Spring 2014

BOSSIER PARISH COMMUNITY COLLEGE PTA PROGRAM

Clinical Newsletter

Medicare Updates … give me the basics!

G Codes. Therapy Cap. 8 minute rule. PQRS. RAC audits. I don't know about you, but I feel very overwhelmed by the volume of Medicare change information I'm reading and hearing about. And I recognize that my understanding about these important topics is *seriously lacking*. For those of you who are in the same boat, I hope you find this very basic review helpful.

Therapy Cap and the SGR (Sustainable Growth Rate) Formula

The **Balanced Budget Act** (BBA) of 1997, as a Medicare cost-saving measure, included a (now recognized as "flawed") **sustainable growth rate formula (SGR)** and placed an annual cap on rehabilitation services. The cap *currently* limits annual PT and SLP payment to $1920 (combined) and OT to $1920 (alone). Since enacting the BBA, Congress acted several times to provide exceptions and prevent implementation of a hard cap. In December 2013 Congress passed legislation extending the Medicare therapy cap exceptions process until March 31, 2014. For 2014 there will be 2 different ways to get an "exception". The **automatic exceptions** process applies when patients reach the $1,920 threshold and they have a condition that justifies additional therapy. The provider adds a "**KX modifier**" to the procedure code to extend coverage. The **manual medical review** exceptions process is required at the $3,700 threshold. Under this process, **Recovery Audit Contractors (RACs)** will either review PT documentation *before* paying the claim (**Prepayment Review**) or *after* paying the claim (**Postpayment Review**) depending upon the state (Louisiana is a Prepayment Review state) and make a decision on whether to approve the exception.

What settings are affected: private practice, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs), and comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals, and outpatient hospital departments.

Functional Limitation Reporting and G codes

As part of the Middle Class Tax Relief Act of 2012, CMS (Centers for Medicare/Medicaid) was mandated to collect information regarding beneficiaries' function and condition, therapy services furnished, and outcomes achieved. This "**functional limitation reporting**" (which became mandatory as of October 2013) is done through the use and submission of **G-codes** at initial evaluation, at specified points in the episode of care, and at discharge. If G-codes are not properly submitted, rehab services will not be paid. There are 42 different G-codes, each identifying a functional limitation that is commonly the primary reason for therapy service. For example, G8978 is "Mobility: Walking and Moving Around Functional Limitation". Therapists also attach to each G-code a **severity modifier** (which identifies the degree of limitation) and a **therapy modifier** (which indicates whether services are provided under PT, OT or SLP).

What settings are affected: private practice, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs), and comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals, and outpatient hospital departments.

PQRS

The **Physician Quality Reporting System** is a CMS mandate affecting physical therapists, occupational therapists, and qualified speech-language pathologists in ***private practice OP settings***. The program began in 2007 as an "incentive" program (clinicians received "bonus" reimbursement for participation) but will transition to a "penalty" program in 2015. This rule requires clinicians to perform a certain number of applicable outcome ***measures*** on a designated percentage of Medicare patients. There are 6 outcomes measures that most commonly pertain to physical therapy including things like BMI assessment; falls risk assessment, and pain assessment. The percentage of patients a clinician is required to report on differs based on the reporting method selected (i.e., claims- or registry-based) but under the most common example a clinician would be required to report on at least 3 measures on 50% of eligible patients to be exempted from the 0.2% penalty and on 9 measures on 50% of eligible patient in order to qualify for the 0.5% bonus payment. The frequency of reporting is linked to the CPT codes submitted with 97001 (PT evaluation) and 97002 (PT re-evaluation) being the most common.
What settings are affected: Only private practice outpatient settings at this time

8 Minute Rule

Although not a "new" Medicare addition, it continues to be a source of confusion and worthy of review. According to this rule, in order to be reimbursed for a time-based CPT code (ther ex, gait training, ultrasound for example), you must provide direct treatment for at least 8 minutes. Sounds simple enough, but becomes much more complicated when you consider that once the 8 minute minimum is met, time based codes are billed in 15 min/unit increments and that some codes are service-based vs time-based. Ultimately, correct billing requires some math and referencing of the CMS 8 minute rule chart. Providers must calculate the total units justified by time, calculate the full 15-minute units, and if time justifies additional units compare the units of the partial (leftover) units remaining and bill the larger.

