Medicare Documentation: Describing Skill Related to Discharge Planning and Maintenance Programming

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- - [Calista] Well, it is my pleasure to welcome back to physicaltherapy.com, Dr. Kathleen Weissberg. Dr. Weissberg and her 25 plus years of the practice has worked in long-term care, as a researcher and educator and has established various programs and nursing facilities including palliative care and end of life care and continence management, falls management and dementia care and staging. She currently provides continuing education support to over 6,000 therapists nationwide as a director of education for select rehabilitation. Thank you so much for being with us today, Dr Weissberg. And at this time I'm gonna turn the microphone over to you.

- [Kathleen] Thank you so much, Calista. Thank you for that new introduction and thank you to those of you who've logged in to hear two hours about documentation today. It's a really important topic. Maybe we need to spend even more than two hours on it but we're gonna talk today a lot about, we're gonna talk about discharge planning, we're gonna talk about maintenance but we're also gonna talk about skill and what your plan of care needs to look like and goals and all those sorts of things. So we're gonna jump right in and start with our objectives. The objectives for this session are to list at least two reasons when rehabilitation services meet medicare coverage criteria. Identify at least three guidelines for writing measurable short and long-term goals. Identify at least two ways to justify services for skilled restorative and skilled maintenance care and outline at least three appropriate steps to take when planning discharge for clients with dementia and or cognitive limitations. So I'm gonna start off with this question. What guidelines do you follow? I think this is a really good question because no matter where you practice you're going to encounter different payers different requirements. Maybe you have a practice act for example, that tells you that your documentation needs to be done every so often or it needs to be reviewed by a therapist a certain amount of times. Payers have very specific requirements. So if you have an HMO, for example maybe they need weekly updates, there are Medicare guideline and there's a lot of different guidelines. So what do you follow? I guess that's the question. And my message to that would be follow that which is most strict.

Definitely know your practice act. You always have to follow that know your payers and whichever one is most strict I think you're probably gonna do fine if you follow that one. Most of what we're talking about today is going to be... well pretty much all that we're talking about today is related to Medicare. What we find though, is that the requirements from Medicare specifically Medicare part B or the outpatient services have the most written guidelines and most written guidance related to documentation. So again a lot of other payers tend to follow those guidelines Medicaid does and a lot of our HMOs and such. So again, where and when you can follow those types of guidelines generally speaking you're going be okay. So let's talk about therapy documentation in general. We're gonna talk about each of these. When you look at the documentation, it needs to show no matter who you are working with that your services are medically necessary. They require the skills of a therapist. You have physician orders and with that, we wanna talk about medical necessity of treatment. So we just said, therapy documentation needs to show that services are medically necessary.

But what does that mean? When we look at the documentation it needs to show that it's reasonable and necessary for the treatment of that person's illness or injury. So we look at that, that's the amount of therapy that you're giving so maybe it's your minutes, your visits, your codes. It's your frequency. How many times per week are you seeing this individual? It's your duration, the number of visits the number of days, months, weeks, whatever that happens to be. And I think the good takeaway here is that when you look at your own practice acts when you look at the evidence and the research that's published in the physical therapy literature there are guidelines out there for specific deficits that a patient may have or specific clinical condition that the patient may have. So we've got to make sure that whatever we deliver whatever services are out there that they are accepted, effective, standard practice for that condition. One of the big things that we see in denials and we're not gonna talk about denials necessarily today but is that they will come back and say it's not reasonable and necessary. So

you had a patient maybe who had a dementia diagnosis and that patient was treated for six months, that's an exaggeration I think, but they look to see that what you are delivering matches the clinical representation of that patient matches their clinical picture and it makes sense. And if it's too little or if it's too much we're probably gonna get called on that. So again, that's pretty important. Now the other piece regarding medical necessity is that we need to show that our skilled therapy services are related to an active treatment plan and that they are a level of complexity that they can only be safely and effectively performed by a qualified therapist or under a qualified therapist's supervision.

So what does that mean? That active treatment plan means that essentially, you have an evaluation or you have a script from the physician, you have something that says, I've developed a plan of care under the guidance of a physician and it is active, it is current the physician knows what I'm doing. The other piece of that is, that level of complexity and we're gonna talk about this when we talk about skill but it's really important if we're just saying... I don't know what's a good example? 10 reps with a five pound weight or ambulated with min assist could they walk with a nurse with min assist? Probably. Could they do those 10 reps on their own?

Maybe. Could they do that at the YMCA with a volunteer? Possibly. You need to show in your documentation that you and only you can provide this service and as I educate clinicians, I oftentimes say you need to show in your documentation what makes you so special. And I don't mean that in a bad way I mean that in a very positive way. We deliver amazing skilled services the documentation needs to show that. That again, it has to be you and not a nurse or a volunteer or that person themselves or their caregiver or their significant other, et cetera. So what is medical necessity? Again, therapy, if you think about it it's a medically prescribed treatment where we're looking at improving or restoring functions that have been impaired by illness or injury. Maybe function has been permanently lost or reduced by that illness or injury. Maybe we're

trying to maintain and we'll talk about skilled maintenance here in just a moment, but when you think about physical therapy, you're improving that individual's ability to perform those tasks that they need to do to function independently, to do what they've always done to do what they're used to doing. So when we look at medical necessity that again refers to what or why skilled therapy is involved in that person's care. So that could include the quality of their movement. So you're working on gauge, so you're working on stance phase or you're working on swing through whatever it is that you're working. So a quality component of that person's performance. Maybe it's completion of a functional task maybe you're working on transfers or bed mobility and that's being impacted by neglect or weakness or poor sequencing or range of motion limitations, et cetera. So you're working on some very specific components but it also refers to potential risk factors. And again, those are things that you want to get in your documentation.

Maybe that person has poor skin integrity and that's what makes your bed mobility program skilled versus something that a nurse would do or maybe they have joint contractures maybe they have poor judgment or limited cognition that list can go on and on. But that medical necessity means that, that treatment that's being provided requires your unique skills and knowledge no one else could provide that. And when we look at medical necessity or judging medical necessity, if you will when your payers are reviewing this, medical review, additional dealt development requests whatever that case happens to be. What they're looking for is a new diagnosis possibly and not just a new diagnosis it's not enough just to say this person has a hip fracture or they have whatever going on, you need to show how that new diagnosis is impacting some functional performance that you can then address in therapy. So just because the person had a fracture doesn't necessarily mean that they need therapy. And again, that probably sounds crazy. You'd be surprised sometimes, I can remember very clearly a relative of mine fell, had hip fracture, no kidding and it was a hairline fracture and never went to PT never went to OT, just kind of managed on his own. So again, you need to

show how that diagnosis is impacting function and what you're going to do about it. It could also be an exacerbation of a chronic condition so COPD or arthritis or whatever they happen to have, document the impact, what you're addressing. A significant loss of function secondary to some other medical problems. So that could be related to shortness of breath or edema that they have or something else. Safety issues. Again, that's a big one that we can certainly address functionally. So if there are safety issues, you're documenting that. The relationship, as I just said, of that problem to function and also this person's ability to participate in the treatment process. Because if that person's not participating the question is why are we continuing to deliver services? So somebody has to be participating with us.

So you hope it's the patient but if it's not the patient it's probably that person's caregiver on their behalf and we wanna see that in the documentation. So that medical necessity is established all throughout documentation. So it's gonna be at that initial evaluation and then it's gonna be through the course of treatment. And so this checklist on this slide it gives you kind of an idea where throughout that documentation medical necessity would be consistently documented. So measurable objective progress that could be your weekly notes that can be a progress report that could be an updated plan of care wherever that happens to be.

The impact of the gains or the progress on function which is meaningful to that person in their everyday life. And hopefully you have progress and if you don't have progress, we'll talk about this, you're maybe revising your goals or revising your plan. Documentation addressing those short-term goals. Maybe you talk about in your documentation the remaining deficits that person has. You clearly identify those and associate those back to their goals and back to maybe their discharge disposition. Any remaining risk factors or precautions that are identified. That again, you're going to continue to address in therapy until those are resolved. You'll talk about your short-term goals your plan for the upcoming week or the upcoming month or even the

next treatment session whatever that happens to be and revisions to that if that's necessary. Maybe in your documentation you talk about how your emphasis of your treatment will be for the next session or the next week. Again, going back to some of those risk factors or precautions and saying, well this is what I'm going to address in the next treatment session and this is why skilled physical therapy is still needed. You have services that demonstrate continuing medical necessity. By again that significant progress made. The treatment is reasonable and necessary. And we always wanna show that the services where such complexity and sophistication that only we could provide them. So if you think about the documentation. what's that old saying? If it wasn't documented, it wasn't done. I think that definitely still applies today. The documentation is the only evidence that our services meet the basic requirements of medical necessity, skills of a therapist. We were in compliance with physician orders. The recipient demonstrated progress and if they didn't, we've documented that and what we're doing about it.

The services provided support the services that were billed. The documentation is a crucial aspect and it's imperative that it's an accurate reflection of what we actually did with the patient. And one of the things that I see as I review documentation 'cause it's one of the things that I do regularly, is sometimes the documentation day after day after day says the same thing. I don't wanna say we've copied and pasted but it kinda looks like that or we've used dropdown libraries because those are available to us in the electronic medical record and we've used the same one every single day. So we've got to make sure that documentation paints a whole picture of the person and it does look like... not that it looks like, it shows that we're doing different things that we're making progress on all of the things that we're working on with that patient. Now, it's an absolute nevers with documentation. I think you know these but if you're still using paper documentation we don't use white-out obviously we don't use pencils. That sounds ridiculous to say but you'd be surprised what we see sometimes out and about in the field. And nothing with an eraser, I've seen people use those pens that still have

erasers on them and try to erase documentation, we don't do that. And we don't backdate. We don't enter a date or a time other than the actual date or time that the entry is made. And I think this is a really important one because people tend to get behind, it's reality sometimes. And even if you're behind, own up to it "Hey, I'm behind on my documentation." Put it in there and make it a late entry. We never backdate to change the documentation or otherwise cover ourselves, we just don't do that. Don't make an entry or sign a medical record for someone else. And again, that happens. "Hey, I left, I forgot to put my charges in "do you mind putting them in for me?" No, we don't do that. It has to be that person.

And again, because if you think about that electronic medical record, it's timestamped, it's dated, it has initials. If that person provided the service they have to document it. I'll give you a great example, this was a while ago, a long while ago I had a therapist who was supervising a student that therapist happened to be off that day, I don't know what the whole scenario was, and the student logged in to the electronic medical record as the therapist, and did documentation and did billing. It appeared as though the therapist did that documentation when that therapist didn't, the person wasn't even there and it was a huge compliance issue.

