2024-0113-QC

PT DOCUMENTATION/ BILLING GUIDE

	COMPONENTS TO INCLUDE	EXAMPLE
HISTORY OF PRESENT ILLNESS (HPI)	What is the functional decline? When did the decline start? Why did the decline occur (the cause)? The cause of decline needs to be within the past 3 months. If >3 months, then need to account for why the delay and why therapy is indicated by answering the question, "Why therapy now?"	Patient was referred to physical therapy due to change in functional performance of: walking, transfers, beginning 3/25/21. Factors contributing to functional change: c/o decreased balance and weakness in B LE's over the past month secondary to fear of falling resulting in decreased activity and need for increased assistance with transfers and ambulation. Patient sustained a fall after tripping on an area rug 2 weeks ago and landing on R hip; evaluated at the ER (negative for fx).Patient is now referred to skilled PT to address these deficits.
SOCIAL HISTORY (ENVIRONMENTAL FACTORS)	Does the patient reside in an SLC? Does the patient live at home? What type of home, and does the home have stairs? Are there any environmental adaptations (i.e., ramp, stair glide, etc.)? What type, if any, assistance does the patient have (i.e., family, caregiver aid, mobility, ADL's, etc.)?	Patient lives in an apartment. Residence is a single level building. Two steps inside with left side railing. Farthest Distance to Travel: 300 ft in order to amb from front door to parking lot Patient lives with spouse. Professional caregiver assistance is provided 3 days/week for 4 hours/day.
PRIOR LEVEL OF FUNCTION (PLF)	All functional goals must have a PLF documented. The PLF for each area of function that has been impacted by the decline, should include the task, details of the task, previous assist level, assistive device or adaptive equipment utilization, compensatory techniques, surface, and distance (i.e., ambulation/wheelchair mobility). If patient has dementia diagnosis, GDS (Global Deterioration Scale) needs to be included.	Transfers - Independent, sit to/from stand with bilateral UE push off, DME/AE: rolling walker Ambulation - Independent, indoors/outdoors, DME/AE: rolling walker, Distance: 300 ft
GOALS	Are all goals measurable, functional, and objective? Do all documented deficits have a goal? All goals must include a specific activity, level of assist/cuing, and a functional component. If you identify a deficit but will not be establishing a goal in that area, need to provide a clear clinical rationale explaining why.	Patient will ambulate on level and unlevel tiled, wood, and carpeted surface for 300 ft with a rolling walker, independently, in order to walk safely to get mail at end of driveway, in 90 days. This goal was established on 3/25/21.
BILLING	Are the appropriate codes billed for the services provided? Need to document reps/ sets and/or time for each activity. Do units billed match treatment time? If a task takes longer than expected amount of time, need to document why increased time is necessary.	Timed Codes/Total Treatment Time: 54 min/54 min 2 units of 97110 (Therapeutic Exercise) 1 unit of 97116 (Gait Training) 1 unit of 97530 (Therapeutic Activity)
HOME EXERCISE PROGRAM (HEP)	Has HEP/HAP or caregiver (CG) assisted program been issued? Should initiate early in course of care, and update/modify as needed per patient presentation. Doc specific exercises/activities, reps, frequency. What was patient/CG level of performance/ understanding? Is patient/CG compliance with HEP documented?	Reviewed HEP with patient: instructed on positioning, safety, technique, rate, frequency, and duration of HEP. Reviewed standing TE: heel raises, mini squats, and hip abd 3x10, 1x/day, requiring minimal assistance, and has reported 50% compliance.