This article was intended to be a *very broad overview* of some very complicated subjects. More detailed information (including forms, FAQ's, podcasts and updates) is available to APTA members at apta.org under "Payment" and then "Medicare".

Helping Students Practice "Defensible Documentation"

With the evolution of Medicare changes, and increasing review of documentation from all payer types, it is crucial that clinicians document well and that students practice and perfect the skills of what APTA refers to as "Defensible Documentation".

While the guidelines for defensible documentation are broad, review and audit of documentation consistently attempts to answer the following questions: (1) Is this service medically necessary? (2) Did it require skilled intervention? (3) Is there evidence of ongoing assessment and progression of care?

Consider the following suggestions for documentation when providing clinical instruction to PT and PTA students :

Medical Necessity

Simply put, medical necessity narratives must describe diagnoses and deficits. Documentation must demonstrate:

1) Medical history, diagnoses, impairments (i.e., strength, ROM, balance) and functional limitations (i.e., bed mobility, transfers and ambulation).

2) Complications and safety issues as a result of the patient's current medical and/or functional status.

3) A service provided for any deficit must meet accepted standards of medical practice and be a specific and effective treatment for the patient's condition. Professional guidelines and literature, payer local coverage determinations (LCDs) and Medicare manuals may help in determining accepted, evidence-based practice interventions.

4) Service must be provided with an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

The following are examples of medical necessity statements that fit nicely into any progress report:

Patient ambulates 30 feet x 1 requiring moderate assistance for mobility and for safe progression of front-wheeled walker. Patient remains at significant risk for falling at this time due to postural instability from Parkinson's, strength and ROM deficits.

Patient is unable to perform bed mobility without further intervention and training. At present, he demonstrates reduced strength and motor control to roll or weight shift to either side due to CVA. He remains at risk for complications of skin breakdown and respiratory complications.

Therapy Documentation Best Practices

Top 5 best practices for therapy documentation and how to include in the evaluation, plan of care, daily notes, progress reports and discharge reports

	BEST PRACTICE	WHERE
1.	Test, measure and document functional scores, performance tests and clinical findings	Initial Evaluation
2.	Relate clinical findings and short term goals to functional deficits and long term goals	Initial Evaluation & Plan of Care
3.	Skilled intervention demonstrated through ongoing patient assessment, exercise, functional progression, and techniques and parameters utilized	Daily Notes
4.	Serially track and update important clinical and functional findings related to goals	Progress Report
5.	Entire episode of care summarized to include , patient progress, goal achievement, and reason for discharge	Discharge Summary

How to Communicate Skilled Intervention:

Consider:

1) What was done in the visit which required the skills of a physical therapist or physical therapist assistant? You might want to consider why you had to provide the intervention and another provider or caregiver could not? What knowledge, training and skills were used to provide the intervention?

Non- skilled: Gait training – patient ambulated with standard walker

Skilled: Moderate assistance provided with gait training to compensate for left sided neglect and assist with weight shifting for proper progression of bilateral lower extremities. Pt able to demonstrate ambulation 30' x 1 with standard walker

Non- skilled: Bike x 15' followed by treadmill x 10' at 3.0 followed by therapeutic exercises per flow sheet.

Skilled: Prior to activity HR- 83 BP- 128/89 and SaO2 – 98% on room air. Patient monitored during the following activities: bike x 15' followed by treadmill x 10' at 3.0 mph. Patient's vital signs after activity as follows: HR- 123 BP- 146/89 and SaO2 – 89% on room air. Patient also visibly fatigued and short of breath. After 5' rest, vital signs returned to baseline.

<u>How to Communicate Progression of Care and Ongoing Assessment in Daily Notes</u>

Consider if the note contains information about:

Status before interventions? Status after interventions? Assessment of patient's response to interventions? What is the plan to continue (or change)?

Transfer Training example: Patient seen for transfer training from bed to chair. Initial status was maximal assist. Patient trained with tactile and verbal cues to promote trunk flexion and facilitate appropriate lower extremity muscle contraction. Patient able to demonstrate both improved pelvic tilt and more effective hip extensor firing. Will continue to facilitate proper and safe technique as patient continues to require moderate assistance. Prognosis for independent transfers remains good.

