AVEANNA HOME HEALTH THERAPY ORIENTATION

Skilled Therapy Documentation Training

Skilled Therapy Documentation Training-Agenda

- Documentation Specifics
- Medicare Chapter 7
- Local Coverage Determinations (LCDs)
- Therapy Goals
- Therapy Orders
- PointCare Documentation
- Knowledge Base

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Documentation Specifics

- Each note must stand alone
  - Notes must be individualized to the patient's current treatment session
  - No copying and pasting permitted
- Aveanna has zero tolerance for fraudulent documentation
  - Fraudulent documentation is grounds for immediate termination
- Sync your device every day (morning, noon, and night) so you have the most updated information
- Perform a Selective Refresh once a week
- Policy is to complete documentation within 24 hours
  - You nor others will be able to document subsequent notes unless prior note is completed and synched

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Documentation Specifics

- If entering a late note, document in the narrative, “late visit entry for (date)”
- OASIS and Evaluation items are critical to develop a plan of care for clinicians to follow and create orders for a physician to sign timely
  - These must be done within 24 hours
- Documentation Tip - Follow the 5-10-5 guidance if you can. It will assist in stretching out your visit time and complete Point of Service documentation
- Challenge yourself to complete the S/O portions of notes while in the home. This includes the physical assessment section in HCHB

Medicare Chapter 7

40.2 - Skilled Therapy Services

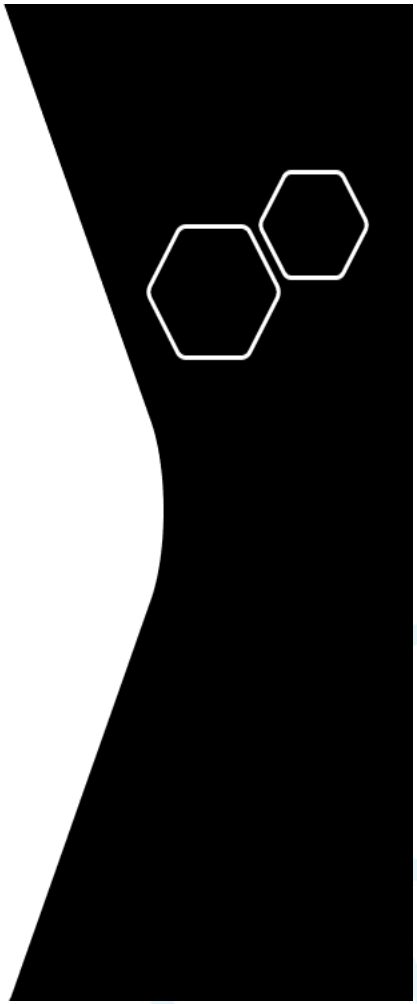
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.2, HHA-205.2

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.



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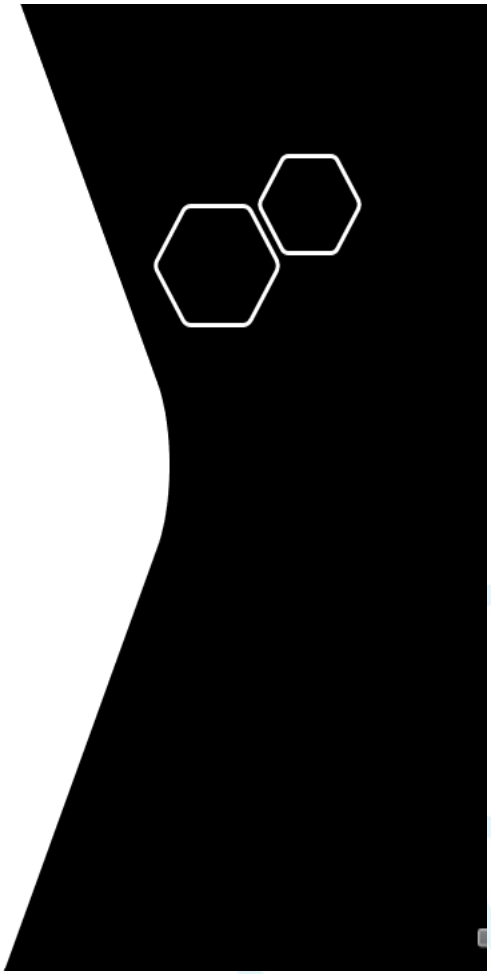
To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

i. **Initial Therapy Assessment**

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.

- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.



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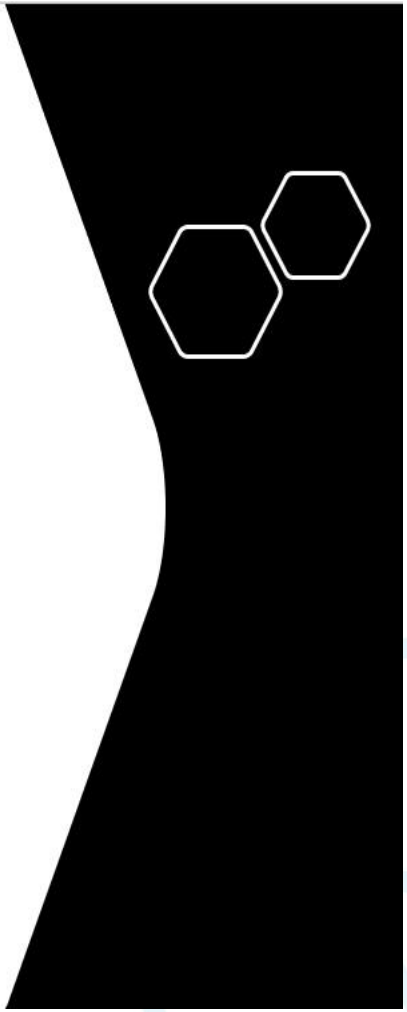
Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.

- For multi-discipline therapy cases, a qualified therapist from each of the disciplines must functionally reassess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

- The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).



