Therapy Reassessment

Final Rule 2015

Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

Final Rule 2015

The 30 day reassessment is required for all patients with episodes beginning on/after January1 2015.

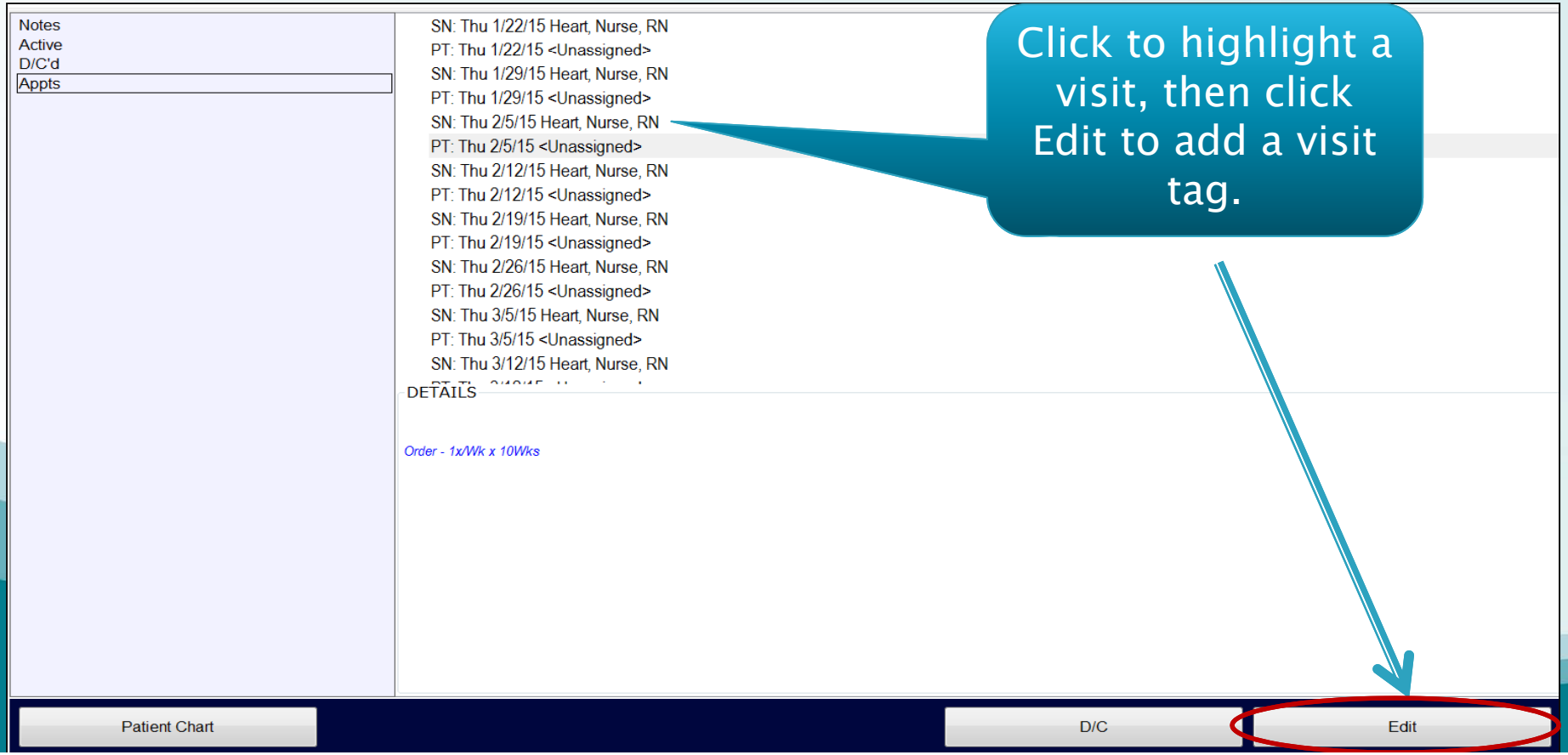
As of March 2, 2015, all reassessments will be required only every 30 days.