Gait training example (without or minimal progress):

Visit #1: Gait training with patient in parallel bars. Patient unable to shift weight to affected side with verbal cueing. Applied manual cues however patient required maximal assistance to shift weight and was unable to maintain weight shift for progression of unaffected lower extremity. Patient complains of vertigo and BP found to be 96/65. Blood pressure and complaints return to normal after sitting x 5 minutes.

Visit #2 - Vital signs normal at start of visit. Gait training with patient in parallel bars. Patient unable to shift weight to affected side with verbal and manual cues. Requires maximal assistance to shift weight in standing. Modified exercise program to include activities to promote weight shifting in other postures.

Visit #3: Vital signs normal at start of visit. Training with patient to weight shift in sitting. Pt able to shift weight to unaffected side after training in sitting. Requires moderate assistance for trunk control when attempts to weight shift to affected side. Pre-gait training in parallel bars demonstrates increased ability in standing tolerance from 1 minute to 3.6 minutes. Will continue to progress pre-gait activities at this time.

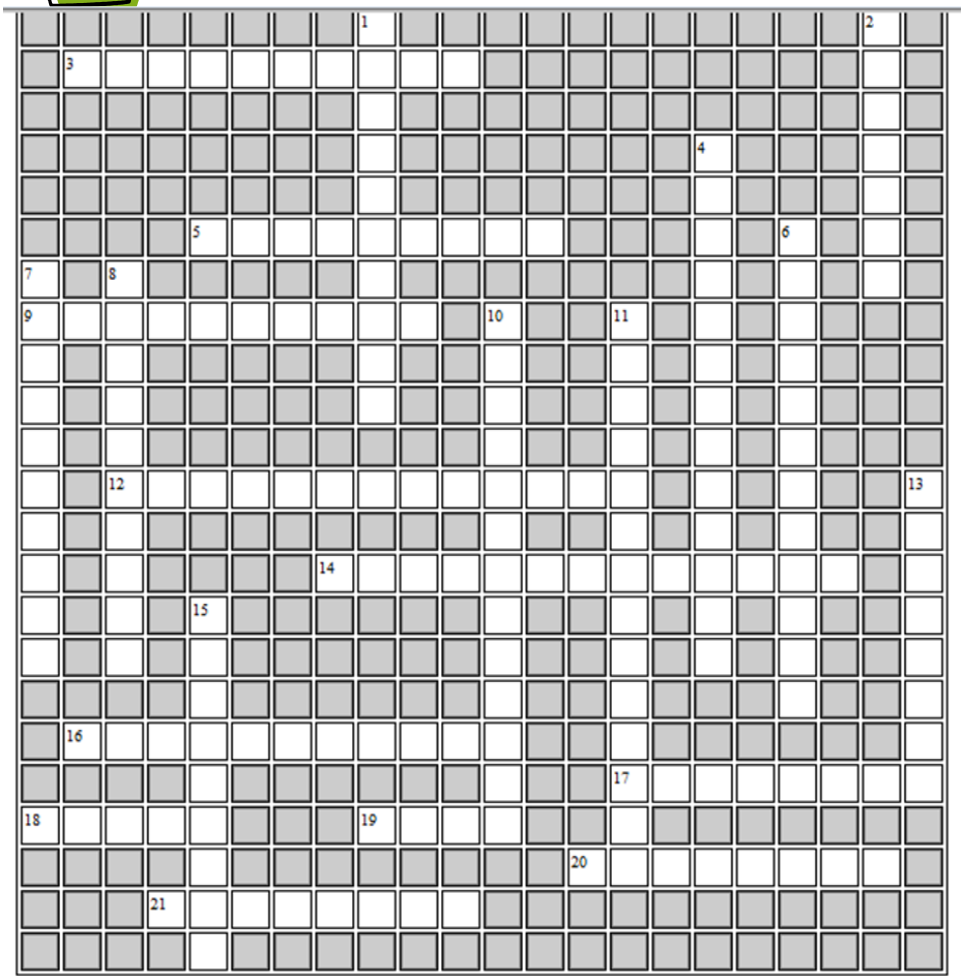
SPTAs can and should be expected to document in a manner that reflects these goals. Encourage your students to describe in their notes the:

- functional rationale for skilled interventions used,
- patient response to those interventions and
- utilize objective assessment tests and measures to reflect patient progress.

For more information members should visit apta.org and select "Practice & Patient Care" then "Documentation".

