19 Therapy Assess/Plan

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Purpose:

To guide therapists on the use of the Assessment / Plan to guide strong clinical documentation and justification of skilled therapy services that are reasonable and necessary.

Question Intent:

The Therapy Assessment / Plan section is intended to provide the interpretation of objective testing as well as the justification of why skilled therapy is reasonable and necessary for the patient at this time. It is important that these primary components are documented to support the patient's need for skilled therapy services.

Per Medicare Benefit Policy Manual Chapter 7 - Home Health Services , the Therapy Assessment / Plan portion of our notes helps support that "*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.*"

At Reassessment (at least every 30 days) timepoints therapy documentation supports continued payment based on a rationale that supports skill. Comparing current and prior levels with discussion to their relevance is a requirement both for CMS compliance and auditing bodies. Per the Medicare Benefit Policy Manual Chapter 7 - Home Health Services *"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."*

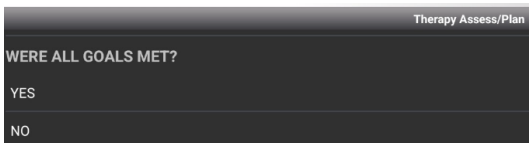
Response – Specific Instructions:

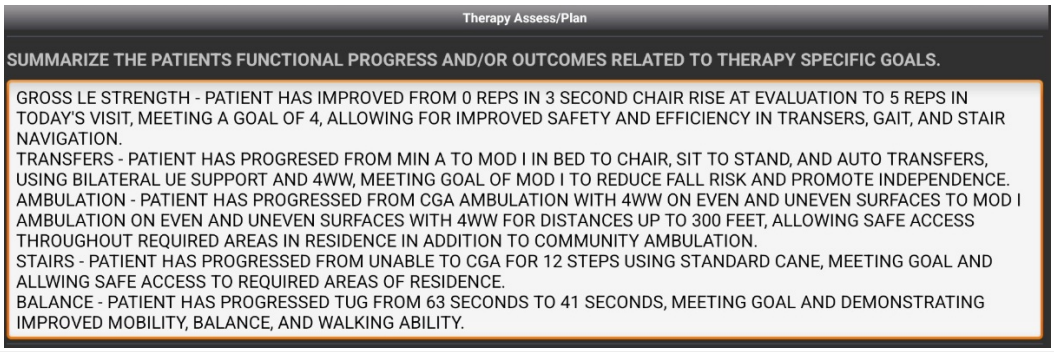
1. **At Discharge (19) visits the therapist will select Therapy Assess/Plan in their visit note. They will first identify if ALL goals were met. To view all goals the therapist should view Therapy Goals/Status as well as using the top right menu and going into Medical Records --> Order History to see all Goals written on the 485/Plan of Care, below is an example of Physical Therapy goals in Order History from Medical Records:**
    1. PATIENT WILL DEMONSTRATE IMPROVED GROSS LOWER EXTREMITY STRENGTH AS SEEN BY A SIGNIFICANT IMPROVEMENT IN 30 SECOND CHAIR RISE FROM 0 TO 4 REPS FROM LIFT CHAIR ALLOW FOR IMPROVED SAFETY AND EFFICIENCY IN FUNCTIONAL ACTIVITIES SUCH AS TRANSFERS, GAIT, STAIR NAVIGATION BY 6/8/24.

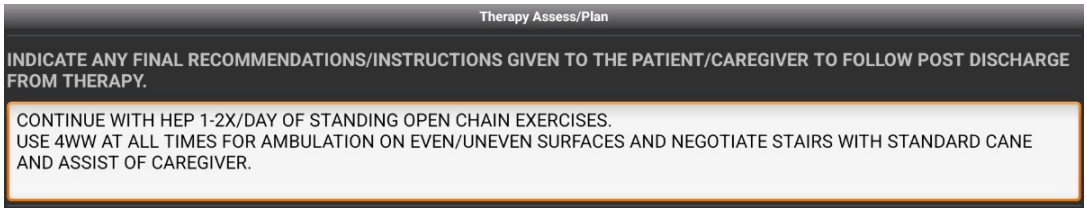
       PATIENT WILL DEMONSTRATE IMPROVED AND SAFE STS TRANFER, CHAIR TO CHAIR TRANSFER, CAR TRANSFER, FLOOR TRANSFER WITH SUPERVISION USING BIL UE SUPPORT AND USING FWW AND PROPER BODY MECHANICS AND TECHNIQUE TO REDUCE FALL RISK AND PROMOTE IMPROVED INDEPENDENCE BY 6/8/24.

       PATIENT WILL SAFELY AMBULATE HOUSEHOLD DISTANCES UP TO 300 FEET WITH SUPERVISION USING WALKER ON LEVEL SURFACES, INDOORS AND UNEVEN SURFACES, OUTDOORS WITH PROPER TECHNIQUES AND MECHANICS TO ALLOW SAFE ACCESS THROUGHOUT REQUIRED AREAS IN RESIDENCE AND/OR RETURN TO BEING ABLE TO PERFORM SAFE FUNCTIONAL LEISURE ACTIVITY INCLUDING COMMUNITY AMULATION FOR APPOINTMENTS BY 6/8/24.

