HEALTHTRUST SOFTWARE POINT OF CARE EVALUATION WALKTHROUGH

UPDATED: FEB 2019

VISIT INFORMATION

Type of Visit: Must be changed if completing a re-evaluation

Reason for Therapy Referral: (EXAMPLES)

- A re-evaluation was administered to determine the need to continued services.
- Patient was seen for a 6-month reassessment to review progress made and to modify speech goals as needed.
- Patient was referred for an initial evaluation due to concerns regarding ____________ and to determine the need for services. The results will help determine eligibility for therapy services.

Referral Source: Who referred the patient?

PATIENT INFORMATION

Start of Care Date: DO NOT CHANGE

Social Security #: If unknown check "Unknown or Not Applicable"

Family Members: Include names and click "Lives in Home" if applicable

Ability to Communicate: Patient MUST be tested in their dominant language

Background Information/Medical History: Include a paragraph that must include the following information:

- Who they live with
- Who provided the case history, prenatal history, birth history (vaginal/C-section, weight, complications, etc.)
- Developmental milestones (first word, walk, etc.)
- Medical history (surgery, hospitalizations with dates, DX, fragile patient)
- Behavior problems
- How patient interacts with his/her parents and siblings,
- Family history of problems or developmental delays
- Previous ST/OT/PT services (agency and date)
- Other services provided to patient (discipline, frequency), school's name, grade, language assessment, use of interpreter

Date Last Seen by Physician: Include approximate date. Unknown/NA is NOT acceptable

Patient/Caregiver Goals: Must include at least 1 specific activity or instruction for the caregiver

ICD-10

First code must be related with the services provided. You can make changes.

PHYSICAL ASSESSMENT (PT/OT ONLY)

Include a brief description in each area.

ASSESSMENTS

Type of Evaluation: Select one

Test (add test area): you can click on and create a table with the necessary rows to include the scores. If you do that, when you complete a re-evaluation, the system adds the previous scores in the report automatically.

- Include a standardized test. If patient is unable to complete a standardized test please include reason.
    - If a different test was utilized, provide (medical) explanation as to why
- Be sure to include: Test's name, Area, Standard Score, Raw Score, Age Equivalents, Percent of Delay/Percentile Rank
    - ******** ST STANDARD SCORES > 77 or > 6 WILL BE DENIED*****

Display Previous Test Scores on Print Out? YES

Strengths and Weaknesses: MUST BE COMPLETED

- This is the area that insurance company's look at to verify medical necessity and the reason for the patient to receive therapy.

Conclusions / Comments: Include the following information: (a) difficult areas, (b) recommendation of services, and (c) medical necessity/reason for therapy.

- **Click on the TEMPLATE button to default in the following and complete the blanks**
    - Based on the information gathered from standardized testing, parent report, and informal evaluation information, patients _______ skills were below the average range for a child of his/her age. Patient exhibited difficulty in the following areas: _____. It is recommended that the patient continues to receive _ST/OT/PT__ therapy services to ___________. If patient does not receive these services, then he/she is at significant risk for continued delay in the development of ____________ further limiting his/her ability to _____________.

SPEECH THERAPY ASSESSMENTS ONLY

- VOICE: Select at least one box
- SENSORY: Auditory/Perception: Select all that apply
- ORAL MOTORE > PERIPHERY: Select all that apply
- FEEDING ASSESSMENT: Select at least one box and document as appropriate

OTHER ASSESSMENT

- Assistive Devices: Check all that apply
- Care of Supplies: Check both boxes

THERAPY PLAN OF CARE

Modalities: Select all areas to work during treatment

- Always select "Patient/Caregiver Education"

Frequency and Duration: DO NOT CHECK THE BOX "Check this to fill Frequency Per Month"

- For initial evaluation frequency must be listed weekly. Example: "1x/ week or 2x/week."
- For Reevaluation, write "1x/week for 6 months" or "2x/week for 6 months"

VO DATE: DO NOT COMPLETE = LEAVE BLANK

Long-term Goals: Include 1-2 measurable goals that can be completed within 1 year.