So we just don't do that. Never destroy part of the medical record never replaced it with a new document. Once that record is there, it's there and we can say that it was an error we could put in additional documentation to clarify, to support, what have you but once it's there, it can't be removed. We don't rewrite a documentation so that we can get better reimbursement whatever's there, it needs to be there. And we also don't take items out of the community or out of the facility. So you're behind, you take your documentation home or you're working electronically and you access that at home. That's a big no, no we don't wanna do that. The only time you might take that documentation out is if you're going to an ALJ or some sort of hearing or denial or what have you where you would need that documentation. Some general guidelines. I

think pretty basic but still important. For all medical record documentation the credentials of the individual must be appropriate to the type of document and the service rendered. So what does that mean? You wanna make sure that the credentials are appropriate. Be sure you're following your practice acts as well as any national guidelines that would come out from a PTA. So for example, if you have a standardized assessment and an assistant is conducting that standardized assessment that might be allowed, check your practice act but you also wanna make sure that, that person has demonstrated competency to do so. Likewise with specialized treatments, maybe it's a modality or maybe it's some other type of treatment. If you are delegating that to another person even if it's another therapist, recognize that they may not necessarily be trained to do that. So you always wanna make sure that everything is appropriate to that person. Obviously the patient's name is gonna be on every page. All the documentation clear and legible if you're doing it handwritten still.

Obviously electronic documentation is probably the direction that we go now, for most of us. Use standardized, approved abbreviations. I think this is a really important one so make sure that if your community or wherever you're working if they have an approved abbreviation list that you're following that, if they don't, check your state practice act check date a PTA, check your other resources. Maybe your company has one, where your community doesn't but follow something that standardized. I'm gonna tell you a really funny story. I was auditing documentation eons ago probably at least 20 years ago, and I was reading through a nursing note and a nurse actually wrote something on the medication log 50 milligrams, 50 mg plus, T-P-I-D-O-T-F. so again, T-P-I-D-O-T-F and I just sat there and scratched my head and scratched my head. I'm like, what in the world does it stand for? I looked it up, couldn't find anything. Finally asked the nurse "What in the world does this mean?" "Oh, 50 milligrams plus the pills I dropped on the floor." She had dropped a pill on the floor and she still gave it to the patient and documented it as such. So funny story, but some craziness out there related to approved abbreviations and make sure you're doing the right thing. And the

last thing on here, providers can use any written format to convey the required documentation. What that means, if we go all the way back a long, long time ago, there were mandated forms from Medicare that we were required to use. They've taken such mandates away and required forms away. So really whatever format you have in place as long as the required elements are in there you're good to go. Documentation is an integral component of this overall clinical practice. It's required when we are providing therapy and it needs to meet all of those requirements. It includes assessments, analysis, treatment techniques all of those things that we do inherently as therapists to help our patients to achieve their therapeutic goals. Remember it needs to be timely and accurate I can't stress that enough. It's probably the one big thing that I see when I do doc reviews, is that it's not timely and I will tell you, we get into some bad habits in some of our communities and maybe you've seen these, you have an electronic medical record and you can't clock out for the day until all your documentation is done and you see people put like a whole line of dots in or a whole line of Xs or something just so they can toss something in there and get their charges in or get their payroll in and don't do that.

Get it done, get it done right the first time because as soon as you start that kind of bad habit it's just gonna carry over and it becomes this trickle down effect. Obviously in the documentation you wanna address all the limitations of the patient how they affect your function. The type and complexity of your skilled interventions. The therapeutic rationale. Why are you even doing this? What does it mean? Why is it important? And I talk to people about that all the time. I've read documentation where, there's all this documentation about pain and this person has this pain and it's X out of 10 whatever that happens to be. But there's never a comment on whether or not I'm addressing that pain with a therapeutic intervention and more importantly, whether or not that pain is impacting that patient and their ability to function. So if it's not impacting the patient I don't know if you treat it or if you don't treat it that's a clinical decision you are gonna make with your patient. But if you are treating or you're not

treating, document that. Makes sure the therapeutic rationale for what you're doing is in there. And why the skills of a therapist are necessary. We're going to continue to talk about that over and over again. It needs to relate to daily function things that are specific to that patient. Again, it's not our goal, right? It's the patient's goal. Whatever he or she needs to achieve, that's what we work on. We need to show the goals are measurable, they're realistic they're achievable in a certain reasonable amount of time and we'll talk about how we set up goals and how we write those, in just a few minutes. We wanna talk about the carryover of function. How... I worked on this group of therapeutic exercise today in the clinic, how did that then carryover to this person's ability to stand? Or this a person's ability to have enough active dorsiflexion while they're walking? Or their ability to transfer whatever it happens to be? You wanna demonstrate any communication as well with health care team members. Now, before I go on, I just want to make a comment about that. Make sure that your communication that you are documenting isn't throwing anybody under the bus.

Nobody benefits from that. If you've provided education, you wanna talk about that. If you've alerted another staff member nursing or something, the patient was having pain and they're planning to medicate, that's fine. That inflammatory language that we oftentimes see and I'm sure you've seen it where we say, went in to do XYZ with the patient and the patient wasn't ready they were soaked in urine or whatever it happens to be that's getting us nowhere. That's a conversation that you have with whomever but I don't know that it has to be in the documentation necessarily. I think sometimes we do that to cover ourselves but when in reality what it does, it ends up harming the entire claim. Clinical reasoning, we need to show that and then every bit of information that is necessary for reimbursement we put that in there as well. So I love this particular slide and this actually came from the general guidelines from a PTA and article that they published many, many years ago reimbursement coding and compliance for physical therapist and I think it's still incredibly pertinent today. The responsibility for proper documentation is no less important than your selection of the

most effective treatment approach to the provision of your best clinical care that you can give to your patient. I'm gonna mention this a couple of different times. It's the only tangible evidence of that link between your clinical reasoning and that patient's functional performance or their outcome. Improper documentation can result in a claim being denied, being returned to the provider or worse yet additional information that jeopardizes that patient's access to further treatment. I said we weren't gonna get into a lot of denial stuff but if you've ever been on that side of it oftentimes the administrative contractors will come back and they'll ask for a sampling of claims and maybe it's 20 claims, maybe it's 40, whatever and then they apply an error rate to that and extrapolate that to all of the claims.

So we wanna make sure that each and every piece of documentation every claim that goes in there is clean, it is descriptive of what we're doing with the patient. Insurance companies rely heavily on our documentation even the justice system when we get to those levels of denials. It is a legal document and without those detailed notes of what's occurred it makes it really difficult to recall a specific patient and instance or what have you. And again, we talk about documentation this is one of those, learn your lesson do your documentation when you treat that patient. Now I think some of us maybe wait until the end of the day maybe that could work, just make sure that you can remember what you did with a patient. Sometimes it's better just to do it when you're treating that patient.

If you can do it point of service, that's great have them be an active participant in it maybe. But I think if you wait til the next day or even the end of the day sometimes you don't necessarily remember all of the details. Every piece of that documentation paints the picture. So it's what's wrong with this patient? That's your evaluation. What's planned? That's your plan of care, that's your goals. What are you doing? What's being performed? Those are the daily notes that we get in there the daily skilled notes. What progress is being made? Again, that can be anywhere. That's daily notes, that's

progress reports, that could be weekly notes, re-evaluations, updated plan of care, whatever that happens to be. And then what's the final result? That is your discharge summary. So one final slide, I think before we get into some of the nitty-gritty I love this slide. Can I see a receipt? Why would you pay a mechanic $ 1,000 for car repairs if he or she didn't have an itemized receipt to support the charges? Or if you went to the supermarket and they just said, "Okay, yeah, your groceries are $100." But they didn't tell you what was actually in those groceries.

So why do we get really upset then when somebody else asks us Medicare or another payer to see your receipt for the services that we've provided isn't that truly what the medical record is? And again, think about it. Think about how many patients you treat a day, per week, per month, per year and you are just one person extrapolate that by everybody in your clinic maybe you have three, four, five people in your clinic and across the whole country. That's a lot of claims. The reality is we're paid most of the time without ever showing anyone what we did without showing the receipt. So we just wanna make sure that when we are asked for the receipt whether we are, whether we're not, it's good and we've clearly documented what we've done. So let's start talking a little bit about the coverage requirements.

So what is a skilled service? Again, we've talked about this. It's so inherently complex that it can only safely and effectively be performed or under the supervision of a professional or a technical personnel as provided by the regulation. So I know what you do in the clinic because I see it every day. What you're doing is highly skilled. The documentation doesn't always support that and I'm gonna pick on, ambulated 50 feet with a wheeled walker. Is that skilled? Possibly. What did you do? Maybe you are working on safety maybe you're working on velocity maybe you're working on hand placement on the walker. I don't know what you were doing but you were doing something skilled that nursing couldn't do. Can nursing walk that person 50 feet? You betcha. So you have to again, showing your documentation what makes it skilled. Now

a lot of questions come up about skilled maintenance I do wanna talk about this for just a few minutes. There's two situations with regard to skilled maintenance that would constitute medically necessary care. One of these is the development of an appropriate maintenance program. So you've treated this person in physical therapy they get to a point where they've met all of their goals they've advanced as far as they're going to advance and you say, "Okay, time for someone else to take over." Whether that's nursing or a caregiver, what have you you develop that program, you teach that program, you tearing that program, that makes sense. The other piece though, there might be certain instances where it's necessary for that program to be carried out by a therapist. And while this isn't new, it came out in 2011 and if you were practicing at that point in time, there were four individuals from Vermont, Connecticut, Rhode Island and Maine and then five different organizations that filed this class action lawsuit.

They finally settled, they approved a settlement in 2013 where that settlement eliminated the requirement for patients to actually make progress in therapy in order to continue to receive therapy services. So there might be a scenario and we'll talk about this actually let me just go to the next slide. Skilled care means... ideally most of the time we're gonna be working on restoration of function, improving function. But there could be a scenario where your skills are required to maintain that person's condition or to prevent or slow further deterioration.

That's skilled maintenance and that's what that settlement allowed. Now can you just do maintenance for the sake of maintenance? No. Your skills still need to be required. So what is skilled maintenance? They're gonna be an individualized assessment and then there's going to be some programs set up where you have to provide that program. Whatever it is, it requires, it's so complex, it's so involved that a caregiver couldn't do it it has to be the therapist who provides that. And I don't know what that is necessarily but just range of motion. Is that skilled? Probably not. Somebody could

carry that over. Providing some sort of modality like E-stim or ultrasound. Yeah, that's definitely skilled. A TENS unit, probably a patient could carry that over. So again, you need to look at what service is being provided and determine if somebody else could do that. Now that said, again this is what it says, the restoration potential is not the deciding factor. Even if full recovery or medical improvement is not possible, a resident may still need skilled services to prevent further deterioration or preserve current capabilities. So I'm gonna keep saying this, it has to be skilled. If someone else could do it then they need to probably be doing it. The fact that maybe there isn't somebody available to do it that doesn't matter. If that person could potentially do it we can't continue to do that if it's not skilled.

