Therapy Documentation in 2011:
*Therapist Assistants*

March 10, 2011

Presented By:

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Cindy Krafft MS PT is the Director of Rehabilitation Consulting Services for Fazzi Associates, Inc. She has 15 years of home health experience ranging from PRN Clinician to the Director of Rehabilitation for a six agency home care system. She serves as the President of the Home Health Section of the American Physical Therapy Association, Chair of the NAHC Therapy Advisory Committee, and is on the NAHC Regulatory Affairs Committee. She has published a variety of articles in Caring Magazine, The Remington Report, Success in Home Care, Home Healthcare Nurse, and the Home Health Section of APTA newsletter. As well as being an expert on therapy practice in home care she also assists agencies with achieving OASIS competency. She served as the Clinical Co-Director of the Delta National OASIS-C Best Practices Project and currently acts as the Clinical Director of the Delta Excellence in Therapy Project. She is a well received speaker at both the state and national levels on the topics of OASIS, therapy documentation, program development, therapy utilization, and recruitment.
Instructions and Handouts for: Therapist Assistants

It is very important that you have these materials printed and ready to use prior to the start of the training.

In order to participate in this training you will need to do the following:

1. Dial 1 (877) 615-4337 at least 10 minutes prior to the start of the webinar.

2. When asked, enter Conference ID 8437358#.

3. Give your agency’s name.

4. At this time you will be entered into the call and in “listen mode.”

5. If at any time you need assistance you may press *0 for the operator.

6. There will be a Q & A period toward the end of the session. Questions will be answered in the order in which they are received. To ask a question, press *1. You will have the opportunity to ask your question and then be returned to “listen mode.” Do not press *1 prior to this time.

7. To view the presentation online you must click on the link sent to you from GoToWebinar.
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**Why the Concerns?**

- Therapy Practice Pattern shifts?  
  - 26% increase 14+
- OASIS Data Analysis  
  - Support for referrals?
- “Incentives” in the PPS structure?  
  - 6, 14 and 20+

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**MedPAC Report**

“MedPAC wrote in the March 2010 report (MedPAC, 2010, p. 206) that payment incentives continue to influence treatment patterns, and that payment policy is such a significant factor in treatment patterns because the criteria for receipt of the HH benefit are ill-defined.”
Semantics?

- PPS 2011 contains “Therapy Clarifications” not new regulations.
- Drive the professions back to basics to support skilled care.

Foundation

- The plan of care must be built upon a solid initial assessment.
- Periodic reassessment ensures the building is progressing as planned or explains why there are delays.

Initial Assessment

- Prior Level of Function:
  - NOT optional
- Tests and Measures:
  - Connected to functional activity
- Determining the “need” for therapy:
  - Not based on diagnosis
- Establish rehabilitation potential:
  - Restorative versus maintenance
Prior Level of Function

- Be specific to the task and the timeframe:
  - PLOF = dependent
  - Bathing PLOF = min A X 1
  - PLOF amb = dependent
  - Patient non ambulatory X 5 years
- Key piece to create baseline and set expectations

Coverage Issue

“Therapy would not be covered to effect improvement or restoration of function when a patient suffered a transient and easily reversible loss or reduction of function.”

Now What?

- Identification of deficits does not automatically support the need for skilled care.
- Must determine what specific interventions are needed to enact change.
Issues by Discipline

- Physical Therapy:
  - Gait – more than distance, device, and level of assistance

- Occupational Therapy:
  - ADLs and IADLS should not be assessed as a group of tasks

- Speech Therapy:
  - Clarity of functional impact of testing.

- Bottom Line – quantity AND quality of patient performance

Connecting the Dots

- Measurements:
  - ROM
  - Strength
  - Balance
  - Vision
  - Pain
  - Sensation
  - Communication
  - Cognition
  - Environment
  - Equipment

- Functional Impact:
  - Ambulation
  - Transfers
  - Bathing
  - Dressing
  - Toileting
  - Incontinence
  - Medication Management
  - Swallowing
  - Home Management

What Does a Therapist See?

- “Gait Deficits”:
  - Patient 1 – Visual and cognitive issues
  - Patient 2 – Leg length discrepancy and pain

- “ADL Deficits”:
  - Patient 3 – Anxiety and lack of transfer bench
  - Patient 4 – Balance and arm in a sling

- “Swallowing Deficits”:
  - Patient 5 – Posture and muscular weakness
  - Patient 6 – Attention and memory
Selecting Interventions

• Current Model:
  – Gait training
  – Transfer Training
  – Ther. Ex./HEP
  – Balance Training
  – ADL Retraining
  – Visual Training
  – Oral Motor Training
  – Cognitive Training
  – Fall Prevention Training

• Moving Forward:
  – Use the assessment to drive the interventions:
    • “Why” is a certain level of assistance needed?

