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Therapy: Address These 5 Issues With Therapists -- And Reap Rewards.

In predicting therapy use, focus on patient need.

Incorporating therapy more consistently into your patients' care plans can improve patient care, outcomes, and your agency's finances.

Adhering to the traditional types of cases for therapy referrals and using physical therapists as the gatekeeper for occupational therapy and speech therapy is a mistake, experts say. So is dividing the patient in half and saying PT works with the lower half and OT with the upper half.

Instead you need to focus on what the patient needs and make therapy referrals when patients have functional deficits. To maximize patient and agency success and minimize denials, consider discussing the following areas with your clinical team:

1. Changes in utilization patterns. The fastest growing group of patients by percentage is those with 20 or more visits, reported physical therapist **Cindy Krafft**, Peoria, Ill.-based consultant with **Fazzi Associates**. Many clinicians will remember the popularity of 10 visits when that number created a big jump in payment, Krafft said. Now that the prospective payment system changed therapy reimbursement in 2008,

10 visits shows up less often in episodes, but 20 visits are more common, she told listeners at the **American Physical Therapy Association** Annual Conference in Baltimore in June.

Make sure your plan of care can stand up to intermediary scrutiny by concentrating on documenting a quality assessment; explaining reasons for your patient goals; and focusing on the patient's needs, Krafft said. When choosing goals, remember to compare patients to people of the same age in the community or to what the patient was doing before the illness, she stressed.

2. Length of visits. The length of therapy visits is creeping downward since the PPS system began, Krafft noted. And although PPS requires no specific visit length, agencies should remember that the average pre-PPS therapy visit lasted 48 minutes, she warned. Not every visit needs to last this long, but shorter visits need specific documentation about the reason for this. For example, if the patient was unable to continue because of fatigue or unusual circumstance, the therapist should note that.

3. Therapy access. Look at what percentage of your patients receive no therapy visits, Krafft urged. A large percentage may indicate your agency is unaware of many areas in which therapy use can improve patient outcomes, she said. "Agencies that are doing well from an outcomes and financial perspective are seeing around 80 percent of patients in first or second episodes receiving at least one therapy visit," Krafft reported.

4. Homebound status. In considering what a therapist can provide home health patients, "homebound status is the qualifying condition, it is not the goal," Krafft emphasized. The goal may be that the patient is able to leave the home without requiring assistance, she said, especially if that was what the patient was capable of before this illness or injury.

Example: If the patient needs to be able to walk across the grass to take the bus, stopping therapy when he is able to walk across the room does not help, Krafft illustrated. Taking this patient outside to practice on grass does not cancel out his homebound status, she stressed.

Make your goals understandable on medical review by including the reasons for them, Krafft advised. Include why it is important that this patient practices walking on grass (or other uneven surfaces). Or explain that walking a certain distance is important so the patient can walk as far as her mailbox.

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Tip: One trip to WalMart does not disqualify a patient from home care. First find out what happened on the trip. If the patient experienced major difficulty with part of the trip, document these problems, Krafft urged.

This shows clearly areas where the patient still needs therapy.

5. Frequency and duration of therapy.

In an ideal world, frequency and duration would be based on patient need, but in reality they often are based on staffing concerns, geography, the experience level of the staff, and the relationship between physical, occupational, and speech therapy, Krafft said.

There is nothing wrong with daily therapy or visits by PT and OT on the same day, she insisted. That is what is done when the patient goes to a rehab facility and it can be appropriate in home rehab as well.

What to do: Get away from cookie cutter therapy plans by taking the following actions, Krafft suggests: Look at other settings for ideas of appropriate frequency and duration. Use your clinical judgment, not just what is habitually done in home care. Communicate and coordinate with other therapists in your agency. Produce a coordinated, unified plan of care.

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