So how long can somebody stay on skilled maintenance? It's the one question that I routinely get and I wished I knew the answer to that, there is no answer. It's very subjective. I think ideally whatever it is that you're doing you want to try to transition that patient off but if you can justify that your services are still necessary and they are still skilled then that could be potentially a covered service. So the next couple of slides, this slide and the next one I believe we're gonna give a couple examples of skilled maintenance. So in this one we have an individual severely disabled congenital quadriplegia, epilepsy, significant cognitive impairments, mental retardation.

Physical therapy was ordered and provided for evaluation, treatment and then staff education. The documentation here states, resident will maintain flexibility and useful motion through all joints of the body via range of motion exercises to prevent deterioration of joint stability and range of motion. So there's no expectation of improvement here but because of skilled maintenance this person could potentially continue to receive skilled therapy to maintain or preventative deterioration. Their goals would be written not to reflect progress but to maintain. Now that said, before I go on what we don't know about this documentation I think there has to be probably something more because range of motion exercises inherently probably are not skilled

past the education piece of it. So there must be some specialized technique I would assume that the physical therapist is doing here and we wanna see that in the documentation. And if it's not specialized, maybe what our skill is, is that teaching and training and that staff education. This next one we have another individual 83, hospitalized seven days due to renal failure among other issues, was admitted to a skilled nursing facility for therapy services. PT and OT services were delivered until the patient plateaued in the progress after about two weeks without progress and then they discharged because they were afraid of a denial. So under this skilled maintenance standard the risk of deterioration with mobility and self-care is how you would determine continuation of therapy.

So the Medicare benefits were supposedly cut after a certain amount of time but this person would potentially deteriorate if they didn't have PT and OT. So rather than making progress we talk about how the skill that we bring to the table would prevent the risk of deterioration. So resident will maintain current mobility, self-care using strategies and techniques introduced in treatment carried out independently or with staff assistance. So the skill there, is those strategies and techniques that we would be teaching. When we get to goals, we'll talk a little bit about skilled maintenance goals as well. So when we talk about justifying services we're gonna go through a whole bunch of things.

Relevant history, reason for referral, prior level, goals and daily notes. So let's start with documenting relevant history. This is the history of the current loss of function that has necessitated therapy services. This could also be talking about their previous therapy or previous treatments that the person has had. And if that is the case we wanna document the patient's response to that prior treatment. So upon examining the patient's present status, you can decide whether or not to initiate a new course of treatment. So you're looking here for a change in condition so maybe it's a recent loss in function, newly admitted and they may require another course of therapy to assist

them to meet their goals. Maybe they've shown an improvement in status that previously interfered and now you're picking that patient back up. Maybe there's a change in medication or medical status that is impacting their response. So anything relevant to the history of this particular illness, injury, exacerbation is what we want to document. Because ultimately what's going to happen is you'll talk about their current loss compare that their prior level of function and where that gap is, if you will that becomes your goal for the patient. So we wanna document this history of current loss that necessitates the therapy. So if it's a loss due to illness and hospitalization you wanna talk about the length of hospitalization, any complications that may have occurred and how those, have impacted the function. If that loss of function is due to an injury maybe it's a fractured hip or something like that it's gonna talk about how that injury occurred and how it's impacting their function. If they've been referred to you whether that's from the physician, it may be as a nurse.

If you're working in long-term care it could be identified through screening. If you're working on long-term care. Who referred that person? Why that person requires those services? When did that loss or that change in function when was that first observed? And then what is the history of this person? What their admission date, their readmission date? The purpose for the referral? And I think most importantly, we clearly state the patient's change in condition or the loss in function. Because comparing that to prior level gives you, your goals. Now when we look at medical history. This refers to the physical, the mental, the emotional disorders that may have a direct influence on the way that person responds to your therapy or maybe in the way that you deliver your services because you could obviously change up your delivery based on where they are and their disease process. So you wanna be documenting your medical stability, any complications, any comorbid conditions, any other disorders that person has. And that's gonna impact your treatment and the progress that they make with your treatment. You wanna explain all of that. A social history is important as well whenever you can get it. I mean the reality is, sometimes our patients are not

reliable historians but once you can get that social history you wanna get it in there because that will speak to their functional status prior to their condition that they're being treated for and I think it's gonna help you to establish your goals for discharge. Maybe they're going back to a home or they're going back to an assisted living or what have you and you need to know what that social history was. So that's the history, the medical history. And I guess the only other thing that I will say about medical history is just make sure that it's pertinent to what you're treating. And I think also in that medical history I also like to include a medication review because I think when we look at our seniors who we might be working with, those medications have a significant impact on maybe their cognition, it could have an impact on their GI and their ability to participate, their pain levels and ability to participate we may see side effects, et cetera.

And I think that medical history needs to be current. We don't really care that they had, they're their wisdom teeth taken out 20 years ago obviously I'm exaggerating. You care about what's going on with them now and what's going to impact your plan of care. Okay, so that's history. Let's move on to reason for referral because I think this is a really important one. This is your justification, why they need therapy. Why were they referred to you? Was it a medical condition? What are their problems? Is it a concern for safe function? And I say it needs to be supported in the nursing documentation.

I'm thinking long-term care type of venue but somewhere it needs to be supported. Maybe it's a physician note where the patient was seen on an outpatient basis and there's clear description and discussion of why this person needs therapy. Maybe it's in a social service note that came from a hospital. Maybe it's some other medical record. But no matter what, you always wanna make sure that something supports you because if that ever goes to a denial you gotta make sure that you are in fact supported in what it is that you're doing. So you wanna ask the question, why does the patient require physical therapy intervention at this time? So not yesterday, not

tomorrow, not two weeks ago, not a month from now, but right now, today. Why do they need intervention? And I think this also needs to be discipline-specific. So if you're working in a community, a long-term care type of community your intervention or your reason for referral for speech is gonna be something maybe totally different than your reason for referral for OT or your reason for referral for PT. Some of the reasons for referrals that we oftentimes see are things like new admit to facility okay great, I'm glad that they were admitted, but do they have to have physical therapy? I mean, they probably will but why do they need physical therapy? You need to spell that out. And per physician order how many times have you seen a scenario where the physician orders therapy maybe at a family request or something, but the person didn't technically need therapy. So just because of physician orders it doesn't necessarily mean that we deliver it. I mean we probably will but it has to be very clear.

Or sometimes we see things like decline in function. Well, what on the world does that mean? That could mean anything under the sun for this patient. So again, you have to be very specific. Lack of a clearly documented change in function could result in a denial or a payment of services. So let's go through some examples we can look at what's good, what's not so good. So in our first example here, we have patient admitted to skilled nursing facility after hospitalization for exacerbation of congestive heart failure. Good or bad? I don't know. We're gonna call it bad. Is it the worst thing I've ever seen? No, not necessarily but it really doesn't include a reason why anybody is getting involved. Okay, they have an exacerbation of CHF but does that also mean that they have shortness of breath? They have issues with endurance? They're not able to walk? Transfer? There needs to be more information there. Next one, therapy order, status post right hip fracture also not so good. First of all, who's treating this patient? We don't know. But what problem are you going to treat? Ideally, of course you're probably treating this person but what is the issue? What has that right hip fracture caused a problem with for this patient? That's what needs to be included. Is it transfers? Is it gait? Is it bed mobility? Is it pain? I don't know what it is. Requires

increased assist with transfers and ambulation. This one's pretty decent because this one clarifies the functional deficit that is actually going to be addressed by physical therapy and I love this particular statement because as short as it is, it's still pretty supportive of what you're going to be doing with the patient. Again, I don't think we have to document these really, really long phrases or long notes. It can be something really short and still saying what it needs to say. Next one, referred to PT by nursing. Three falls in one week due to a balance dysfunction, decreased ankle strength, inability to transfer from the toilet without assist. Obviously, you know that's a pretty good one. This is very specific regarding impairments, the impact on function that are going to require PT. Again, this is really long. I would take even one piece of this, referred to PT by nursing, three falls in one week due to limited lower extremity strength. Would be totally fine. Next one, referred to PT by nursing.

Decreased ability to walk in the room, distracted in the environment tripping over furniture, doesn't recognize barriers. Very good. This shows the new onset of symptoms that require, oops! has swallowed function by physical therapy. I'm not sure why it does, I'm so sorry about that. But obviously why physical therapy is getting involved with this patient. And it could be super short it doesn't have to be as lengthy as it is. Next one, generalized weakness.

This goes back to decline in function, right? Why is therapy necessary to address this? You could potentially have some sort of weakness that you just do your own physical, not physical therapy but your own exercise program or you go to the Y MCA or you get a personal trainer or something like that I have no idea what you're doing. But we have to say, why does PT need to address this and what is it impacting? Final one left, PT evaluation and treat for splinting the left lower extremity. Again, you're probably going to splint and address that left lower extremity. But the question remains why? Why does that person need that splint? Where's the change in function? What is the issue? Where is the deficit with the patient? So we're gonna switch gears now and talk a little

bit about prior level of function. So very similar to what we've been talking about. It needs to be documented on the evaluation also needs to be discipline-specific. So we're not gonna see swallow function documented on a physical therapy note as much as we wouldn't see gait on a speech therapy note. Has to directly relate back to their current functional status and their goals. So they were able to do this previously now they can't. That's why I have to be involved. So this obviously establishes that medical necessity for physical therapy. So some of the questions that you can be asking and I will tell you this is a really tough one because a lot of times our patients are not reliable historians. They'll tell you they were doing everything under the sun when in reality they weren't, they had helped for a lot of things. So this is where you want to ask your caregivers ask for additional information. But did they have prior PT? How did they do? What are their medical problems? How's their general health? What about their vision, their hearing?

'Cause obviously that's going to impact cognitive function. This is something we're talking about a lot in the industry right now because cognitive function affects everything. If that person isn't able to sequence, are they gonna be able to use that walker appropriately? If they can't follow directions and you're trying to give them an exercise program will they be able to follow through? So I think there's a lot of questions that you can ask there. I love the hobbies and preferences question obviously I'm an OT. But the reality is, if somebody is coming into therapy they're gonna wanna do something engaging, so if you can tap into that, that's never a bad thing. Questions for physical therapy. So this is going to get you to the root of how were they doing previously? What was their walking ability? What about the stairs? What about curbs? Did they walk outside? Did they walk outside in bad weather, good weather? How far? What kind of footwear were they wearing? Were there any balance deficits previously? Did they use an assistive device, a walker, a cane? How often? Could they do their transfers? Were there any falls? Again, the list goes on and on. But at any very specific questions that you can ask is going to get you this information. I

think if you just say, "What were you doing previously or what...?" That sort of question, you're not going to get to the crux of what you need. So we're gonna practice again, fun times. So our first prior level of function, patient lives in a two-story home with wife. What's wrong with this? What's wrong, is the fact that there's not a single bit of information on how that person was actually performing in that two-story home. They could have lived in a two-story home but have had a first floor set up for the last 20 years and never needed to do stairs. So maybe those stairs are not pertinent Better revised prior level, able to climb two stairs with a railing on the right side ascending independently, independent gait and transfers, responsible for yardwork and home maintenance. That's really specific. Even if he had just said ambulating independently or independent with gait and transfers, two stairs with a right side rail. I think is even, a lot of really good information.

