GOAL WRITING

1. **FUNCTIONAL:** All therapy goals must be related to function or safety. While it is OK to have a goal to improve a resident's strength or ROM, you must also explain in your notes or through your other goals how this will affect function or safety. For e.g. explain how the ROM will affect gait pattern and stability, how the strength will affect transfers, or how the positioning will reduce the risk for falls or contractures, etc.

2. **MEASURABLE:** All goals must be objectively measurable. Do not write "return to highest level of ADL's" or "improve weight bearing and decrease pain". Instead, document "increase dressing to minimal assist, increase weight bearing by 25% and decrease pain to 2/10".

3. **REASONABLE:** Goals must be reasonable for the resident's status and expectations. Long-term goals are usually to return the resident to his prior level of function, and should not exceed the patients' prior level of function. If they do, you must explain why you are expecting a higher outcome for the resident now, for e.g. decreased pain, increased level of alertness, etc. This must be documented in your progress notes.

4. **CORRELATION OF GOALS WITH BOTH THE PLAN OF CARE & D/C PLAN**:

   a. The therapy goals should relate to the problem areas identified on the evaluation, and the plan of care/modalities should correspond to the goals you have established, for e.g. if a resident has pain, there should be a goal to decrease pain. Furthermore, if there is a goal to decrease pain, then be sure you include pain modalities in the plan of care.

   b. The therapy goals must correlate to the patient's discharge plan, for e.g.:

      1. If the resident is going home, it is essential to document goals specific for the home, i.e. ambulating on uneven surfaces, out doors, curbs, steps, cooking, going to the bathroom etc.

      2. If the resident is staying in the facility, it is important to document goals that can be carried over to nursing. For e.g. instead of writing "increase ambulation distance", write a goal to "ambulate from room to nurse's station" or to "ambulate daily on a restorative nursing program".

5. **BE SPECIFIC:** The more specific you make your goals, the easier it will be to show progress from week to week. When goals are broad, it is often hard to show progress, but if goals are broken up into component parts, progress can be documented easier. One long term goal can be comprised of many short term goals that can be updated weekly. Even if a patient has not improved from mod A to min A, it should be possible to show progress in some areas if goals are broken down. (OT specifically is based on activity breakdown. Therefore, this is essential when setting your goals.)

(See handout for examples)

GOAL WRITING (cont'd)

The following are examples of long term goals that are broken down into several short term goals. Remember, these are just examples; any long term goal you determine appropriate can be broken down into component parts.

EXAMPLES

A. PHYSICAL THERAPY:

1. **Long Term Goal:** **Independent bed mobility**
   Short Term Goals:
   - Scoot side to side and up and down
   - Bridging
   - Rolling with and without bed rail in both directions
   - Move legs over the edge of the bed
   - Assume sitting (supine to sit, and sit to supine)
   - Sitting balance
   - Need for verbal or tactile cues

2. **Long Term Goal:** **Independent transfers**
   Short Term Goals:
   - Bed mobility
   - Sitting/standing balance
   - Scoot hips forward
   - Upper extremity strength (specifically triceps)
   - Ability to push off w/c
   - Come to stand
   - Ability to pivot
   - Ability to reach for w/c
   - Standing to sitting and sitting to standing
   - Transferring bed to chair to toilet to wheelchair

3. **Long Term Goal:** **Independent gait**
   Short Term Goals:
   - Bed mobility, transfers
   - Lower extremity strength/ROM (especially knee & ankle)
   - Ability to swing leg and advance lower extremity
   - Heel strike, push off
   - Weight bearing/weight shifting
   - Step length, stride length, cadence
   - Base of support
   - Midline control, balance
   - Advancing assistive device
   - Pivoting
   - Ability to back up
   - Ability to avoid barriers
   - Ability on stairs, ramps, uneven surfaces, different floor textures, walking outdoors/curbs
   - Verbal/tactile cues needed

GOAL WRITING (cont'd)

4. **Long Term Goal:** **Normal balance**
   Short Term Goals: Ability to bend over and pick up objects
   Ability to reach overhead
   Dynamic activities
   Ability to turn around/turn corners
   Sidestep/backup
   Tolerating challenges i.e. being pushed, carrying objects from place to place, catching/throwing, stepping over obstacles etc.

