REGULATORY TIPS DEPARTMENTAL INSERVICE

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EVALUATION MINUTES

- What constitutes an evaluation vs. treatment?
- Rounding of minutes is not acceptable for eval or treatment

MEDICAL HISTORY

- A critical piece of information needed in the evaluation/plan of care is the Reason for Hospitalization. This should always be included when the patient was recently discharged from the hospital.
- The past medical history should not just be a list of all patient diagnoses but, rather, those relevant to therapy at the time of the evaluation. When possible, include dates of past medical events which might impact therapy, e.g. for prior strokes, amputations, fractures, head injuries, etc. Also important to point out are diagnoses of newly diagnosed diseases such as new onset of Parkinson's and Alzheimer's.
- When only a diagnosis list is included in the Medical Diagnosis and the Medical History sections, it is impossible to know what is current and what is relevant.

REASON FOR REFERRAL

- Avoid non-relevant information here. The Reason for Referral should be:
    - Discipline specific
    - Functional
    - Task-oriented
    - Examples: PT/OT/ST
- Examples of non-relevant reasons for referral

Examples of Reasons for Referral for ST- cognition patients
Decreased ability to:

- Manage money
- Manage meds
- Problem solve emergency situations
- Make and keep appointments
- Sequence the use of appliances
- Use call light effectively

PRIOR LEVEL OF FUNCTION (PLF)

- This is one of the most critical pieces of information. Without it, the medical necessity of the evaluation and, subsequently, of treatment is not supported.
- PLF must be:
    - Discipline specific
    - Functional
    - Task-oriented
    - Objective
    - Comprehensive, including higher level tasks
    - Should mirror the Reason for Referral
- If the Reason for Referral indicates a decline in ambulation, money management and dressing, the PLF should indicate the patient's prior status for these tasks.
- Therapy documentation is part of the patient's legal medical record.
    - One should never document unsubstantiated PLF. For example, unless there is documentation from a very recent episode of therapy, one cannot objectively state what the patient's prior status was for component deficits such as strength, balance, ROM, problem solving, memory, etc.
    - The patient, family, friends or other caregivers can report on the patient's ability to perform defined tasks such as walking, transferring to the toilet, managing their medications, etc. but cannot report on component deficits.
    - Ultimately, the PLF should be reserved for functional tasks, vs. component tasks
- What to do if PLF is not obtainable, at the time of the evaluation

GOAL WRITING

- Per Chapter 15 of the Medicare Benefit Policy Manual *"improvement is evidenced by successive objective measurements".*
- Goals are another critical component of documentation.
- Only short term goals are required to be reported on in the weekly note. Therefore, all goals, including those as long term goals, must appear as short term goals in order to capture weekly status.
- Goals must be:
    - Objective
        - Not acceptable- increased, decreased, maximum potential, adequate, maximize independence
    - Functional
        - Not acceptable- stand-alone goals for strength, balance, activity tolerance, yes/no questions, problem solving, sequencing, etc.
    - Comprehensive

      The lack of comprehensive goals:
        - Decreases the opportunity to capture progress
        - Reduces the ability to support duration
        - Can result in assistants working outside of their scope of practice
        - Can result in therapists and assistants working outside of the physician-approved plan of care
    - Backed up by PLF

        - If there is no PLF for a functional task being addressed in treatment, there is no proof there has been a decline- therefore Medicare can, and has, denied services for a specific task.

SKILLED INTERVENTION

NGS' LCD L33631 indicates that *"The services shall be of such a level of complexity and sophistication…..shall be such that the services required can only be safely and effectively performed by a qualified clinician or therapists supervising assistants."*

- Must show evidence of the need for skilled personnel
- Must show evolution of treatment, cannot be repetitive to the point that non-skilled personnel could be trained to take over- even if the patient is making progress
- Non-covered services:
    - Activity tolerance, endurance, and/or aerobic conditioning
    - Clinically non-beneficial treatment- not medically necessary
        - Treatment when the patient is already at supervision, set-up, modified independence or independent
        - ROM exercises with no ROM deficits noted, and/or goals with strength 3/5 or greater
        - Many electronic options include a variety of tasks addressed. Make certain all are goals in the poc.
- Non-acceptable practice
    - Stating what the patient did in lieu of what you, the therapist, did
        - E.g. Patient completed, practiced, ambulated, performed, etc. is not a substitute for what was instructed, facilitated, adjusted, modified, upgraded, revised, etc.
    - Stating patient status in lieu of skilled services provided
    - Not stating the specific task addressed- e.g. ADLs and functional mobility noted vs. specific ADL tasks (UBD, clothing management, etc.) and specific mobility tasks (e.g. ambulation, w/c mobility, car transfers, rolling, etc.)
    - Using generic terminology such as instruction in (non-identified) compensatory strategies, work simplification, energy conservation techniques, safety and body mechanics.
    - Instruction in techniques, activities, tasks, and training without identifying specific techniques, activities, tasks, and training.
        - Non-specific- "dressing techniques". More specific/skilled- hemi-dressing techniques
        - Non-specific- "balance activities". More specific- upper body mobility on lower body stability activities or reaching out of base of support in sit/stand activities
        - Non-specific- "safety awareness". More specific- instructed to maintain appropriate base of support in stand to prevent falls.
        - Non-specific- "bed mobility training to improve functional performance". More specific- segmental rolling, roll toward the affected side, etc.
    - Therapeutic exercise with a list of exercises but no skilled instruction or modification
    - Use of exercise equipment with no mention of skilled instruction
    - Stating the reason for doing a task in lieu of the skilled techniques provided

DAILY NOTES

- While daily documentation of skilled intervention provided is not a requirement of Medicare, it is becoming increasingly more important to capture skilled services for each CPT service provided each day.
- Daily notes provide additional detail to support the medical necessity of treatment, to capture one-time events such as patient was ill, at a doctor's appointment, was upgraded from NWB to WBAT, etc.
- Daily notes also allow the person who actually provided the service to document what was done vs. skilled intervention found in weekly notes written by one person but, perhaps, provided by multiple clinicians and
    - Allow improved recall of events and services of each treatment session
    - Provide more current information for the next-day treating clinician
- Pitfalls of sporadic or occasional daily documentation