Get as much as you can but definitely do the bare minimum for sure. So next one, required assistance with transfers. Is this a good prior level? The answer is no. But what's wrong? It's not specific. How much assistance? And what aspect of the transfers? I do most of my work obviously in long-term care and if you look at the MDs and the way the nurses document, they document in a language that is limited assistance and extensive assistance. And if you've ever tried to equate that to what we do in therapy, they don't match up. So extensive assist means that there's weight-bearing assistance which could mean min assists, modest or max assists because all of those have weight-bearing.

So just to say assist or extensive assist isn't enough for our purposes. And what part of the transfer was the problem? Was it standing up? Was it sitting down? Was it reaching back? I'm not exactly sure. So better revised prior level of function. Min assist of wife for transfer to level surfaces required verbal cues for safety and hand placement when sitting. We could talk about transfers to uneven surfaces. We could talk about pretty much anything as it relates to this, but that's a bigger much more specific. Last

example, bed-bound, requires max assist. Is that the worst thing I've ever seen? No. But it's not really specific. What do they need max assist with? Is it transfers? Is it bed mobility, dressing? I'm not entirely sure. So we have to have a little bit more detail there. A better revised prior level of function. Caregiver able to move and complete bed mobility for resident with max assist at risk for skin breakdown. That's telling us that their prior level of function related to bed mobility and if they're no longer at max assist, then possibly physical therapy intervention would be required. So let's move on now and talk a little bit more in detail about the evaluation or the plan of care. The purpose is to establish that baseline data. If that functional loss, the need for skilled therapy. Maybe it's self care, maybe it's mobility and maybe it's safety, maybe it's something else but on that evaluation, that's where you're gonna talk about your outcome or your goals, your interventions, your CPT codes potentially that you're going to do. How long is it gonna take? Your frequency and duration.

Pretty much every payer is gonna require some sort of plan of care and those requirements may look a little bit different, payer to payer. Again, I think Medicare is probably our most strict. The one thing that I will say about the initial evaluation or the evaluation plan of care is that no matter, what we just talked about reason for referral, no matter what your initial referral was for, you are strongly, strongly encouraged to evaluate the whole person and identify all of those deficits and impairments and how they impact that person. Don't evaluate just with blinders on. So for example, if you're referred just because that person has tightness or a range of motion deficit in some limb, you also wanna look at, okay, well how does that impact transfers? What about their balance? What about their strength? You still need to look at that whole person because what tends to happen is when we only focus on one thing, we miss something. We miss the whole picture, and oftentimes we go back after the fact and say, "Oh, I missed that. "I have to go back in and treat that." Every impairment that you identify, weakness, tone, pain, whatever it happens to be, tie it back to function. That's a really important thing. How does this affect the person's ability to do what it is that

they need to do for themselves? That evaluation has to paint the picture paint the clinical picture, clearly show their deficits and how that translates into something. And I just said that, it paints the picture. Think about it, that reviewer, that person who's paying the the claim never sees that patient so they never see the wonderful things that you do so that documentation has to really paint the picture. And in this step of the initial evaluation we're asking ourselves, "Okay, where are we?" And we say, "This is the current level, "this is where that person is "and then this is where we want to go to." That's what our goals are all about.

I do believe that the initial evaluation should begin with a patient interview and I think we do this. I think sometimes though, we maybe go through it a little bit quickly, but I like the interview. It is a crucial component. It's a prerequisite because what happens there is we identify what can the patient do, how often are they doing these? How often do they need to do particular activities? Are they satisfied with their performance? Do they think they could be doing something a little bit better? The successful interview will uncover their perceived problems, their physical, their cognitive disabilities, their relevant medical history, their support that they have maybe from their family or their community.

And it really establishes that request for services too. I really identify those areas where the person's doing very well or doing poorly and we need to work on their goals. I always tell a story, my father-in-law, this was a while ago, was in a community and was receiving therapy and he was just so upset, the one day that I went to visit and I said, "Well, what is wrong?" And he said, "I'm working on X Y and Z in therapy." And I said, "Well okay, what's the problem here?" And he said, "Well, that's not what I want. "I need to learn how to do this." And what he actually wanted to learn how to do was transfers on and off his couch so that he could stand up and turn the channel on the TV because he didn't wanna use the remote and he's like, "They're just not getting it. "They're doing this and I want to do that." That's why that interview is so important

because the more you can drill into what that person needs and what they want the more motivated they're gonna be and probably the more successful your program will be. So some guidelines for evaluation. I think we've talked about a lot of these. We're gonna have a physician's order prior to the initiation of treatment. We'll have a script or something that identifies we need to be in there. It's going to include objective, measurable data to get that prior level of function their current impairments and a baseline of where they are today. It demonstrates the resident's need for skill therapy based on their diagnosis, their prior level, their present impairments or prognosis, any prognostic indicators, which we'll be talking about in just a second. It demonstrates an expectation that the resident is actually gonna achieve those goals. It's very individualized with goals and a discharge location.

And I say that, I would encourage you all to go back and look at the documentation that you currently have. What I know just by looking at the documentation that it is absolutely individualized. Or are you doing the same exercise sets with everybody? Same billing code, same kinds of goals? We need to make it very individualized to that person. And includes the modalities to address the individual patient problems. So this is right there in your plan of care. I have pain, we're gonna do exercise or we're gonna do ultrasound with that person. So it's gonna talk about how you're gonna address those impairments with those deficits. And as we already said, it needs to be complete and address all areas. So part of that plan of care, our goals. So these are the functional performance objectives that we expect that patient to reach or to achieve as a result of the physical therapy that you are delivering. It needs to be very specifically relevant to the performance of functional activities and realistically reflect a patient's rehab potential. Now, one of the things with goals that, we hear different types of opinions on this, shall I say but I can only express to you what I've seen in my history as I've gone to ALJs, as I've worked on denials, et cetera. They really do want those goals to be focused on function. So if you see a goal that says, patient will achieve this score on the Berg or this score on a Tinetti or something like that okay, that's great but

how does that translate over to function? If you're going to write a goal like that you still need to be able to say, in order to transfer to and from bed without loss of balance or without a retrograde loss of balance whatever it happens to be. So goals should not be solely around a standardized assessment. They always still need to be related back to function. That's the one thing we keep hearing from the reviewers. Obviously we need goals. So it not only talks about what we're going to do in physical therapy but it talks about its priority of your treatment. So this is what is the biggest priority right now and when I've achieved that goal, I'm gonna add in this goal. So it talks about your roadmap, what you're working on. I think the other piece of it, is that it helps you to communicate to payers, to other healthcare professionals, to family members. You have a family meeting or you have somebody coming in to observe treatment and those goals are what help you to communicate with them and talk about what it is that you're working on, in your therapy program.

So long-term goals. I mean these are... this is kind of basic, but I think this is important. Long-term goals, short-term goals, I don't think it matters. They need to all have the same components. We oftentimes will see things long-term goals that'll say return to prior level of function. Like, okay, are they going to return exactly to their prior level of function or maybe prior level of function engaged but maybe not in transfers or what have you. So it does need to be very specific to the function. Obviously the long-term goal is where you expect that patient to be at the time that you discharge them from your services and it needs to reflect reasonable amounts of time obviously. So you want that to reflect what it is, your length of treatment your frequency or duration. The short-term goals, same thing. These are your building blocks obviously, for your long-term goals. So incremental steps, realistic to needs and status, functional, reasonable time, duration, et cetera. One of the things that I see, when I review short-term goals is that sometimes they're a little lofty. Maybe it's better. I think it depends on how often you're reviewing those goals and updating those. Is that weekly? Is that something else? I don't know. But consider the fact that maybe, when

you write that for a short-term goal it shouldn't be for min assist if the person is right now at max assist maybe you need to have building blocks. And we're gonna talk about low level patients in just a few minutes. But sometimes having little, I call them splinter skills if in the goal, might be better than trying to go an entire functional level. So what I mean by that is, patient may stay at max assist but may only require 50% verbal cues for appropriate hand placement versus 75 that they have right now. So sometimes having small, small increments related to that goal is sometimes more achievable because, I don't know about the rest of you, but I sometimes see, we've written this short-term goal week one we didn't meet it, week two we didn't meet it week three we didn't meet it. Well maybe it doesn't have to do with the patient not meeting the goal, maybe that goal was just a little too lofty to begin with. So maybe we need to break that down a little. The components of the goals. Pretty easy. There's a participant, who's going to do this.

The important piece about the participant is that it's either the patient or it could be a caregiver. It's not going to be the therapist. And why I say that is because... so I'm sure you've seen them, goals that'll say, therapist will complete XYZ assessment on the patient by this date. It's a Berg, a tenacity, a dynamic gauge, whatever the assessment happens to be. But that's your plan of care. That's what you're going to do in treatment. That's really a goal, the goal needs to be patient-specific, patient-centered. It's the behavior. What do you expect that person to do? What are the conditions? These are the requirements or the circumstances necessary to perform that activity. And the more conditions you put into a goal probably the longer that you're gonna work on it. So you could put a condition in there for balance. You could put a condition in for strength. It could be cueing, it could be whatever. You could put a number of different conditions to really specify what you want in that goal. Measurement, that makes sense. Some sort of objective measure of their progress and then the functional outcome and a time component. That's the one piece that's not on here. So here's an example. Resident will or patient will ambulate a 100 feet. So that's the behavior, I want

them to walk basically. Using a rolling walker equals step length, heel strike less than two loss of balance require min assist or less to correct. So in a lot of conditions in there rolling walker equals step length, that's two equal heel strike, loss of balance requiring min assist or less to correct. So there's four different conditions in there. I could have less, but the more I put in there obviously the longer I'm going to work on it and the more I have to comment on. With contact guard assist, that's measurement. In order to attend meals in the dining room that's your functional outcome. And again, you're going to have a time component in two weeks, in three weeks, whatever that happens to be. So let's take a second and practice here's our first goal. Patient will be independent with transfers in four weeks.

