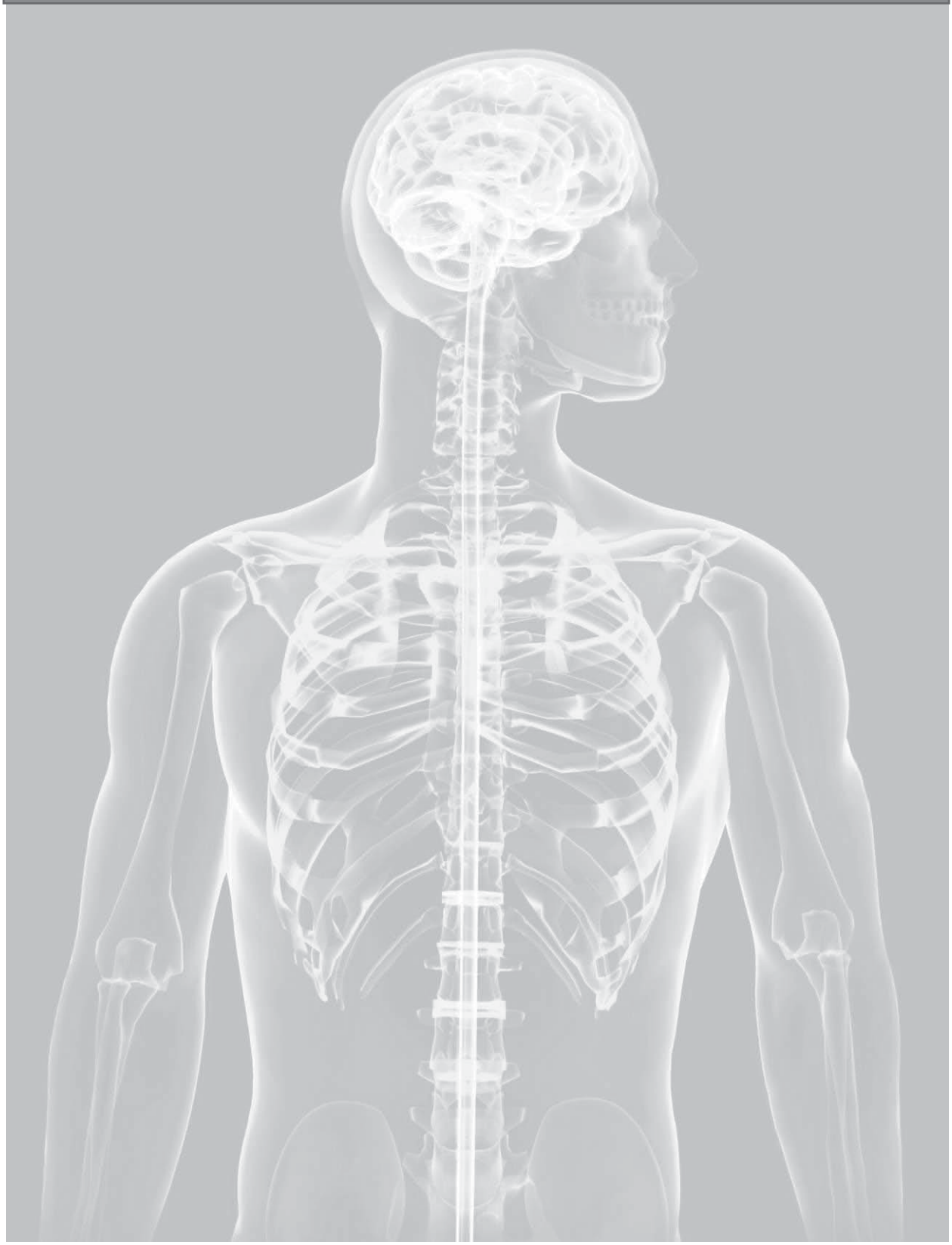
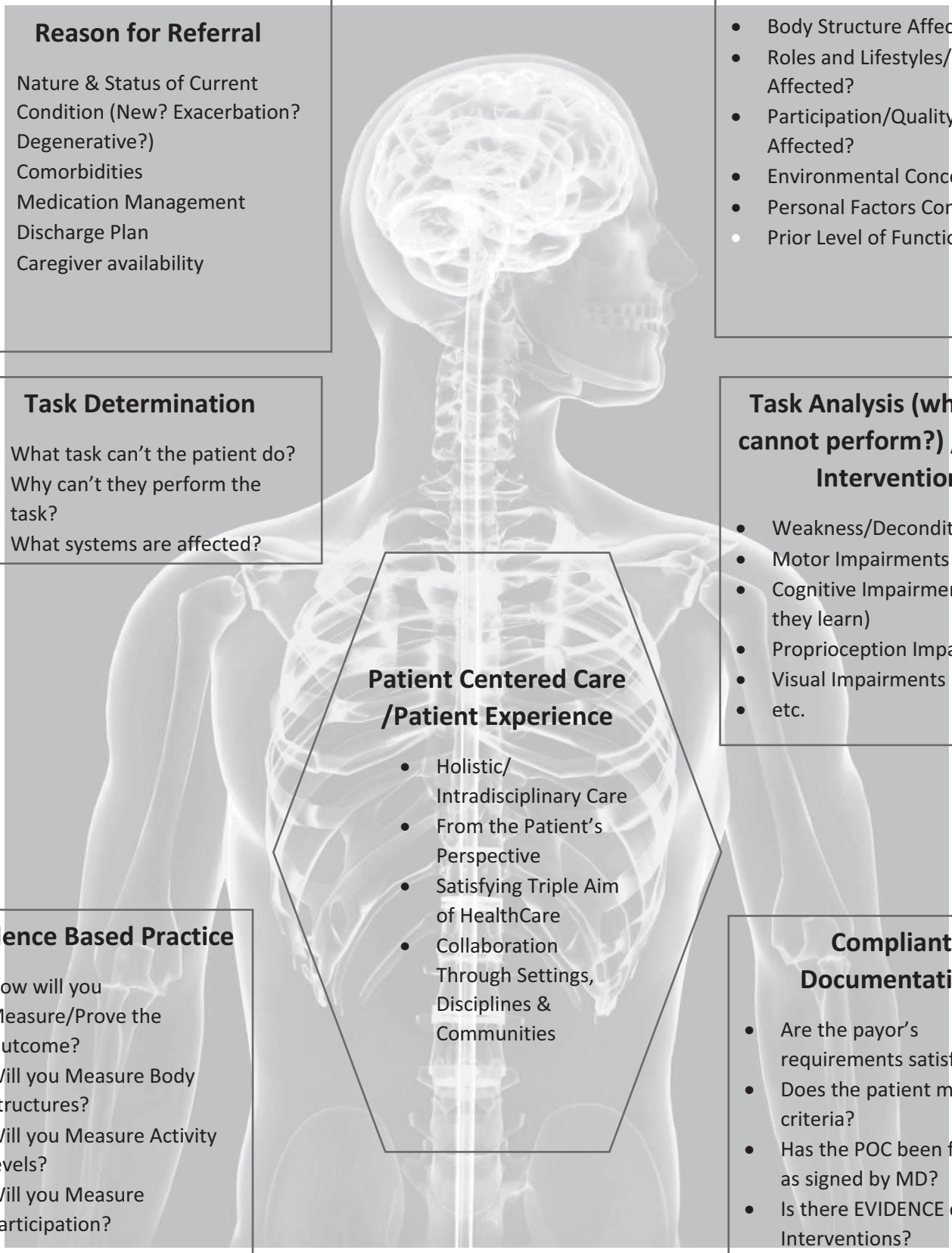
Reference Materials