Scheduling Therapy Reassessment Visits using Visit Tags

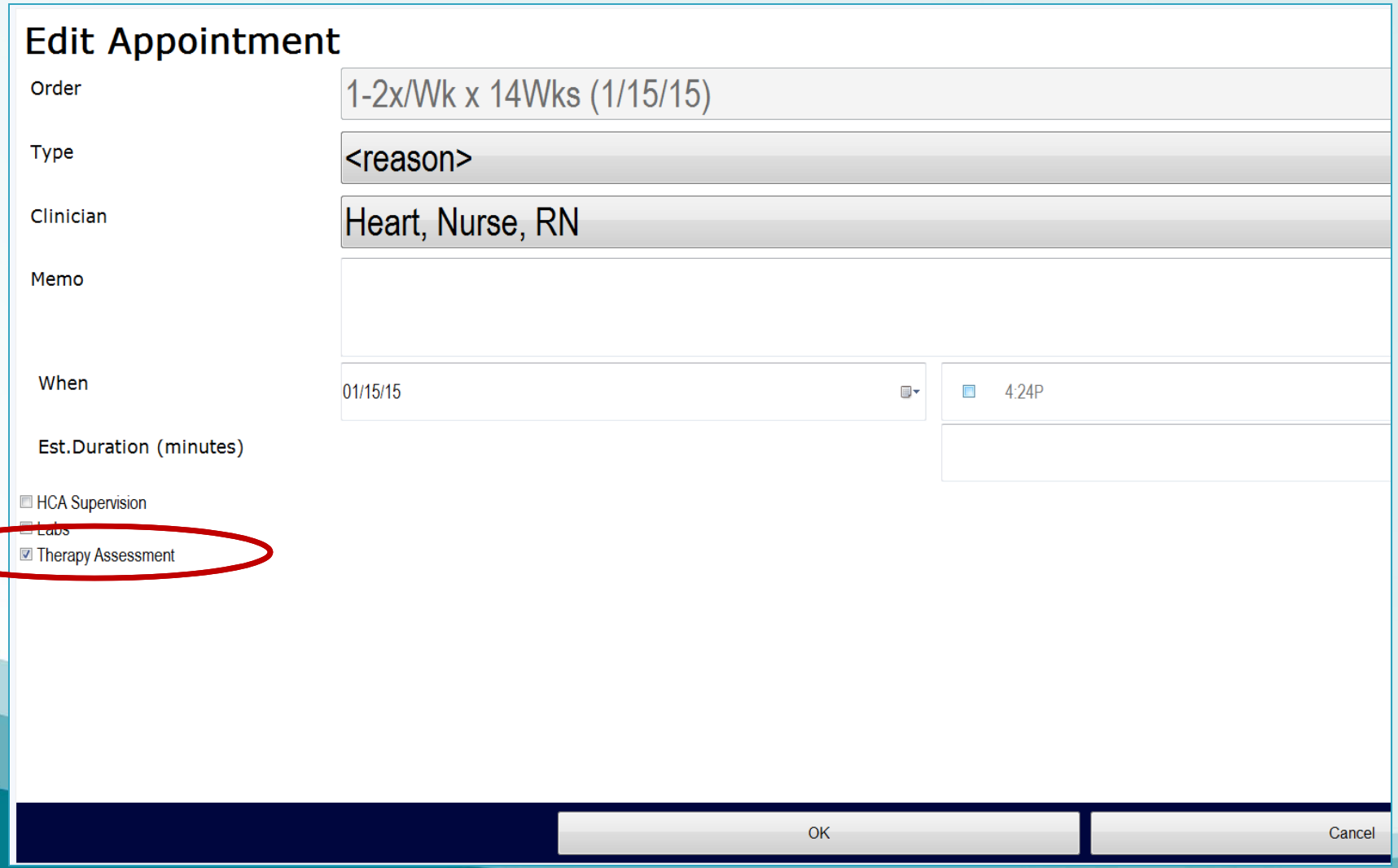
- Clinician should look ahead to tag reassessment visits when doing:
  - Eval after SOC
  - Eval after ROC
  - At recert when creating new frequency/frequencies
  - ANY time you change your frequency
- CSC will check to confirm that reassessment visit is scheduled/tagged, but scheduling/tagging is the clinician's responsibility.