• Example:
  – Visual compensation techniques for macular degeneration that impacts safe dressing and med management

How Far Can We Go?

• Considerations:
  – Prior level of function
  – Homebound status
  – Patient goals

• Need to expand view beyond being functional in the home environment for those patients that want to re-enter the community.

Community Access

• Can the patient:
  – Multi-task while walking (walk and talk, walk and look from side to side or up and down)?
  – Carry a package up and down the stairs?
  – Carry a 5 pound weight for >1000 feet?
  – Carry packages averaging 6-7 pounds for short distances?
  – Walk a minimum of 1000 feet per errand for 2 – 3 errands per trip?
  – Change speeds and maintain balance?
  – Negotiate safely around obstacles, slopes, or curbs while looking in a variety of directions?
Community Access
(Cont.)

• Can the patient:
  – Safely engage in postural transitions such as changing directions, reaching, looking up or down or sideways, move backwards?
  – Rise from a chair without the use of arms with minimal effort?
  – Walk at 4 feet per second for at least 1 minute to cross a street?
  – Walk at a minimum speed of 160 feet per minute or about 2.6 feet per second?

Don’t Forget OASIS

• Improvement in ambulation/locomotion
• Improvement in bathing
• Improvement of oral medications
• Improvement in transferring
• Improvement with pain interfering with activity
• Any emergent care provided
• Any emergent care provided

Don’t Forget OASIS
(Cont.)

• Acute care hospitalizations
• Improvement in dyspnea
• Improvement in urinary incontinence
• Discharge to the community
• Improvement in the status of surgical wounds*
• Emergent care wound infections/deteriorating wound status*
M1830 - Bathing

(M1830) Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

- 0: Able to bathe self in shower or tub independently, including getting in and out of bathtub.
- 1: With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the bathtub.
- 2: Able to bathe in shower or tub with the intermittent assistance of another person.
  (a) For intermittent supervision or encouragement or reminder.
  (b) To get in and out of the shower or tub.
  (c) For washing difficult to reach areas.
- 3: Able to participate in bathing self in shower or tub. Requires presence of another person throughout the task for assistance or supervision.
- 4: Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5: Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6: Unable to participate effectively in bathing and is bathed totally by another person.

M2020 Management of Oral Meds

(M2020) Management of Oral Medications: Patient's current ability to prepare and take oral medications safely and safely, including administration of the correct dosage of the appropriate times/dosages. Excludes:

- 0: Able to independently take the correct oral medications(s) and proper dosage(s) at the correct times.
- 1: Able to take medication(s) at the correct times if
  (a) One medication is prepared in advance by another person.
  (b) Another person develops a drug diary or chart.
- 2: Able to take medications at the correct times if given reminders by another person at the appropriate times.
- 3: Takes, but is not reminded, aware of medication, arranges administration by another person.
- N/A: No oral medications prescribed.

M1615 When Urinary Incontinence Occurs

(M1615) When does Urinary Incontinence occur?

- 0: Timed voiding defers incontinence
- 1: Occasional stress incontinence
- 2: During the night only
- 3: During the day only
- 4: During the day and night
M1242 Frequency of Pain Interfering

(M1242) Frequency of Pain Interfering with patient’s activity or movement.

- 0 - Patient has no pain
- 1 - Patient has pain that does not interfere with activity or movement
- 2 - Less often than daily
- 3 - Daily, but not constantly
- 4 - All of the time

Interfering Pain:
- Causes an activity to take longer to complete
- Results in the activity being performed less often than desired
- Requires the patient to have additional assistance (person or device)
- May prevent an activity

Reasonable and Necessary?

“If an individual’s expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, therapy would not be considered reasonable and necessary, and thus would not be covered.”