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Medicare Chapter 7

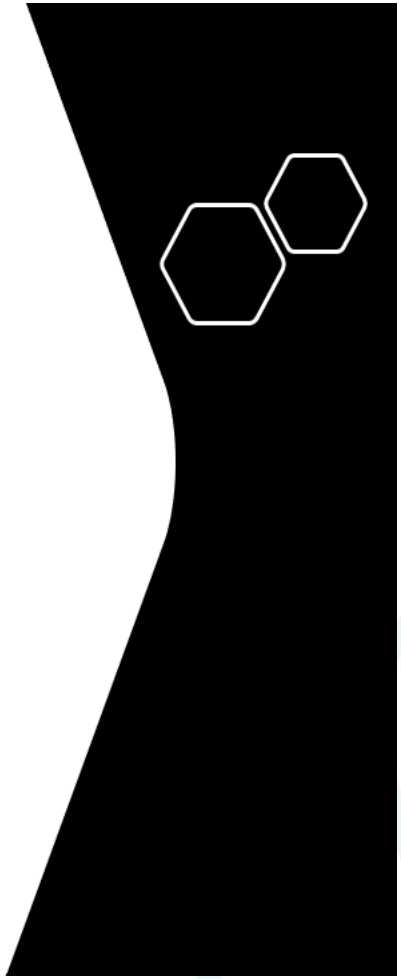
d. Assuming all other eligibility and coverage requirements have been met, in order for therapy services to be covered, one of the following three conditions must be met:

1. The skills of a qualified therapist, or by a qualified therapist assistant under the supervision of a qualified therapist, are needed to restore patient function:

- To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician or allowed practitioner of the patient's restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements.

- Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.

- Therapy is not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes



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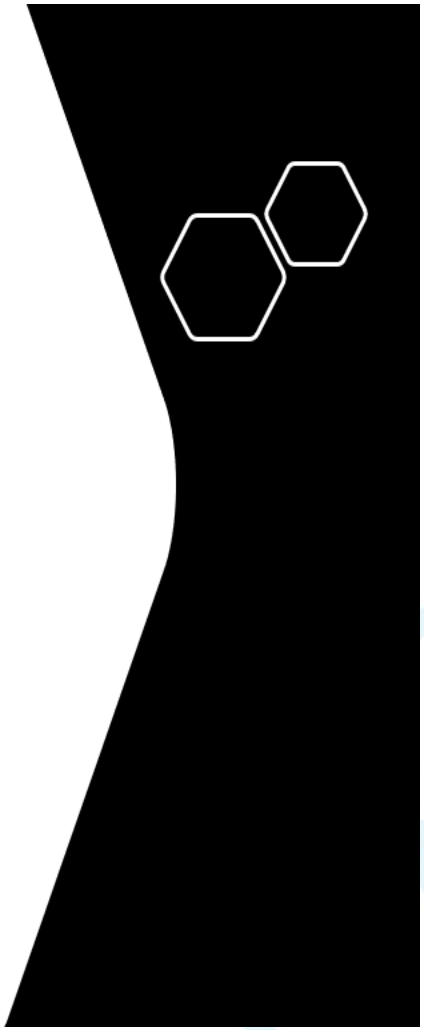
Medicare Chapter 7

2. The patient's clinical condition requires the specialized skills, knowledge, and judgment of a qualified therapist to establish or design a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation,

- For patients receiving rehabilitative/restorative therapy services, if the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, the expectation is that the development of that maintenance program would occur during the last visit(s) for rehabilitative/restorative treatment. The goals of a maintenance program would be to maintain the patient's current functional status or to prevent or slow further deterioration.

- Necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are covered if the specialized skills, knowledge, and judgment of a qualified therapist are required.

- Where a maintenance program is not established until after the rehabilitative/restorative therapy program has been completed, or where there was no rehabilitative/restorative therapy program, and the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, such services would be considered reasonable and necessary for the treatment of the patient's condition in order to ensure the effectiveness of the treatment goals and ensure medical safety. When the development of a maintenance program could not be accomplished during the last visits(s) of rehabilitative/restorative treatment, the therapist must document why the maintenance program could not be developed during those last rehabilitative/restorative treatment visit(s).



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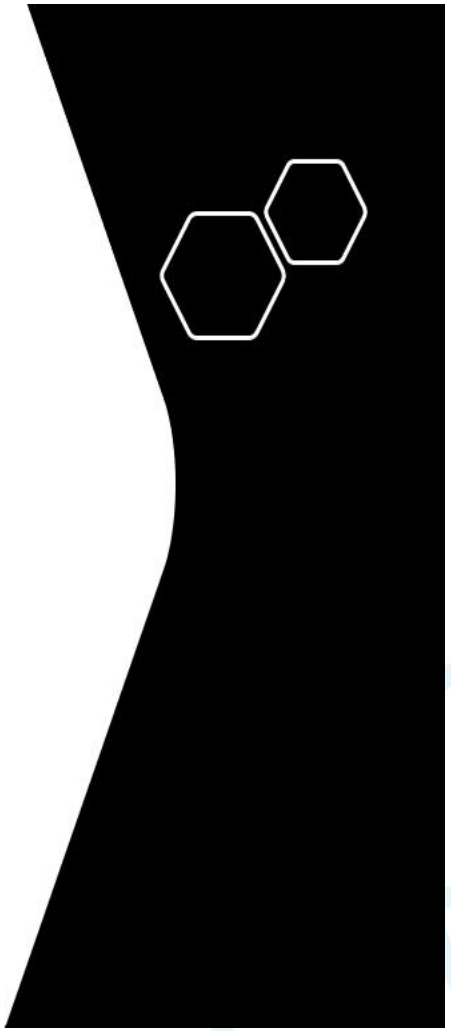
3. The skills of a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist are needed to perform maintenance therapy:

   - Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist or by a qualified therapist assistant under the supervision of a qualified therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered.
   - Further, under the standard set forth in the previous paragraph, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

The amount, frequency, and duration of the services must be reasonable.



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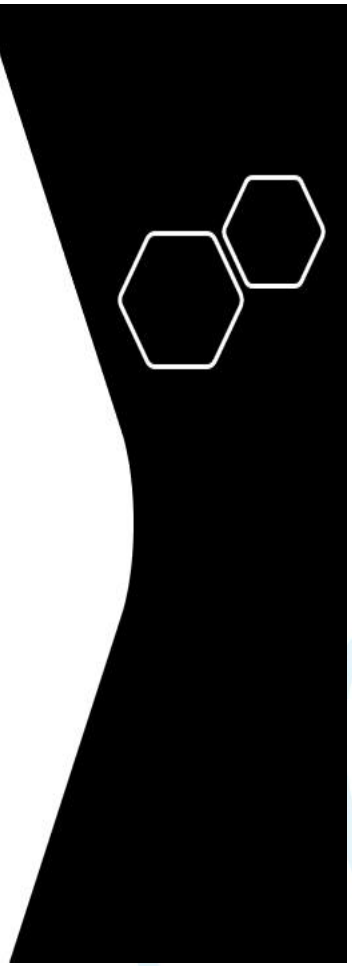
Medicare Chapter 7

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each 30-day period, this includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team

regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.



