Skilled, Reasonable and Necessary Therapy Documentation in 2017 and Beyond

Live Webinar December 15, 2016

Sponsored by the Home Health Section of the American Physical Therapy Association

Skilled, Reasonable and Necessary Therapy Documentation in 2017 and Beyond

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Course Objectives

• Define skilled, reasonable and necessary in practical terms.

• Articulate the impact of the IMPACT Act on home health delivery and documentation.

• Use PCR concepts to ensure documentation defensibility is clear and consistent

Lay of the Land

• Healthcare costs continue to rise

• Affordable Care Act

• Physician Fee Schedule/SGR broken

• SNF therapy utilization questioned

• HH therapy utilization scrutinized

• Post-Acute Care Reform

• Focus on Value and Quality
Data Driven Decision Making

Objective Data Analysis

Subjective Opinions

Shift to Quality as the Focus

85% by end of 2016

90% by 2018
Pre Claim Review

• What is Pre-Claim Review
  • Affirmation of final payment for HH services of a homebound patient receiving skilled and necessary care under the supervision of a physician ordered plan of care
  • Only currently in the state of IL

Pre-Claim

• Why should we care about pre-claim review
  • First time CMS has chosen to require documentation prior to final billing to determine if payment is necessary
  • Placing a high level of scrutiny on the clinical documentation of services as well as the coordination of reason for services with the referring physician AND the reason for homebound
  • Basically a full ADR process prior to payment
PCR- Review F2F

- Physician and Clinician documentation – what does it mean for the therapists
- Under pre-claim review the physician visit documentation must support the clinical needs for care - OUR clinical documentation and the physicians need to support the same thing
- It’s important that our clinical documentation supports skilled services related directly to the referring diagnosis that matches the reason the physician also say the patient

PCR– Homebound

- Two Criteria – must be met and well documented
- Placing a high level of scrutiny on this documentation
  - Standardized checkbox answers offered in many EMR are not affirmed
  - Consistent documentation of homebound throughout the medical record
    - RN needs to match Therapy!!
PCR—Skilled Care

• 4 questions that need to be answered
  • 1: What are the structural impairments
  • 2: What are the functional impairments
  • 3: What are the activity limitations
  • 4: What is the RN/Therapist going to do about it
• We need clear action for our intervention
  • Gait training and therapeutic exercise statements get you a trip to non-afﬁrmation – TOO VAGUE
  • Gait training with wheeled walker to improve ambulatory endurance – will re-evaluate TUG in 3 weeks
  • Show our value for all diagnosis
    • Example Hypertension

PCR – Lessons Learned

• Documentation from physician encounter all the way through the clinical documentation from each professional must paint a clear consistent picture of the patients need for services
• Goals MUST be objective and measurable- evidenced based standardized measures improve afﬁrmation
• Clear documentation is necessary- checking your EMR box for homebound puts you on the path to non-afﬁrmation
PCR- Lessons Learned

- PCR is like having a complete chart audit for every single patient prior to final payment
- If you don’t think the documentation you do on every single visit note could stand up to a complete review - Then you have work to do
- Potential for PCR to move to other states in the very near future

Real Documentation

- “faint periods of forgetfulness”
- “anxiety and depression gentleman with shelved look”
- “by time he made it home he had started having word salad”
- “Patient using Google Tylenol for pain”
- “Patient endorses stress incontinence”
Real Documentation

- “patient is fairly independent with ADLs”
- **Referral Dx:** L total shoulder replacement
- **Primary Dx:** pain in unspecified shoulder
- “patient showered this RN in the bathroom”
- Wound #1: proximal to head part of body.
  Wound #2: lateral to wound #1
- “Due to fall risk recommend patient get rid of her dog”

State of Therapy Doc

<table>
<thead>
<tr>
<th>What we “do”</th>
<th>What we document</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prescribe individualized, exercise programs</td>
<td>• “3 x 10 toe tapping and seated marching”</td>
</tr>
<tr>
<td>• Progressive resistive</td>
<td></td>
</tr>
<tr>
<td>• Progressive aerobic</td>
<td></td>
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<tr>
<td>• Educate on positioning, range of movement,</td>
<td>• “I had PT before. They walked me and did leg kicks.”</td>
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<tr>
<td>substitution, delayed onset of muscle soreness</td>
<td></td>
</tr>
<tr>
<td>• Monitor both patient &amp; program for appropriateness</td>
<td>• 1lb weight x 30 reps</td>
</tr>
<tr>
<td></td>
<td>• Yellow theraband resistance for all exercises/on all patients</td>
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<tr>
<td></td>
<td>• Programs that never change . . .</td>
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</tbody>
</table>
Getting to the Root of Documentation Issues

- New Student
- Independent Practitioner
- Variability of Instruction
- Subsequent Clinical Experiences
- First Clinical Experience

Blame the EMR?