Reason for Referral

- Nature & Status of Current Condition (New? Exacerbation? Degenerative?)
- Comorbidities
- Medication Management
- Discharge Plan
- Caregiver availability

Evaluation Process

- Body Structure Affected
- Roles and Lifestyles/ Activities Affected?
- Participation/Quality of Life Affected?
- Environmental Concerns?
- Personal Factors Concerns?
- Prior Level of Function

Task Determination

- What task can't the patient do?
- Why can't they perform the task?
- What systems are affected?

Task Analysis (why they cannot perform?) /Skilled Intervention

- Weakness/Deconditioned
- Motor Impairments
- Cognitive Impairment (Can they learn)
- Proprioception Impairment
- Visual Impairments
- etc.

Patient Centered Care /Patient Experience

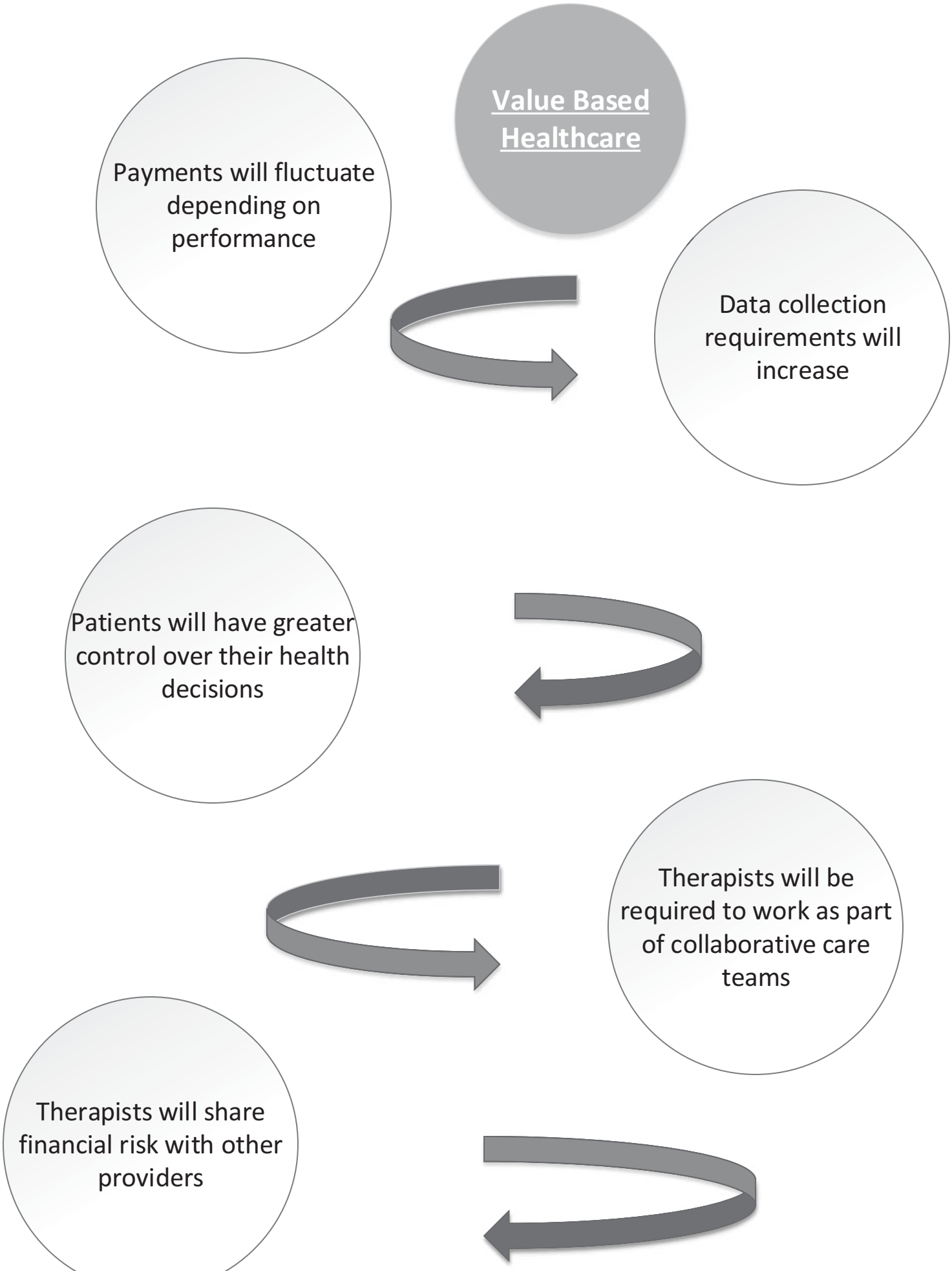
- Holistic/ Intradisciplinary Care
- From the Patient's Perspective
- Satisfying Triple Aim of HealthCare
- Collaboration Through Settings, Disciplines & Communities

Evidence Based Practice

- How will you Measure/Prove the Outcome?
- Will you Measure Body Structures?
- Will you Measure Activity levels?
- Will you Measure Participation?