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Medicare Chapter 7

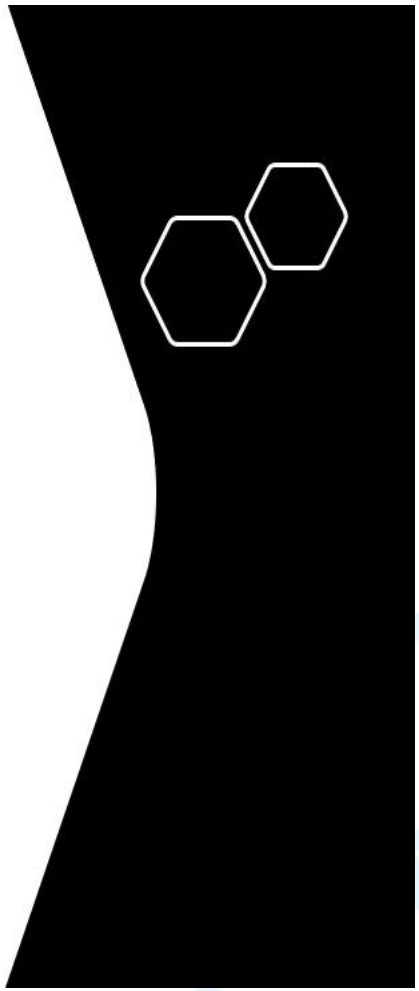
Therefore the home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit , (including the response or changes in behavior to previously administered skilled services) and
- the skilled services applied on the current visit, and
- the patient/caregiver's immediate response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results.

Clinical notes should be written such that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.



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LCDs-Physical Therapy (L34564)

- Describe the therapy interventions and name of technique, approach, strategy, process, etc. and their outcomes
- Document gait patterns, assistive devices, caregiver training
- List any barriers to progress
- Detail cueing and levels of assistance provided
- Avoid use of the following statements: Continue with POC, caregiver instructed in medication management, patient improving, less pain, increased ROM, increased strength, tolerated treatment well
- Include important details such as ROM in degrees, distance that can be walked, validated scales of functional independence, objective measurement scores, effects on progress such as reduced swelling, reduced spasticity, etc.

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LCDs-Occupational Therapy (L34560)

- OT narratives should be written using objective measurements and functional accomplishments. Use statements which demonstrate the patient's response to the therapy such as:
  -Able to perform exercises as prescribed for 15 reps
  -Able to safely transfer from bed to toilet with standby assistance
  -Patient can now abduct shoulder 120 degrees
  -Able to don a pull over shirt with minimal assistance
  -Implemented and instructed on use of weighted utensils to decrease tremors for self-feeding

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LCDs-Speech Therapy (L34563)

- Document the history and physical exam, pertinent to the day's visit (including the response or changes in behavior to previously administered skilled services), skilled services applied on the current visit, objectives measures, the patient/caregiver's immediate response to the skilled services provided, and overall impact on communication of wants and needs, swallowing skills, speech intelligibility, voice, and/or cognitive linguistic function.

Documentation of Therapy Goals

- There should be no overlapping, nor duplication of goals, between 2 disciplines. For Example, Transfer and Balance Goals with PT and OT or Feeding and Cognition goals with OT and ST
- In general, the bulk of home health therapy goals should revolve around functional M1800 items in the OASIS.
- PT: Ambulation (M1860), Transfers (M1850), Fall Management
- OT: Upper and Lower Body Dressing (M1810 and M1820), Grooming (M1800), Bathing (M1830), Toilet Hygiene (M1845) and Transfers (M1840)
- ST: Feeding/Eating (M1870)
- Therapists should also consider Pain and Dyspnea, as warranted, in goal development.
- Review goals and collaborate if goals do not have a functional foundation.

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Documentation of Therapy Goals

All goals should contain the following characteristics:

1. **Identify the person**: patient/caregiver
2. **Description of the movement/activity**: transfers, ambulation, dressing, swallowing, knee flexion
3. **Connection of the movement/activity to a specific function**: able to wash clothes, climb stairs, reach dining area, get to toilet timely
4. **Factors for achieving the outcome**: amount of assistance, distance ambulated, ROM measurement, functional test scores, % of time, pain levels
5. **Time frame to meet short- and long-term goals**

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Documentation of Therapy Orders

Chapter 7, Section 30.2.2-Specificity of Orders: the orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

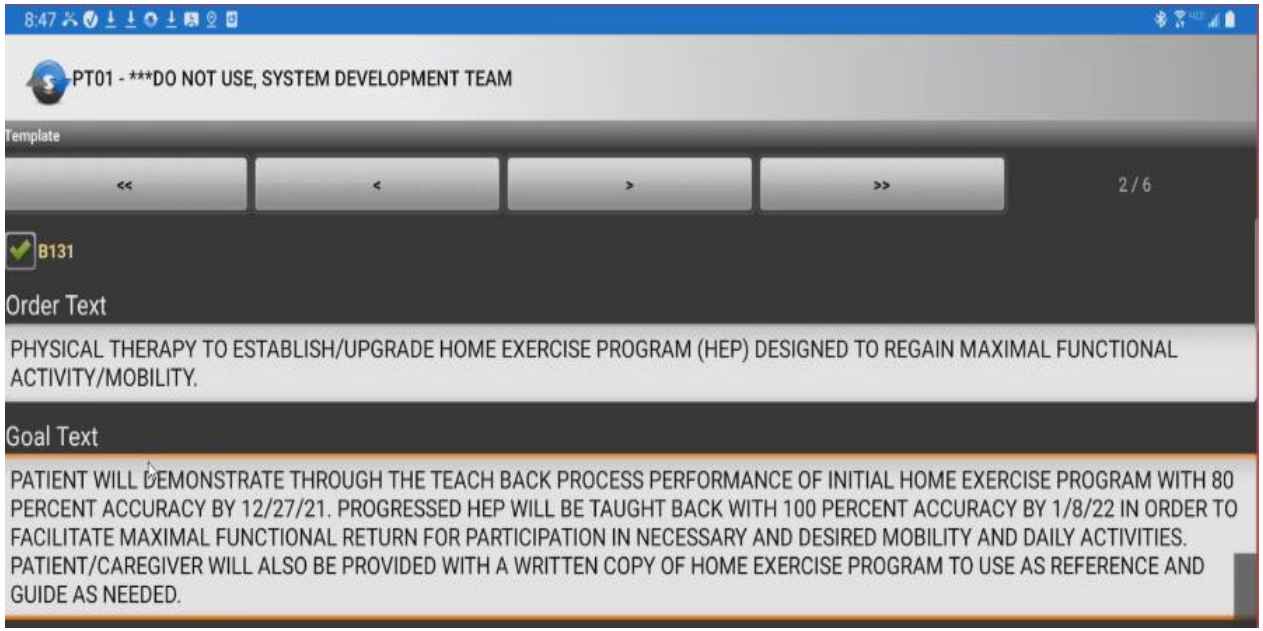
- Intermediaries, i.e. Palmetto, provide this guidance regarding therapy orders: Services are to be furnished according to a written plan of treatment determined by the physician after any needed consultations with the qualified therapist and signed and dated by the physician after an appropriate assessment (evaluation) of the condition (illness or injury) is completed. The plan of treatment must be completed before active therapy begins. The written plan of treatment may not be altered by the therapist.
- Orders should include:
- A. Diagnosis being treated and the specific problems identified that are to be addressed
- B. Treatment techniques, modalities, and procedures being used for specific problems to attain goals
- C. Specific functional goals for therapy in objective measurable terms
- D. Amount, frequency, and duration of therapeutic services
- E. Rehabilitation potential