B. OCCUPATIONAL THERAPY:

1. **Long Term Goal:** **Independent dining**
   Short Term Goals: UE strength/ROM (specifics such as supination of the forearm)
   Eye/hand to mouth coordination
   Fine motor coordination
   Ability to grasp and control utensils
   Opening packages/pouring/unwrapping/cutting
   Ability to assume correct positioning
   Ability to swallow
   Verbal tactile cues needed

2. **Long Term Goal:** **Independent UE/LE dressing**
   Short Term Goals: Bed mobility/bridging
   Ambulation to retrieve clothing
   Sitting/standing balance
   Specific ROM/strength
   Fine motor coordination
   Putting on shoes, pants, putting arms through sleeves, etc.
   Management of zippers, buttons, velcro closures, laces, etc.
   Use of adaptive equipment
   Ability to follow safety precautions
   Verbal/tactile cues needed

3. **Long Term Goal:** **Independent grooming/hygiene**
   Short Term Goals: Specific UE strength/ROM
   Fine motor/eye/hand coordination
   Sit/stand balance
   Transfers
   Hair/tooth brushing
   Washing face/hands

Daily Documentation of Skilled PT Intervention

Task sequencing during bed mobility while using left knee immobilizer

Gluteal strengthening for improved sit ⇨ stand

Knee ext exercises to facilitate upright position in pivot transfers

Dynamic balance and weight-shifting during gait with hemiwalker

Postural control focusing on proper head & RUE position for sliding board transfers

Advancing RLE & stabilizing LLE while using L knee immobilizer for stability

Gross motor tasks while maintaining dynamic sit balance

Sit ⇨ stand with focus on weight shift forward and pushing from wheelchair

Gluteal squeeze and knee ext exercises to maintain stable upright stand position

Patient measured for custom AFO to facilitate assist with L ankle dorsiflexion & knee stability in gait

Bilateral quad strengthening for upright posture

Gluteal strengthening to improve hip ext in gait

Vestibular cues & cues for bilateral knee extension to promote upright posture in gait

LE strengthening with emphasis on quads, hip extension, trunk rotation during transfers & bed mobility

Compensatory techniques for sit ⇨ stand & bed ⇨ wheelchair transfers

Instructions on sit ⇨ stand techniques, walker placement, and gait pattern sequence during gait training

Stretching of bilateral heelcords to ⇧ ROM and improve balance, posture & gait pattern

Balance activities to increase reflex with ability to recover balance quickly when lost posteriorly

Ice massage & quick stretches of LLE to increase contraction

GOAL WRITING (cont'd)

4. **Long Term Goal:** **Independent W/C mobility**
Short Term Goals:
UE strengthening
Efficiency of self propulsion, i.e. distance and time
Managing footrests and legrests
Unlocking/locking brakes
Sitting balance - dynamic/static/supported/unsupported
Maneuvering around obstacles/turning corners
Verbal/tactile cues needed

C. SPEECH PATHOLOGY:

1. **Long Term Goal:** **Safe swallow**
Short Term Goals:
Achieve proper position
Swallow with tactile cuing
Bite size
Swallow/delay time
Pocketing/coughing
Independence with various food/liquid textures and diet consistencies
Verbal/tactile cuing needed

2. **Long Term Goal:** **Ability to communicate needs**
Short Term Goals:
Verbalization
Naming objects
Word recall
Intelligible articulation
Voice volume
Formation of phrases and sentences
Accuracy of yes/no responses
Verbal/tactile cues needed

3. **Long Term Goal:** **Patient will be able to comprehend instructions**
Short Term Goals:
Localize and respond to voice
Follow one-step instructions
Progress to two-step and complex instructions
Ability to make eye contact
Speech reading ability
Verbal/tactile cues needed

Vibration techniques for Ant Tibiales, quads & hamstring incorporated into JROM

Sequence retraining with sup ⇔ sit & sit ⇔ stand with verbal cues for LLE placement

Closed chained strengthening activities to increase wt. bearing

Open chained strengthening activities to increase muscle control and coordination

Tactile/verbal cueing to facilitate increased . . . stride, length, heel strike, stance phase, swing through, base of support

Tactile/verbal cueing to decrease hip hiking, toe drag, steppage gait, scissoring

Tactile/verbal cueing in order to normalize step through gait pattern

Verbal/tactile cueing to facilitate a reciprocal stair gait pattern

Lower trunk rotation activities to facilitate segmental trunk movement

LE/UE PNF patterning techniques to facilitate independent rolling

Instruction/demonstration on use of siderails / trapeze to facilitate bed mobility skills

Bridging/hip extensor strengthening exercises to facilitate scooting

Instruction/demonstration of stand-pivot or swing pivot bed to w/c techniques

Tactile cueing to facilitate proper weight bearing during transfer activities

Tactile cueing to facilitate recovery from balance loss during gait & transfers

Reaching activities to increase dynamic balance outside base of support

Resistive trunk strengthening exercises to improve trunk control/balance during sitting/standing activities

Tapping/vibration techniques to facilitate motor return of _____

FES to facilitate motor return of _____

PNF patterning techniques to facilitate motor return/pattern of _____

NDT postural retraining to normalize movement patterns of _____

Therapeutic Exercise

1) Toss the bean bag

2) Marching music; hokey pokey to music (good for balance, too)

3) Traditional weight training

4) Ball toss into a basket

5) Balloon toss or game of catch

6) Velcro mitt and ball

7) Parachute with wrist weights

ADLs

1) Relay race for dressing

2) Hanging clothes on a clothesline

3) Home management tasks like watering plants, cleaning a table, doing dishes, making beds in a room, cooking

4) Obtaining clothes from a closet, or cabinet

5) Ironing or folding laundry

6) Money management: writing checks, balancing checkbook (both fine motor and cognitive-perceptual)

Activities for Group Therapy

Balance Group

1) Use the basketball hoop and the beanbag toss as 'fun' activities to work on reaching out of base of support and challenging both supported and unsupported balance.