Good or bad? Hopefully you said bad. Here's the issue, it's not specific enough. What type of transfers? Is this transfer to bed? Transfer to the toilet? Transfer to the car? Transfer to a low couch? I have no idea. You can't just say all transfers because if you had a low surface versus a high surface that would take a completely different skill set. So you do have to make that more specific. And will that person be truly independent? I don't know. Will they need cues? Might they need a cane or a walker? Need increased time? So I think there's some other components that potentially would go in there. Next one.

Patient to ambulate independently with a standard cane with normal cadence and symmetrical gait pattern to reach the dining room 400 feet in her assisted living facility in four weeks. This is a much, much better goal. Obviously it's very patient-focused, it specifies several conditions and it explains why that increased need for distance. I don't know that I like "normal cadence and symmetrical gait" I like symmetrical gait pattern, I can be fine with that. I don't know what normal cadence is for this person maybe it could be a little more specific but ultimately, it's pretty good. And there's a reason I put this goal in here. I have to share with you. So many years ago, I was working in home care. I was overseeing a home care agency, and we had a therapist

who was working with a patient on stairs and did one flight of stairs, did two flights of stairs three flights of stairs, and just kept doing stairs and stairs and stairs and stairs and the prior level of function talked about this person living on, whatever floor it happened to be, and using the elevator for access to her apartment. And I went back in and review it. I'm like, "Well, she has an elevator. "That's how she gets to her apartment. "Why are you doing all these stairs?" I mean, there had to be a valid reason for it. And anybody who's listening probably knows that this person had to have an evacuation plan had to be able to do the stairs in the event of fire. Well that's great. It was absolutely warranted that they continued to work on it. Guess what? They never spelled it out in the prior level of function and they never spelled it out in the goal and that was the problem.

And it actually did go to a review. And when we finally went back and talked about the evacuation plan it was a paid claim, but it was a problem 'cause they never really specified it. So I think that's a really good example. Next one. Increased right shoulder flexion and abduction within functional limits to improve ADL. Again, it's not the worst thing I've ever seen but first of all, there's no timeframe. I do like they've said flexion and abduction so that's kind of specific. But what is within functional limits? There's a saying out there. What is it? Within functional limits says we forgot to look and within normal limits or WNL is, we never looked. I don't know if you've ever heard that joke. What is functional limits? We don't know.

Let's give a specific range there. And more importantly, what ADL? Do we need to reach all the way overhead to change a light bulb or do we just need to be able to have something maybe within the plane scaption or something to put on a shirt? I don't know what the answer is there. Obviously we revised it. Improved right shoulder flexion and abduction to 160 degrees to be able to wash hair in three weeks. Yeah, that's a much better goal. Very specific with regards to the range of motion, measurement, the functional task, the impact. In two weeks, patient will be independent with bed mobility.

Obviously you know the answer here. Not so good. But it's as good, why? Okay, so let me talk about that. If that's your only goal, it's a little bit better. I would like however, that they recommend a very specific component of bed mobility that could be bridging, that could be rolling, that could be scooting, I mean that could be a million things. So I think it needs to be more specific as to which aspect of bed mobility. But if that's all I got I probably wouldn't complain too much. I'd like it to be better but as it is, it's not the worst thing I've ever seen. So education goals. I do want to talk about these for just a second. I already mentioned this, educate caregiver on safe transfers. We see these types of things. Remember that, it's never going to be the therapist who is doing this. So that appears to be very much the therapist-driven. We don't say the patient or caregiver focus, the audience here is the therapist. It's not specific, it's not measurable, there's no timeframe. Here's another one. So we revised this one. Caregiver to safely assist patient with bed to wheelchair transfers via sliding board with min assist less than three cues for proper technique in two weeks.

That is a really, really good goal, that is very specific and it's specific to the caregiver. It's specific to what we're expecting them to do. Here's another one. Patient to understand hip precautions. Again, these are common goals that we oftentimes see and it's not functional, it's not specific there's no timeframe and what does understand means? And I'm not entirely sure what that means. In two weeks, patient to verbalize and demonstrate understanding 3/3 posterior hip precautions during bed mobility transfers and ambulation without cues. That is much more specific. So verbalizing and demonstrating shows that they have understanding and it's measuring their level of understanding. As I told you before, I promised you some maintenance goals and I'm not gonna read these at you. You can certainly read them. Following a manual relaxation technique resident demonstrate 90 degrees of right elbow extension blah, blah, blah, blah. Staff to correctly apply the right elbow extension splint according to the wear schedule with a 100% return demonstration. So there's a staff related goal. Patient will follow one step verbal instructions as presented at a slow pace by trained

caregivers so on and so forth. The comment that I wanna make and you can read through the rest of these, is that your maintenance goals really and truly are not that much different than your other goals that you might be writing. There still has to be on behavior. There still has to be a measurement. There still has to be a participant. There still has to be a functional outcome. They're set up very similarly and in a lot of cases they will look almost exactly like your traditional physical therapy goals except for the fact that you're maintaining that function, you're not improving that function. So you might be maintaining their gait 150 feet with a wheeled walker as opposed to trying to improve to that. Next piece is documenting rehab potential. Rehab potential. What is that? It's the potential projection about the future status of that patient based on your observable behaviors today and we call these positive prognostic indicators. When do you determine it? Will you determine this?

Obviously your initial evaluation and this can change throughout the course of treatment. You have somebody who comes into you and is very, very low level and lethargic they have a medication change. Does the rehab potential change? Probably and possibly. How do you determine it? It's your objective diagnostic procedures. It's your clinical judgment. It's your clinical observation about that patient. Maybe it's a use of a standardized test. And it's really the prognosis it's a prediction about the future status. This along with the rehab potential are gonna support the clinical judgment of why therapy is indicated for this patient. I think the one important piece is that the diagnosis or the prognosis is never the sole factor in deciding whether or not a service is skilled. And what do we mean by that?

Years ago, many, many years ago if a patient had a diagnosis of dementia that was automatically denied, it was not paid and Medicare came back and said, "No, no, you can't just use diagnosis alone "and saying yes, this person needs services "or no, that person wouldn't benefit." So it's not just the diagnosis it's that whole medical record. Now, the one thing I do wanna say about the rehab potential and the prognosis and

such, this is your rehab potential as a therapist, your rehab potential to meet the established physical therapy goals. Ideally, this should be good or excellent to meet the goals that you've established on this plan of care or that your therapist is established on this plan of care. If you can't say that the rehab potential is good or excellent to meet those goals we probably wanna go back and revise the goals, right? So that they are goals that are achievable and reasonable for that patient. This is your potential for the patient not the medical potential, not what the physician is saying. Some of the positive prognostic indicators. I'm not gonna read all of these at you, can read them but these are behaviors that we think are signs of good rehab potential. So when you have good orientation, attention span, eye contact, initiation, motivation, whatever those are all positive things to say, "Yes, absolutely. "This person is gonna benefit from physical therapy "and they're going to do a great job." So the prognostic indicators and then here's your rehab potential. Who determines it? It's you, the therapist.

You determine the rehab potential for meeting those goals and this is where I just said this, it should always be good or excellent for the goals that are stated. Your physician could have a poor rehab potential documented that it could still be excellent for your physical therapy goals because you've written the goals accordingly for the level that the patient is. You wanna document this in the assessment. You can put it in subsequent documentation if it changes, if it goes off, if it goes down. Some of the negative prognostic behaviors we talked about the positive, these are some of the negatives that may lead you to poor rehab potential. So pain, orientation, arousal, no family support, those sorts of things. Does it mean that you're not going provide therapy? Of course not. You can still provide therapy with all of these things but what are you going to do? You're gonna revise your goals or set up a plan of care that makes sense based on these prognostic indicators. Precautions and contraindications. This is pretty basic stuff but I think it's really important to get it in there. Weight-bearing, oxygen, aspiration whatever it happens to be. Because I think what's

important is that you may set up this plan of care and then somebody comes behind you and follows it or you might be the person following it. And if the therapist never documented specific precautions or things that you need to watch out for, you could place that patient at great risk for some adverse event or issues. So you wanna make sure that gets in there. Next area, as it relates to the plan of care is the frequency and duration. So I'm not gonna tell you what frequency and duration is. Obviously it's a number of times that treatment is delivered and the length of the therapy program. What you do wanna talk about though, is how we recommend that. it's the individual patient needs that you've interpreted as the therapist that will help you to determine your frequency and duration of treatment. It's the type and severity of their disorder that may also play a role if they're very involved or if they're pretty high level.

And one of the handouts, two of the handouts that you have one of them is a high level worksheet and one of them has a low level worksheet. I don't know about the rest of you, I find it just as hard to establish goals and a plan of care for my really high functioning individuals just like I do my low functioning individuals. So use some of those types of worksheets to look at what should you be addressing with this patient? And what can help you to determine your frequency and duration?

Obviously your intensity is based a lot of times on the endurance level of the person and obviously how complex the services are that are administered and the intensity of treatment can vary. And if you don't have that endurance maybe they are only treated once a day. Maybe they're treated twice a day, if they have great endurance. Maybe you split the treatment to get it all in, into two or three sessions throughout the course of the day because their endurance is so poor. So you can change that up and do what you need to do based on their tolerance and their needs. Obviously the duration is determined by the long-term goals. The patient's potential to meet those goals. And then there's your pass your goal attainment and your frequency, how many times a week, et cetera, et cetera. What I wanna say there is that, when we look at frequency

and duration, it shouldn't be a cookbook. You know, every ortho patient is treated, this number of times a day b.i.d or whatever all outpatients are this or that. Based it on the clinical indications of your patient based on their clinical representation. Now obviously that said, you're gonna have specific payers, your HMOs or managed cares or different things like that where they may have very specific frequency or duration based on a specific protocol that you have to follow or a formulary. I get that totally. But in absence of that, you wanna make sure that you are looking at the clinical picture of this patient therapy. It's not a game of chance. It's not a cookbook. It's our opportunity to make a big difference in this person's life. The other thing, I just wanna throw out there we don't choose frequency and duration based on my convenience when I happen to be scheduled or something like that. It has to be based on what the patient is experiencing or what the patient needs. The only other thing that I do wanna say is, the frequency and duration should be specific and should not be a range. So this is one thing that we get in trouble with Medicare quite a bit.