Documentation of Therapy Orders

- **Foundation of orders need to be individualized, specific, and based on the patient's needs within the HCHB system and Chapter 7 guidelines.**

- ***They must include therapy discipline, frequency, duration, and interventions***
  - PT to instruct gait training, balance activities, and therapeutic exercises effective 3/2/22 for 1wk1, 2wk2, 1wk2 to ensure patient safety in home
  - PT to continue 2wk2 to achieve long term goal of demonstrating safe and independent bed mobility and sit to stand transfers for improved safety
- ***Specify interventions***
  - What kind of transfers are you working on (I.E. bed to chair, sit to stand, tub, toilet)
  - What ADLs and IADLs are you targeting (I.E. bathing, upper body dressing, grooming, meal prep)
  - What is the diet and liquid modification (I.E. Honey, Nectar, Puree).
- ***Modalities - name of modality, location of use, purpose, frequency, duration, dose***
  - Instructions to use cold pack for edema reduction for 20 minutes to left knee 3 times a day for 2 weeks

Documentation of Therapy Orders



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Prior Level of Function

- **Clinicians will be required to enter a PLOF for the patient**
  - This will establish medical necessity and should help you establish restorative goals
  - Include pertinent information, for example the patients previous use of AD, ambulation distances, assistance needed for transfers/ambulation, and a timeframe referencing patients PLOF

Example: PATIENT REPORTED PRIOR TO HOSPITAL STAY ON 11/17/22, SHE WAS IND WITH NO AD NEEDED IN THE HOME AND USED 4WW FOR COMMUNITY AMBULATION FOR PROLONGED DISTANCES AND WAS IND WITH BED MOBILITY AND STS TRANSFERS.

PointCare Documentation - System Assessments

- Physical Assessment --> Respiratory, Cardiovascular, Integumentary, Functional
  - Must assess each system during evaluation, clinicians should **NOT** select the Not Applicable option.
  - If a system is assessed and shows no impairment, then the clinician should select **No Problems Identified**
- At least one of the systems should show an impairment was identified if the clinician is going to set a POC for skilled therapy services.
  - IE: Physical therapy assessment for TKA: Under functional system assessment, the clinician will likely select Limited ROM and Decreased Strength options and anything else that may apply to the patient
  - After selecting what impairment was identified, the clinician will be prompted to specify location of impairments

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PointCare Documentation - Functional Tests and Measures

- Physical Assessment --> Functional Test and Measures
  - At minimum, **ONE** Functional Test and Measure should be performed at Evaluation
- If the clinician chooses the selection for “No Tests Performed this Visit”, then the therapist **MUST** choose the selection for “Other” and document why the patient was unable to perform any Functional Test/Measure at Evaluation
- All functional tests and measures performed should have a corresponding goal in the Therapy Goals/Status section **IF** the outcome does not meet normative data for that specific test
  - Otherwise, the functional tests performed at the evaluation will not carry over to future visits for reassessment.

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PointCare Documentation - Pathways/New Orders

- In the ‘Pathways’ portion of the note the Evaluating Therapist will identify ‘Problem Statements’ from their assessment to be addressed in the plan of care.
  - Remember that each pathway that you select will generate 1 or more interventions that will appear on the subsequent visits.
  - Best practice is to choose only those that are most relevant to the patient assessment and functional deficits.
- After identifying all Problem Statements, the system will auto-generate Orders and Goals when the Therapist selects ‘View Instructions’ in the New Order portion of the note.
- Each Problem Statement is connected to an Order and Goal that should be customized to the patient. This is the creation of your plan of care for the episode.
  - Make sure that the goal you document is objectively measurable and includes a time frame that is within the frequency set.
  - These should directly correlate with the goals that you have set in the Therapy Goals/Status section. This will help ensure all goals are addressed for future reassessments