2) High level patients use a BAPS board or balance board

3) Any exercise in standing which challenges the calf musculature

4) Place cones on the floor and sit patients on a mat and have them reach in unsupported sitting out of their base of support

5) Standing balance-stand on toes for a count of three

6) Standing balance-practice standing on one leg for a count of 10. Try not to hold on.

7) Zoom ball-2 residents standing or sitting for balance, strength, coordination, breathing endurance

8) Simple balloon, ball, or beach ball toss/bounce. Have resident say name or the name of the person they are throwing to. Can be done sitting or standing and can have then do it with one hand. Can kick, too.

9) "Ballet" in the parallel bars with the therapist in the middle

10) Bowling with a medium sized ball and cones

11) Basket ball in a laundry basket

12) Batting a balloon for standing dynamic balance

13) Try dancing. Therapists report teaching and being taught the box step, electric slide and the polka. This facility also has residents share their ballet expertise in teaching how to work on single leg stance. Tai Chi concepts can be integrated into these sessions

14) Borrow rec equipment like ring toss, bowling, basketball, or golf. (this facility's children join in the evening or weekends and assist with the games-residents love it)

15) Kite flying session

Activities for Group Therapy

Balance Group

1) Use the basketball hoop and the beanbag toss as 'fun' activities to work on reaching out of base of support and challenging both supported and unsupported balance.

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3) Any exercise in standing which challenges the calf musculature

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15) Kite flying session

UPPER EXTREMITY FUNCTION GROUP

Performance Components and Skills that can be addressed during UE Function group include:

Neuromusculoskeletal:

_____ Strength
_____ Range of Motion
_____ Muscle Tone
_____ Soft Tissue Integrity
_____ Endurance
_____ Posture Control

Motor:

_____ Gross Motor Coordination
_____ Crossing the Midline
_____ Bilateral Integration
_____ Fine Motor Coordination
_____ Laterality
_____ Motor Control
_____ Praxis
_____ Visual-Motor Integration

Perceptual Processing

_____ Stereognosis
_____ Pain Response
_____ Right / Left Discrimination
_____ Position in Space
_____ Depth Perception
_____ Kinesthesia
_____ Body Scheme
_____ Form Consistency
_____ Figure Ground
_____ Spatial Relations

SENSORIMOTOR FUNCTION GROUP

Performance Components and Skills that can be addressed during Sensorimotor Function group include:

_____ Sensory Awareness
_____ Sensation
_____ Vestibular Status
_____ Perceptual Processing
_____ Form Consistency
_____ Visual Closure
_____ Depth Perception
_____ Sensory Processing
_____ Topographical Orientation
_____ Visual Acuity
_____ Right / Left Discrimination
_____ Position in Space
_____ Figure Ground
_____ Spatial Relations

LOWER EXTREMITY FUNCTION GROUP

Performance Components and Skills that can be addressed during LE Function group include:

Neuromusculoskeletal:

_____ Strength
_____ Range of Motion
_____ Muscle Tone
_____ Soft Tissue Integrity
_____ Endurance
_____ Posture Control

Motor:

_____ Gross Motor Coordination
_____ Crossing the Midline
_____ Bilateral Integration
_____ Fine Motor Coordination
_____ Laterality
_____ Motor Control
_____ Praxis
_____ Visual-Motor Integration

Perceptual Processing

_____ Spatial Relations
_____ Pain Response
_____ Right/Left Discrimination
_____ Position in Space
_____ Depth Perception
_____ Kinesthesia
_____ Body Scheme
_____ Form Consistency
_____ Figure Ground

SENSORY / COGNITIVE / LANGUAGE PROCESSING GROUP

Performance Components and Skills that can be addressed during Sensory / Cognitive / Language Processing group include:

_____ Level of Arousal
_____ Recognition
_____ Attention Span
_____ Initiation of Tasks
_____ Categorization
_____ Spatial Operations
_____ Problem Solving
_____ Judgment
_____ Memory
_____ Pragmatics
_____ Generalization
_____ Orientation
_____ Spatial
_____ Temporal
_____ Termination of Activity
_____ Concept Formation
_____ Sequencing
_____ Deductive Reasoning
_____ Inductive Reasoning
_____ Situational Awareness
_____ Learning
_____ Self Awareness