Tagging a Therapy Reassessment Visit

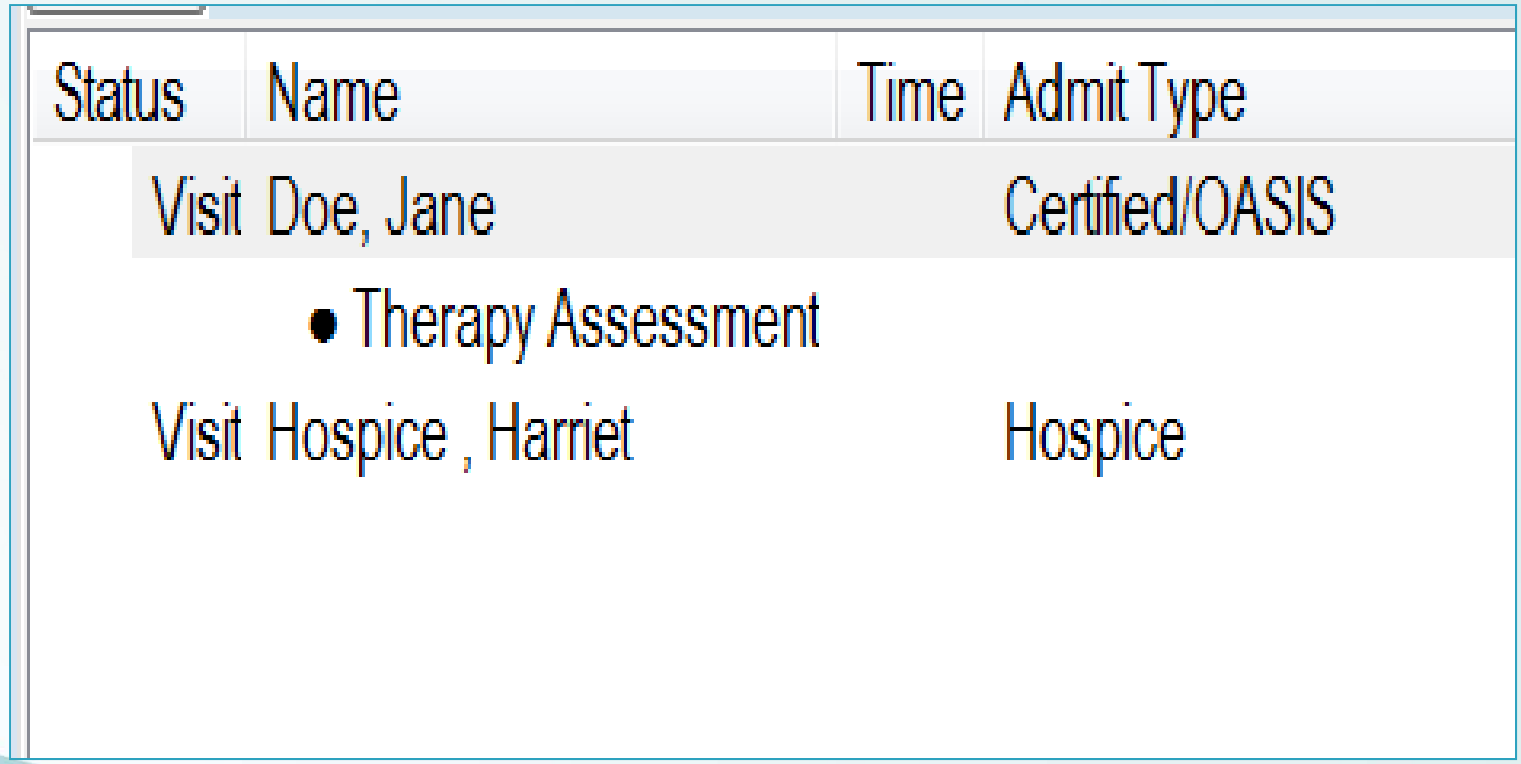
- In the Schedule screen or in the 485, Visit Frequency Orders, Appointment use the Edit Appointment button to check/add the Therapy Reassessment Visit Tag.



Tagging a Therapy Reassessment Visit



Viewing a Therapy Reassessment Visit Tag in the Schedule



Therapy Reassessment

- Perform reassessment every 30 days
- Update of goals/plan of care
- 30 Day Clock resets with each reassessment

Documentation Requirements

- The therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements.