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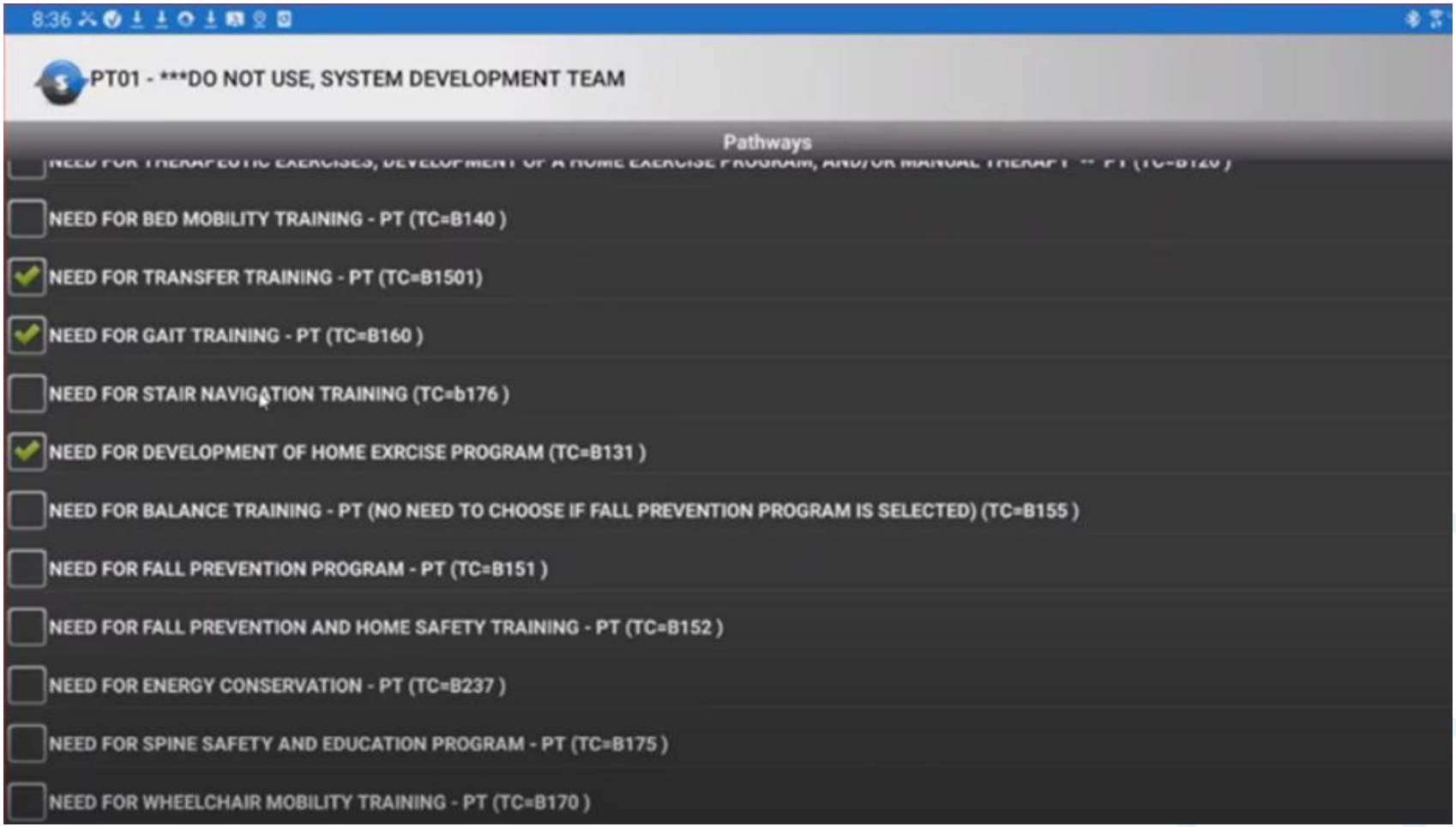
PointCare Documentation - Pathway Format



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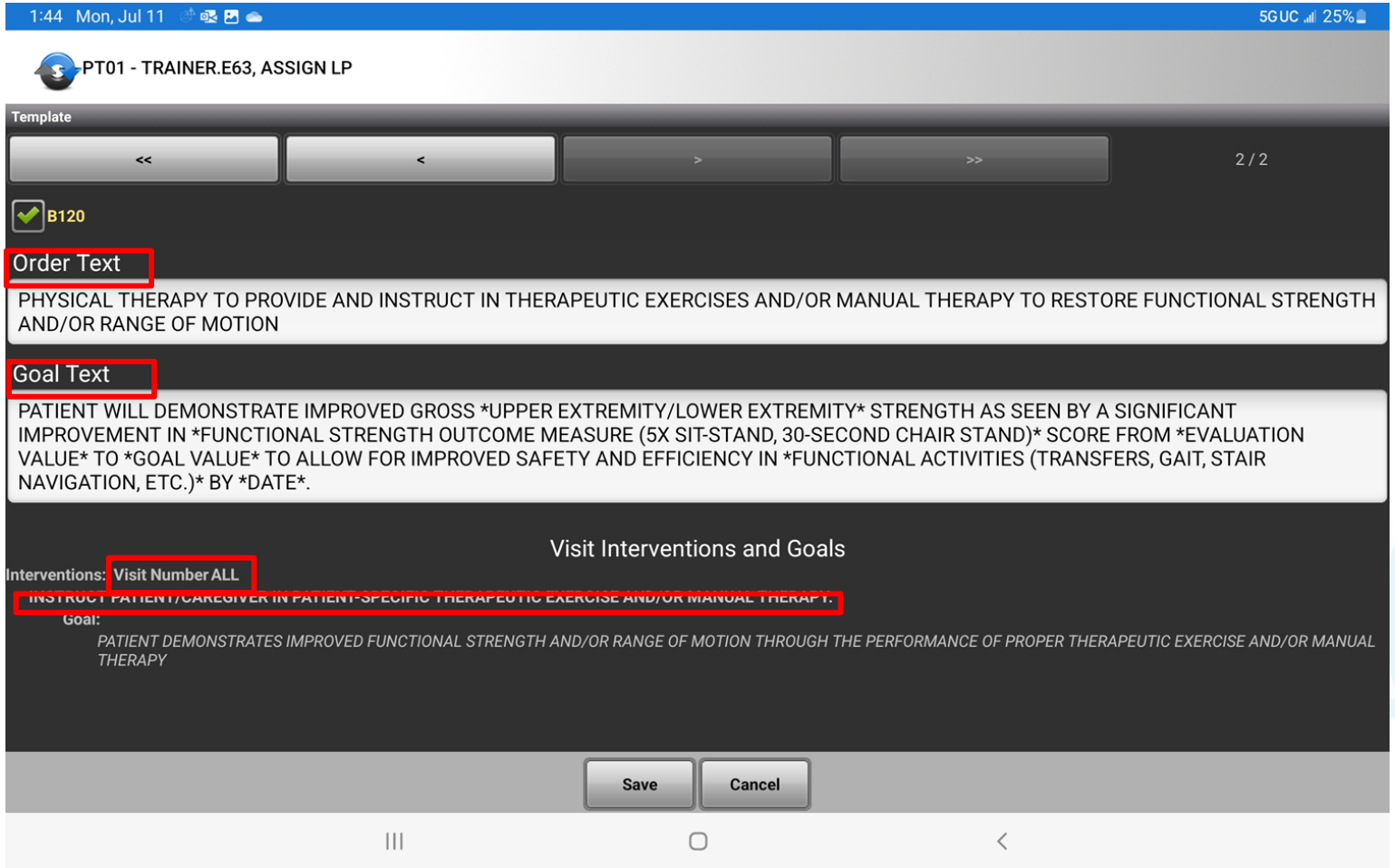
PointCare Documentation - Pathway Format



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PointCare Documentation - Interventions