- Example: Patient will _________ over four consecutive session, with 40% accuracy within 6 months. Baseline: 10%.
- **(REQUIRED)** Include a Long-term goal for parents.
  - Example: Parent/cg will be independent with Home Program within 6 months

Short-term Goals: Include 4-5 goals (no more than 5) that are specific, measurable, and attainable within a 3-6 month period AND include a baseline

- **Do not write academic goals**
- Example for general wording: Patient will….specific goal…with % accuracy, trials, #, etc…cueing level…time frame…statement of medical necessity…in the home and community

Additional Orders to Include: Click on magnifying glass and select **"Required on all Plans of Care"** and click **"Submit**."

PLEASE SEE THE LAST PAGE OF THIS DOCUMENT FOR INSTRUCTIONS & EXAMPLES OF HOW TO WRITE FUNCTIONAL GOALS!

ADDITIONAL

Check the box **"Create Auth Request Form"**

Has the child received therapy in the last year from the public-school system? Yes or **No**

Procedure Codes:

- ST: 92507, S9128. Re-evaluations = S9152,
- PT: 97110, 97161, 97162, 97163. Re-evaluations = 97164
- OT: 97530, 97165, 97166, 97167. Re-evaluations = 97168

Check the box "**Create CCP Outpatient Therapy Form**"

- **Condition:** Chronic (if patient is expected to need therapy for greater than 6 months)
- **Prescribing Provider:** Include Physician name and last MD visit date
- **Place of services:** Home
- **ST requested for:** CCP (if applicable)
- **Total # visits or units:** Please include # and the word visit or units. (26 visits or 52 visits)
    - **26 or 52 visits**
    - **104 units or 208 units**
- **Check the box "We agree to the following statement."**

Additional Comments to Include on Evaluation:

- Include previous goals and progress
    - You can copy/paste the previous goal by clicking on "Medical Record" then selecting the last note and copy/paste the goals in the report.
    - Include baseline and progress toward unmet goals
    - If goals were met, list and indicate which ones
- Include member's attendance for certification period and explanation of missed visits.
    - The member's attendance for certification period (***List previous auth period date span***) was as follows; He/She missed 44 out of 46 authorized visits. He/She missed 2 visits due to holidays.
- Include parent participation in therapy session %.
    - The Parent /Guardian is (*is not*) in attendance during therapy.
        - *If parent not present, provide brief explanation (ie., parent works during session)*
    - "The Parent /Guardian has participated in the Home Program and continues to follow through with instructions at ____%."

DISCHARGE PLANNING

Prognosis: Check the box that applies

Discharge Plans: Check the box

Additional Rehabilitation Potential and Discharge Plans: Include the following information

- Must be specific and established according to the patient's prognosis (Long Term Goals)
- "Pt. will be discharged from therapy when she/he has met goals and no longer requires skilled intervention, when no longer making progress, per family/physician request, or with non-

compliance with attendance policy. Family/caregivers will be with provided adequate notice and will be involved with discharge planning".

Triage Risk/Level:

- **Level 1 (High Priority**): A patient who is bed-bound or paralyzed, ventilator dependent, unable to meet physiologic and safety needs, or who 3 requires daily insulin injections for diabetes but is unable to self-administer the medication.
- **Level 2 (Moderate Priority):** A patient who uses equipment such as an oxygen tank, suction pump, nebulizer, or patient-controlled analgesia pump.
- **Level 3 (Low Priority):** A patient who is mobile and independent in functioning or a patient who needs uncomplicated routine wound care.
- **Level 4 (Lowest Priority) Recommended:** Patients for whom visits may be postponed 72 hours or more with little or no adverse effects, patients who have a willing and able caregiver available, or patients who are independent in most activities of daily living (ADLs).

Emergency Contact: Must include the name and number of a family member to contact

Emergency Plans: Please verify the emergency plan on each re-evaluation with the caregiver.

CARE COORDINATION

Care Coordination: Select "Family/Caregiver" and all that apply.

Care Coordination Comments: Include recommendations for parents and what you discussed/explained with the parents at the end of the evaluation.

