Physical Medicine and Rehabilitation

Brittany Ferri

Effective Occupational Therapy Documentation

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PHYSICAL MEDICINE AND REHABILITATION

EFFECTIVE OCCUPATIONAL THERAPY DOCUMENTATION

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PHYSICAL MEDICINE AND REHABILITATION

EFFECTIVE OCCUPATIONAL THERAPY DOCUMENTATION

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NOTICE TO THE READER

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Chapter 1

MEDICAL NECESSITY

ROLE OF A UTILIZATION REVIEWER

A utilization reviewer, sometimes referred to as utilization management (UM) reviewer, is a clinician who evaluates physician, therapy, and nursing documentation. This evaluation is used to determine duration of a therapy plan of care and corresponding reimbursement rates. Reimbursement rates are based on a specific schedule, whereas durations of stay are solely based on medical necessity (Olmos, 2018). This text will address the importance of and purpose for medical necessity.

Clinicians in UM roles are found in hospitals, insurance companies, and third party agencies. UM reviewers work across the continuum of care – from inpatient acute rehab to home health services.

Medical Necessity

In order to justify initial or continued rehabilitation stay at any level of care, medical necessity must be met at all points during the therapy plan of care. The review process ensures the services provided are

medically necessary, meaning they could not be provided at a lower level of care (Olmos, 2018).

Medical Necessity Based on Level of Care

- Patients appropriate for acute rehabilitation admission are those with a high prior level of function who now demonstrate marked deficits across several functional areas. Rehab services are provided for a combined 3 hours per day at acute rehabilitation facilities (Center for Medicare and Medicaid Services [CMS], 2012).
  - A patient with acute respiratory failure requires close supervision and adjustments to ventilator settings, necessitating treatment at the acute level. These interventions cannot be addressed at a lower level of care (sub-acute rehab, outpatient therapy, or home health). All documentation must support the patient's tolerance for and progress toward this required 3 hours of therapy per day. This demonstrates medical necessity for admission to an acute rehabilitation facility (CMS, 2012).

  Of note: This is similar to, but not the same as, an inpatient hospitalization. In the case of larger hospitals, there may be both inpatient hospital units and acute rehabilitation units within the same facility.

  An inpatient hospitalization will include a therapy evaluation and possibly several treatments; however, stays are typically brief and used to stabilize the patient's immediate medical condition. Therapists at the inpatient hospital level assess and order essential durable medical equipment (DME) or other adaptive equipment (AE) needed for the patient's discharge location. The discharge location will be to the patient's home (if

the patient has few or simple remaining deficits), or to a different level of inpatient care (acute inpatient rehab or sub-acute rehab) for continued medical care (CMS, 2012).

- Sub-acute rehabilitation is advised for those who have moderate to severe functional deficits, but cannot tolerate the daily therapy requirement for acute rehabilitation. This typically includes those who required some degree of assistance before their admission (often geriatric patients or those with chronic conditions) (CMS, 2012).
  - A patient requiring vacuum-assisted closure, or a wound VAC, for slow-healing ulcers or incisions needs treatment at the sub-acute level because this cannot be addressed at a lower level of care (outpatient therapy or home health). This demonstrates medical necessity for admission to a sub-acute rehabilitation facility.
- Outpatient therapy is appropriate for those who have mild to moderate deficits which still allow a patient to live in their homes or the community with little to no assistance (CMS, 2012).
  - A patient with carpal tunnel syndrome (CTS) who is having difficulty working or completing household chores for an extended period would benefit from modalities such as ultrasound or electrical stimulation (e-stim). This patient needs treatment at the outpatient level because these services cannot be addressed at a lower level of care (home health).
- A patient who is homebound, and otherwise unable to access services due to barriers such as transportation, needs treatment through home health services. Mild to moderate impairments cannot be addressed at the next highest level of care, which is outpatient therapy (CMS, 2012).
  - A patient with early-stage dementia who recently lost the ability to drive may have no means of transportation and would benefit from home health services. This also provides

the patient with a home health aide for assist with personal care/ADLs along with therapies to address cognitive impairments in the home. This demonstrates medical necessity for home health therapy.

Proving Medical Necessity through Documentation

Medical necessity can be proven through a combination of services including social work (SW), skilled nursing (SN), physical therapy (PT), and occupational therapy (OT). Each discipline demonstrates medical necessity in different ways; however, all disciplines are interconnected, making it essential for collaboration within a treatment team. For example, therapists working in an inpatient facility may not know a patient's discharge planning updates without attending team meetings or speaking with the patient's social worker. This ensures fluidity of documentation across disciplines and allows for the most accurate discharge plan.

Social Work

Social work may demonstrate medical necessity by stating a patient is unable to safely discharge to the community due to lack of social supports, insufficient financial assets, and absence of safe housing. Without social work intervention, the patient may experience an exacerbation of environmental risk factors and a decline in medical condition, warranting continued social work intervention to increase supports and establish a safe discharge plan (Office of Government Relations and Political Action).

