



Documentation of Skilled Versus Unskilled Care for Medicare Beneficiaries

Medicare guidelines state that all services must be medically necessary and be provided at a level of complexity and sophistication that requires a speech-language pathologist to perform the tasks. They further stipulate that the interventions provided “require the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently” (Medicare Benefit Policy Manual, Chapter 15, Section 220.3B www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf).

What are examples of skilled services?

Speech-language pathologists use their expert knowledge and clinical decision-making to perform the skilled services listed below.

- Analyze medical/behavioral data and select appropriate evaluation tools/protocols to determine communication/swallowing diagnosis and prognosis.
- Design plan of care (POC) including length of treatment; establishment of long- and short-term measurable, functional goals; and discharge criteria.
- Develop and deliver treatment activities that follow a hierarchy of complexity to achieve the target skills for a functional goal.
- Based on expert observation, modify activities during treatment sessions to maintain patient motivation and facilitate success.
 - Increase or decrease complexity of treatment task.
 - Increase or decrease amount or type of cuing needed.
 - Increase or decrease criteria for successful performance (accuracy, number of repetitions, response latency, etc.).
 - Introduce new tasks to evaluate patient’s ability to generalize skill.
- Engage patients in practicing behaviors while explaining the rationale and expected results and/or providing reinforcement to help establish a new behavior or strengthen an emerging or inconsistently performed one.
- Conduct ongoing assessment of patient response in order to modify intervention based on:
 - patient performance in treatment activities;
 - patient report of functional limitations and/or progress.
- Ensure patient/caregiver participation and understanding of diagnosis, treatment plan, strategies, precautions, and activities through verbalization and/or return demonstration.
- Train and provide feedback to patients/caregivers in use of compensatory skills and strategies (e.g., feeding and swallowing strategies, cognitive strategies for memory and executive function).
- Train caregivers to facilitate carry-over and generalization of skills.
- Develop, program, and modify augmentative and alternative communication system (low tech or high tech).
- Instruct patient and caregiver in use and care of communication system.
- Develop maintenance program—to be carried out by patient and caregiver—to ensure optimal performance of trained skills and/or to generalize use of skills.
- For patients with chronic or degenerative conditions, evaluate patient’s current functional performance; provide treatment to optimize current functional ability, prevent deterioration, and/or modify maintenance program (**Medicare Benefit Policy Manual, Chapter 15, Section 220.2 C&D**).

Examples of Information to Be Included In Documentation of Skilled Services

To document skilled services, the clinician applies the tips listed below.

- Use terminology that reflects the clinician’s technical knowledge.
- Indicate the rationale (how the service relates to functional goal), type, and complexity of activity.
 - To address word retrieval skills, patient named five items within a category. A limit of 12 seconds made the activity more complex than that tried in the last session.
 - Because patient has residue in the mouth with solids, putting him at risk to aspirate that material, he performed tongue sweeps of the buccal cavity with minimal cues on 80% of solid boluses.
- Report objective data showing progress toward goal, such as
 - accuracy of task performance (e.g., 50% accuracy in word retrieval in sentence completion tasks);
 - speed of response/response latency (e.g., patient demonstrated 7–10 seconds of delay for auditory processing of sentence level information; delay reduced to 3 seconds with supplemental written cues);
 - frequency/number of responses or occurrences (e.g., patient swallowed 6/10 PO trials of ½ tsp boluses of puree textures with no delay in swallow initiation);
 - number/type of cues (e.g., initial phoneme cues provided on half of the trials);
 - level of independence in task completion (e.g., patient verbally described all compensatory strategies to maximize swallow safety independently, but required minimal verbal cues from SLP/caregiver to safely implement them at mealtimes);
 - physiological variations in the activity (e.g., patient demonstrated increased fatigue characterized by increasingly longer pauses between utterances).
- Specify feedback provided to patient/caregiver about performance (e.g., SLP provided feedback on the accuracy of consonant production; SLP provided feedback to caregiver on how to use gestures to facilitate a response).
- Explain decision making that result in modifications to treatment activities or the POC.
 - Explain how modifications resulted in a functional change (e.g., patient’s attention is enhanced by environmental cues and restructuring during mealtime, allowing her to consume at least 50% of meal without redirection).
 - Explain advances based on functional change (e.g., coughing has decreased to less than 2x/6 oz. drink; liquids upgraded from nectar to thin).
 - Indicate additional goals or activities (e.g., speech intelligibility remains impaired due to flexed neck and trunk posture and reduced volume; goals for diaphragmatic breathing will be added to POC to encourage improved respiratory support for verbal communication and increased volume of phonation).
 - Indicate dropped or reduced activities (e.g., cuing hierarchy was modified to limit tactile cues to enable greater independence in patient’s use of compensatory strategies at mealtimes).

- Indicate changes in target activities or response criteria (e.g., patient was able to identify target picture with 90% accuracy in field of four; picture communication chart [four pictures/page] was introduced to train patient for functional communication of wants and needs; patient perseverating during naming task, so added a 5-second pause between stimuli and this improved accuracy).
- Elaborate on patient/caregiver education or training (e.g., trained spouse to present two-step instructions in the home and to provide feedback to this clinician on patient’s performance).
- Evaluate patient’s/caregiver’s response to training (e.g., after demonstration of cuing techniques, caregiver was able to use similar cuing techniques on the next five stimuli).

What are unskilled services?

Unskilled services do not require the special knowledge and skills of a speech-language pathologist. Skilled services that are not adequately documented may appear to be unskilled. Unskilled documentation examples are listed below.