Activities — Group Name	Functions That Can Be Addressed in the Activity
Activity: Home Maintenance **Groups:** UE Function, Sensorimotor Function, LE Function, Sensory/Cognitive/Language Processing, Gait Training, Auditory Comprehension, Home Management, W/C Mobility, Expressive Language Ask patient to demonstrate or simulate cleaning spills, changing light bulbs, dusting, cleaning refrigerator, changing frayed appliance cords, etc. Ask to describe what they are doing or the sequence in which it must be done.	Safety, problem solving, auditory comprehension, balance, gait, coordination, sequencing, verbal production/expression
Activity: Men's Grooming **Groups:** UE Function, Sensorimotor Function, Sensory/Cognitive/Language Processing, Self Care ADLs, Auditory Comprehension, Expressive Language Have patients perform grooming activities that can be done around a table, without a sink: shaving, combing hair, clipping nails, etc.	Sensory processing, body scheme, stereognosis, right-left discrimination, position in space, figure ground, depth perception, spatial relations, reflexes, ROM, strength, endurance, postural control, balance, gross and fine motor coordination, laterality, bilateral coordination, dexterity, visual-motor coordination, recognition, attention span, initiation and termination of activity, memory, sequencing, problem solving, new learning, generalization, interpersonal skills, time management, safety.
Activity: Women's Grooming **Groups:** U E Function, Sensorimotor Function, Sensory/Cognitive/Language Processing, Self Care ADLs, Auditory Comprehension, Expressive Language Have patients perform grooming activities that can be done around a table, without a sink: combing hair, applying make-up, doing nails, etc.	Sensory processing, body scheme, stereognosis, right-left discrimination, position in space, figure ground, depth perception, spatial relations, reflexes, ROM, strength, endurance, postural control, balance, gross and fine motor coordination, laterality, bilateral coordination, dexterity, visual-motor coordination, recognition, attention span, initiation and termination of activity, memory, sequencing, problem solving, new learning, generalization, interpersonal skills, time management, safety.
Activity: Cooking **Groups:** UE Function, Sensorimotor Function, Sensory/Cognitive/Language Processing, Home Management, Gait Training, Auditory Comprehension, W/C Mobility, Expressive Language Can be done with or without a kitchen. May have a holiday theme; may incorporate into a Bake Sale for Activities. Adjust level of complexity for each participant's ability and goals. Include planning, shopping/gathering of supplies, and clean up for more complexity. Cooking and smells invoke memories for many; incorporate conversation about patient's past participation in cooking activities.	Sensory processing, stereognosis, right-left discrimination, position in space, figure ground, depth perception, spatial relations, reflexes, ROM, strength, endurance, postural control, balance, gross and fine motor coordination, laterality, bilateral coordination, dexterity, visual-motor coordination, recognition, memory, attention span, initiation and termination of activity, sequencing, problem solving, new learning, generalization, interpersonal skills, time management, safety.

Activities — Group Name	Functions That Can Be Addressed in the Activity
Activity: Gardening Groups: UE Function, Sensorimotor Function, LE Function, Sensory/Cognitive/Language Processing, Gait Training, Auditory Comprehension, W/C Mobility, Expressive Language Can be performed indoors or outdoors, based on the weather and climate. Use raised planters; individualize activities according to patients' abilities and goals. Can include preparation of the beds, planning, selection of plants/seeds, planting, weeding, watering, and harvesting. Cooking and activities with blooming flowers can be incorporated into other groups.	Sensory processing, stereognosis, right-left discrimination, position in space, figure ground, depth perception, spatial relations, reflexes, ROM, strength, endurance, postural control, balance, gross and fine motor coordination, laterality, bilateral coordination, dexterity, visual-motor coordination, recognition, memory, attention span, initiation and termination of activity, sequencing, problem solving, new learning, generalization, interpersonal skills, time management, safety.

d. **Positive Terminology**: Buzz words such as increased, improved, "doing well" etc., gives a sense of progress.

e. **Specifics**: Describe everything significant that occurred that week.

f. **Focus and Organization**: Make sure the information follows coherently from week to week, for e.g. if you discuss splinting issues one week, you should discuss it the following week too. Don't leave issues hanging.

(see "points to ponder" for more recommendations)

Weekly Narrative

Weekly narratives should not be taken for granted. Very often extensive effort is placed on the evaluation/re-evaluation, but in actuality the weekly notes may support a questionable claim because of progress and/or skilled interventions recorded there. Medicare reviewers place great importance on weekly notes.

The weekly narrative is a summary of all activities that occurred that week. It should include:

- Progress/setbacks and response to treatment (if progress is not as rapid as expected, include a reason).
- All interventions (provision of splint/cushion etc.) and reasons for the interventions.
- New incidents such as falls or spells of illness.
- Meetings with vendor/family/IDCP team.
- Pertinent information documented in the nursing notes, for e.g. new falls, complaints of pain etc.
- Nursing/patient recommendations. Medicare reviewers often look for on-going upgrades in nursing/patient/family recommendations throughout the course of treatment. Nursing/patient recommendations should be descriptive, specific and skilled in nature and should begin on day one.
- Indication of any goals that were met and any establishment of new goals. Any changes in plan, goals, or frequency should be documented, along with an explanation for the change.