You don't wanna say three to five times a week or five to six weeks because it's not specific, it doesn't give you the clinical rationale or the clinical reasoning behind why you chose the frequency or duration. So you want it to be very specific. Recognizing that it could potentially change. You could start at five times a week and then potentially back off to three times a week as the person improves. So now as I say that again, I just wanna back up and make one particular comment that most of what I'm talking about here would be like Medicare part B or outpatient that type of thing. Medicare part A totally different story in order to be skilled, skilled is five times a week treatment. So I do wanna make that distinction. I already said this. Staffing, scheduling, blankets, service delivery protocols et cetera, that should not dictate your frequency or your duration. Not everybody should be scheduled for the exact same thing unless everybody's going to benefit from it and that's what their clinical need is. We need to be very, very individualized. And as I already said, you're not 100% locked into that frequency and duration. If the condition changes or else it improves, it declines you

can change that frequency and duration. You just get new orders, you write maybe new documentation whatever that happens to be. So just things to think about. So we're gonna talk a little bit about the daily note now. I'm switching gears. So we talked about skilled interventions. This is really important, you're gonna be billing, right? Your CPT codes, your skilled interventions, all go together. Skilled intervention describes the therapy only services that you did. What did you do during the treatment? I wanna know what my patient did. That's their objective progress, that's how they reacted to the treatment or how they responded to the treatment. But I need to know what you did? What, I'll say it again What makes you so special?

What did you do that was skilled? But before I go on, I just wanna go back very quickly 'cause I see that I've failed to mention this. Skilled interventions, you have one of your handouts for this session, a list of skilled interventions by type of intervention. I'm not gonna say that list is all inclusive and exhaustive but it's an idea of some skilled interventions. I also provided you with some goal banks and some sample maintenance goals I failed to mention that. So if you're looking at good goals for a patient there just some samples that are out there for you.

As I already said, I'm regarding skilled interventions that's a level of complexity that only requires your service. Now this is important. It could be the complexity of the intervention itself. So maybe you're doing inferior glides of the scapula maybe you're doing some sort of modality. It could be the complexity of the patient too and the documentation would show that, that they have a CVA plus these three comorbid conditions that are impacting their ability to participate and that's why you need to be involved. When we look at what is skilled? We've already talked about some of this. Skilled observation, evaluation, skilled treatment training, education, establishing, maybe delivering that maintenance program. What is not skilled? If that person's therapy can proceed without you it's not skilled. So I liken that to, let's be very honest, a lot of exercise programs that we end up putting together. Now if you are advancing

that exercise program, if you are adding weights, you're checking for the person's level of participation and maybe changing parameters as that person is exercising that is absolutely skilled. But to say, "Okay, I want you to do 10 minutes on the bike "and I'll be back in when you're done." Is that skilled? I don't know. Are you observing? Are you assessing? Are you doing something there that makes that skilled? Could that person carry that over on their own, without you? And it's a rhetorical question, that only you can answer. But if they can do it and it's a home program type of thing maybe we need to allow them to do that and then we focus again on those highly skilled things. I'll tell you a story. I was in a contract, this was again quite awhile ago, where the physical therapists, I thought this was brilliant. Patients were coming in and they had a lot of orthopedic types of clients and the patient would come in and like two, three, four days into the stay, whatever it happened to be, this was part A again. They would develop the home program, some exercise programs with the patient teach and train, have that person do it. And then that was that person's home exercise program.

They'd come back into the physical therapy gym and do the program but the physical therapist wasn't overseeing it. They were independent in it and then the physical therapist was doing the higher level types of activities, the gait and the stairs and transfers and things. And what was really very brilliant about that was it focused the PT on what was skilled. But I think more importantly really prepared that person for discharge. So if they can proceed without you then you don't need to be there. If it's routine or repetitive. If it's a community program. If it's a self management program. Palliative types of procedures. Services just related to activities for the general good. So fitness types of activities or... what do I want to say? Recreational types of activities. The important piece here is the fact, so we see sometimes that therapy will oversee or will do a maintenance program or restorative program or something in a community because there's no one to do it. Or "I've got to do this "because I've discharged it to nursing "and they just fell through, "they couldn't do it, I have to do it "because they don't have the staff to do it." Well just because there's not a competent

person just because that person's unavailable, doesn't necessarily make it skilled just because you do it because somebody else isn't available. Again, still not skilled. How do you document it? We've been talking about this, the skill of components of the intervention, the strategies, the training. I love the term return demonstration. That is a wonderful term because it talks about if I don't have a 100% return demonstration or something pretty close to it, I'm probably gonna need to continue my education efforts and that's very skilled. New exercises, changes to the exercise. What you're observing for? While that person is exercising. Are you monitoring their vital signs? Are you teaching them pursed lip breathing?

Are you teaching them energy conservation techniques? I don't know what you're doing but that would be skilled obviously. If the treatment is added, changed, what have you anything that you've changed, you wanna make sure that you record and justify that. Skill isn't just what you did, isn't just what the patient did. So dressed with moderate assist. I didn't need a therapist for that. What did you do? Transferred without physical assist. Again, what did you do there? The exercise name, the number of repetitions, the amount of weight, the amount of assistance and the distance ambulated. You have to spell out the skill what did you provide?

And even those CPT descriptors. So we oftentimes see patient participating gait training exercises today. What does that say? What did you do during that gait exercise or that gait training? So there it is. Skilled treatment requires more documentation than just ther ex or therapeutic activities or gait training or whatever that happens to be. Some great skilled terminology. I'm not gonna read these at you you can certainly read them. Analyze, assess, customize, skilled feedback, facilitate, inhibit, evaluate, measure, et cetera. What we don't want to say, routine, practice, endurance, repetition, monitor, trial. Trial is one of my favorite. Did you really trial something or did you assess the effectiveness of something to meet an outcome or meet a goal? So I think there's always a way. Let's be honest. Sometimes what we're doing, is we're kinda

wordsmithing it but in doing so, you're showing your skilled nature. So just watching, helping, monitoring is not necessarily skilled. Remember that only what you can verify in the medical record only what's documented in the medical record as skilled can be considered for payment. And again, that is really important. It would not be the first time that a reviewer would come back and say, "Oh, you billed XY and Z "but I don't see anywhere in the documentation "that you either provided this "or what you provided was skilled." So let's make sure that it is. So some examples, standing balance activities with min assist for balance recovery, balloon toss and reaching. Again, it's probably not the worst thing that I've ever seen. But is it highly skilled? No. You might say balance activities. I think balance recovery is for sure skilled terminology but balloon toss, not so much. A better statement. Multidirectional balance challenges in standing via balloon toss. Okay. That's fine. Self-imposed challenges to the cone of stability via reaching up and down and across midline. That makes it 100% totally skilled. Another one, bed mobility training performed supine to sit with modest assist. Obviously, that's not our best documented statement.

Tactile and verbal cues, 50% of the time for a logroll to maintain a neutral spine and avoid counter-rotation of the lumbar spine. That says exactly what you were training in your bed mobility. I was doing logrolling and I'm working on the position of the spine during that and I'm working on supine to sit, et cetera. Why does the person need me? Oh, because they can't carry over that strategy themselves they need tactile and verbal cues. This is addressing on an ADL one, upper body dressing at the edge of bed with modest assist. Again, ADL training at the bed edge, hemiplegic dressing techniques introduced. So this is obviously more of like an OT example, but hemiplegic dressing. So are there hemiplegic strategies for transfers or for gait? If we are working with somebody so this is somebody obviously who has a CVA. Are we working on cognition? The answer is yes. Can you work on cognition as a physical therapist? Yes, of course you are. You're working on safety awareness, you're working on sequencing and you're working on attention to task to safely perform that mobility. So again,

there's nothing wrong with getting that in the documentation. This is also addressing one and I apologize for tossing these in here, but I think it speaks to the skill. Improved upper body dressing from mod to min assist with compensatory training on the hemi techniques. Continued left neglect, deficits with body image. Mod tactile and auditory cueing required. I think all of that, could easily be translated over to a physical therapy note. So left neglect as observed and I need to provide verbal cues to negotiate architectural barriers during gait training due to that left neglect. I need to provide min assist or minimal verbal cues or something like that. And I'm sorry, I wanna go back to this one for just a second, even though it's an OT-ish type of example, if you look at this, the resident has improved upper body dressing from mod to min assist. That's the objective performance. That's the residence response or the patient's response to that treatment. what is your skill? I think that note has to have both. That's what our payers really are looking at from us, is how did the patient respond and what was skilled? And I think that has both of them.

Resident ambulating 25 feet with mod assist and wheeled walker 20 feet last week. So we're talking about the patient's response to the ambulation, we're talking about them improving from last week. But where's the skill? Here's the skill. Focus of treatment is to improve the weight shift over the right lower extremity and posture to midline through gait and balance training. That's your skill. That is not something that nursing is necessarily working on. Nursing can ambulate 25 feet to and from the bathroom but can they work on weight shifting and posture and all of those things? Probably not. Okay, so the next couple of slides just give you some additional skilled examples. I'm not gonna read these at you. They are here for your reference but you can certainly look through some of these as skilled examples. These are interdisciplinary so there's a whole bunch of stuff in here for you. And that last one I'm just gonna hit on for a second. Assessed two-hour use of wedge cushion in a wheelchair during daily activities to reduce posterior pelvic tilt and forward sliding. Patient with no complaints of pain or discomfort. So if any of you are working on positioning types of things it's

the word trial, trial the wedge cushion. Can nursing grab a wedge cushion out of a closet and put it on a wheelchair? You betcha. What did we really do? We were assessing the impact of that cushion to get a specific outcome. Here's some maintenance examples. Educated husband on appropriate handling techniques to decrease tone. Husband verbalized understanding but required multiple verbal cues to slow down, maintain appropriate hand placement to decrease clonus and muscle spasms. That's a really detailed statement and highly skilled. So that is maintenance but you can see the skilled nature of that. That's not something nursing would do. And here's a few others. I'm not gonna read all of these at you. Performed passive range of motion, maintaining anatomic alignment, splint and sling reapplied, nursing notified, so on and so forth. That's a big note.

But you can see pieces of skill there. Humeral alignment preserved during all range of motion activities. So I don't know what the issue is with that patient but maintaining that humeral alignment on the glenoid fossa is that something that skilled? You betcha. And here we go. Here's the wedge cushion again. Transfers with mod assist, ambulating 25 feet. They're non-skilled. This is probably a lot of what we see in documentation but you have to step back and say, could somebody other than a physical therapist provide this? And the answer is yes. And then again, resident has improved bed mobility, bed mobility training, patient independent with basic mobility skills. Again, what does that say? It's very, very vague.