- Cookie cutter version
  - Reliance on what is in EMR
    - (+) = standardization
    - (-) = non-specific; generic; incomplete phrases/categories
- Free form version
  - Reliance on the clinician
    - (+) = individualized
    - (-) = clinicians variable competency in home health regulatory requirements and professional guidelines
Defining Key Therapy Concepts

- Skilled Therapy Services (ref: HH Benefit Policy Manual, Chapter 7, 40.2 – Skilled Therapy Services)

**Skill**
- proficiency, facility, or dexterity that is acquired or developed through training or experience; an art, trade, or technique

**Progress**
- to grow or develop, as in complexity, scope, or severity; advance:
  
  Progress does not equate to skilled therapy.

Understanding “Skill”

- When a care plan is created including frequency and duration and the patient misses a visit, what are the implications?
- What DIDN’T happen because a visit wasn’t made?
What Demonstrates “Skill?”

- Complexity such that safety and/or efficacy of the intervention can only by achieved under the supervision of a therapist
- Development, implementation, management and evaluation of a care plan
- Management and periodic reevaluation

This applies to both restorative and maintenance programs

Defining Skill – Home Health

Medicare Benefit Policy Manual; Ch 7; 40.2.1

- The service of a PT, SLP, or OT is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely &/or effectively only by or under the general supervision of a skilled therapist.

- To be covered, the skilled services must also be reasonable and necessary to the treatment of the patient’s illness or injury or to the restoration or maintenance of function affected by the patient’s illness or injury

- The development, implementation, management & evaluation of a patient care plan based on the physician’s order constitute skilled therapy services, when, because of the patient’s condition, those activities require the skills of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety.
Defining Key Therapy Concepts

- Reasonable and Necessary Therapy Services (ref: HH Benefit Policy Manual, Chapter 7, 40.2 – Skilled Therapy Services)

**Reasonable**
- governed by or being in accordance with reason or sound thinking; not excessive or extreme

**Necessary**
- Absolutely essential; needed to achieve a certain result or effect; requisite

Understanding “Need”

- Is every patient problem is going to be “fixed” with therapy interventions?
- How do patient issues that cannot be changed impact the care plan?
Conditions for Coverage of Therapy Services

Skills of a qualified therapist are needed to restore function

Skills of a qualified therapist are required to perform maintenance therapy

Patient's condition requires a qualified therapist to design or establish a maintenance program

Restorative

Maintenance

Maintenance

Condition #1: Restorative

- Must be reasonable & necessary for the treatment of the patient's illness or injury
- To the restoration or maintenance of function affected by the patient's illness or injury within context of his/her unique medical condition
- Must be inherently complex = safely and/or effectively performed only by or under general supervision of a skilled therapist
- Must be consistent with the nature and severity of the illness/injury and patient's particular medical needs
- Must be considered specific, safe, and effective treatment for the patient's condition

Ref: PPS-2011 Final Rule

- §40.2 – Skilled Therapy Services (Rev. 1, 10-01-03) A3-3118.2, HHA-205.2
- §40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy (Rev. 14, Issued: 05-06-11, Effective: 04-01-11, Implementation: 05-05-11)
### Condition #2: Maintenance

| Patient is responding to therapy and can meet the goals in a predictable period of time | The maintenance program must be established by a qualified therapist (and not an assistant) | The unique clinical condition of a patient may require the specialized skills, knowledge, and judgment of a qualified therapist to design or establish a safe and effective maintenance program required in connection with the patient’s specific illness or injury | Must include the program design, instruction of the beneficiary, family, or home health aides, and the necessary periodic reevaluations of the beneficiary and the program to the degree that the specialized knowledge and judgment of a PT, SLP, or OT is required |

Ref: PPS-2011 Final Rule:
- Rehabilitative v/ Maintenance Therapy
  - §409.44(c)(2)(H)(4)

### Condition #3: Maintenance

| Where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involve the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant), or | The clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient’s safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered. |

- Skills of a qualified therapist are needed to perform maintenance therapy

Ref: PPS-2011 Final Rule:
- Rehabilitative v/ Maintenance Therapy
  - §409.44(c)(2)(H)(4)
Osteoarthritic patient who recently underwent elective total joint arthroplasty of knee

Diabetic patient with peripheral neuropathy and retinopathy with reduced gait stability

CVA with tonal dominance including sustained PF clonus impacting transfers/gait

Restorative  Maintenance  Maintenance

**Jimmo v. Sebelius: Transmittal 179**

- **Specifically:**
  - No “Improvement Standard” is to be applied in determining Medicare coverage for maintenance claims that require skilled care.
  - Enhanced guidance on appropriate documentation
    - Notes that “the presence of appropriate documentation is not, in and of itself, an element of the definition of a “skilled” service, such documentation serves as the means by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.”
What Makes Home Care Different?