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	COMPONENTS TO INCLUDE	EXAMPLE
PATIENT/ CAREGIVER EDUCATION	Is patient and/or caregiver education documented early on and frequently t/o entire course of care as appropriate? Is significant documentation of caregiver education present for a patient with documented cognitive impairment? Does each bout of education include the area of education, level of assist, and patient/caregiver response?	Educated caregiver regarding safety with ambulation, including the importance of utilizing the walker for outdoor ambulation to decrease fall risk, requiring minimal assistance. Additional training required due to safety, technique, and carryover. Report of adherence to education: 51-75%.
SKILLED CARE	Do all functional tasks have level of assist and/or cues documented? Is progression of treatment components evident, with no significant repetition noted with performance of interventions? Is there consistent documentation of response to interventions when required (i.e., MT)? Are vitals documented per FOX's Cardiac Protocol? Is it clear to the reader that an unskilled worker or family member could not perform the same care as the PT safely and effectively?	Patient performed sit to/from transfer from a firm chair and bed using a wheeled walker, requiring moderate physical assistance, tactile facilitation, verbal instruction, and visual demonstration secondary to compromised balance, coordination, pain level, posture, safety, strength/ROM, and technique. Patient performed this activity for 3 trials. VC/TC for coming to edge of seat, pushing from surface when standing, and reaching back when sitting.
PR STATUS/ GOALS	Are all baselines, updates, and goals present for all established goals, AND for all areas addressed during reporting period? Same tasks should be compared to show gains/ status change. If unable to assess, then need to document justification, including a plan to reassess with a specific time frame.	Bed Mobility Baseline: Patient transferred sit to/from supine to the left with left rail using both upper extremities, requiring moderate physical assistance, tactile facilitation, verbal instruction, and visual demonstration secondary to compromised coordination, pain level, strength/ROM, and technique. Required increased time for sequencing and task completion. Most Recent Treatment: Patient transferred sit to/from supine to the left with left rail using both upper extremities, requiring minimal physical assistance, tactile facilitation, and verbal instruction secondary to compromised coordination, strength/ROM, and technique. Goal: Patient will transfer sit to/from supine to the left with left rail using both upper extremities, independently in 90 days. This goal was established on 3/25/21. It is in progress, on 5/3/21.

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	ASSESSMENT	EXAMPLE
IE	Is my documentation detailed enough that it could only ever apply to one patient? It should outline the medical complexities of the case (including the patient's current deficits as well as any medical diagnoses potentially affecting recovery), the patient's potential to improve, why skilled therapy is indicated, what the plan of care is expected to achieve, and provide an explanation of the clinical decision making that will be ongoing. These components should be described in a way that makes it clear to anyone reading the documentation that a skilled PT needs to be present to perform the indicated interventions.	Patient is a 74 year old woman with Parkinson's Disease, having sustained a fall two weeks ago with no fracture. Patient c/o pain in left knee and demonstrates decreased B LE strength and AROM, decreased dynamic standing balance, and increased difficulty with transfers and ambulation. Patient requires skilled PT to increase her B LE strength and AROM with therapeutic exercise, address her knee pain utilizing manual therapy techniques, and decrease her fall risk with complex dynamic balance training, addressing the patient's specific gait deviations, and patient/ caregiver education regarding safe mobility, in order to promote return to prior level of independence with all functional mobility in her home and when accessing her community appointments (physician, church, grocery store).
PR	Need to include four components: current functional status, hindrances, how clinician adjusted care to overcome the hindrances, and why skilled care is required to continue. Each progress report assessment needs to be unique and non-repetitive from the previous progress report. The stated hindrances should vary from progress report to progress report. If a hindrance continues past one progress report, then it is necessary to include documentation as to why it continues to persist and to document a new plan to overcome.	Changes to patient's status include improved B LE AROM, B LE, strength and dynamic standing balance. Patient requires less PA with transfers since last treatment period. Hindrances to plan of care include L LE edema. Hindrances are being addressed with patient and caregiver education on the importance of elevating LE's for edema management and monitoring edema for further potential evaluation. Plan of care cannot be trained to a caregiver due to patient requires further skilled modification/advancement of treatment activities (specifically progression of dynamic balance activities and gait training) to continue to maximize her independence with functional mobility and decrease risk of falls in order for her to ambulate safely to/from meals in the dining room without physical assist.
DC	Need to include three components: What gains were made over the entire course of care? What is the reason for D/C? Has there been an HEP established?	Patient has made significant gains over course of care, returning to Independent level for transfers and ambulation, with a RW for 500 ft; all mobility is pain free. Patient has demonstrated independence and compliance with standing TE HEP. Patient has achieved all goals and is functioning at PLF; no further PT is indicated at this time.