Nursing

Nursing may demonstrate medical necessity by stating a patient has complex wounds which warrant nursing care several times each day.

Nursing medical necessity may also include administration of intravenous antibiotics several times each day. Antibiotics provided any more than once per day cannot be done through home health services, warranting the need for nursing services at the inpatient level (HCPro, 2004).

Physical Therapy

Physical therapy may demonstrate medical necessity by stating a patient is unable to independently transfer from one position to another. Without physical therapy services, the patient is at a high risk for falls due to impairments in balance, frequent shortness of breath, and decreased step length. The need for ambulation assistance along with active treatment of medical complexities warrants the need for physical therapy services at the inpatient level (Olmos, 2018).

Occupational Therapy

Occupational therapy may demonstrate medical necessity by stating a patient is unable to independently bathe. Without skilled occupational therapy services, the patient is at a high risk for falls and other safety risks due to impaired judgment and decreased upper extremity range of motion. The need for assistance with bathing along with active treatment of medical complexities warrants the need for occupational therapy services at the inpatient level (Olmos, 2018).

Occupational Therapy Medical Necessity

You must be specific, as saying poor ADL (activities of daily living) is not specific enough! Some doctors may write this as a reason for referral on a prescription for therapy. It is part of a therapist's role to encourage details from others as much as possible to help guide treatment. The reason for referral is written on evaluations and all other

documentation throughout the therapy plan of care, so it must be accurate.

Since therapists do not have the capacity to diagnose patients, they rely on doctors to provide diagnoses based on physician assessments. From there, therapists treat symptoms based on therapy assessments and knowledge of the diagnosis. This is just one instance where each practitioner on a treatment team relies on concise and accurate documentation in order to effectively complete their job duties.

Chapter 2

NOTE WRITING

JUSTIFICATION

Most forms of documentation require practitioners to state the burden of care caused by the patient's impairments, or specifically state the justification or need for skilled services. These are appropriate places to enter the medical necessity information by itself, though it should also be incorporated into daily notes. This will vary depending on the specific program used for documentation; however, it will be labeled something similar to burden of care, justification for services, medical necessity, etc.

THE BASIS OF A NOTE

The major points to keep in mind when writing notes are to provide sufficient details while keeping the note concise, quantify your treatments, and use of abbreviations which are universally known among therapists. It is important that any therapist can understand and replicate your treatments. Some examples of universal abbreviations are listed

below (Inverarity, 2018). Links to other lists of universal abbreviations can be found in the resource section.

- FWW, RW (front-wheeled walker, rolling walker)
- AE/AD (adaptive equipment, assistive device)
- s/p (status post, meaning after a procedure or injury)
- NWB, PWB, TTWB (non-weight bearing, partial-weight bearing, toe-touch weight bearing)
- DME (durable medical equipment)
- GMC (gross motor coordination)
- 2/2 (secondary to, meaning as a result of)
- ALOS (average length of stay)
- HEP (home exercise program)
- FMC (fine motor coordination)
- LOC (loss of consciousness)
- DOE (dyspnea on exertion)
- SOB (shortness of breath)
- don, doff (put on, take off)
- HOH (hand over hand)
- HHA (handheld assist)
- LOB (loss of balance)
- NPO (no oral intake)
- BID (twice per day)
- OOB (out of bed)
- AAT (at all times)
- IV (intravenous)
- Sx (symptoms)
- Dx (diagnosis)
- Fx (fracture)
- Hx (history)
- QD (daily)

PUTTING IT INTO PRACTICE

Here are some basic examples of what a therapy scenario may look like. Formulate these into clear, concise statements in several lines to practice how treatments are written as daily notes. Just as there is no one correct note to rule them all, there is no one correct response to these exercises.

Scenario 1 - Skilled Nursing Facility

You are working with a patient on a balloon toss activity in standing. She needs to sit down twice to take a break, but is able to complete the toss for as long as you ask with 50% therapist assist.

How would you form this scenario into a clear and concise note?

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See some examples below:

Note A.

20/20 trials of balance activity in standing w/mod A (for LOB) and 2 rest breaks d/t dyspnea. Patient avoided use of LUE with significant L neglect present. Visual-spatial deficits appeared to have mild/moderate impact on task completion.

Note B.

Balance activity for 10 min with mod verbal cues to maintain NWB status. Required 2 rest breaks for due to SOB, sit <> stand with min A for hand placement. Able to restart task using adequate safety awareness without OT cueing.

Scenario 2 - Outpatient Orthopedic Clinic

You are giving 25% assist to a patient who is playing a Go Fish with a peer. He requires cueing on 2 occasions to return to completing the game each time someone else walks into the room, but can continue the game. He is able to complete several rounds of the game before getting hungry and begins asking when the session will be over. He does not respond to cueing to return to the game. You end the session early.