- This section needs to describe the intervention performed and what skill the clinician provided
  - You (PT, PTA, OT, SLP etc) did what (skill documented so specifically it could be reproduced) to whom, (patient/caregiver), why did you do it, and how did that person respond to or understand your skill
  - Ex: PT instructed patient/CG in gait training on indoor surfaces using a FWW with Min A. PT provided intermittent verbal cues to increase step length and to increase heel strike for improved safety. Patient able to increase step length but will require further training to meet goal
- Make sure to include details pertinent to the education you provided as well as the patient response
  - Ex: PT instructed patient to always use RW during ambulation to improve safety, patient verbalized understanding
- Make sure that your visit is documented well enough that if somebody followed you, they could 100% reproduce it
  - Avoid using **ONLY** the “Show Details” verbiage that is in the drop-down menu. Individualize the comment to the current treatment

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PointCare Documentation - Assessment/Plan

- **Assessment**
  - –Must prioritize the patient's problems
  - –Must interpret the significance of the results from objective testing and justify why therapy is necessary to address the problems
  - –Must paint a picture of the patient and their current functional level for anyone who would read it and/or follow up for treatment
- **Plan**
  - –Should be objective, actionable, and patient specific
  - –Should include POC frequency
  - –Avoid vague terminology
    - Continue with POC
    - Progress as patient tolerates

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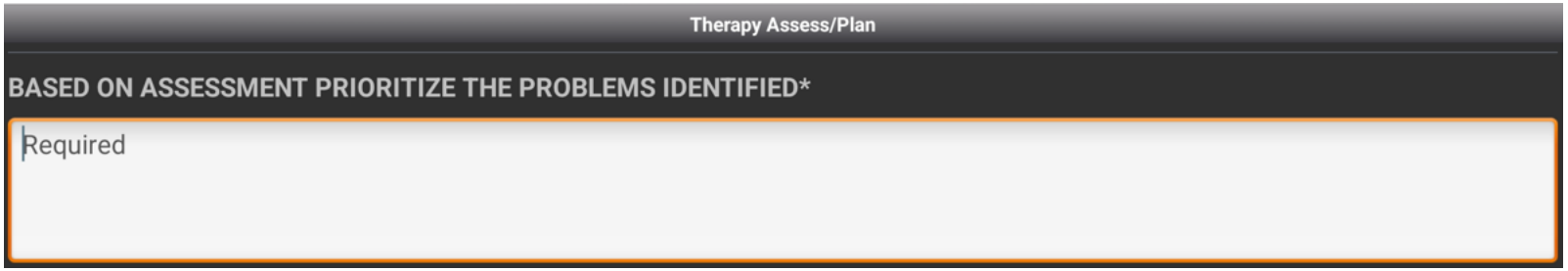
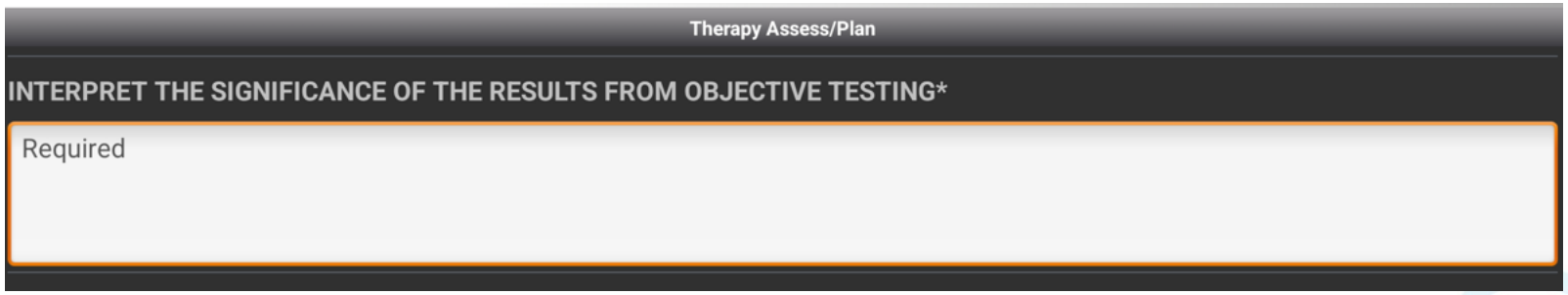
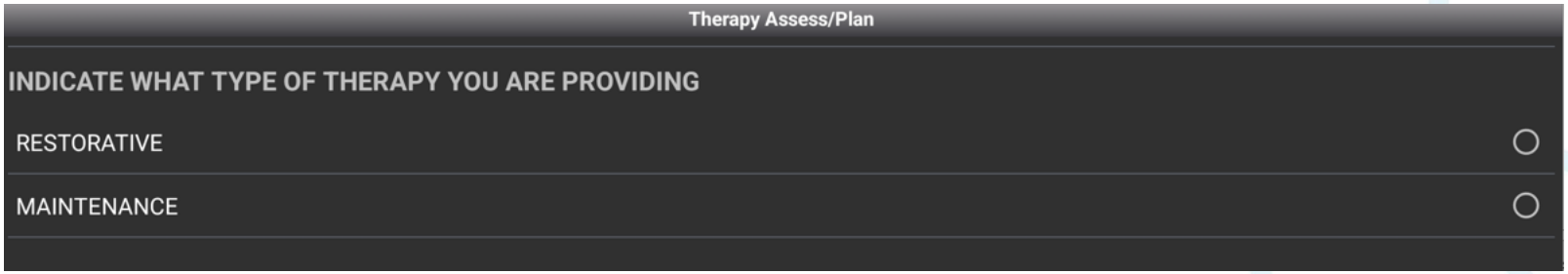
PointCare Documentation - Evaluation Assessment/Plan