All documentation should include:

a. **Objective Measurable Progress**: Progress made should be written in measurable terms i.e., Fair, min A etc.

b. **Comparative Progress**: Comparing the resident's present status to last week's status helps justify your claim and also helps focus you on areas of improvement and remaining goals. The resident's status should be written in a clear comparative fashion, for e.g. "patient increased ambulation to 50' with min A from 10' with max A".

c. **Skilled Terminology**: In order to justify that your skill as a therapist was needed, skilled terminology is essential. Description of gait pattern, grasp pattern, specific musculature etc. helps support your claim.

Points to Ponder cont'd

17. If a resident expires or is discharged because he refuses, then you still have to document the status of the resident at the time of discharge. Medicare wants to know what you were doing with the resident up until that point.

18. **Occupational Therapy:**
Generally speaking, Occupational Therapy is not required to restore function where a patient suffers a temporary loss of function that could reasonably be expected to spontaneously improve as the patient resumes normal activities, (for e.g. temporary weakness following prolonged bed rest after a hospitalization for pneumonia, dehydration, etc.). In this case, it would be wise to postpone occupational therapy for one week to give a chance for spontaneous recovery. If, after a week, the resident does not regain his function, the OT may evaluate the resident, but should document "resident admitted to facility with functional decline following hospitalization for pneumonia. Resident has been given a week for spontaneous recovery, but has not resumed his prior functional level on his own and still exhibits weakness and functional decline; therefore, OT evaluation indicated". Bear in mind, however, that goals for contractures and/or positioning may require immediate intervention.

19. **Speech Therapy:** Infrequent re-evaluations will be covered when deemed necessary if they require the skills of an SLP and are a distinct service which can only be done by an SLP, for e.g. re-evaluating the appropriateness of peg tubes or thickened liquid. Documentation must be present in the nursing notes to support the evaluation prior to the referral to speech. Evaluations in the absence of signs or symptoms are not covered.

20. **Cognitive therapy/retraining:** Cognitive therapy is not covered alone, but is covered when incorporated into the plan of care and provided along with other covered OT services. Treatment must be focused on restoration of function (i.e. to know where to locate clothes in order to get dressed). Documentation must support the patient's ability to participate and benefit as well as retain the newly learned information. Services to improve memory are not covered. When a patient has chronic conditions (dementia, Alzheimer's etc.), services to establish compensatory methods that affect safety or function will be covered for a limited amount of visits. The nurse's notes must support the need for those services and potential to retain the learned information. If nursing notes document inability to participate, benefit, or retain information, services will be denied. Services to set up a maintenance program is covered.

c. Expectation statements - A "positive expectation" statement is a strategy that can improve documentation. A positive expectation statement is an assessment of the clinician's professional judgement of functional progress, for e.g. "The patient is now able to _____ and now has the functional potential to _____" . Another approach is to emphasize the skilled need in your assessment, such as, "The patient requires the skills of a therapist to facilitate muscle return and gait quality to enable safe ambulation and allow patient to return home". Both of these examples identify the clear expectation of progress to a functional goal. This can be written in your progress notes, or in the recommendation/impression column on the evaluation.

13. **Evaluation only:** If you evaluate a resident and have a justifiable reason why you decided to evaluate him, then this is reimbursed even if you decide not to order further treatment. It is necessary, however, to make some type of recommendation, and be clear why you chose to evaluate the resident rather than just screen him.

14. **Maintenance Programs:** Therapy is allowed for up to two to three visits to establish or revise a maintenance/ROM/ambulation program. This is in order to evaluate, set up a program, in-service the staff, and follow up appropriateness and effectiveness of program. Documentation must support the re-evaluation to be reasonable and necessary.

    Please note: if a patient is under a restorative therapy program for a while, the therapist should be constantly re-evaluating the resident and should have initiated designing the D/C maintenance program while the resident was still on therapy. Therefore, when a maintenance program is not established until after the restorative treatment is completed, services will be questioned.

15. **Be careful not to duplicate services between therapies.** If the resident is on more than one therapy, goals, treatment plans and modalities should be different. Be aware, however, that the objective measurements between disciplines should correlate; i.e. if PT documents that sitting balance is F +, OT should document the same thing.

16. **Recent Onset/New Diagnosis** - If you recognize a functional decline and determine a resident is appropriate for therapy, it's always preferable to have a recent onset: i.e. a fall, an illness, a hospitalization, an exacerbation of an old condition, a new medication, etc. You should always first look in the hard chart to see if you can find an onset for the present decline. If you feel the resident is exhibiting symptoms of a certain diagnosis that is not documented in the hard chart, or you notice an exacerbation of an old condition, then you may consider asking the doctor to examine the resident and document an appropriate diagnosis or symptom; i.e. if you think a resident has symptoms of OA, or exhibits rigidity due to Parkinson's, tell the doctor. If he agrees with you and then document these findings in the chart, use this as your onset. (Note: Medicare has a record of the resident's previous therapy history, therefore, an onset is important in order to justify why you are seeing the resident now.)