Spring Crossword Puzzle

Hey Clinical Instructors!! Try this crossword just for fun but also to get an idea of what didactic content BPCC PTA students are covering during the spring semester of the PTA Program. Challenge your PT & PTA co-workers to brush the brain cobwebs off some of this information to help you finish the puzzle! Then feel free to quiz your spring PTA students about these subjects too!!



Across

3. term for an infection acquired during hospitalization
5. problem with coordination that presents as limb "overshooting and undershooting"
9. when this lab value falls below 8 g/dL, exercise is generally contraindicated
12. PNF "element" that facilitates co-contraction and joint stability
14. primary descending pathway in the spinal cord responsible for voluntary motor activity
16. posturing in which both the UE's and the LE's are fixed in extension
17. one of the cranial nerves innervating the muscles that move the eye
18. another term for an ankle disarticulation
19. law that describes that electrical current is directly proportional to voltage and inversely proportional to resistance
20. polarity appropriate when using dexamethasone during an iontophoresis application
21. one type of gait deviation associated with tibialis anterior weakness/paralysis

Down

1. passive insufficiency in the hamstrings would limit ROM for this motion
2. type of transmission based precautions appropriate to use when caring for a patient with influenza
4. a lateral trunk lean during stance is commonly indicative of weakness in this muscle
6. current that is similar to interferential but requires only 1 channel and is useful on smaller areas
7. type of lever system in which the mechanical advantage is always <1
8. part of the limbic system that plays a key role with fear and aggression
10. classification of burn formerly referred to as "third degree"
11. growth disorder causing tibial bowing
13. part of the brain responsible for receiving incoming sensory information and relaying it to the appropriate part of the cortex
15. parameter of an ultrasound application expressed in w/cm2

It's About You!

BOSSIER PARISH COMMUNITY COLLEGE

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PTA PROGRAM UPDATE—SPRING 2014

BPCC PTA students, faculty, and alumni participated in a variety of community service and professional development activities this year including:

Right: BPCC PTA students, faculty and alumni participated in "Hustle for your Health" - the Shreveport District LPTA PT Month 5K—October 2013

Left: BPCC PTA students and faculty participated in "Sign-Up Saturday" (a local health and wellness fair for school-age children) August 2013

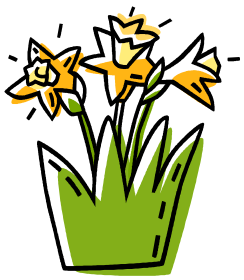
Right: PTA students and alumni participate in a wiffle-ball tournament to raise money and support for Jackson Kennedy's fight with cancer. November 2013.

Way to Go!!

The BPCC PTA Program is very fortunate to have a large community of skilled and dedicated clinical instructors who not only model excellent technical skills but who also devote time to and energy to *teaching*. PTA students are asked to give feedback to the question "**What did your CI do well to facilitate learning?**" at the end of each rotation — See just *some* of the great things our CI's are out there doing!!

"I loved the way that my CI gradually transitioned me into more and more independence. First few days were spent getting to know patients, reviewing charts, & observing/discussing treatments transitioning into more responsibility. Duties increased from taking vitals and other pieces of the treatment to full implementation of POC."

Re: Tiffany Engle, PT
Trinity Home Health



" After completing a treatment session my CI would discuss with me why particular interventions were used. He helped me to see and appreciate the connection between the intervention selection and the evaluation findings and goals."

Re: Michael DiGrazia, PTA
University Health

"He was very good at teaching and explaining. When I asked questions he was very detailed in his answers and he would even bring some of his text books out to show me things. With many skills, he would demonstrate the skill on me and then allow me to practice on him"

Re: Mark Green, PT
Performance PT

"My CI was always willing and eager to answer questions and demonstrate techniques. He openly shared skills and knowledge that had been learned over time. He actively sought to expose me to as many PT experiences as available."

Re: Justin Grigsby, PT
Overton Brooks VAMC

"My CI would give me a quick run through of the patient's condition and their status while on the way to the patient's home. She let me take the lead during the treatment session, but was right there to help guide and give feedback."

Re: Jean Brasseaux, PT
STAT Home Health

"I loved that my CI did a LOT of quizzing (which really helped keep me on my toes) but that she did it in a way that let us both laugh when I didn't remember an answer! "

Re: Becky Sherwin, PT
Melanie Massey Physical Therapy