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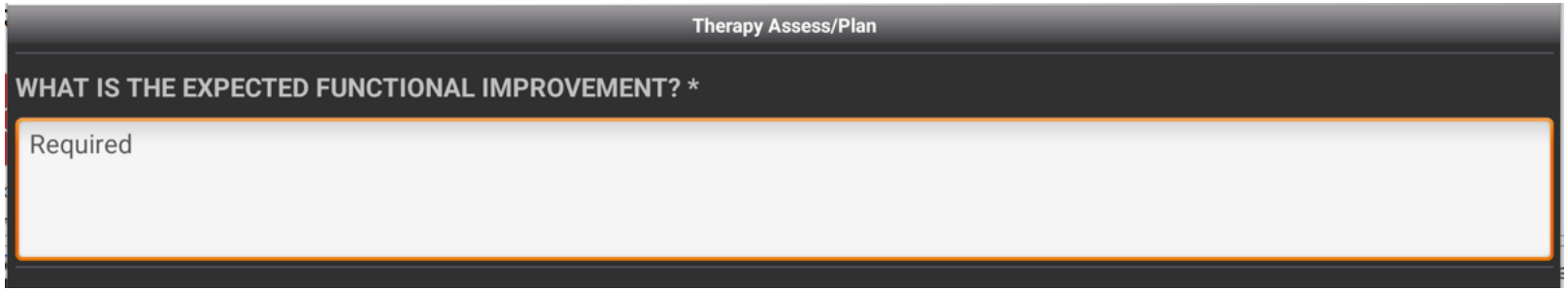
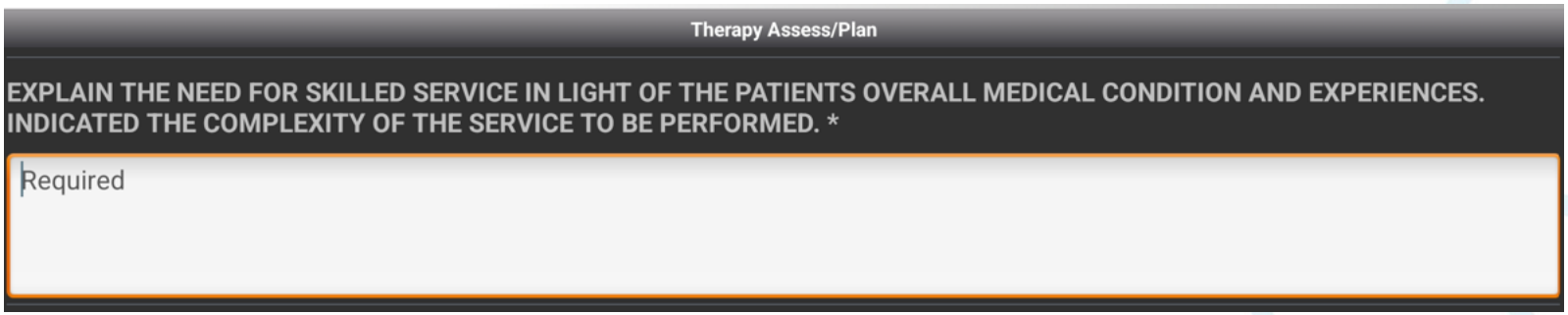
PointCare Documentation - Evaluation Assessment/Plan

- If Restorative therapy is selected, this box will appear next.



- If Maintenance therapy is selected, this box will appear next.



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PointCare Documentation - Evaluation Assessment/Plan

- Here is a sample of Restorative Assessment text boxes, followed by the Plan section.
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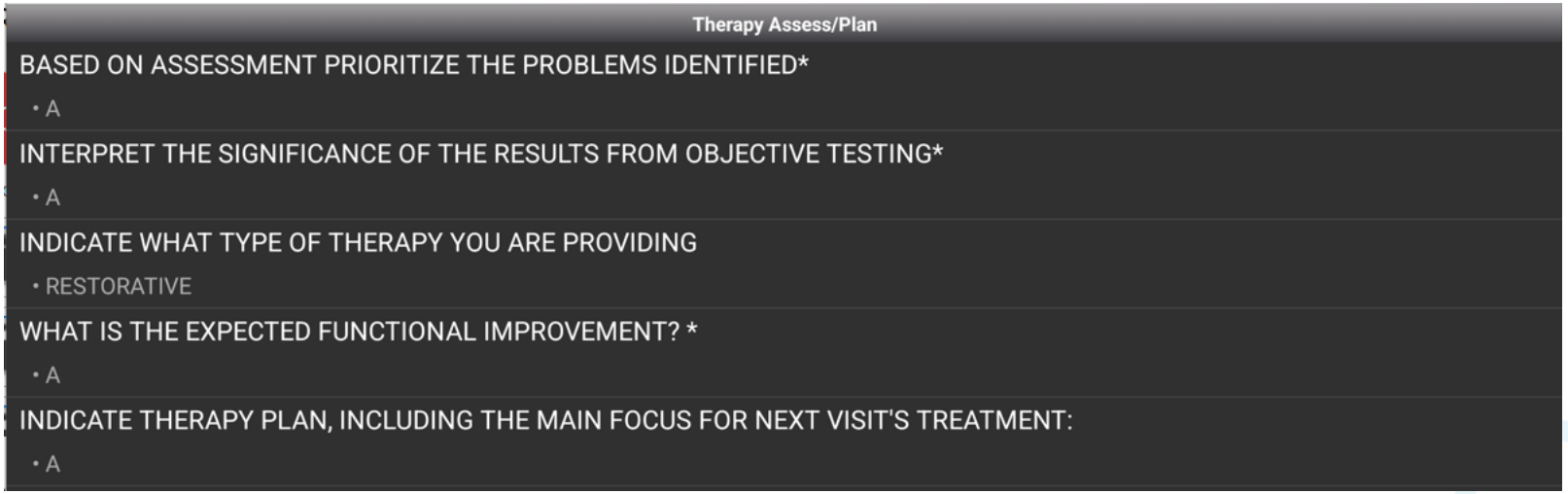

