RehabCare
Because Outcomes Matter

QualityWISE NEWSLETTER

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JANUARY 2017

We hope you had a festive holiday season! The start of a new year provides a perfect opportunity to commit to doing everything we can to ensure exceptional outcomes for our patients and partners over the course of the next 12 months. To start 2017 off on the right foot, this edition of QualityWISE will provide a review of some frequently asked questions related to the new PT and OT Evaluation/Re-evaluation codes.

What You Need to Know About the New PT and OT Evaluation Codes

1. Do the new Evaluation and Re-Evaluation codes affect ST?

No, the new Evaluation and Re-Evaluation codes only affect PT and OT.

2. Do the new Evaluation and Re-Evaluation codes only apply to Medicare?

No, the new Evaluation and Re-Evaluation codes will apply to all insurance carriers – not just Medicare – as all HIPAA-covered entities must use the current adopted standards that include the Current Procedural Terminology (CPT). The only exception may be workers, compensation.

3. What is the typical amount of time for each physical therapy level of complexity evaluation?

- 97161 – Physical Therapy Evaluation, Low Complexity: Typically, 20 minutes are spent face-to-face with the patient and/or family.
- 97162 – Physical Therapy Evaluation, Moderate Complexity: Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 97163 – Physical Therapy Evaluation, High Complexity: Typically, 45 minutes are spent face-to-face with the patient and/or family.

4. What is the typical amount of time for each occupational therapy level of complexity evaluation?

- 97165 – Occupational Therapy Evaluation, Low Complexity: Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 97166 – Occupational Therapy Evaluation, Moderate Complexity: Typically, 45 minutes are spent face-to-face with the patient and/or family.
- 97167 – Occupational Therapy Evaluation, High Complexity: Typically, 60 minutes are spent face-to-face with the patient and/or family.

5. Do I bill the typical amount of time as indicated by CMS for my evaluation?

No, therapists should bill the actual amount of time that it takes to complete the comprehensive evaluations. Note: From RAI Manual Section O: Record the actual minutes of therapy. Do not round therapy minutes (i.e., reporting) to the nearest fifth minute. The conversion of units to minutes or minutes to units is not appropriate.

6. Do I base my PT or OT Evaluation levels of complexity on the amount of time it takes me to complete my evaluation?

No, the evaluation complexity level is based upon the clinical decision making process, taking into consideration all of the required components.

7. What if PT does the evaluation and determines that the patient is moderate complexity and OT determines that the patient is high complexity; is that OK?

Yes, the complexity level for each discipline is based upon a comprehensive evaluation and may vary based upon the assessment of body structures and functions, activity limitations, and/or participation restrictions for PT and the assessment of physical, cognitive and/or psychosocial skills, as well as an analysis of the occupational profile for OT.

8. If PT does the evaluation and determines that the patient is high complexity should OT also say that the patient is high complexity?

No, the clinical decision making to determine the level of complexity should be made after the completion of a comprehensive evaluation for each discipline.

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9. If I do not have time during the evaluation to complete standardized tests and measures, can I have the assistant do them for me during the next treatment?

No, a standardized assessment on evaluation is required to be in accordance with regulatory guidelines.

10. Are there new components that will be required for our evaluations in order to determine the level of complexity?

Yes, the new evaluation codes have new required components and there are differences between the Physical Therapy Evaluation components and the Occupational Therapy Evaluation components.

- Physical Therapy Evaluation Components:
  - History and/or co-morbidities.
  - An examination of the body system(s) utilizing standardized tests and measures.
  - Clinical decision making, which includes an analysis of the occupational profile, assessment information, consideration of treatment options, co-morbidities impacting occupational performance, and modification/assistance required.
- Occupational Therapy Evaluation Components:
  - Occupational profile.
  - Medical and Therapy history.
  - An assessment of performance deficit.
  - Clinical decision making, which includes an analysis of the occupational profile, assessment information, consideration of treatment options, co-morbidities impacting occupational performance, and modification/assistance required.

11. What are the physical therapy definitions that are included in the Evaluation?

- Body Regions: Head, neck, back, lower extremities, upper extremities and trunk.
- Body Systems: Musculoskeletal, neuromuscular, cardiovascular pulmonary and integumentary.
- Body Structures: The structural or anatomical parts of the body, such as organs, limbs and their components, classified according to body systems.
- Personal Factors: Factors that include sex, age, coping styles, social background, education, profession, past and current experience, overall behavior pattern, character, and other factors that influence how disability is experienced by the individual. Personal factors that exist but do not impact the physical therapy plan of care are not to be considered, when selecting a level of service.

12. What are the occupational therapy definitions that are included in the Evaluation?

- Performance Deficits: The inability to complete activities due to the lack of skills in one or more of the categories below (i.e. relating to physical, cognitive or psychosocial skills).
- Physical Skills: Impairments of body structure or body function (e.g. balance, mobility, strength, endurance, fine or gross motor coordination, sensation and dexterity).
- Cognitive Skills: The ability to attend, perceive, think, understand, problem solve, mentally sequence, learn and remember, resulting in the ability to organize occupational performance in a timely and safe manner.
- Psychosocial Skills: Interpersonal interactions, habits, routines and behaviors, active use of coping strategies, and/or environmental adaptations to develop skills necessary to successfully and appropriately participate in everyday tasks and social situations.

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13. Do I bill for a re-evaluation when completing a UPOC?

No, a re-evaluation is not a routine, recurring service and requires the following components:

- An assessment of changes in patient functional or medical status with revised plan of care;
- An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and
- A revised plan of care. A formal re-evaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required.

14. Is evaluation documentation time billable?

Documentation of the evaluation time is not a "skilled billable service." Collecting information needed to complete an evaluation (such as medical history, prior level of function, prior living status, discharge plans, results of special tests/measures, etc.) are all critical to the development of a plan of care. However, time spent doing this is not considered "billable skilled minutes" according to Medicare regulations. Time spent that is just documenting and not involving assessment or skilled treatment time should not be counted either as evaluation or treatment time.

- There is a difference between completing documentation at point of service and billing for documentation time. Refer to MDS Users Manual Section O-17 for specific regulations:
  - Documentation, when done in isolation, should not be counted as billable minutes for MDS purposes.
  - If the patient is engaged in or is participating in the evaluation and assessment then it is the skills, knowledge, and judgment of the therapist that the patient is being billed for, and not the documentation time.
  - The decision to count minutes on the MDS as skilled minutes of therapy is a clinical decision and should be based on the therapist's determination that skilled services are being provided.

15. Does Knect have resources on standardized assessments?

Yes, your resources can be found by following this path: Log into Knect ››› Kindred Rehab Services ››› Clinical Services Skilled Nursing (RHB) Skilled Nursing Rehab Group-Clinical Information ››› Assessment Tools & Tests.

Remember, every issue of the *QualityWISE Newsletter* is archived at **http://www.rehabcare.com/employees/qualitywise/**, along with helpful FAQs. If you have any questions or concerns related to quality, compliance or the CIA, you can email **RehabCareQualityWISE@rehabcare.com** or contact Kindred's Compliance Department at **compliance@kindred.com.** And you can always contact the Compliance Hotline at 800.359.7412 to report suspected violations of any federal healthcare program requirements or Kindred's policies and procedures.

Thank you for everything you do
to ensure exceptional outcomes for our patients and partners.