So question. How long can we see someone for skilled therapy? I have no idea. I wish I could answer that. This is very, very much patient-specific. Always remember that patient needs to have something medically necessary, skilled services either to maintain or prevent decline that would occur without therapy, without nursing intervention. The only caveat to that, that I would say and it's just something for you all to keep in mind and it's outside of the scope of this training but know who your Medicare administrative contractor is for your jurisdiction, for your area. A lot of times

those contractors will put into their LCDs or their local coverage determinations, very specific guidelines. For example, you can only do this type of CPT code with this type of diagnosis or if you're going to bill manual therapy for example, all of this has to be in your documentation and it's only covered for these types of conditions. So know what's in there. Sometimes they will put into those, and these are more for outpatient and part B types of situations, guidance that'll say, you should theoretically only bill Fairfax 12 times a month. I don't know, I'm just throwing that out off the top of my head as an example, I don't know that's out there. But you need to know if your LCD says that, can you exceed those 12 times a month? Probably. But what has to be in place? Your documentation to support it. So you need to know what that LCD says and if there are some of those types of restrictions, your documentation has to be stellar to make sure that you justify when in fact you go over that. So I'm gonna start talking a little bit now about discharge planning. This is where some of those interdisciplinary worksheets come into play. When we look at discharge planning.

Again, I think this is, I'm just gonna look at some of the questions that might be out there, that you can ask yourself. So if they've established all the goals that you established for them, they've met all those goals, then ask, okay has every goal been met or just maybe one or two of them? Could there be more progress? Can you go past the prior level of function? If your documentation supports a good reason why you're going past that prior level, there's not necessarily a problem with that. You also have to figure that maybe their prior level was impacted by a disability that now is being resolved. What I mean by that, is maybe their prior level two months ago or three months ago was impacted by constant pain and now that pain is improved. So yeah, possible you could surpass their prior levels. So again, as long as your documentation supports it. Were the goals applicable to the environment? If the person's going home, did you address everything? And again, outside of the scope of this but that's where I love home assessments. I think sometimes we use home assessments in our industry as I call it, a report card to say, I did all my treatment. How did I do? Did I do a good

job? Can they do this stuff in their discharge environment? Maybe flip your thinking around and look at that home assessment early on and say, "Oh, these are the 10 things they need to do "to be successful in their discharge environment." Let's use that, to set all of our goals. So making those goals applicable. Has everyone been trained? So it's not just your community but it's also the patient, the caregiver, et cetera. Is the resident satisfied, the patient satisfied? Did they want to do more? Do they have additional goals? Are they at their highest functional level? And is there follow through? I think that's really important.

We say, "Oh yeah, I educated them. "I did that, I took care of it." But is it really happening? Is it occurring? Is there good follow through? Maybe we need to do training and education again to make sure that there is. What if you're discharging the person because they're not making progress anymore. They've hit the "plateau" So you need to say, what's the reason for the plateau? Is everybody aware of that plateau? Maybe it's something medical, maybe there's something that can be done from a medication standpoint or what have you. Did you do comprehensive treatment? Maybe they've plateau is because they are still having residual pain or residual tightness in a joint or something. And did you do what you could do, to resolve that? So maybe they get past that plateau.

Are there cognitive deficits? And we're gonna talk about that in just a second because that's a really tough one to try to get around. Did you modify the goals? Maybe your goals were a little too high for the person. Maybe you needed to back those goals down just a little bit. Maybe there wasn't equipment to do that. So let's make sure that the DME is there, the assistive devices are there. And maybe it's a opportunity for us to do skilled maintenance instead. If the resident is being discharged or the patient is being discharged due to a decline in status. I think this is very similar to what we just said, is the physician aware? Is the family aware? Is nursing aware? Did you modify your goals? Could you have modified your treatment plan? Maybe there is a medical

instability and they couldn't participate in your session for an hour. What could you have done? Three, 20-minute sessions with that person throughout the course of the day? Or two, 30-minute sessions? If they didn't have the endurance. What did you do to kind of alter that? So that patient may be could have participated. What if the person in this, this happens? Particularly with any individual who has dementia or maybe a traumatic brain injury or that sort of thing. Maybe they're being combative, maybe they're uncooperative, maybe they're just disruptive. Have you looked at maybe why that's happening? Have you looked at other approaches? And I'm gonna give you a great example. I was in a clinic, not all that long ago and the physical therapist was saying, "Gosh, I got to discharge this individual "because she's just not following through "on any of my instructions. "I don't know what to do. "She's not cooperative with me." And so I happen to be with another clinical person and we're like, well let's try something. And the person had dementia and we said, "Okay, we want you to stand up "and walk over there, whatever we told her to do "reach back, push up off the chair "stand up, grab your walker, do this, do that." And we stood there, no lie and waited.

This person had a moderate stage of dementia and kind of the thought process was she needs time to process those instructions. She needs time to process what we're asking her to do, and we waited. And no kidding about a minute, a minute and a half went by and sure enough, this individual locked her brakes, put her hands on the armrest, pushed herself up, grabbed her walker, walked 100% safely across the room and sat down. So here was a situation where we said, "Oh, she's uncooperative, she's belligerent, "she's not working with me" When instead we needed to change our approach. So I think a lot of times it comes up with dementia which we're gonna talk about here, in just a second. And it comes up with where we need to change our approach because it's unfair to ask the patient to change their approach. They may not be in position or physically or cognitively able to do that. Oops, sorry. There we go. I'm sorry about that. So let's talk a little bit about those behaviors because that's what we just talked about, disruptive behaviors and such. The reality is disruptive behaviors,

problematic behaviors, disturbing, challenging behaviors whatever we wanna label them as. And I don't like labeling but that's what we hear them called, right? They're very common unfortunately. In our industry when we're working with geriatric individuals, particularly if we're working in a nursing home they can be dangerous, they can be incredibly disruptive. The reality is from Ahn and Horgas in their research there's common "disruptive behaviors" Wandering is occurring in anywhere between 40 and 60% of individuals with dementia. Aggression and agitation is occurring in upwards to 80% of individuals who have a cognitive impairment. And the reality is, that the cost of care for individuals who have these types of behaviors is significantly increased as well and it impacts our therapy and what we're able to help that person to do and what we're able to work on in therapy.

The reality is the behaviors are somewhat common and they're oftentimes the primary reason that somebody comes to a long-term care type of institution because they become too difficult too demanding, if you will, for loved ones to care for at home. Now when we talk about behaviors this is what I want to bring to light is that if you are seeing behaviors positive, negative, what have you it's indicating something. That person's trying to tell you something. I don't know what it is that's your skilled intervention to figure out what it is obviously but you need to look at it as a form of communication. You need to look at it as an unmet need.

That person may be by their behavior telling you, you're giving me too many instructions at once, You're talking too fast to me, you're talking down to me, the environment is too distracting. You have no idea, but you need to try to, I don't want to say by trial and error, but it is kind of sort of by trial and error to figure out what that behavior means. The behavior is really only a problem when the safety or the wellbeing of the patient is compromised. A trigger or a cause can't be identified. Some of the common behaviors and I'm not gonna go through this in great detail but we see a lot of these. We see anger, we see sleep issues, we see rummaging, we see sundowning.

Those are very common common behaviors but I will tell you a lot of them are related back to what we're doing in therapy. So, for example, I'm just gonna give the resistance to ADL and I'll deep dive that a little bit. If anybody's ever worked in long-term care, you know all about shower day when that person is maybe placed on a shower chair and wheeled down the hall to a shower that maybe doesn't have warm water. They're rushed through it, it's not a pleasing experience and then we see behaviors. So I think we can go on the opposite side and say, what are we doing in therapy? Maybe to cause some of these behaviors ourselves. Think about it. If we're just providing exercise to that person but that's not something they've ever done in their lifetime and they don't have a litmus test or a frame of reference to look at those exercises. Does it make sense to them? It may not.

And might you see belligerence or behaviors, you might. So that's again where I go all the way back to that interview in that prior level of function. Find out what their hobbies are, find out what their interests are because then you can tailor your therapy program to address that and then you're gonna talk about in your documentation how you've altered that activity. Where it occurs, maybe it's not in the busy gym, maybe it's in their room, maybe you've changed the lighting, maybe you've changed how you give instructions or the task or what have you. And that's again your skilled intervention back to this person. Some of the causes of these behaviors.

Environmental, it could be lighting, it could be temperature, it could be noise. It could be physiological, that person is fatigue maybe they have impaired vision or hearing or something like that, maybe they're constipated and they don't wanna participate. It could be psychological. it could be medication induced. The vast majority are communication-related, are task-related, are pain related. Outside of the scope of this, but when we look at pain, if you look at the research the vast majority of our patients who have dementia have some other comorbid condition known to cause pain but their pain medications oftentimes are written as a PRN order. And that's where you as

physical therapist can play a huge role, and I am digressing for a second, but I think it's important. You can look at that person and their facial expressions, their mannerisms, their bodies, what they're doing with their body and say, yeah, this person could possibly be in pain and you can address that pain through various interventions and then be able to promote just really a better quality of life for that patient all the way around. So as we look at the person who has dementia or the person who is low level, TBI low on the Rancho scale or somebody who's had a CVA who's just really, really low functioning. This advocacy model of care comes into play. When we look at Medicare requirements, OBRA requirements, the Omnibus Budget Reconciliation Act. Patients have the right to achieve and maintain the highest functional levels and as therapists, it's our opportunity to be advocates preserve those rights. Recognize not everybody's going to restore function. So it's our responsibility to identify spared skills, if you will. What skills they do have? And designed care plans or plans of care to maximize those strengths and abilities.

Our job is to focus on their abilities, their learning potential, their functional needs, their goals, realistic outcomes. I love this model of care because I think it makes perfect sense. You're gonna have that person who comes in to you who is probably a short-stay type of patient whatever their insurance happens to be or maybe it's a high level outpatient or something and are you gonna restore their function? You betcha. They came into you with shoulder pain and they weren't able to do XYZ. You're able to resolve that pain or maybe they had low back pain or something, you gonna resolve that and the person becomes functional once again. That's restoration. The person who is at a restoration level of care has very few adaptations that they need, they have high level goals. It's a very dynamic therapy program. It's pretty intense probably. There's not a lot of changes to the discharge environment, et cetera. This is what we were trained to do. This is what we were born to do as therapists, is restoration. Are you gonna fully restore everybody? No. There could be a level of compensation that's a next level of the advocacy model of care. Where instead we're not restoring, but we're

compensating. So we use a walker, we use a cane we use some other piece of a durable medical equipment. Maybe we're using some sort of modality when we teach them do use a TENS unit to manage their own pain or something like that. We teach them to use a sliding board in order to do their transfers. We change the level of the couch by adding cushions or we put wood underneath it to make it more stable. I don't know what it is, you're compensating for. You teach them energy conservation, pursed lip breathing those types of things. That's compensatory. So pretty intense therapy still but not as intense as our restoration level. Then there is the adaptation or maintenance. And I will tell you, I think this is probably the level where folks get stuck.

This is that person who has a chronic condition, they have chronic Parkinson's, they have chronic dementia, whatever it happens to be and are they gonna get better? Not necessarily. Are they gonna improve their function? Not necessarily. But can you adapt? You betcha. So this is that person where... maybe I'm not gonna get any better with my gait than a min assist but I can set up the environment in a way that person's gonna be safe. I can give the right types of cues to them so that nursing can follow through with it. So this is that adaptive level.