Compliant Documentation

- Are the payor's requirements satisfied?
- Does the patient meet the criteria?
- Has the POC been followed as signed by MD?
- Is there EVIDENCE of Skilled Interventions?


Value Based Healthcare
Payments will fluctuate depending on performance
Data collection requirements will increase
Patients will have greater control over their health decisions
Therapists will be required to work as part of collaborative care teams
Therapists will share financial risk with other providers

Medicare Beneficiaries in need of post-acute care are discharged to 4 main settings

Medicare spending on PAC services has more than doubled since 2001 27B -59B 2013

Skilled Nursing Facilities
SNF provide skilled nursing & rehabilitative care to individuals who have had an acute care stay of at least 3 days

20%

Home Health Agencies
Beneficiaries qualify for HHC if they are under the care of a physician and need skilled nursing care on an intermittent basis

17%

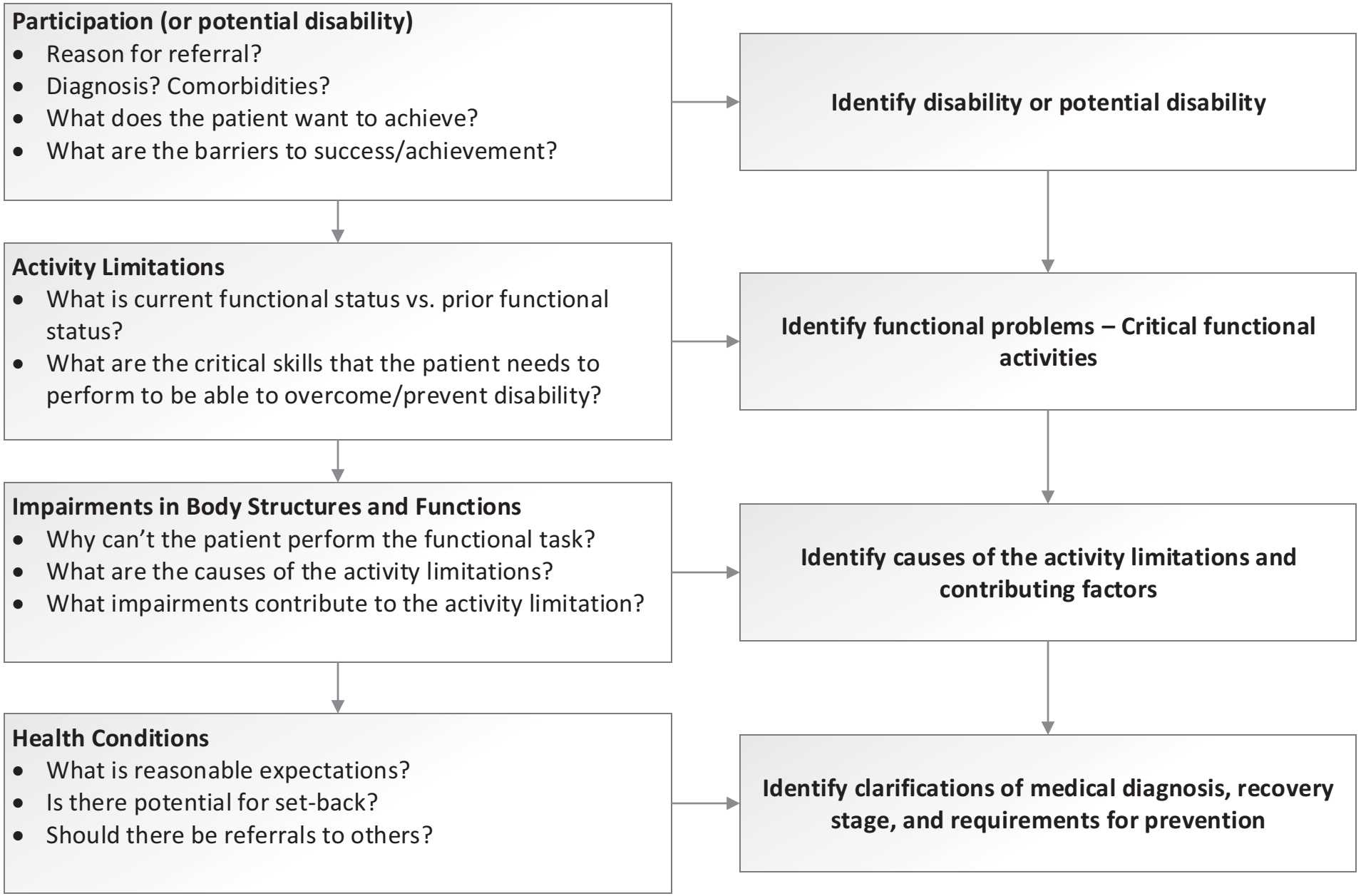
Inpatient Rehab Facilities
IRDs have to provide 60 percent of their care to patients with1 or more of 13 conditions (e.g., stroke, spinal chord, brain injury)

4%

Long Term Care Hospitals
LTCGs are classified as such if the average inpatient stay is longer than 25 days. LTCHs typically provide extended care to clinically complex patients

1%

The Process of Disablement Analysis



Medical Necessity

Services related to activities for the general good and welfare of the patient (general exercise to promote overall fitness and flexibility, and activities to provide diversion or general motivation , **do not** constitute therapy services for Medicare purposes.
Services related to recreational activities (golf, tennis, running, etc.) **are not** covered therapy services

To be covered, the patient's condition has the potential to improve or is improving in response to therapy, and there is the anticipation that the anticipated movement is attainable in a reasonable and generally predictable period of time