**Inpatient Care**
- 24/7 in person access to skilled care
- Direct control of the physical environment
- Focus is health care

**Home Care**
- Intermittent visits by skilled care
- Limited to no control of the physical environment
- Focus is on daily life

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Documentation Risk Areas

- Incomplete assessments
- Goals not measurable and meaningful
- Generic interventions
- Repetitive visits
- Insufficient reassessments

AVERAGE RISK PER EPISODE = $1500
Discipline Specific Risk Areas

- Physical Therapy (75% of total volume)
  - Gait assessment, goals, interventions, training,…..

- Occupational Therapy
  - Connecting meaningful to measureable

- Speech Language Pathology
  - Connecting measurable to meaningful

Initial Assessments

Create the Foundation

- Measuring Impairments in Body Structure/Function
- Patient Specificity
- Activity Limitations
- Participation Restriction
- Contextual Factors
ICF: A Biopsychosocial Model

Disability and functioning are viewed as outcomes of interactions between health conditions and contextual factors.

Clinical Decision Making: Initial Assessments

- Must begin with initial assessment/evaluation of the beneficiary
- There is NO DIFFERENCE between the assessment expectations for patients who receive therapy:
  - Prior level of functioning (reasonable time period)
  - Use of tests and measures
  - Detailed functional assessment
  - Includes a system-by-system review (cardiopulmonary, neuromuscular, integumentary, etc . . .)
Collecting Subjective Data

- Content shows patient involvement in therapy decision making.
- More than an area to document pain related issues.
- Positive information should be included as well.

“Prior Level”

Function
- Creates Context
- Is NOT Rehab Potential

Care
- Creates Expectations
- Is NOT a formula for care
Collecting Objective Data

- Range of Motion
- Manual Muscle Test
- Balance
- Gait
- Endurance
- 30 Sec Chair Stand Test
- 2 Min Step Test
- Gait Velocity
- Tinetti POMA
- MOCA
- Timed Up and Go
- Barthel Index
- Falls Efficacy Scale

Available Resource

- The Home Health Section Toolbox of Standardized Tests & Measures
Analyzing Results

Levels of Assistance

- Maximal Assistance
- Moderate Assistance
- Minimal Assistance
- Contact Guard Assistance
- Stand By Assistance
- Independent
What Do They Mean?

- Independent, Supervision, SBA, CGA, Min A, Mod A, Max A, Total, Dependent quantifies assistance.
- It is the qualitative details that address WHY the level of assist is required and WHAT skill the therapist is providing to improve the functional limitation.

Defining the Problem

- Patient transfers from sit to stand with moderate assistance.
- Patient requires minimal assistance to dress upper body.
- Patient ambulates 80 feet with a walker and CGA.

- Weakness
- Balance
- Pain
- Cognition
- Environment
- Fatigue
- Fall Risk
### Documentation Focus

**Initial Assessment:**
- Measure impairments
- Determine functional impact
- Select interventions
- Establish goals
- Set frequency and duration

**Reassessment:**
- Update measurements
- Describe functional changes
- Review interventions
- Update goals
- Confirm ongoing need

### Reassessment Tips

**DO:**
- Be objective as possible
- Analyze findings
- Connect improvement in measures to functional relevance
- Clarify the need for more therapy

**DON’T:**
- Repeat the initial evaluation
- Use tests or measures because it's “required”.
- Use unsupported phrases such as “continue therapy” or “continue per POC”
Collecting Assessment Data

- In the professional opinion of this therapist……
- In my professional opinion……
- CRITICAL element of defending “skill”

How Many Goals?

- Focus should be on the quality of the goals and not the quantity.
- Key words:
  - MEASURABLE
  - MEANINGFUL
"Measurable" Goals

**CONSIDER:**
- ROM
- MMT
- Distances
- Level of assistance
- Environment
- Testing Scores
- Specific Equipment
- Caregiver Role
- Specific Instructions

**AVOID:**
- “fair/good/poor”
- “LRAD”
- “household”
- “community”
- “safe”
- “increase/improve”
- “min/mod”
- “Modified Independent”

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"Meaningful" Goals

- Connection to what is meaningful TO THE PATIENT

**Consider:**
- “to allow patient to”
- “so patient can”
- “to comply with”
Available Resource

- PRACTICE RESOURCE DOCUMENTS FOR HH THERAPISTS
  - Goal Writing Guidelines for Home Health Therapists by Diana Kornetti, PT, MA, HCS-D, COS-C; Kenneth L. Miller, PT, DPT; Jonathan Talbot, PT, MS

Goal Setting 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

- 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?
- Multi-task while walking (walk and talk, walk and look around)?

Community Access

- Carry a package up and down the stairs?
- 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?
Limits on Goals?

“Any ‘rules of thumb’ that would declare a claim not covered solely on the basis of elements, such as lack of restoration potential, ability to walk a certain number of feet, or degree of stability, is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary’s total condition and individual need for care.”

Changing the Plan of Care
More than a Task List

S
P
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A

Ask Yourself...

Why You?
Why Now?
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