Reassessment Requirements

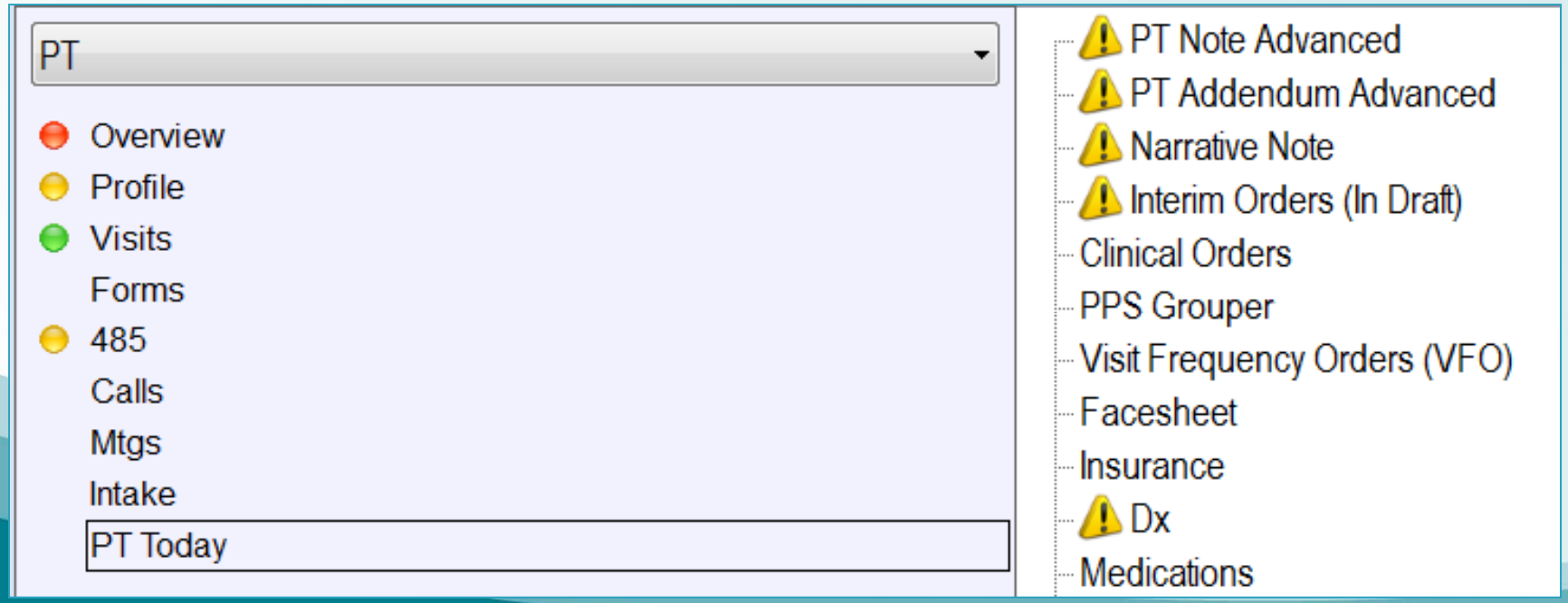
- Assess the patient's functional status and objective measures. Document results (include Tinetti, TUG, distance ambulated etc).
- Assessments selected should correlate with plan of care (485).
- Compare measurements to prior reassessments – spell it out!
- Document the effectiveness of therapy, or lack thereof.
- Update care plan, goals and interventions, as appropriate.

Review the Goals in the Plan of Care

- DC goals that have been achieved or are no longer appropriate. Add new goals as needed.
- Be sure to include measurable and functional goals.