SUPERVISION

Who was supervised? Check "N/A"

PATIENT SIGNATURE

Patient/Caregiver/Other Signature: MUST BE OBTAINED ELECTRONICALLY WITHIN POINT OF CARE

- For some tablets/phones you will need to use the "Alternate Signature Option"
    - Click the link
    - Have caregiver sign on the line
    - Click "Submit"
- The person who signs must be at least 18 years of age.

Patient/Caregiver/Other Signatory: The person's name & relation must be typed into the line provided

CLINICIAN SIGNATURE

End Date and Time: Enter the time and date that the visit ended

Clinician Signature: All visits must be signed by the therapist who performed the visit

HOW TO WRITE FUNCTIONAL/S.M.A.R.T. GOALS

Specific Measurable Attainable Relevant Time-Bound

Functional Goals: A series of behaviors or skills that allow the client to achieve an outcome relevant to his/her health, safety, or independence within the context of everyday environments.

Long-term Goals: Should span the authorization period requested

- Example: Client will independently complete a morning dressing routine 5/7 mornings in 3 months.

Short-term Goals: Nest within Long-Term Goal. May be an isolated component of long-term goals

- Example: client will don pull-over shirt independently in 4 weeks. Baseline: ___
    - Must document baseline performance

Examples of PT & OT Functional Goals

1. Client will demonstrate simple problem solving with ambulation identify possible obstacles strategy to safely navigate around obstacles 80% acc with 4 verbal cues in X weeks. Baseline:___
2. Client will maintain head placement in neutral 100% of trials, Maintain appropriate food placement/Effective mastication of soft solids. Decreasing aspiration chances. Increasing feeding safety in X months. Baseline:____
3. Client will increase independent mobility, Crawl on hands and knees 8 feet cross the living room floor 3 times per day within X months. Baseline:___
4. Increase independent play within X months demonstrate controlled release of grasp, setting 3 favorite figurines on a tabletop surface without dropping/knocking over. Baseline:____
5. Within X months, improve motor planning and independence perform events associated with toileting sit on toilet fully clothed for3 0 seconds with 4 verbal prompts in 3/4 trials.

Examples of ST Functional Goals

1. Improve participation in mealtime routines with family use gesture or gaze indicate food choice in ¾ trials with choice of 2 snacks during snack time within X months. Baseline:___
2. During family meals at home rotate head to weaker side for all swallows up to 4 verbal prompts no signs/symptoms of aspiration increase swallow safety; reduce aspiration risk. Baseline:___
3. Initiate assistance request during daily routines using short phrase 4/5 opportunities after a verbal model within X months. Baseline:_____
4. In case of emergency accurately verbally provide biographic information response to a directive question 100% of the time independently within X months.
5. Request preferred entertainment using ACD with eye gaze interaction 10 times during a 2 hour block of time per day 5/7 maintain everyday expressive communication. Baseline:____
6. Pt. will improve language skills by describing 5 events using a sequential, logical manner, with visual cues within 5 months. Baseline: 0% New goal.
7. Patient will identify 10 actions by pointing using picture stimuli with moderate visual cues over 3 consecutive sessions within three months to improve language skills when communicating wants and needs for safety and independence in the home and community. Baseline:___
8. Pt. will improve length utterance using 2-3 word utterances to request desired items and communicate his/her needs with moderate cues over 3 consecutive sessions with __% acc. Baseline;____
9. Pt. will improve articulation by suppressing the phonological process of cluster reduction /gr, br, fr/ by producing four-syllable words in: (a) words (b) words in structured phrases (c) words in unstructured phrases, with 80% accuracy over four consecutive therapy sessions. Baseline 0% accuracy.
10. Pt. will improve his/her intelligibility by formulating multiple sentences using10 given words/ situations, with appropriate and clear meaning and increasing accuracy. Baseline:______
11. Pt. will improve pragmatic language skills by: (a) tolerating an entire therapy session with no redirection (b) maintaining topic during an entire activity (c) attending to clinician-directed activities for two consecutive activities with no redirection, with little to no cues over four consecutive therapy sessions. Baseline: two of four given opportunities.

Client specific, measurable short and long-term functional goals within the length of time the services are required. - TMPPM Handbook