In the case of **maintenance therapy** treatment by the therapist is necessary to maintain, prevent or slow further deterioration of the patient's functional status and the services cannot be safely carried out by the beneficiary him or herself, a family member, another caregiver or unskilled person

- If the goal of the POC **is to improve** functioning, the documentation must establish that the patient needs the unique skills of a therapist to improve functioning
- If the goal of the POC **is to maintain**, prevent or slow further deterioration of functional status the documentation must establish that the patient needs the unique skills of a therapist to maintain, prevent or slow further deterioration

All services are to be specific and effective tx for the patient's condition according to accepted standards of medical practice. The amount, frequency and duration must be reasonable

The services that are provided must meet the description of **skilled therapy**

Skilled Therapy

- A service is **NOT** considered **SKILLED** merely because it is furnished by a therapist/assistant or
- It can be self-administered or provided by unskilled person
- The unavailability of a competent person does not make it skilled

Skilled services may be necessary to improve or maintain a patient's current condition or prevent or slow further deterioration

Services that do not require the professional skills of a therapist to perform or supervise are not medically necessary, even if performed by a therapist

The services shall be of a level of complexity and sophistication that can ONLY be delivered by a skilled professional

The fact that a patient has a significant diagnosis is not in and of itself sufficient.

If the patient cannot learn, services are **NOT** covered. Limited sessions to teach a caregiver ARE covered

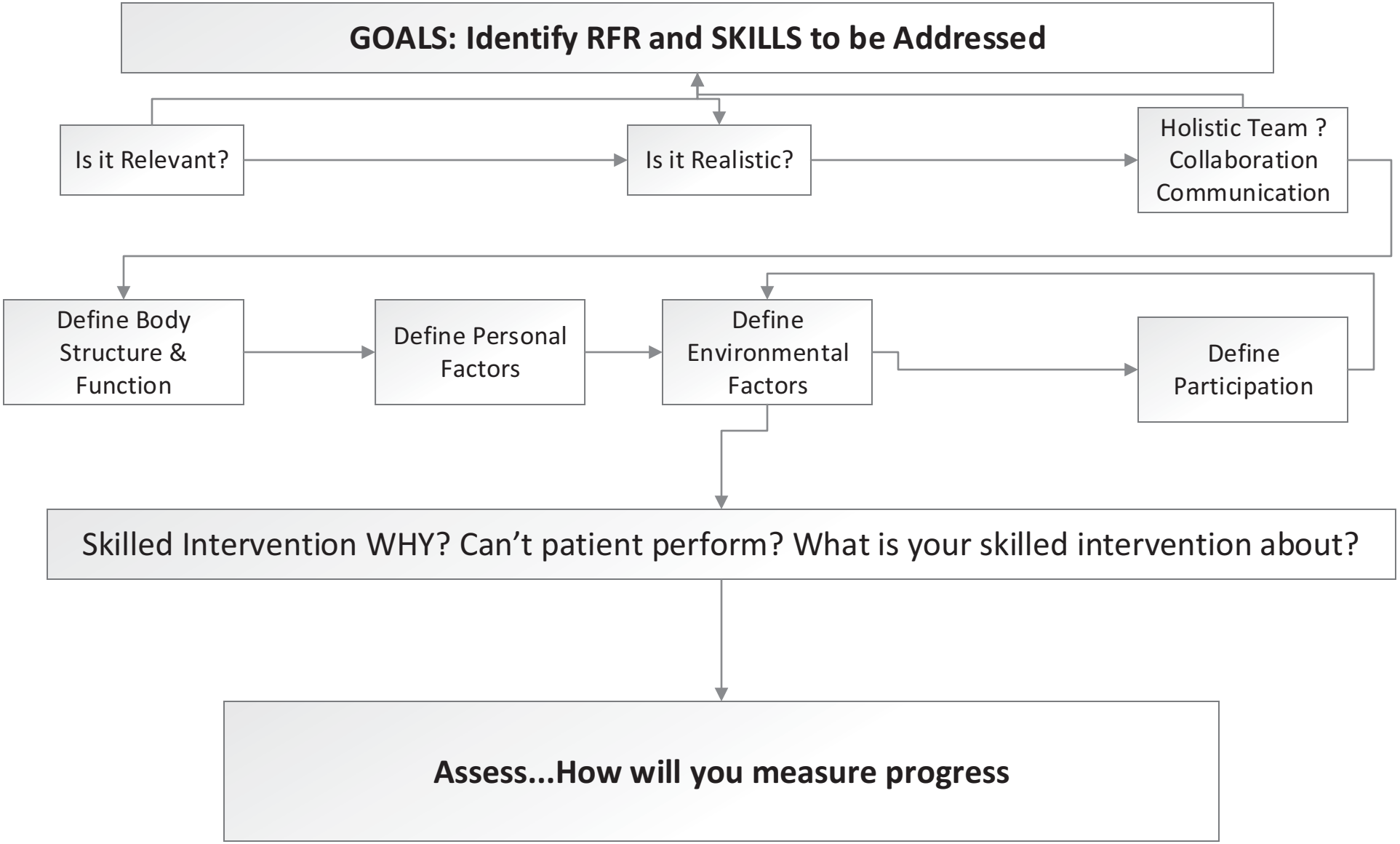
Maintenance Therapy

<u>Establishment or Design</u> of Maintenance Programs:

- If the specialized skill, knowledge and judgment of a qualified therapist are required to establish or design a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration, the establishment or design of a maintenance program by a qualified therapist is covered.
- If skilled therapy services by a qualified therapist are needed to instruct the patient or appropriate caregiver regarding the maintenance program, such instruction is covered.
- If skilled therapy services are needed for periodic reevaluations or reassessments of the maintenance program, such periodic reevaluations or reassessments are covered.

<u>Delivery</u> of maintenance programs:

- Once a maintenance program is established, coverage of therapy services to carry out a maintenance program turns on the beneficiary's need for skilled care.
- A maintenance program can generally be performed by the beneficiary alone or with the assistance of a family member, caregiver or unskilled personnel. In such situations, coverage is not provided.
- However, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program.
- Such skilled care is necessary for the performance of a safe and effective maintenance program only when
- (a) the therapy procedures required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure or
- (b) the particular patient's special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient's current function or to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures.