- Report on performance during activities without describing modification, feedback, or caregiver training that was provided during the session (e.g., patient was 80% accurate on divergent task; patient tolerated diet [or treatment] well).
- Repeat the same activities as in previous sessions without noting modifications or observations that would alter future sessions, length of treatment, or POC (e.g., continue per POC, as above).
- Report on activity without connecting the task to the long- or short-term functional goals (e.g., patient has treatment plan to address intelligibility related to dysarthria, but the note simply states “patient able to read a sentence and fill in the blank on 90% of trials”).
- Observe caregivers without providing education or feedback and/or without modifying plan.

Examples of Skilled and Unskilled Documentation

Treatment Notes

Motor Speech

Goal: Improve speech intelligibility of functional phrases to 50% with minimal verbal cues from listener.

Unskilled treatment note: Pt continues to present with unintelligible speech. Treatment included conversational practice. Recommend continue POC.

Comment: This treatment note does not provide objective details regarding patient’s performance.

Skilled treatment note: Pt continues to have unintelligible speech production; unable to consistently make needs known. Intelligibility at single word level: 60%; phrase level: 30%. Pt benefits from SLP’s verbal cues to reduce rate of speech and limit MLU to 1–2 words. Listener has better understanding if pt points to 1st letter of word first. Pt demonstrated improved self-awareness of intelligibility relative to last week’s session.

Aphasia

Short-term goal: Pt will produce one-word responses to functional *wh*- questions x 60% with min cues.

Unskilled treatment note: Pt produced word-level responses with 70% accuracy in treatment session with verbal cues.

Comment: This note does not include modification of the plan of care based on patient performance and does not detail skilled treatment activities.

Skilled treatment note: Word level responses to *wh*- questions to:

- self and ADLs: 70% accuracy
- semantically abstract questions: 50% accuracy

Benefits from phonological (initial syllable) cues but unable to self-cue successfully. Naming nouns is better than verbs. Performance improves when pt attempts written response to augment verbal output to facilitate phone-grapheme associations.

Dementia

Short-term goal: Pt will use compensatory strategies for orientation to time to reduce agitation with 80% accuracy when cued by staff

Unskilled treatment note: Pt recalled events that occurred earlier today with 50% accuracy.

Comment: This treatment note does not support the short-term goal in the plan of care.

Skilled treatment note: Spaced retrieval techniques were used to train pt to locate calendar, check clock, and look on whiteboard for daily schedule. Pt responded to temporal orientation questions relating to personal history (x 50% accuracy) and schedule at current living environment (x 60% accuracy) with mod verbal cues provided by SLP/caregiver. Pt benefitted from verbal rehearsals to improve independence in use of compensatory strategies.

Voice

Short-term goal: Pt will communicate in phrase level utterances x 10 with appropriate vocal quality, pitch, and loudness to indicate wants/needs.

Unskilled treatment note: Pt tolerated speaking valve for 30 minutes.

Comment: There is no clear connection between the daily note and the short-term goal.

Skilled treatment note: Speaking valve was placed to help facilitate verbal communication. Pt repeated 10 phrases without visible signs or symptoms of respiratory distress for 30 minutes. Pt's SPO2 level maintained 99%–100% during the entire session.

Progress Notes

Cognition/Executive Function

Short-term Goal: Pt will use compensatory strategies to record upcoming appointments with 90% accuracy.

Unskilled progress note: Pt was given an appointment book for recording upcoming appointments. Continue established POC.

Comment: This note does not report the patient's performance and provides no description of modification or feedback.

Skilled progress note: A 3-step process was provided in writing to help Mrs. J go through the steps of recording appointments in her pocket calendar. She practiced with trial appointments until she replicated the 3 steps with 100% accuracy with minimal verbal cues.

Dysphagia

Short-term goal: Pt will safely consume mechanical soft diet with thin liquids x 3 meals per day with ≤ 1 overt s/s of aspiration to meet all nutrition/hydration needs.

Unskilled progress note: Pt has been tolerating mechanical soft/thin liquid diet well.

Comment: This progress note does not reflect change in status as a result of skilled intervention.

Skilled progress note: Pt has been seen for 8 treatment sessions during this period. Pt's diet was upgraded from puree/nectar thick liquids to mechanical soft/thin liquid diet. Pt safely consumed 3 trial meals at lunch with no overt signs and symptoms of aspiration. Pt requires mod verbal cues to safely implement compensatory strategies. The short-term goal has been updated to include trials of regular texture foods. Plan of care includes caregiver education prior to discharge.

Discharge Notes

Dysphagia

Unskilled discharge note: Pt has made progress during treatment. Pt and wife educated on use of swallow strategies for safety. Recommend discharge SLP services at this time.

Comment: This note does not detail skilled intervention, patient's functional change in status, or skilled aspects of caregiver training.

Skilled discharge note: Skilled SLP services included caregiver education, dysphagia management, therapeutic diet upgrade trials, compensatory strategies (pacing, full oral clearance, cyclic ingestion, relaxation technique for controlled breathing) and discharge counseling. Pt currently has orders for mechanical soft with thin liquids x 2 meals (breakfast/lunch) but remains on puree at dinner. Significantly reduced swallow safety noted in evening due to increased cognitive-behavioral changes associated with sun-downing. Pt and his wife educated re: compensatory swallow strategies to improve safe and efficient swallowing with 100% return demonstration of strategies by his wife. SLP educated pt and family on the need to implement relaxation strategies while eating due to pt experiencing anxiety during meal times. Recommend pt returns home with home health SLP services to address swallow safety while maximizing efficient PO intake on mechanical soft diet with thin liquids.

The interpretation of Medicare guidelines and examples above are consensus-based and provided as a resource for members of the American Speech- Language-Hearing Association.

For clinical and documentation questions, contact Healthservices@asha.org.

For Medicare and reimbursement questions, contact reimbursement@asha.org.