Points to Ponder cont'd

7. **Each HCPCS code must be supported**. Therapy documentation must support the need for each modality/HCPCS code chosen. Medicare may partially reverse a claim by paying for certain modalities, but denying others that are not supported by the documentation.

8. **Never leave a problem hanging.** If you document a problem, give a solution. If you state that the resident is being discontinued because of his recent refusals or lack of motivation, document that you notified nursing, recommended a psychology consultation and will consider rescreening if there is any change in motivation. If you state a resident has pain, document that you notified nursing and will treat the resident after pain medications, or that you're addressing the pain in another way.

9. **Decreased cognition, confused OBS, Alzheimer's** - Medicare views these residents as not having learning ability and therefore not having carry over. Don't harp on this. Document "can follow simple commands with tactile or verbal cues" etc.

10. **Skilled Terminology** - Therapy must be skilled in order to be reimbursed. When writing the progress report, use skilled/technical/functional terms. Describe the type of grasp, gait pattern, specific muscle strength, etc. Be specific with the skilled intervention performed, for e.g. joint mobilization, PNF, NDT etc. Medicare wants to know why your skill as a therapist was needed and that this couldn't have been done by a CNA.

11. **Repetitive tasks:** Maintenance or repetitive exercises are not covered. Medicare wants to see improvement, restoration and skilled services. Increased ambulation distance alone is not enough as a goal. The amount of assistance, assistive device and/or gait pattern must improve. Repeated range of motion to a limb, or monitoring a splint is not a skilled service, unless you can document that there has been an increase in the degree of range of motion.

12. **Reasonable and necessary:**

a. Medicare does not reimburse therapy as a luxury, i.e. if strength is good, you cannot put the resident on only for a goal of making it normal. If ROM is limited but it's functional, therapy will not be reimbursed. If the resident ambulates with CG, therapy is not justified to get him to be independent, (unless he is being discharged home). If, however, the above factors are causing safety issues; i.e. risk of fall, or decreased ROM which can result in skin breakdown or decreased hygiene, then therapy may be initiated. However, it is important to justify the therapy by documenting the sequellae that you are trying to prevent.

b. If a valid and reasonable expectation exists at the time of the evaluation, then therapy is still reimbursed even if the resident does not meet his goals or make significant progress. It is important, however, to discharge services when no further progress is expected. If very little progress was made, then document that "at the time of the evaluation, the resident was an appropriate candidate for therapy".

Points to Ponder When Documenting

1. **Don't ramble** - be focused and specific, not vague. It's not necessary to document every area if there has been no change of status in that area. Only document things that are important; things you want to focus on.

2. **Document everything you do. Remember:** You are trying to justify your number of visits. Even if you have made unsuccessful attempts at something like splinting or positioning, it is still important to document everything. If you have educated the resident on compensatory/safety techniques, elaborate on them.

3. **Always be positive.** It's always preferable to start with the progress. Even if a resident has not made progress, has had a temporary setback, or has declined, you can still be positive; i.e. explain why he was an appropriate candidate at the SOC, explain why he did not make the progress you originally expected (recent decline in motivation, recent illness, etc.) and explain why you are still continuing (resident feels better and is now expected to improve) or discontinuing treatment at this time.

4. **Be functional.** Decreased pain, increased ROM and increased strength are not justification for visits if they don't affect function. Always document how these changes affected function i.e. UE strength increased from 3 + to 4/5, therefore transfers sit to stand have improved to CG. ROM bilateral knees increased to -10°, therefore stance is more erect and resident can tolerate standing longer during ADL's. Pain decreased to 2/10, therefore, resident able to ambulate with less assistance.

5. **Therapy duration must be reasonable;** i.e. not too long and not too short.

   If it's too long, Medicare will question the need for all of the visits. They would want to know why each visit was necessary to bring the resident towards his goal. Services are only covered up until the point the resident has reached his max potential. Often Medicare will pay for part of the treatment, but will deny the last several sessions if they consider them unnecessary. Once improvement is insignificant, therapy should be disccontinued.

   If therapy is too short, and the resident met all of his goals too quickly, Medicare will question if therapy was justified altogether and if the resident could have recovered on his own.

6. **Treatment duration must be reasonable**. The duration of a treatment session (i.e. 30 min., 60 min. etc.) and/or RUG category must be supported by the **diagnosis, level of alertness/cognition** and **patient potential**. A longer treatment session would warrant a longer progress note to describe what was performed and to justify treatment services. In addition, make sure more HCPCS codes are checked on the progress note.

   A normal treatment session is 30 to 60 minutes. If a session exceeds 60 minutes, then the documentation needs to reflect specific reasons why an extended length of time was required (in cases of positioning, longer treatment sessions are often common).

   With regards to Medicare A, be aware that the progression of rehab RUG categories must be gradual and reasonable.