GOALS: Identify RFR and SKILLS to be Addressed
Is it Relevant?
Is it Realistic?
Holistic Team ?
Collaboration
Communication
Define Body Structure & Function
Define Personal Factors
Define Environmental Factors
Define Participation
Skilled Intervention WHY? Can't patient perform? What is your skilled intervention about?
Assess...How will you measure progress

Documentation Core Concepts
Thorough Documentation is a Matter of BEST PRACTICE

Technical Requirements

POC: Frequency, Duration, Orders, DME, etc

MD signatures + verbal orders

Setting Expectations

Updating POC as NEEDED!

Fullfill all requirements prior to billing

Clinical Requirements

Must show **SKILL**

Must be Reasonable & Necessary (Think primary + co-morbidities+ personal factors)

The 3 "C"s of Documentation:

- **Content**: what you did/ observed/patient reacted.
- What was pre-morbid status? Are goals achievable? How will you prove it?

Clarity: how was treatment skilled, demonstrate clinical decision making why more skilled treatments are needed, what was pre-morbid status

- **Communication:** is patient making progress? Measured through objective tests & measures,
- What type of cues, location of cues ? Activity set-up? Quality of movement? Safety Risks?
- Consistent & Reliable performance. What could happen if skill is **NOT** provided?
- Reason for treatment is to achieve **FUNCTION**

Documentation MINDFULNESS
Thorough Documentation is a matter of BEST PRACTICE

Be mindful of notes that do not reflect PROGRESS unless it is a MAINTENANCE case then the note should reflect SKILL

Lack of objective measures

Pay close attention to levels of assistance (burden of care), changes in devices, pain levels correlated to functional activities (reduction in pain leads to increased tolerance?)

Is the patient part of the decision making? Are they onboard with POC and Goals? Are they realistic and achievable? Can the patient learn? If not, can the caregiver learn?

Are goals, progress, POC updated as needed? Are all impairments/goals addressed?How does the patient tolerate treatment?

Did you terminate services appropriately?

New Evaluation Codes for PT & OT

Low Complexity

(PT 97161 - OT 97165)

- A history with no personal factors and/or comorbidities that impact the plan of care
- An examination of body system(s) using standardized tests and measures and patient assessment instrument and/or measurable assessment of functional outcome addressing 1-2 elements from any of the following: body structure and functions, activity limitations, and/or participation restrictions; and
- A clinical presentation with stable and/or uncomplicated characteristics

Moderate Complexity

(PT 97162 - OT 97166)

- A history with 1-2 personal factors and/or comorbidities that impact the plan of care
- An examination of body system(s) using standardized tests and measures and patient assessment instrument and/or measurable assessment of functional outcome addressing a total of 3 or more elements from any of the following: body structure and functions, activity limitations, and/or participation restrictions; and
- An evolving clinical presentation with changing characteristics

High Complexity

(PT 97163 - OT 97167)

- A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care
- An examination of body system(s) using standardized tests and measures and patient assessment instrument and/or measurable assessment of functional outcome addressing a total of 4 or more elements from any of the following: body structure and functions, activity limitations, and/or participation restrictions; and
- A clinical presentation with unstable and unpredictable characteristics

Reevaluation

(PT 97164 – OT 97168)

- An examination including a review of history and use of standardized tests and measures is required and,
- Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome
- A clinical presentation with unstable and unpredictable characteristics

Documentation Considerations for Evaluation Code Selection

Required Component	Supporting Documentation
Personal factors/Comorbidities	• Clearly document any personal factors & comorbidities that influence the patient's participation in the plan of care and his/her ability to progress • Identify the number of pertinent personal factors and/or comorbidities, as this number is a key determinant of the level of complexity • It isn't enough to retain a past medical history checklist or to identify comorbidities and/or personal factors in the evaluation report. You must establish and specify their impact on the course and/or outcome of treatment
Body Systems Elements (Body Structure and Function, Activity Limitations, Participation Restrictions)	• Clearly document all body structures and functions that you will address during treatment, and any activity limitations and any participation restrictions that will be affected by interventions • Identity the combined number of body structures, body functions, activity limitations and /or participation restrictions, as this number is a key determinant of the level of complexity • Use standardized tests and measures to objectify the examination findings
Clinical Presentation	• Clearly document evidence of the patient's clinical presentation as either stable, evolving or unstable • Include this identification within the assessment portion of the report • Evidence of the clinical presentation might include, but is not limited to: vital sign response; continuous, intermittent or changing levels of pain; and varying levels of awareness or cognitive performance
Clinical Decision Making	• Clinical decision making is not a separate component; you demonstrate it through effective documentation of your evaluation findings. • Clinical decision making reflects your judgment and multidimensional thinking • Documentation demonstrating the number of components that you analyze, examine, and coordinate will support the specific level of clinical decision making
Functional Outcomes Tools	• Standardized patient assessment and/or measurable assessment of functional outcomes are required components that you must include in your documentation • The results of any standardized patient assessment and functional outcomes tools you performed should support your level of clinical decision making
Evaluation Complexity Level	• Clearly document the assigned level of complexity (low, moderate, or high) on your evaluation report • Your documentation throughout the report should support the selected evaluation codes

Reference: Evans WK. The keys to effective documentation. PT in Motion. 2016;8(7):8-12

Therapeutic Exercises (97110)

Appropriate to:
Develop/restore strength
Develop/restore endurance
Develop/restore ROM
Develop/restore flexibility
Can be Active/active assisted

Reasonable & Necessary :
As a result of disease, injury which has resulted in:
FUNCTIONAL LIMITATIONS

Can be passive

If passive, usually not more than 2-4 visits to develop & train patient/caregiver. If more then documentation speaks to instability of joint, unhealed status, requires **SKILL of therapist ONLY**

- Once instructions completed, repetition and monitoring in the absence of additional skilled care is non covered
- Its appropriate to transition portions of the treatment to an HEP as pt/caregiver master the technique

Exercises to promote overall fitness, flexibility, endurance (in absence of a complicated patient condition), aerobic conditioning, or weight reduction are **NOT COVERED**. Maintenance exercises to maintain ROM/strength may only be covered when **ALL** criteria for skilled maintenance are met

