 1. Conducting a records review to ensure that records are complete, accurate, and maintained on a proper schedule.
 - 2. Developing troubleshooting techniques by:
 - a. Predicting potential problems.
 - b. Planning response to remediate each problem.
 - c. Following up on each problem.
 - 3. Developing checklists for completing each form so that it is completed accurately the first time.
- K. Clinical records must be kept in an organized and systematic fashion, for example:
 - 1. If kept as hard files, keeping a chronological log on inside of folder for easy reference to list dates and services provided, name or initials of provider, and other client identifying information (contact sheet).
 - 2. Safeguarding against loss (e.g., affix records to record jackets, backing up computer systems).
 - 3. Separating current from historical files and storing them appropriately.

4. Indicating where and to whom reports are sent (e.g., appropriate *cc* notations on reports and consistent notations on contact sheets).

VII. Additional Considerations

- A. Medical/clinical records are the property of the facility, unless otherwise provided by law (refer to state regulations).
- B. All information and records are confidential unless otherwise provided by law.
- C. Confidentiality of records and patient privacy are of paramount concern (see HIPAA regulations regarding Protected Health Information [PHI] and privacy).
- D. For reimbursement purposes, documentation needs to prove that professional treatment is warranted. That is, there must be evidence of functional deficits requiring intervention (medical necessity) only by a skilled professional (skilled services) who is qualified to assess client needs, plan and implement effective treatment, and consider (and prevent) potential medical complications. Elective services, such as accent reduction, are not typically reimbursable from a third-party payer and these guidelines need not apply.
- E. Records should be organized according to alphabetical or numerical order. Records and files should be organized systematically so that they can be accessed and understood by all potential readers, including the original documenter in future years.
- F. In medical facilities, regulations differ as to who can write orders or take verbal orders in a patient's medical chart. Refer to specific facility policy and/or applicable state law.

GLOSSARY

CARF. The Commission on Accreditation of Rehabilitation Facilities. An independent, not-for-profit accrediting body promoting quality, value, and optimal outcomes of services through a consultative accreditation process.

CMS. Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration or HCFA). The federal agency within the Department of Health and Human Services that administers Medicare and Medicaid programs.

CPT Codes. Current Procedural Terminology codes. Codes maintained and copyrighted by the American Medical Association and used by health care providers and payers to provide uniform language for medical and surgical procedures. ASHA participates in the formal process for development of CPT codes that represent procedures rendered by SLPs or audiologists.

HIPAA. Health Insurance Portability and Accountability Act of 1996. The privacy rule and electronic data interchange provisions of HIPAA set forth regulations designed to

protect the confidentiality of all health care related information and to mandate the format of all electronically stored and transferred patient data.

ICD. International Classification of Diseases and Related Health Problems. Published by the World Health Organization (WHO), the ICD manual consists of numeric codes assigned to written descriptions of a diagnosis, condition, or problem for the purpose of establishing standardized disease classifications. The codes are required documentation for Medicare B claims by physicians, as well as by many private payers. The version commonly used by health care providers is the ICD-9-CM (i.e., Ninth Revision, Clinical Modification).

ICF. International Classification of Functioning, Disability, and Health. The ICF was published by the World Health Organization (WHO) in 2001. The WHO considers the ICF classification system to be a partner to the ICD (*International Classification of Diseases and Related Health Problems*) system used in the United States and abroad. Whereas the ICD classifies disease, the ICF focuses on a person's functional abilities.

JCAHO. Joint Commission on Accreditation of Healthcare Organizations. An independent, not-for-profit accreditation organization that develops standards to improve the safety and quality of patient care and accredits health care facilities (hospitals, home health agencies, long-term care facilities, ambulatory care, etc.).

Medical necessity. Regulation by Medicare and most third-party payers that services provided must be necessary for the diagnosis or treatment of a patient's medical condition and that the services meet the standards for good medical practice. For more information on medical necessity, refer to ASHA's publication, *Medical Necessity for Speech-Language Pathology and Audiology Services*.

Medicare. Federally funded health insurance program for individuals age 65 and older, individuals with end-stage renal disease, and some severely disabled individuals under age 65. Part A covers hospital services, hospice care, home health services, and the first 90 days and 100 days, respectively, of inpatient hospital and skilled nursing facility care. Part B is a voluntary supplemental program that covers medical services, inpatient ancillary services after Part A services have been exhausted, and outpatient services other than home health and hospice care.

Skilled service. Service that is sufficiently complex in nature to require the knowledge and training of a professional.

Third-party payer. The payer of a health care service, typically a health insurance company, health plan, or publicly funded program. The provider of a service is the first party and the receiver of the service (client/patient) is the second party in the payment for health care services.

UPIN. Unique Physician Identification Number. A UPIN is assigned to every Medicare applicant (physicians and nonphysician providers) at the time they initially apply for a

Medicare PIN and is used to identify the referring and ordering physician on Medicare claims.

REFERENCES AND RESOURCES

- American Speech-Language-Hearing Association. (2003). Code of ethics (revised). *ASHA Supplement, 23*, 13-15.
- American Speech-Language-Hearing Association. (2004). Admission/discharge criteria in speech-language pathology. *ASHA Supplement, 24*, 65–70.
- American Medical Association. (2003). *Physicians' current procedural terminology* (4th ed.). Chicago: Author.
- Centers for Medicare and Medicaid Services. (2000). *Medical review guidelines for speech-language pathology services*. In *Medicare program integrity manual*. Baltimore, MD: Author.
- Commission on Accreditation of Rehabilitation Facilities. (2003). *Standards manual and accreditation sourcebook*. Tucson, AZ: Author.
- Horner, J. (2004). Legal implications of clinical documentation. *Perspectives on Swallowing and Swallowing Disorders (Dysphagia), 13*(1), 10–15.
- Joint Commission on Accreditation of Healthcare Organizations. (2004). *Comprehensive accreditation manual for hospitals: The official handbook*. Oakbrook Terrace, IL: Author.
- Joint Commission on Accreditation of Healthcare Organizations. (n.d.). *JCAHO patient safety goals*. Available from:
www.jcaho.org/accredited+organizations/patient+safety/npsg.htm
- Kibbee, R., & Lilly, G. (1989). Outcome-oriented documentation in a psychiatric facility. *Journal of Quality Assurance, 10*, 16.
- Miller, R., & Groher, M. (1990). *Medical speech pathology*. Rockville, MD: Aspen.
- National Student Speech Language Hearing Association. (2000). *Contemporary Issues in Communication Sciences and Disorders: Clinical writing and documentation*. Rockville, MD: Author.
- Slominski, T. (2004). Medicare documentation requirements for dysphagia service delivery. *Perspectives on Swallowing and Swallowing Disorders (Dysphagia), 13*(1), 3-6.
- U.S. Department of Health and Human Services. (1991). *The international classification of diseases* (4th ed., 9th rev.). Washington, DC: Author.
- World Health Organization. (2001). *International classification of functioning, disability, and health*. Geneva, Switzerland: Author.