So taking it back to documentation what you end up doing, if you look at this person are you gonna treat them for six weeks? Probably not. It's probably going to be a reasonably short length of treatment. But what you're doing is figuring out, what cueing strategies work? How many tasks can they take on at one time? How much can they sequence? What is their attention span? Et cetera And that's when you then teach and train the caregiver in order to carry all of that over. And that's a very, very skilled intervention. And I think it's frustrating sometimes when you're working with a patient that you're not going to see them improve you're not going to see them get better. But picking out all of those elements, that I just mentioned are 100% totally skilled if you're documenting those as such. So again, back to discharge planning and I think this kind of taps into what we just talked about with dementia with palliative care, with that

person maybe who has cancer or something. Maybe somebody is saying to you, "Okay, you can't treat this person "because their comfort care, they're on hospice, whatever." Ask the question, was the treatment comprehensive? Did you modify the goals? Have you trained the caregiver on everything? And I realized that we have limitations where we sometimes can't treat that person. But I think sometimes it's also important to go back to the patient and ask the patient, "What do you want?" Maybe that person, even though they're on hospice, really, really wants to walk to the bathroom or really wants to be able to get out of bed independently or they want their spouse or their significant other to help them to do that. So if that's the sole reason that we're discharging let's take a look and see if we've met the patient's goals for what they were expecting. Because if the patient is saying that they want something then there might be an opportunity to deliver that. For every situation as it relates to discharge planning. Did you document everything, your caregiver training? your recommendations?

So you might be saying, "After this is over, "I'm recommending that home care follow this person, "I'm recommending they use a wheeled walker, "I'm recommending they use this home program "three times a week." Whatever that happens to be. And then also recognize that you may have other options available to you. Maybe it's restorative or maintenance or those sorts of things. I think what's really important and I probably live in the ivory tower, I'm not sure, maybe. I want this to be your clinical decision whether or not you discharge. I want you to look at every avenue and every option for that patient. I feel that we have to be strong advocates for them. So if we're saying, "Oh, they're not making any more progress, "they're not working with me." Did we look at everything? On the flip side, you know somebody... it has to be our clinical decision. It can't be somebody else saying, "You must keep this person." It can't be somebody else hopefully saying, "You have to discharge." I know there's limitations with insurance providers and such but when those are not the case, we want this to be our clinical decision making process and to do what is absolutely best for the patient. Some of the

questions that come up, at least from my end is, can we use the same rationale for skilled therapy every week? And how often does it need to change? And this is one of those things, I would say it's a benefit and it's a drawback of electronic medical records because we tend to choose the exact dropdowns every single time we treat a patient. So my advice to that is, pick I don't want to say pick a skilled intervention that you worked on that day. Maybe try to look at what was the focus of your treatment that day and really hone in on that for some good skilled documentation. If you're saying the same thing every single day, day in, day out, that's maybe a denial waiting to happen.

Could you use the same dropdown maybe, but then maybe you do some free text on top of that to say how that impacted function or what you specifically did that was a little more skilled. Remember that rationale for continuing is based on what's in that documentation. So you wanna make sure that it's showing the skill and you probably do in fact wanna change it up a little bit. Other question. I think this is again a really important one. What's the best way to document caregiver training? And I don't know what you're documenting out there right now but think about the person with dementia where we have to train nursing to carry over certain strategies or where you're training that patient or their caregiver in preparation for going home.

If we just say, "Or maybe it's nursing staff." If we're just saying train nursing on transfers. Like what is that saying? That's kind of not saying anything. On the flip side, do I want to be totally specific where I say I trained three to 11 staff and I trained Sally and Susie and Joe and David. No, we don't wanna be that specific either. So what do we want in there? What was the instruction? Is it transfers? Or is it just transfers to level surfaces focusing on hand placement? Transfers to level surfaces focusing on the setup of the wheelchair? I don't know. You can get very specific there. Who is being taught? You can say nursing. You can say the CNAs. I'm okay if you say CNAs on night shift or something I think that would be totally fine. What I'm always cautious about is,

we identify it very, very specifically by name, got a surveyor come in and say, "Okay, Susie, it says in the PT note, "you learn how to do this, show me." And I don't ever wanna throw anybody under the bus that's not my job. How is that teaching being conducted? Did you do it virtually? Did you do it via conference call? Did you do something videotaped? Did you do it via Skype? Or some sort of encrypted type of network? Did you do it in person? Was it hands on? I don't know. But we wanna get some of that information. When is the teaching conducted? Is it being conducted during your treatment session with the patient? Obviously, hopefully. Who's doing that training or that teaching? Ideally it's probably you but it could have been somebody else on your behalf. What's the duration of the instruction? I instructed this person for 20 minutes. Why is that instruction necessary? They need this information in order to XYZ and then again, I didn't put it here but I think it's critically important. What is the return demonstration? So I think that is the critical piece because we always say, and I know you've heard this, we do education the whole way through our treatment or we're supposed to be, right?

And we're supposed to be documenting that. You can't just wait until the very end to do all of your education. Medicare really frowns upon that now, the Medicare administrative contractors. But if you're documenting your education and that's really all that you're doing that is skilled at this point and you say that the caregiver or the spouse or whomever is only at 50% return demonstration, do you need to continue that teaching and training? The answer to that is yes. That's gonna continue the rationale and the need for your skilled care because if you send them home and only 50% return demonstration, how successful is that discharge going to be? Not, not very successful. So if they're only at 50%, that's where you're going to talk about how you maybe changed your training, you change what it is that you're teaching, whatever that is, so that person can get a little bit better at it. So here's some examples, obviously there's some incorrect examples and good examples. So patient educated in home exercise program for lower extremity strength. Not saying a whole lot. A better

statement. Instruct a patient in right lower extremity strengthening exercises per the physician protocol, a copy is located in the chart, focus on smooth, controlled execution of the exercises within the surgical precautions. Patient demonstrated exercises one through five independently after instruction and demonstration. Very, very long note but very, very descriptive. So caregiver educated in transfers. Again, not so good. Revise skilled statement. Patient's son, Jim, trained in the proper use of the gait and transfer belt cueing strategies during stand pivot transfers from bed to wheelchair. Son able to cue the patient appropriately to scoot to the edge of the bed, the wheelchair, whatever to bring the center of gravity over the base of support, correctly executed the transfer to the strong side, three repetitions. Really skilled, wonderful teaching and training type of note.

So there is a question in queue and it's hard for me to see the whole thing but I think I understand the gist of it. A development of a maintenance program can be training and the answer to that is, absolutely yes. So developing that maintenance program for someone else to carry over is 100% skilled, and yes, thank you very much for expanding that box, to achieve the goals that you developed. So yeah, you're gonna establish goals for nursing or someone else to carry over teaching and training. That maintenance program is 100% skilled and you probably don't wanna give it over until you're sure that they are competent to follow it through. So that's where your return demonstration becomes important. And it could also be, I mean restorative as a nursing-led program.

But let's be honest, I think we all probably write restorative goals and we discharged a restorative if we're working in long-term care. So same type of thing, developing that program, teaching and training the restorative staff is absolutely education but you wanna go back here, to who's being taught? How are you conducting it? When is that being taught? What's the duration? Why is it necessary? Et cetera. And your return demonstration? So great question. Thank you for bringing that up. So we are at the

end of our two hours. For me, I will tell you that went pretty fast. So I'm gonna go through a couple of the references and then certainly answer any questions that you have. So most of what I talked to you about today came directly from the Medicare Benefit Policy Manual, chapter 15, section 220, which relates very specifically to outpatient services and there's a few other references here as well. I deal a lot with the Medicare administrative contractors and their LCDs. So pretty much everything that we talked about came from there. So I will open it up to questions, if you have any go ahead and type those into queue and there is one in the queue right now. And the question says, do you find maintenance programs are scrutinized in different settings differently? And I would say yes. Scrutinized, I'm not sure. But would they be viewed differently? I think the answer to that is 100% yes. I'm coming from a perspective of this is Medicare, this is Medicare part B and this is just what Medicare part B does regardless I think of industry or setting but could you work in a setting where you follow a different rule set?

Yeah. I think regardless of the program you may have different requirements but regardless of the setting that you're in, I think if you continue to focus on skill make sure that any documentation you write is clear that you need to be doing this, no one else can do this. You're still obviously, you're gonna be okay regardless of the setting regardless of it's a skilled maintenance if you're setting up that maintenance program if you are seeing that through. Hopefully, that answers that question. I think if you always go back to what makes you special, what makes it skilled, you're still gonna be fine even if there's scrutiny in that setting. So here's a great question. The question says we screen most of the time to determine the need for skilled services. Do we need to be doing an evaluation instead? So for the person who asked that question, thank you. I appreciate you asking it. This is what I have always been taught and this is what I will say to you. A screen answers the question, do I evaluate? The evaluation answers the question, do I treat? I think that's the best way to think of it. If you're going in and do a screen, I don't know your setting or what your requirements are for that setting but it's

a hands off kind of thing and it shouldn't be super lengthy. If you're doing that screen and something is not sitting well with you, I would say get the evaluation because if something's not sitting well with you there's a reason for it. And then evaluation, then we'll say to you, "Oh, I should treat three times a week and I should do XYZ with this person. So you don't wanna make recommendations off screens generally speaking because that screen is being done without a physician's order and it's completely hands off.

How do you know if you recommend whatever, I don't even know what you'd be recommending on a screen that it's the best recommendation and that it's going to truly work for that patient in every setting and such. So that's a great question. so question number nine reads... Sorry about that. All of these statements are true except, So while progress is not required, therapist must still demonstrate skill in their interventions and documentation. That is true. A physical therapy evaluation is needed in order to determine if skilled therapy is needed to develop a maintenance program. That is true. Skilled care is covered for services to maintain function or to prevent or slow further deterioration. That is true. That maintenance standard, if you will. Therapy can continue to treat a patient on a maintenance program if there's no nurse or caregiver available to carry out the program. That is false. So if you go back to that one slide just because you don't have a caregiver who can carry something over or is competent to do so if there's not staff available, that doesn't mean that you can continue to treat forever and ever ad nauseum. Medicare is very clear and I think I put the reference on that slide. That Medicare is pretty clear that you can't just continue to do that. That's not a reason for continuing. So thank you. Sorry about that.

- [Calista] All right. Well I don't see any other questions in queue. So we're gonna go ahead and close it out today. Thank you again so much, Dr. Weissberg.

- [Kathleen] Thank you for having me. I appreciate it and thank you for everyone who joined in.

- [Calista] And we're gonna go ahead and officially close out today's course. Thank you everyone for attending.