Therapeutic Exercise
DOCUMENTATION REQUIREMENTS

Documentation **MUST** describe new exercises added or changes made to exercise program to help justify that the services are skilled

Documentation **MUST** also show that exercises are being transitioned as clinically indicated to an independent or caregiver assisted exercise program (HEP)

The HEP is an integral part of the therapy POC and should be modified as the patient progresses during course of treatment

Documentation should include not only measurable indicators such as functional loss of joint motion or muscle strength but also information on the impact of these limitations on the patient's life and how improvement in one or more of these measures leads to improved function

At every time point reassessment documentation **MUST** include: objective measurement of loss, strength and ROM (with comparison to uninvolved side) and effect on function

If used for pain, documentation **MUST** include pain rating, location of pain, effect of pain on function

When skilled cardiopulmonary monitoring is required, documentation **MUST** include recordings of pulse oximetry, HR, BP, perceived exertion, etc.

Documentation **MUST** clearly support the need for continued therapeutic exercise

Documentation **MUST** describe specific exercises performed, purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skill of a therapist were required

- Supportive Documentation (at time point re-assessment especially) **MUST** Contain:
  - Objective measures (strength, ROM with comparisons to uninvolved side, prior level of function and effect on **FUNCTION)**
  - If used for pain, pain ratings and effect on **FUNCTION**
  - Instructions given, assistance needed to show **SKILL** of therapist

Neuromuscular Re-Education (97112)

Appropriate for:

- Re-ed of movement
- Re-ed of balance
- Re-ed of coordination
- Re-ed of kinesthetic sense
- Re-ed of posture
- Re-ed of proprioception

Reasonable & Necessary :
To restore balance, coordination, kinesthetic sense, posture, proprioception, PNF, BAP's board, vestibular rehab, desensitization, balance/posture training

Can be in supine, sitting or standing

Reasonable & Necessary :
For restoring prior FUNCTION affected by loss of deep tendon reflexes/vibration sense, nerve palsy, muscular weakness or flaccidity as a result of CVA, nerve injury or disease or spinal cord disease or trauma. Poor static or dynamic sitting/standing balance. Postural abnormalities. Loss of gross/fine motor coordination, Hyper/hypo tonicity

- VOR Exercises once **MASTERED** then become HEP. No longer Reasonable & Necessary
- Repetitive cues once **MASTERED** should be turned over to caregiver. **No longer Reasonable & Necessary**

- Once instructions completed, repetition and monitoring in the absence of additional skilled care is **non-covered**
- Its appropriate to transition portions of the treatment to an HEP as patientt/caregiver master the technique

Neuromuscular Re-education
DOCUMENTATION REQUIREMENTS

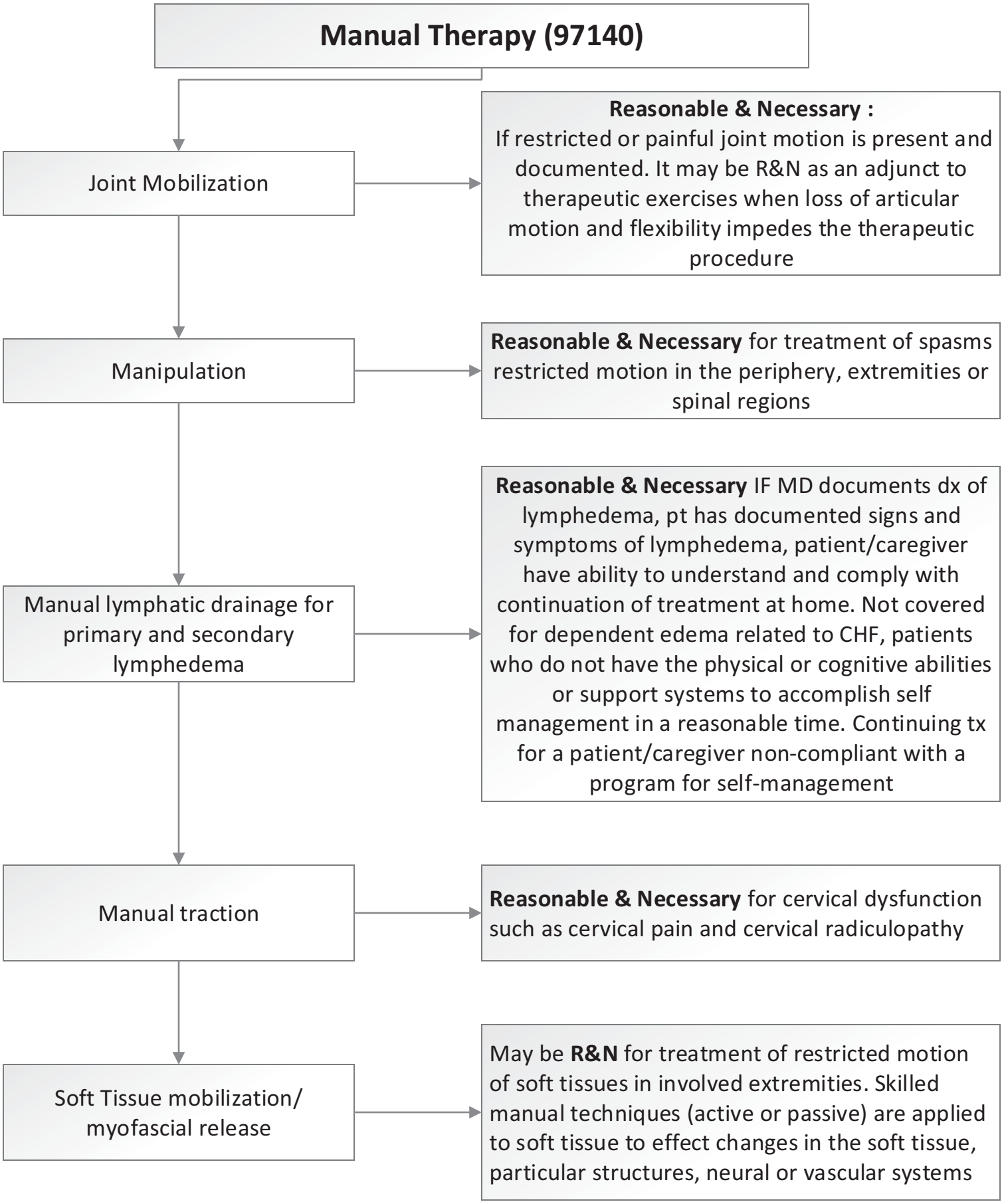
Documentation must include objective loss of ADLs, mobility, balance, coordination deficits, hypo and/or hypertonicity posture and effect on **FUNCTION**

