2024-0113-QC

OT 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 Occupational Therapy due to change in functional performance of: toileting, dressing, functional mobility, and transfers, beginning 1/4/21. Factors contributing to functional change: patient hospitalized for urinary tract infection from 1/4/21-1/6/21 and upon return home has experienced decreased B UE strength, decreased endurance and decreased balance, requiring increased assistance with ADL's, functional mobility and transfers. Patient is now referred to skilled OT 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 memory care unit of an SLC. Residence is a single level building. Farthest Distance to Travel: 1,200 ft from his room to outside activity area. Bathroom Setup: shower stall, shower chair, grab bar. SLC staff has 24/7 professional caregiver assistance.
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., functional mobility/wheelchair mobility). If patient has dementia diagnosis, GDS (Global Deterioration Scale) needs to be included.	Bed Mobility: Independent, sit to/from stand, BUE support Functional Mobility: Independent ambulation, indoors/outdoors, DME/AE: rolling walker, Distance: over 1,200 ft Dressing: set up, upper and lower body, use of long handled shoe horn.
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 perform upper and lower body dressing, requiring set up assistance, in order to improve independence with ADL's to participate in SLC activities, in 90 days. This goal was established on 2/1/2021.
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: 55 min/55 min 2 units of 97110 (Therapeutic Exercise) 1 unit of 97530 (Therapeutic Activity) 1 unit of 97535 (Self Care)
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 seated TE: shoulder flexion/abduction, elbow flexion/extension with green theraband 3x10, 1x/day, requiring minimal assistance, and has reported 50% compliance.
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 toileting assistance, including transfers and clothing management, requiring moderate assistance. Additional training required due to safety, technique, and carryover. Report of adherence to education: 25-50%.

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	COMPONENTS TO INCLUDE	EXAMPLE
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 OT safely and effectively?	Patient performed toileting with grab bars and wheeled walker, requiring maximum tactile facilitation, verbal instruction, and visual demonstration secondary to compromised balance, cognition, pain level, posture, safety, strength/ROM, and technique. Patient has difficulty with obtaining supplies, maintaining position, clothing adjustment, and cleaning body. Patient performed this activity for one trial. Moderate to maximal cueing for hand positioning with transfer and moderate assist with clothing management.
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.	Grooming Baseline: Patient performed grooming while standing with minimal PA for support at sink, requiring maximum verbal instruction secondary to compromised balance, cognition, safety, and technique. Patient has difficulty with washing hands/ face and hair care. Most Recent Treatment: Patient performed grooming while standing unsupported at sink, with SBA. Patient completes with set-up of materials and SBA t/o task for ensuring stability. Goal: Patient will perform grooming while standing, independently in order to improve patient participation and safety with ADL's, in 90 days. This goal was established on 2/1/2021. It is in progress, on 3/2/2021.

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	ASSESSMENTS	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 OT 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 right shoulder and demonstrates decreased B UE strength and AROM, decreased dynamic standing balance and increased difficulty (requiring increased assistance) with ADL's, transfers and functional ambulation. Patient requires skilled OT to increase her B UE strength and AROM with therapeutic exercise, address her shoulder pain utilizing manual therapy techniques, and increase her independence with ADL's by providing dynamic balance training as well as patient/caregiver education regarding safety with mobility and self-care, in order to promote her return to prior level of independence with all functional mobility in her home and in her community (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 UE AROM, strength and dynamic standing balance. Patient requires less PA with toileting since last treatment period. Hindrances to plan of care include poor vision which affects safety with ADL's. Hindrances are being addressed with environmental modifications to bathroom set up and patient/ caregiver education regarding safe technique. Plan of care cannot be trained to a caregiver due to patient requires frequent monitoring of vitals and modification of treatment activities in accordance with her current cardiac instability.
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/HAP established?	Patient has made significant gains over course of care, returning to independent and pain free level for toileting, transfers and functional ambulation, and set up for dressing. Patient has demonstrated independence and compliance with UE strengthening HEP. Patient has achieved all goals and is functioning at PLF; no further OT is indicated at this time.

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97165—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.

97166—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.

97167—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.

97168—Re-Evaluation: Is a separately payable code when the professional assessment of a clinician indicates a significant change, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care; add a -59 modifier if treatment distinct from the evaluation is performed on the same day.

97110—Therapeutic Exercise: Amb. or w/c mobility done for CV stamina as a skilled service; A/PROM/flexibility, stretching/strengthening patient or clinician generated, e.g., clinician performing hamstring flexibility on patient; clinician performing amb or wc mobility with vitals assessment for stamina/endurance

97112—Neuromuscular Re-Education: Fine motor coordination exercises, non-functional balance exercises (such as weight shifts, balloon volley, and ball toss), PNF, postural exercises/feedback, and sensory reintegration exercises, activities to improve neuromuscular control.

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; transfers, bed mobility, functional ambulation requiring assistance or cues, body mechanics education, standing tolerance, stairs/curbs/ramps, and functional balance exercises (such as folding laundry while standing, kitchen/closet management, or picking up papers from the floor).

97532—Cognitive Skills Therapy: Limited diagnosis use, cannot be billed with a "progressive disorder" with no potential for restoration; cannot be billed with a dementia diagnosis.

97535—Self Care/Home Management: Toileting, actual showering/bathing, feeding, meal prep, dressing, AE education, home management tasks, meds management education, calendar set-up/review, home safety assessment/ mods, education on oxygen use, staff education on dementia communication techniques, and any patient or caregiver education that does not fall into any of the above categories, such as ECT (energy conservation techniques), pursed lip breathing disease management, etc.

97750—Physical Performance Testing: 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—WC Management/Mobility: 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.

97018—Paraffin Bath: May only be billed one unit max on any date.

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; cannot be billed simultaneously with 97140.

97760—Orthotic Management and Training: Including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s), and/or trunk; must be billed with another functional code.

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97761—Prosthetic Management and Training: For initial visit. Includes preparation of the stump, skin care, modification of prosthetic fit (revisions socket liner or stump socks), and initial mobility and functional activity training.

97762—Prosthetic Checkout: When a device is newly issued or modified; must be billed with another functional code; cannot bill on evaluation or re-evaluation.

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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