Daily Documentation Cue Sheet

Required Components

Skilled Intervention

* supports therapy as medically necessary

* unique to PT, OT, SLP

* modalities / intervention plus detail

Transitional Phrase / Word & Verb

* links skilled therapy provided that day to a STG/LTG, justifying keeping patient on caseoad

Transitional Word + **Verb**

during
to
for
while
with
in order to

able
address
advance
allow
apply
attempt
attend
avoid
correct
decrease
demonstrate
educate
emphasize
enable
ensure
facilitate
incorporate
increase
initiate
involve
maximize
observe
promote
reduce
re-train
train

Function

* justifies unique therapy intervention

* reference each patient's unique goals, as documented on the 700/701

Optional

Patient's Response to Skilled Intervention

* if different than usual (e.g., much better, much worse, new)

* if detail adds justification for skilled therapy

Verb

able
attain
follow
improve
learn
maintain
perform
re-learn
return demonstration

Patient's Required Level of Assistance

DOCUMENTATION GUIDELINES

WORDS TO AVOID	*WORDS TO USE*
insignificant	significant
decreased cognition, confused, demented, senile, OBS, Alzheimer's, cannot follow directions	- able to follow simple one-step commands - follows commands with tactile cueing
frustrated, uncooperative, hostile, combative, unmotivated, refusing	requires encouragement
poor/fair potential	good, very good potential
chronic	acute exacerbation
maintain	restore
discussed, monitored, practiced	instructed, educated
general weakness	be specific: - specific musculature/extremity - SOB upon exertion - # reps - ambulates "x" feet and then tires - Hemiparesis (specify extremity)
'urance	- functional activity tolerance - work simplification techniques - energy conservation - be specific: - tolerance for standing during ADL's - distance for walking

BUZZ WORDS *(Words to incorporate whenever possible)*	
significant/favorable	ability/capable
progress/gains/improvement	interaction
good/excellent/extremely/well	mobility
steady	independence
appropriate	recommended
attentive/cooperative/responsive	in-serviced (family, nursing, patient)
concentration	nursing carryover
increased	patient educated
'abilitative/restorative	functional/safe
usiastic/motivated	patient scheduled to go home if progress is made in therapy

MEDICAL NECESSITY SAMPLE STATEMENTS

SPEECH THERAPY

Patient would benefit from skilled Speech therapy intervention to treat:

- Dysphagia related to CVA.
- Cough during meals.
- Feeding difficulties and mismanagement related to stricture of esophagus.
- Feeding difficulties and mismanagement related to esophageal reflux.
- Dysphagia related to aspiration pneumonia.
- Dysphagia as determined from MBS.
- Aphasia related to CVA.
- Agnosia (timing and sequencing) placing patient at high safety risk.
- Aphonia related to chronic laryngitis.
- Dysarthria related to closed head injury and effect to hypoglossal nerve.

OCCUPATIONAL THERAPY

Patient would benefit from skilled Occupational therapy intervention to treat:

- Pain in wrist related to fracture complicated by DJD.
- Joint (hip) stiffness related to hip fracture and osteoarthritis.
- Feeding difficulties and mismanagement related to abnormal posture.
- Hemiparesis related to CVA.
- Spastic hemiplegia related to closed head injury.
- Lack of coordination related to gangrenous foot ulcer and subsequent BKA.
- Abnormal involuntary movement (tremors) related to Parkinson's disease.
- Contracture of _____.
- Muscle wasting and disuse atrophy related to extended hospitalization (3+ weeks) to treat complicated pneumonia.
- Swelling of limb (arm, leg) related to osteoarthritis and recent frequent falls.
- Lack of coordination related to new treatment of continuous oxygen use due to severe exacerbation of COPD.

PHYSICAL THERAPY

Patient would benefit from skilled Physical therapy intervention to treat:

- Muscle wasting and disuse atrophy related to extended hospital stay (3+ weeks) to treat complicated surgery for small bowel obstruction.
- Difficulty walking (hip, knee, ankle – muscle group were specifically identified on 700) related to extended hospital stay (3+ weeks) to treat complicated surgery for small bowel obstruction.
- Lack of coordination related to closed head injury.
- Difficulty walking related to hip contusion sustained in fall.
- Gait abnormality related to knee pain from recent episodes of frequent falls.
- Lack of coordination related to new treatment of continuous oxygen use due to sever exacerbation of COPD.
- Hemiplegia related to CVA.
- Abnormal posture related to closed head injury.
- Joint (knee, hip, …) stiffness related to degenerative joint disease.
- Gait abnormality related to degenerative disc disorder.

Statement of Medical Necessity should:

- help justify that therapy is reasonable and medically necessary
- help justify that skilled therapy is needed
- help justify picking the pt. up at this time
- relate the need for skilled intervention to an acute onset / hospitalization / specific medical condition (Part A), or a positive / negative change in pt's condition that warrants skilled therapy now (Part B)
- indicate key deficits underlying the functional problems (e.g. joint instability, poor balance, gait deviation, significant muscle atrophy, multiple perceptual processing deficits)

Sample Format

Patient would benefit from skilled (PT, OT, SLP) **intervention to address** (treatment diagnosis) **related to** (medical diagnosis) [and any other qualifying statement].