Documentation of specific exercises/activities performed (including progression of the activity), purpose of the exercise as related to **FUNCTION**, instructions given, and/or assistance needed, to support that the skills of a therapist were required

When therapy is instituted as a result of a fall risk, history of falls, documentation must include: specific fall dates and/or hospitalization and reason for fall if known; most recent prior functional level of mobility, use of assistive device if any, levels of assist, frequency of falls or "near falls". Also **MUST** include cognitive status, functional loss due to recent change in condition, balance assessments, patient & caregiver training, and carry-over of therapy techniques to objectively document progress

Documentation must clearly support the need for continued neuromuscular re-education past an average of 12-18 visits

- Supportive Documentation **MUST** include (every time point reassessment)
- Objective loss of ADL, mobility, balance, coordination, deficits, hypo/hyper tonicity, posture and effects on **FUNCTION**
- Specific exercises/activities performed, purpose as related to **FUNCTION**. Instructions given, assistance needed that support the **SKILL** of the therapist


Manual Therapy (97140)
Joint Mobilization
Reasonable & Necessary :
If restricted or painful joint motion is present and documented. It may be R&N as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure
Manipulation
Reasonable & Necessary for treatment of spasms restricted motion in the periphery, extremities or spinal regions
Manual lymphatic drainage for primary and secondary lymphedema
Reasonable & Necessary IF MD documents dx of lymphedema, pt has documented signs and symptoms of lymphedema, patient/caregiver have ability to understand and comply with continuation of treatment at home. Not covered for dependent edema related to CHF, patients who do not have the physical or cognitive abilities or support systems to accomplish self management in a reasonable time. Continuing tx for a patient/caregiver non-compliant with a program for self-management
Manual traction
Reasonable & Necessary for cervical dysfunction such as cervical pain and cervical radiculopathy
Soft Tissue mobilization/ myofascial release
May be R&N for treatment of restricted motion of soft tissues in involved extremities. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissue, particular structures, neural or vascular systems

Manual Therapy
DOCUMENTATION REQUIREMENTS

Documentation must include area being treated, soft tissue or joint mobilization technique being used, objective and subjective measurements of area treated (may include ROM, capsular end-feel, pain description and ratings) and effect on **FUNCTION**

For Lymphedema treatment documentation **MUST** include medical history related to onset, exacerbation and etiology of the lymphedema comorbidities, prior treatment. Cognitive and physical evidence that the patient/caregiver are able to follow self-management techniques. Limb measurements of affected and unaffected lims start of care and periodically throughout treatment. Description of skin condition, wounds, infected sites, scars

Documentation **MUST** include cognitive and physical evidence that the patient/ caregiver are able to follow self-management techniques

Documentation **MUST** include limitation of function related to self-care, mobility, ADLs, and/or safety

Documentation **MUST** include reference to prior level of function

Documentation **MUST** include evidence of skill prolonged treatment. Treatment should be ended when patient/caregiver have been instructed on continued management/practice

Self-Care/Home Management (97535)

Appropriate for:

- ADL re-training
- IADL re-training
- Compensatory training
- Meal preparation
- Safety procedures & instructions

Reasonable & Necessary :
Only when it requires the skills of a therapist, is designed to address specific needs and is part of an active treatment plan directed at a specific outcome
FUNCTIONAL LIMITATIONS

The patient must have a condition for which self-care/home management is **R&N.** The training should be focused on **FUNCTIONAL LIMITATIONS** in which there is a potential for improvement in a functional task that will be meaningful to the patient and the caregiver. The patient/caregiver **MUST** have the capacity to learn.

Services provided to the same patient by P.T. & O.T. may be covered as long as separate and distinct goals are documented in the tx plan and there is **NO DUPLICATION OF SERVICES**

Repetitious completion of the activity, once taught & monitored is **non-covered care.**

Self-Care/Home Management DOCUMENTATION REQUIREMENTS

Documentation **MUST** relate the training to expected functional goals that are attainable by the patient

Documentation of objective measurements of the patient's activity of daily living (ADL/IADL) impairment to be addressed

The specific ADL and/or compensatory training provided, specific safety procedures addressed, specific adaptive equipment/ assistive technology utilized, instruction given and assist required (verbal or physical), and the patient's response to the intervention, to support that the services provided required the skills and expertise of a therapist

As the patient progresses through an episode of care involving self care/home management training, documentation needs to clearly support that the skills of a therapist continue to be necessary. Documentation that demonstrates progression in the technique to more complex or less patient dependence will assist in demonstrating that the technique remains skilled. **It is important that documentation demonstrates that the skills of a therapist are needed and that the patient is not merely practicing techniques that have already been taught**

Gait Training/Stair Climbing (97116)

Appropriate to:
Train patients and instructing caregivers in ambulating patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma

Indications for gait training include, but are not limited to:

- CVA, now stabilized & ready to begin rehabilitation
- Musculoskeletal trauma
- Chronic or progressive condition
- An injury or condition that requires instruction in the use of a device, orthosis, prosthesis
- A condition that requires retraining in stairs/steps or uneven surfaces
- Instructing a caregiver in appropriate guarding and assistive devices

Gait training is not considered **Reasonable & Necessary** when the patient's walking ability is not expected to improve

Repetitive walk-strengthening exercise (such as for feeble patients or to increase endurance or gait distance) does not require the skills of the therapist and is considered **not R&N**