Therapy G Codes: “Restorative”

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151</td>
<td>Physical Therapist in the home health or hospice setting, each 15 minutes.</td>
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<tr>
<td>G0152</td>
<td>Occupational Therapist in the home health or hospice setting, each 15 minutes.</td>
</tr>
<tr>
<td>G0153</td>
<td>Speech-Language Pathologist in the home health or hospice setting, each 15 minutes.</td>
</tr>
<tr>
<td>G0157</td>
<td>Physical Therapist Assistant in the home health or hospice setting, each 15 minutes.</td>
</tr>
<tr>
<td>G0158</td>
<td>Occupational Therapist Assistant in the home health or hospice setting, each 15 minutes.</td>
</tr>
</tbody>
</table>
Therapy G Codes: “Maintenance”

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0159</td>
<td>Physical Therapist in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.</td>
</tr>
<tr>
<td>G0160</td>
<td>Occupational Therapist in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.</td>
</tr>
<tr>
<td>G0161</td>
<td>Speech-Language Pathologist in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.</td>
</tr>
</tbody>
</table>

Focus of Care

- **Restorative Therapy:**
  - Intent is to improve the patient’s ability to function
  - Qualified therapist establishes the plan of care and completes required reassessments
  - Therapy assistants CAN provide care

- **Maintenance Therapy:**
  - Intent is to prevent further loss of function
  - Qualified therapist establishes the plan of care and completes the required reassessments
  - Therapy assistants CANNOT provide care

Maintenance Therapy

- “Require the specialized skills, knowledge, and judgment of the qualified therapist to design or establish a safe and effective maintenance program.”
- “The unique clinical conditions of a patient may require the specialized skills of a qualified therapist to perform a safe and effective maintenance program.”
Reassessment Timeframes

- Minimally every 30 days.
- Key areas around 13 and 19 total therapy visits.
- Done by "qualified therapist" who actually participates in the assessment directly.
- Done as part of a treatment visit.

If One Therapy Providing Care

- Reassessment required minimally every 30 days.
- If completing more than 13 visits, the reassessment is required on the 13th visit.
- If continuing on to more than 19 visits, the reassessment is required on the 19th visit.
- Exceptions: 10 - 13 and 16 - 19:
  - Rural area
  - Circumstances "outside the control" of the therapist

Example

- Only therapy involved is SLP:
  - Reassessment required minimally every 30 days
  - If plan is for 15 visits, the reassessment is required at #13
  - If plan is for 22 visits, the reassessment is required at #13 AND #19
  - Windows (10 - 13 and 16 - 19) apply for patient driven reasons
If More Than One Therapy

- Reassessment required minimally every 30 days.
- If completing more than 13 visits, the reassessment is required by all continuing services close to the 13th visit.
- If continuing on to more than 19 visits, the reassessment is required by all continuing services close to the 19th visit.
- Exceptions:
  - Rural area
  - Circumstances “outside the control” of the therapist

Example

- Patient receiving PT and OT:
  - Reassessment required minimally every 30 days
  - If plan is for 15 total visits, the reassessments are required “close to but before” #13
  - If plan is for 22 total visits, the reassessment is required “close to but before” #13 AND #19
  - Required for services that are relevant

Reassessment Documentation

- Objective assessments.
- “Effectiveness” of therapy in relation to the goals.
- Plans to continue or discontinue:
  - Refer to clinical findings and treatment plan revisions
- Changes in goals or an updated plan of care – MD signature required
- “Clinically supported statement of expectation that the patient can continue to progress” or resume progress after plateau or regression
Building the Team

Effective delivery of therapy services in home health requires active collaboration and communication, and solid documentation.

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The process for therapy CEUs varies state to state. In order to assist therapists with getting a session approved, we have provided material that can be submitted to the state licensing board. Please check with your individual state for more specific information as to the process.

**EDUCATIONAL ACTIVITY CONTENT OUTLINE**

**Title of Activity:** Therapy Documentation in 2011: *Therapist Assistants*  
**Date:** March 10, 2011

**Purpose/Goal:** To provide strategies in understanding the details of PPS 2011 as they relate to the therapist assistant to ensure compliance by the April 1, 2011 start date.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>CONTENT (Topics)</th>
<th>TIME FRAME</th>
<th>PRESENTER</th>
<th>TEACHING METHODS</th>
</tr>
</thead>
</table>
| 1. Discuss in detail the PPS 2011 changes that involve therapy services. | • Examine the reassessment expectations and timeframes in 2011.  
• Understand why the changes are being made. | 15 mins | Cindy Krafft MS PT | Lecture, power point |
| 2. Explore the implications specific to the role of the therapist assistant. | • Discuss the challenges and opportunities specific to the therapist assistant in PPS 2011.  
• Understand the level of skill that defines interventions and care progression. | 25 mins | Cindy Krafft MS PT | Lecture, power point |
| 3. Discuss the specific strategies to ensure compliance with the expectations that go into effect on April 1, 2011. | • Examine the documentation issues surrounding assessments/reassessments and demonstrating skilled care as the therapist assistant. | 20 mins | Cindy Krafft MS PT | Lecture, power point |