Examples:

1. **Patient would benefit from skilled** OT **intervention to address** abnormal posture and feeding difficulties and mismanagement **related to** Parkinson's Disease and decreased dietary intake.

2. **Patient would benefit from skilled** PT **intervention to address** muscle disuse and atrophy **related to** deep vein thrombosis with extensive hospital stay (3 weeks) from a pulmonary embolism while treated for the DVT.

3. **Patient would benefit from skilled** SLP **intervention to treat** dysphagia **related to** MBS identifying silent aspiration.

Daily Documentation of Skilled SLP Intervention

Therapeutic feeding of thin liquids conducted, while utilizing safety precautions and compensatory strategies.

Skilled instruction provided for proper head position and to increase safety during swallow.

Skilled cueing to promote head turn with chin tuck.

Cueing system devised for increased recall and word discrimination.

Caregiver training utilizing augmentative communication device to facilitate expression of needs.

Dysarthria addressed through serial verbal output exercises to increase expressive intelligibility.

Oral-sensory techniques utilized to facilitate lip closure and swallowing reflex.

Bolus manipulation exercises to facilitate safe swallowing strategies.

Dietary consultation for diet modification to account for texture and taste sensory deficits.

Caregiver training provided on compensatory swallowing techniques, alternating liquids and solids. Return demonstration observed.

Word finding strategies taught to increase patient ability to communicate needs.

Verbal cues provided to decrease rate of speech and improve intelligibility.

Oral motor exercises provided in order to improve speech intelligibility, with demonstration requiring verbal cues.

Skilled training in respiratory techniques to improve voice quality, intelligibility, and rhythm.

Compensatory strategy of voice intonation provided to improve conversational techniques.

Skilled training in respiratory techniques to decrease glottal air loss increasing number of syllables produced per breath.

Word-finding and phrase comprehension exercises provided to decrease the use of nonspecific words and word substitution.

Caregiver education provided in the use of visual aids to improve patient memory.

Melodic intonation exercises demonstrated to improve voice modulation and speech intelligibility.

righting self while reaching toward left & maintaining sitting balance

RUE positioning using weightbearing on elbow to increase muscle contractions of the deltoid, biceps, triceps, traps (upper / middle)

WC positioning to increase pelvic tilt, reduce forward lean, & improve position between bilateral supports

pt. instructed in use of energy conservation & work simplification techniques for self-care ADLs

patient instructed in pacing techniques & deep breathing with pursed lip exhale followed by UE exercises

dynamic standing activity at kitchen table to maintain upright posture & knee extension

R resting hand splint modified for increased MCP & PIP angle of flexion

leeder grip orthotic fit to patient's wrist with medium sized palm roll, followed by joint mobilization/tendon massage/deep pressure

edema reduction glove modified with caregiver & wife training on glove & splint don/doff, laundering, & recommended wearing schedule

progressive weighted strengthening exercises to promote transfer stability

end range soft tissue stretch/manipulation to facilitate full JROM

verbal/physical cueing for proper w/c preparation/placement and safety techniques

verbal/physical cueing to properly place transfer board for bed to w/c transfer

tactile/verbal cueing for appropriate use of grab bars during w/c to toilet transfers

tapping/vibration techniques to facilitate motor return of _____

PNF patterning techniques to facilitate motor return/pattern of _____

NDT postural retraining to normalize movement patterns of _____

sensory processing cues to increase proprioceptive awareness & safety

task sequencing during multi-step hygiene activities

motor planning strategies to facilitate upper and lower body dressing

Compensatory techniques to facilitate self-care ADLs on edge of bed

Daily Documentation of Skilled OT Intervention

bilateral UE integration while sitting to promote improved self-feeding

triceps strengthening to facilitate coming to stand and maintaining wgt-bearing status

postural control and body alignment techniques using transfer tub bench during bathing

perceptual strategies focusing on safety, L side awareness & position in space to decrease falls during transfers

balance tasks with mm facilitation of trunk & neck, and rotation & realignment of trunk after task

trunk control and alignment while WB to LUE with emphasis on RUE motor control

trunk mobilization & neck stability in order to promote functional sitting balance

visual-motor integration while performing wheelchair mobility

dynamic sitting balance activities while incorporating simultaneous use of BUE

trunk stabilization, control & balance activities focusing on ability to correct balance

mm reeducation for trunk to improve posture for functional needs

R-L discrimination, righting self, & task initiation to maximize dressing skills

right hand fine motor coordination for functional kitchen tasks, focusing on upright postural alignment in sitting

neuromuscular re-education and reflex integration with focus on transfer techniques

RUE weight bearing to promote normalization of tone

air splint applied to LUE with JROM and weight-bearing to decrease edema and promote joint mobility

weightbearing to LUE while performing midline cross activities

electric vibrator stimulus applied to LUE to facilitate increased muscle tone

joint mobilization applied to R glenohumeral joint while addressing soft tissue integrity