Antalgic gait alone does not support the need for ongoing skilled gait training. Antalgic gait refers to a gait pattern assumed in order to avoid or lessen pain. Limited gait training may be appropriate, when supported as medically necessary in the documentation, to teach the patient improved gait patterns to reduce stress on the painful area. In most circumstances as the pain decreases the gait will improve spontaneously without the need for skilled gait training intervention

Gait Training/Stair Climbing
DOCUMENTATION REQUIREMENTS

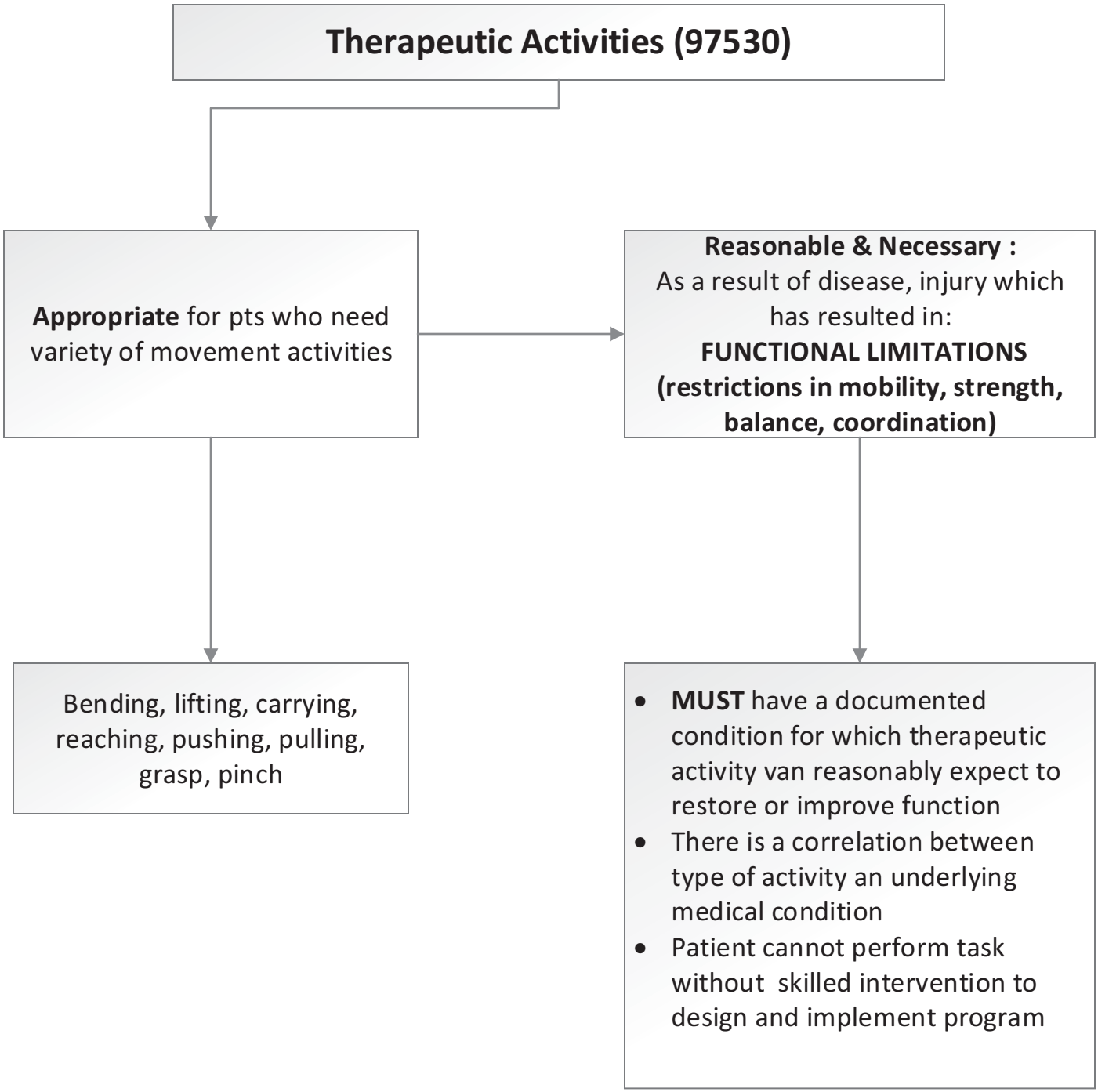
Documentation of objective measurements of balance and gait distance, assistive devices used , amount of assistance required, gait deviations and limitations being addressed, use of orthotic or prosthesis, need for and description of verbal cueing

Documentation of objective measurements of the presence of complicating factors (pain, balance/gait deficits, stairs, environment, safety concerns)

Specific gait training techniques used, instructions given, and/or assistance needed, and the patient's response to the intervention, to demonstrate that the skills of a therapist were required

Documentation must clearly support the need for continued gait training beyond 12-18 visits within a 4-6 week period

- Supportive Documentation Requirements (every time point reassessment) **MUST** include:
- Objective measures of balance, gait distance, adaptive equipment, assistance, gait deviations, limitations, use of orthosis/prosthesis, need of and description of verbal/tactile cueing
- Presence of complicating factors (pain, balance deficits, gait deficits, stairs, architectural or safety concerns)
- Specific gait training techniques used, instruction given, and or assistance needed and patient's response that demonstrate the **SKILL** of the therapist


Therapeutic Activities (97530)
Appropriate for pts who need variety of movement activities
Reasonable & Necessary :
As a result of disease, injury which has resulted in:
FUNCTIONAL LIMITATIONS
(restrictions in mobility, strength, balance, coordination)
Bending, lifting, carrying, reaching, pushing, pulling, grasp, pinch
MUST have a documented condition for which therapeutic activity van reasonably expect to restore or improve function
There is a correlation between type of activity an underlying medical condition
Patient cannot perform task without skilled intervention to design and implement program

Therapeutic Activities
DOCUMENTATION REQUIREMENTS

Documentation **MUST** clearly support the need for continued therapeutic activity beyond 10-12 visits

Objective measurements of loss of ADLs, balance, strength, coordination, ROM, mobility and effect on function

Specific activities performed, and amount and type of assistance to **demonstrate** that the skills and expertise of the therapist were required