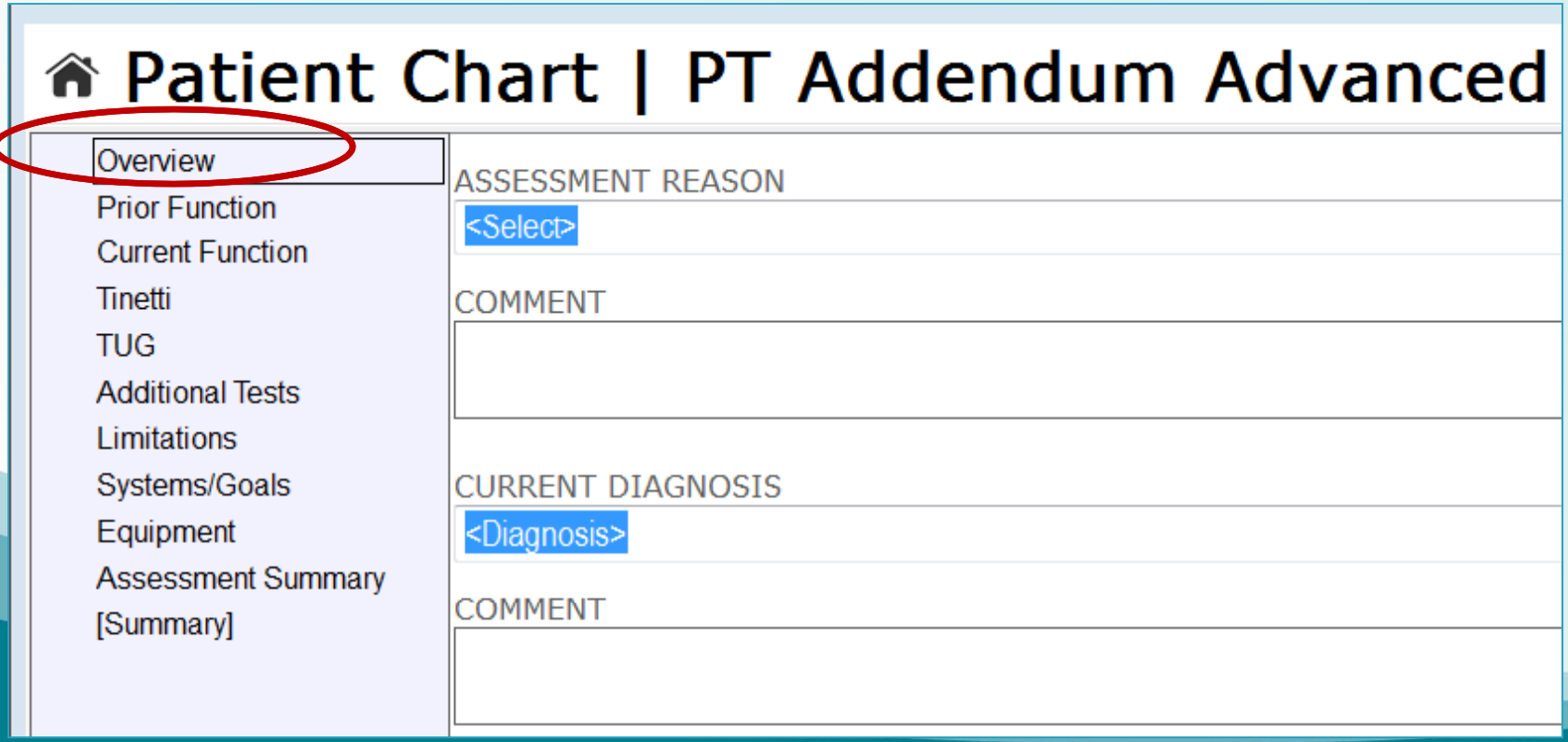
Reassessment Forms

- Use “PT/OT/ST Note Advanced” (regular note)
- Add “Addendum Advanced”
- Add “Narrative Note”
- Don’t double document in duplicate fields



Addendum Advanced

- Must document in Overview Tab indicating Assessment Reason.
- Complete remaining Tabs in Addendum as indicated.



Complete the Narrative Note using the Template for Therapy Reassessment

Remember…

- Continually reassess patient
- Include objective measures to your notes at least every 2 weeks
- Document the effectiveness of therapy and progress towards goals
- Update care plan as appropriate

Sample Reassessment Narrative (initial)

- 12/18/14 – Patient is an 80 year old female admitted s/p fall & sacral fractures 3 weeks ago. Has DM and newly diagnosed CHF. Weakness post hospital & SNF. Has pain 7/10 limiting mobility. MAHC 10 = 7. Tinetti = 14/28. Strength = 3/5 BLE. Plan HEP, gait training with walker → cane. Expected outcomes of increased mobility, strength & safety and decreased pain.

Subsequent Reassessment – (compliant/measurable)

- 1/2/15 – Patient is an 80 year old female with dx s/p fall & sacral fractures 5 weeks ago. No new medical problems. Compliant with HEP & gait training program. Tinetti = 20/28 improved from 14/28. BLE strength is improved from 3/5 to 3+/5. Pain is improved from 7/10 to 3/10. Progressed to cane during day, walker at night still. Therapy is effective. Progressing toward goals. Will progress HEP. Pt is ambulating safely.

Subsequent Reassessment – (not compliant, not measurable)

- 1/2/15 – Patient is an 80 year old female with dx s/p fall & sacral fractures 5 weeks ago. No new medical problems. Has been doing well, making steady gains. Has made progress with transfers, gait on level and stairs; she has also made progress with strength BLEs, balance and tolerance for activity. Patient will achieve independent transfers, gait on level with rolling walker, and assisted gait on stairs and uneven surfaces.