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97161—Initial Evaluation (Low Complexity): Performed only once per case. Add a -59 modifier if treatment distinct from the evaluation is performed on the same day.

97162—Initial Evaluation (Moderate Complexity: Performed only once per case. Add a -59 modifier if treatment distinct from the evaluation is performed on the same day.

97163—Initial Evaluation (High Complexity): Performed only once per case. Add a -59 modifier if treatment distinct from the evaluation is performed on the same day.

97164—Re-Evaluation: Is a separately payable code when the professional assessment of a clinician indicates a significant change, or decline, or change in the patients condition or functional status that was not anticipated in the plan of care

97018—Paraffin: Service based code, therefore only may bill one unit

97110—Therapeutic Exercise: Amb. or wheelchair mobility done for CV stamina as a skilled service; AROM/PROM/ flexibility, stretching/strengthening patient or clinician generated; e.g., clinician performing hamstring flexibility on patient.

97112—Neuromuscular Reeducation: Fine motor coordination, posture, balance exercises, activities to improve neuromuscular control.

97116—Gait Training: Working on impairments of gait, as well as steps/curbs/elevations, and assistive device instruction. For skilled CV stamina, bill 97110.

97140—Manual Therapy: Manual traction, joint mobilization, myofascial release/soft tissue mobilization, manipulation, manual lymphatic drainage/complex decongestive therapy (MLD/CDT)

97530—Therapeutic Activities: This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching, pushing, pinching, grasping, transfers, bed mobility, and overhead activities) to restore functional performance in a progressive manner.

97535—Self-Care/Home Management Training: This code should be used for activities of daily living (ADL) and compensatory training for ADL, safety procedures, and instructions in the use of adaptive equipment and assistive technology for use in the home environment.

97750—Physical Performance Test or Measurement: Billed for Functional Outcome Measures (FOMs); questionnaires without physical performance are not billable; there must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report; cannot be billed at time of an evaluation or re-evaluation.

97542—Wheelchair Management: Wheelchair measurements and type determination, adjustments, wheelchair management, and mobility. If billing for wheelchair propulsion, there must be a tie into a functional goal for the propulsion. When billing this code, there must be clear documentation that the patient has the potential to learn and it must be clear that caregiver or patient is directly benefiting from the training; for skilled CV stamina, bill 97110.

97032—Electrical Stimulation (Manual): Requires constant attendance with direct (1:1) manual patient contact by clinician. Typically delivered by probe or handheld devices that clinician holds throughout the entire session. Training on a home device should be completed in 1-2 session.

97124—Massage Therapy: Massage may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to reduce edema, improve joint motion, or relieve muscle spasm. Massage is not covered as an isolated treatment.

97760—Orthotic(s) Management and Training: Including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s), and/or trunk.

97761—Prosthetic Training, Upper and/or Lower Extremity(s): For initial visit; includes preparation of the stump, skin care, modification of prosthetic fit (revisions to socket liner or stump socks), and initial mobility and functional activity training. Once a patient begins gait training with the prosthesis, use code 97116.

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97762—Checkout for orthotic/prosthetic use, established patient: For follow up visits. These assessments are intended for established patients who have already received their orthotic or prosthetic device.

97550—Caregiver Training in Strategies and Techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living, instrumental ADLs, transfers, mobility, communication, swallowing, feeding, problem-solving, safety practices) without the patient present, face-to-face; initial 30 minutes

97551—Caregiver Training in Strategies and Techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living, instrumental ADLs, transfers, mobility, communication, swallowing, feeding, problem-solving, safety practices) without the patient present, face-to-face; each additional 15 minutes.

G0283—Electrical Stimulation (Unattended): Provided in a supervised manner without constant, direct contact throughout the entire session. Typically delivered through the application of electrodes. Examples include Interferential Current (IFC), Transcutaneous Electrical Nerve Stimulation (TENS), and cyclical muscle stimulation (Russian stimulation).

- *If treatment is not effective by 12 visits, then clinical assessment needs to indicate why, and POC needs to be revised to effectively address patient presentation.*

Note: Patient and caregiver education should be billed under the CPT code which best represents the topic of education provided (i.e., transfer training education = 97530, Therapeutic Activities).

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