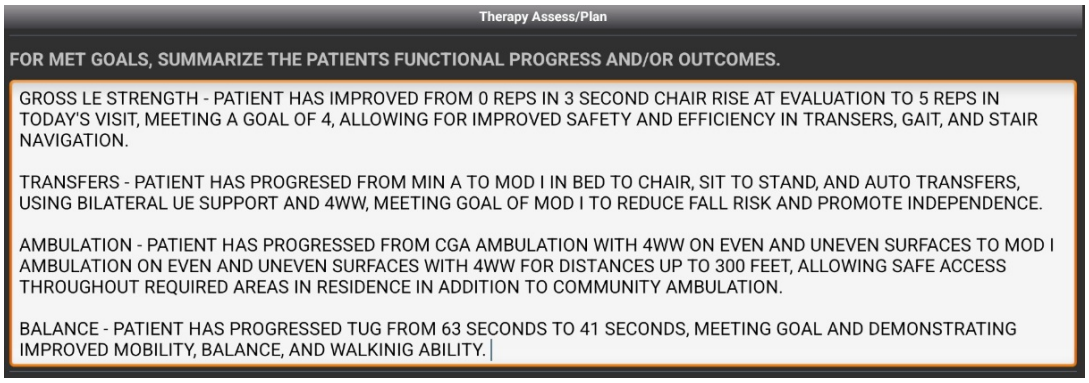
       PATIENT WILL NAVIGATE (ASCEND/DESCEND) 12 STEPS WITH CGA USING LRD (CANE AND/OR RAILING) ON STEPS INSIDE AND OUTSIDE OF LIVING ENVIRONMENT TO ALLOW SAFE ACCESS TO REQUIRED AREAS OF RESIDENCE AND ALLOW SAFE ACCESS TO UPCOMING MEDICAL APPOINTMENTS AND RETURN TO ACTIVITIES OF LEISURE AND ACTIVITIES OF NECESSITY SUCH AS GROCERY SHOPPING BY 6/8/24.

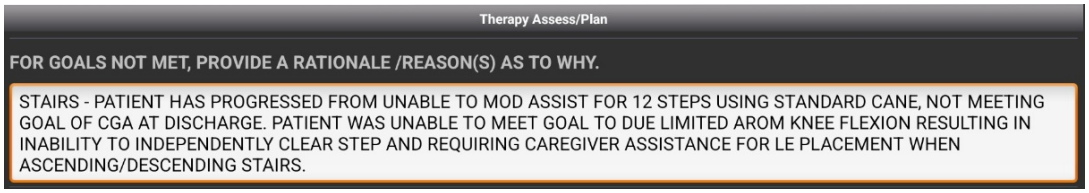
       PATIENT WILL DEMONSTRATE A SIGNIFICANT IMPROVEMENT IN BALANCE DURING FUNCTIONAL ACTIVITIES AS EVIDENCE BY IMPROVED TUG FROM 63 SECONDS TO 53 SECONDS WITH FWW BY 6/8/24
2. **The system will prompt questions slightly different if ALL goals were met or not.**
    1. 

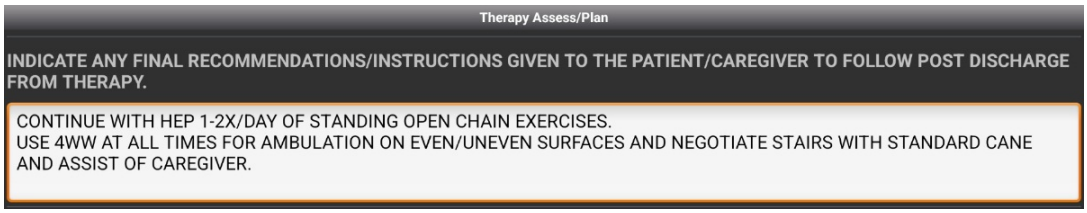
3. **If 'YES':**
    1. **First Question - Use this question to summarize your patient's progress towards goals by comparing the curent objective tests/measures to the initial/previous tests and measures. This comparison is a mandatory expectation to meet compliance for these visits. Below is an example of what is expected. Compare each test showing prior and current goals. Reference goal status. Simply list each test and summarize.**
        1. 

2. **Second Question - Use this question to summarize recommendations/instructions to patient/caregiver to follow after discharge. Below is an example:**
    1. 

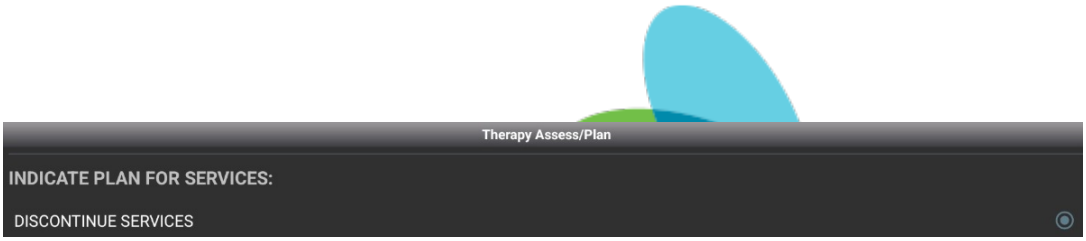
3. **Lastly, the system will auto-populate the plan to 'DISCONTINUE SERVICES':**
    1. 

4. **If 'NO':**
    1. **First Question - Use this question to summarize your patient's progress towards goals by comparing the current objective tests/measures to the initial/previous tests and measures, for ALL MET GOALS. This comparison is a mandatory expectation to meet compliance for these visits. Below is an example of what is expected. Compare each test showing prior and current goals. Reference goal status. Simply list each goal and summarize.**
        1. 

    2. **Second Question - Use this question to summarize your patient's unmet goals and a rationale/reason as to why the goal was not obtained. This is a mandatory expectation to meet compliance for these visits. Below is an example of what is expected. Compare each test showing goal and current level of function. Simply list each goal and summarize.**
        1. 

    3. **Third Question - Use this question to summarize recommendations/instructions to patient/caregiver to follow after discharge. Below is an example:**
        1. 

    4. **Lastly, the system will auto-populate the plan to 'DISCONTINUE SERVICES':**
        1.



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