How would you form this scenario into a clear and concise note?

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Note A.

Completed 5/5 trials of card game with min verbal cues to improve focus and short-term recall. Completed additional 2/5 trials with new instructions and demo min/mod impaired short-term recall. Patient began perseverating due to onset of hunger. Unable to redirect, session ended early.

Note B.

Patient self-selected cognitive activity, completed in 4/5 trials with min physical assist to improve L hand pinch pattern. Patient required min A to maintain focus on task, mod A to improve sitting posture and LUE purposeful movement. Intention tremors with mild impact on task completion. Patient minimally responsive to cueing in second set of 1/5 trials, reported anxiety, wished to stop. Session ended early and patient left in care of RN Stephanie.

Scenario 3 - Outpatient Mental Health Center

A patient participates in community integration training at a local grocery store. He chooses which meal he would like to cook and picks out ingredients with 50% therapist assist. He is able to wait in line, exchange money for his order, and bring items to the car without any therapist assist. Once back at clinic, he categorizes 4 ingredients correctly, requiring 25% verbal cueing from therapist to categorize the remaining item. He acted appropriately throughout the entire treatment lasting 90 minutes.

How would you form this scenario into a clear and concise note?

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Note A.

Patient participated in 90 minutes community reintegration training. He appropriately picked out 5/5 recipe ingredients with mod A to improve attention to task and decrease impulsivity. He completed

checkout with SBA, using appropriate currency. During checkout, he demonstrated appropriate affect, impulse control, turn-taking, and expressive communication without therapist assist. Patient categorized 4/5 ingredients with min verbal cueing for attention. Patient given task to call mother and ask for chicken casserole recipe. Will start cooking next session.

Scenario 4 - Home Health Agency

A patient is able to complete morning routine with therapist assistance to lay out ingredients and clothing in 4/4 trials. Patient is able to manage medications with 50% therapist assistance for instructions. Adequate ability to walk within the home, but patient is unable to avoid throw rugs. Patient is able to demonstrate and verbalize home exercises with assist of caregiver and needs 100% verbal cueing to record next appointment on calendar.

How would you form this scenario into a clear and concise note?

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Note A.

Patient completes 4/4 trials of morning ADLs with set-up assist with shoulder pain limiting reach to upper shelves. Med management with 50% cognitive assist for short-term recall and sequencing. Able to functionally ambulate bedroom <–> bathroom using RW with SBA due to poor navigation around enviro obstacles. Patient able to demonstrate HEP with assist from caregiver. Unable to verbally confirm next

appointment in 1/3 trials using spaced retrieval. Patient able to record time/date using visual aid with Max A for cognition.

Scenario 5 - School-Based Therapy

Child is having difficulty writing unaided, per her teacher. She walks to therapy with OT and is excited to "do crafts". OT helps her complete games to prepare for writing. She requires 50% therapist assist to write her name with no distractibility. She has trouble keeping the paper in one place while she is writing and needs 100% therapist assist for this. She tries using a pencil grip but it does not help. OT trials AE to assist with pencil grip. Child gets frustrated but is able to return to task after playing a game. OT asks teacher if strategies taught in previous session have been working.

How would you form this scenario into a clear and concise note?

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Note A.

Teacher reports child demonstrates difficulty writing letters during class. Child completes 4/6 trials of fine motor activity with min A to prepare for writing, with s/s of moderate hand fatigue d/t facial grimacing and rest breaks. She is able to write her name in 2/2 trials with HOH assist and total A from OT to stabilize paper with ipsilateral UE. OT educates child in use of universal cuff for RUE pencil grip in 2/3 trials. Child willing to break for 3/3 trials of fine motor activity with min A for peg placement. Teacher updates OT that sensory strategies have been

very effective to moderate frustration tolerance during class. To continue trialing universal cuff next session.

Of Note: School-based therapy notes are typically longer and more detailed than notes found in other practice areas, as they are included in more comprehensive documents called IEPs (Individualized Education Plans). It is still important to be clear and accurate in documentation, despite slightly different requirements.

Scenario 6 - Acute Inpatient Hospital

A patient requires 50% therapist assist to sit up in bed and requires significant stabilization from therapist. Patient comes to seated with bad balance when reaching for cones using R side. Patient demonstrates difficulty seeing cones when placed on left side, requiring assist from therapist to avoid falling. Patient is able to take off and put on socks with 75% assist from two therapists to prevent falling off bed. Patient educated on use of tool to assist with dressing, but was unable to use.

How would you form this scenario into a clear and concise note?

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Note A.

Supine <–> sit in 3/3 trials with mod A for poor trunk control. Continues to require CGA to maintain upright position safely. GM activity with SBA in 7/10 trials, good ability to reach to R side with RUE. Completed 3/10 trials of GM activity with mod A to improve awareness and minimize LOB when reaching to L side with LUE. Dons/doffs socks