

## 19 Therapy Assess/Plan

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## Purpose:

To guide therapists on the use of the Assessment / Plan on their discharge visit 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 services were necessary and the progress the patient made towards goals. It is important that these primary components are documented to support the patient's need for skilled therapy services.

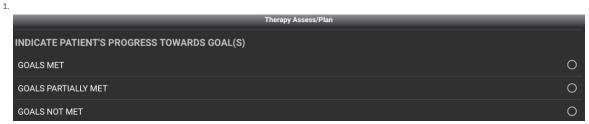
Per Medicare Benefit Policy Manual Chapter 7 - Home Health Services , the Therapy Assessment / Plan portion of our notes helps support that "the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function 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.

1. At Discharge (19) or Agency Discharge (18) visits the therapist will select Therapy Assess/Plan in their visit note. They will first identify one of 3 options (GOALS MET, GOALS PARTIALLY MET, or GOALS NOT MET).



- 2. NOTE To view all goals in making this determination, 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.
- 2. Once Progress Towards Goals is selected, a free text box will appear indicating DISCHARGE SUMMARY OF PATIENT'S FUNCTIONAL PROGRESS TOWARDS OUTCOMES AND GOALS. Here the therapist will address all goals objectively. An example where patient has met all goals is below:

DISCHARGE SUMMARY OF PATIENT'S FUNCTIONAL PROGRESS TOWARDS OUTCOMES AND GOALS

GROSS LE STRENGTH - PATIENT HAS IMPROVED FROM 2 REPS TO 6 REPS IN 30 SECOND SIT TO STAND TEST, MEETING A GOAL OF 5 REPS. RESULTING IN IMPROVED SAFETY AND EFFICIENCY IN TRANSFERS, GAIT, AND STAIR NAVIGATION.

TRANSFERS - PATIENT HAS PROGRESSED FROM CGA TO MOD I IN BED TO CHAIR, SIT TO STAND, AND AUTO TRANSFERS, MEETING GOAL OF MOD I TO REDUCE FALL RISK AND PROMOTE INDEPENDENCE.

AMBULATION - PATIENT HAS PROGRESSED FROM CGA TO MOD I WITH AMBULATION ON EVEN AND UNEVEN SURFACES WITH 4WW FOR DISTANCES UP TO 300 FEET, MEETING GOAL AND ALLOWING SAFE ACCESS THROUGHOUT REQUIRED AREAS IN RESIDENCE IN ADDITION TO COMMUNITY AMBULATION.

STAIRS - PATIENT HAS PROGRESSED FROM UNABLE TO SAFELY ATTEMPT TO CGA FOR 3 STEPS USING STANDARD CANE. MEETING GOAL AND ALLOWING SAFE ENTRY AND EXIT FROM HOME WITH CAREGIVER ASSIST.

BALANCE - PATIENT HAS PROGRESSED TUG FROM 37 SECONDS TO 19 SECONDS, MEETING GOAL AND DEMONSTRATING IMPROVED MOBILITY, BALANCE, AND SAFE WALKING ABILITY.

3. Upon completion of this summary, a pick list will appear prompting POST DISCHARGE PATIENT/CAREGIVER INSTRUCTIONS/PLANS TO PREVENT HOSPITALIZATIONS AS ORDERED. Here the therapist will select all relevant discharge plans/instructions:

1.

Therapy Assess/Plan	
POST DISCHARGE PATIENT/CAREGIVER INSTRUCTIONS/PLANS TO PREVENT HOSPITALIZATIONS AS ORDERED.	
REVIEWED MEDICATION NAME, DOSEAGES, FREQUENCY AND INSTRUCTED TO TAKE AS ORDERED.	
CONTACT PRIMARY PHYSICIAN WITH ANY CHANGES IN CONDITION	<b>✓</b>
FOLLOW UP WITH NEXT PHYSICIAN APPOINTMENT	
REVIEWED ON-GOING HOME EXERCISE PROGRAM	<b>✓</b>
MEASURES FOR OBTAINING MEDICAL SUPPLIES	
EMERGENCY PROCEDURES (911, ER, COMPRESS FOR WOUND/SKIN TEARS, EMERGENCY PHONE NUMBERS LOCATED NEAR PHONE.)	
FOLLOW UP WITH OUTPATIENT THERAPY	<b>✓</b>
FOLLOW UP ON OUTPATIENT LABS	
MEASURES FOR MEETING PERSONAL CARE NEEDS	
PHARMACY NAME AND NUMBER	
service codes will end now. 18 service codes will have a pick list stating NEXT PROVIDER VISIT VERIFICATION. It is best practice for our patients to have	e a confirmed
vider follow up visit following discharge from agency to best ensure continued positive clinical outcomes. The therapist will choose one of the 2 options:	
1. Therapy Assess/Plan	
NEXT PROVIDER VISIT VERIFICATION	
PATIENT VERBALLY CONFIRMED A PROVIDER FOLLOW UP VISIT IS SCHEDULED	0
PATIENT VERBALLY CONFIRMED A PROVIDER FOLLOW UP VISIT HAS NOT BEEN SCHEDULED.	0
2. If the second option 'PATIENT VERBALLY CONFIRMED A PROVIDER FOLLOW UP VISIT HAS NOT BEEN SCHEDULED' is selected, a second pick	list will appear.
Therapy Assess/Plan	
EDUCATED PATIENT TO THE IMPORTANCE OF TIMELY FOLLOW UP WITH PHYSICIAN SO NECESSARY INTERVENTION IMPLEMENTED AND PREVENT ER VISITS AND HOSPITAL STAYS.	IS CAN BE
PATIENT VERBALLY STATES THEY WILL SCHEDULE A FOLLOW UP APPOINTMENT WITH PROVIDER.	0
CLINICIAN AND PATIENT SCHEDULED A FOLLOW UP APPOINTMENT WITH PROVIDER.	0
NO FOLLOW UP APPOINTMENT NEEDED AT THIS TIME.	0
3.	

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