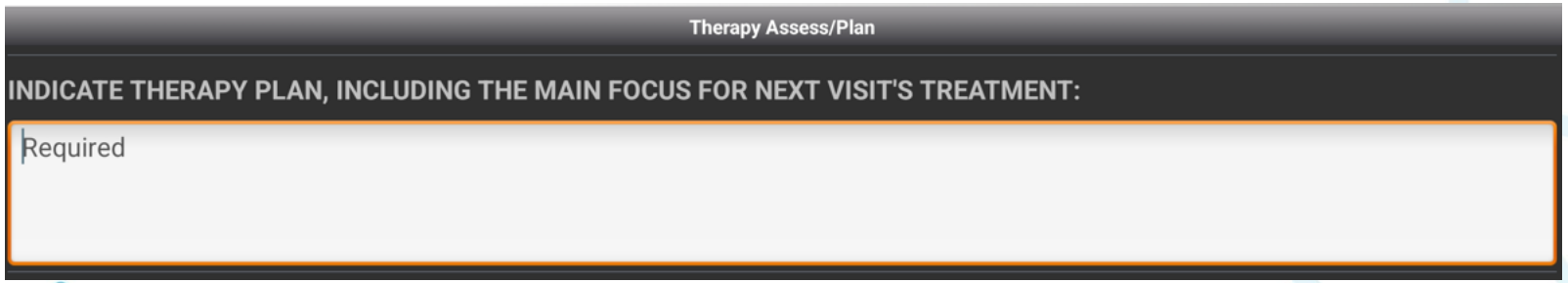

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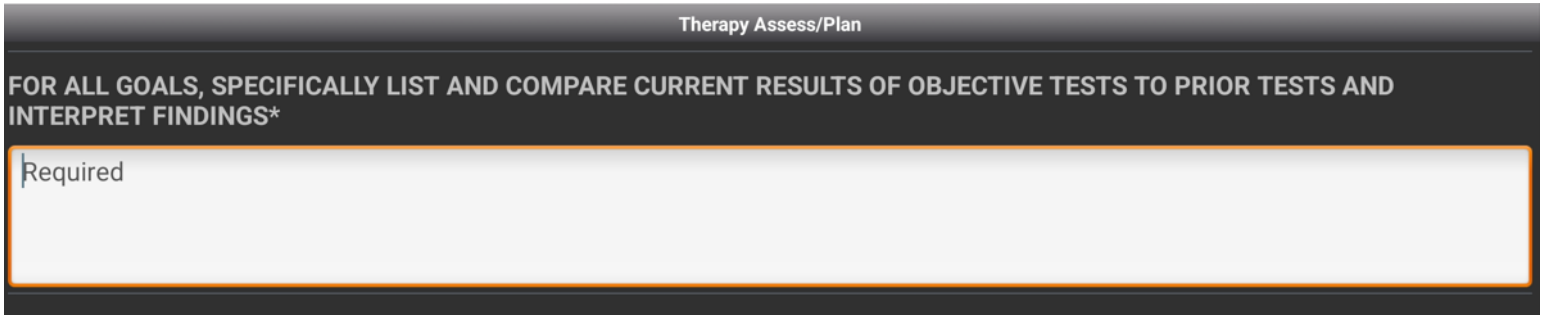
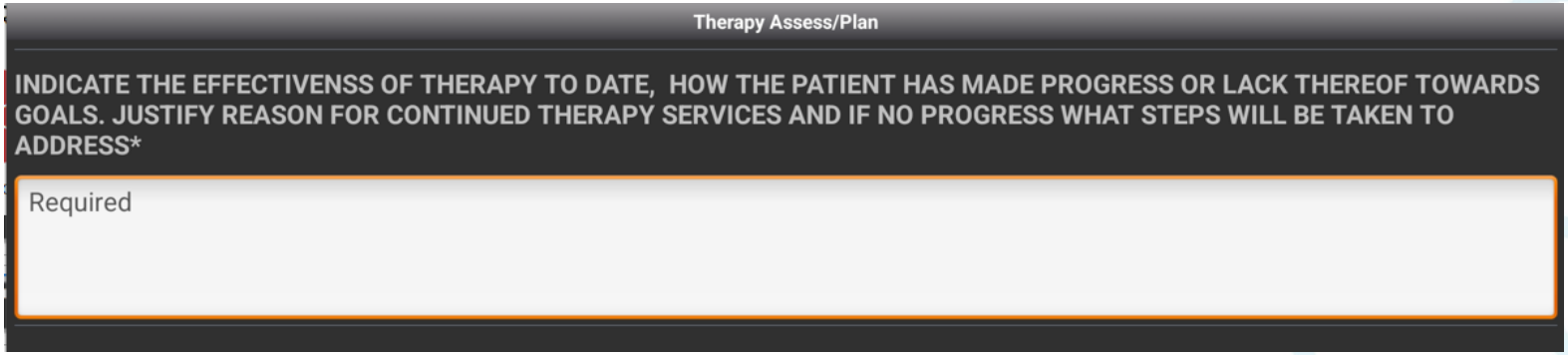
PointCare Documentation - Reassessments/Recerts

- During a reassessment (33) or recert (06,02), you MUST compare the patient's current functional status to their status at the previous assessment for EACH goal, address what the POC has been, and justify why you need to continue providing skilled services.





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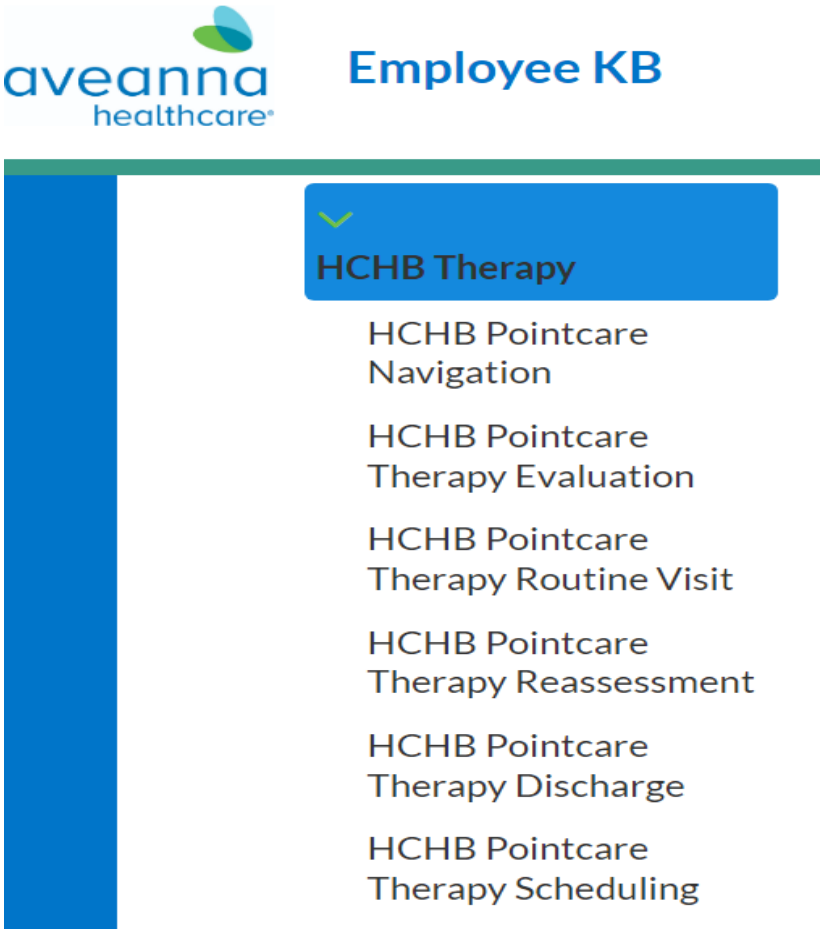
Documentation Training Videos



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