The following tips will help you complete the Medicare grid for an evaluation and visits with your Medicare patients. This is our opportunity to document that therapy works, how close we get to our goals of improvement OR decline. AND they penalize me 2% of each payment if you miss any of the items below. After your first time, you won’t need these instructions. If it helps, remember that for some clients, Medicare is their only way to access therapy.

The grid tells us how to bill for your time. Send the grid to us with each note or set of notes. Send the same grid over and over until you reach 10 visits or you discharge.

G-Code Reporting Process -

1. Enter your name and patient info at the top.
2. During your eval use at least one Functional Assessment, if possible. The following are relevant to home visits: (All available online for free and on my website)
* 30 Second Stand
* TUG, Tinetti and others
* Caregiver Burden Scale (there are several)
* Depression (PHQ-9
* ABC, Activity-specific Balance Confidence: (which assesses fear of falling)
* (others available on request and some on my website)
1. Choose an abbreviation from the grid below to match the goal area you will be addressing the most. You can change it when you set new goals.

|  |  |  |
| --- | --- | --- |
|  | **G-Code LIMITATION AREA (pick ONE at a time)** |  |
|  | MOB: Mobility: Walking and Moving Around |  |
|  | POS: Changing and Maintaining Body Position | Continued on next page. |
|  | HAN: Carry Move and Handle Objects |  |
|  | SC: Self-Care Functional Limitation |  |
|  | OTH 1: Other PT/OT Primary Limitation |  |
|  | OTH 2: Other PT/OT Subsequent Functional Limitation |  |
|  | SWA: Swallowing Functional Limitation |  |
|  | ATT: Attention Functional LimitationMEM: Memory ST: Motor speech, Spoken lang comprehension, Spoken language expressive, Voice, and Other.  |  |

1. On the Medicare Grid in top row, use the three letter abbreviation to answer: WHICH limitation area? (In this example POS)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WHICH limitation area?: \_POS\_\_**Assess at Eval, at 10th visit, and at DC (or 30 days)  |  | NOW Goal |  % Impaired |   |  |  |  | % Impaired | Goal/DC status |  |

1. Write your goals on your evaluation as functional limitation areas in which you show a % DISABLED measurement, as shown below. Transfer the TOTALS (see below) to the evaluation day which is the first column on the grid. You will need a current status % and a goal %. Use functional assessment measurements as a more objective way to show change; otherwise use your best descriptor of the level of function. (By the way, you don’t have to complete the evaluation in one day; you can gather data over several days, but the G-Codes are reported on the first day.)
* I have found this format to be helpful so that at DC I can compare and write DC status percents easily. I just copy this page of my eval, and handwrite in the DC status and percent disabled.

G code Limitation area: POS

**Current** **Goal** **% Disabled Measurement**

100% 30% able to get off floor

100% 20% can do own exercises 10 reps, 5 sets with verbal cues to start

 90% 30% initiation to get out of bed without verbal cues

 70% 0% 30 Second Stand Test with 6 good stand/sits

 90% 20% TOTAL

1. Add up the % numbers in your current status column and divide by number of functional limitation areas to get TOTAL which you will put as the top number, to the left of “NOW.” For the limitation areas written above 100+100+90+70 = 360, divided by four limitation areas = 90% which I put in the first column next to NOW in the example below.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WHICH limitation area?: \_POS\_**Assess at Eval, at 10th visit, and at DC (or 30 days)  | **90%** | **NOW** Goal |  % Impaired |   |  |  |  | % Impaired | Goal/DC status |  |

1. Next, add the % numbers in your goal column and divide by the number of functional limitations to get the bottom number, and note it to the left of “GOAL.” For the goals %s written above, they average 20%. (30+20+30+0 divided by 4 = 20). This person is 90% disabled in these areas now, and you hope to get them to 20% disabled.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WHICH limitation area?: \_POS\_**Assess at Eval, at 10th visit, and at DC (or 30 days)  | 90%**20%** | NOW **Goal** |  % Impaired |   |  |  |  | % Impaired | Goal/DC status |  |

1. You don’t write any more in this top portion until the 10th visit or day of DC, when you review you functional limitation areas and determine percent disabled. Goal percent and new status go in that day’s column.
2. On the 11th visit, start a new grid, with your name and patient name, determine a new (or keep the same) three letter functional limitation area, do more functional assessment and goals, write new %s and repeat. I feel there is justification for the type of patient we see to go over the cap when needed. With this grid we can keep an eye on the cap.

**PQRS Reporting Questions (see questions on page 6 and 7)**

1. Next you will need to see the questions on page 6 and 7 and your list of options. For the day of your evaluation you will fill-in your grid with the numbers that pertain to your patient from the list of PQRS questions for **ALL** questions. Pages 6 and 7 can be used as a cheat sheet in the future. WHEN YOU DON’T FILL THESE IN I AM PENALIZED 2% by MEDICARE.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Funct’l Outcomes Assessed, POC each vis | **1** |  |  |  |  |  |  |
| Pain & f/up plan >18yo EACH VISIT  | **2** |  |  |  |  |  |  |
| Med changes >18 yo EACH VISIT | **1** |  |  |  |  |  |  |
| Falls Risk Assessment, >65 yo, at EVAL | **1** |  |  |  |  |  |  |
| Falls F/u plan in place >65 yo, at EVAL | **1** |  |  |  |  |  |  |
| Depression >12 yo, at EVAL w q or phq9  | **4** |  |  |  |  |  |  |
| ElderAbuse >65, EVAL w one of 3 tools | **2** |  |  |  |  |  |  |

**NOTE:** the first three PQRS questions must be answered on your grid for **EACH** visit as shown below, an example of your grid after 10 visits. You keep the same grid for a total of 10 visits or until you discharge if prior to the 10th visit.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Funct’l Outcomes Assessed, POC EACH VIST | 1 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Pain & f/up plan >18yo EACH VISIT  | 2 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| Med changes >18 yo EACH VISIT | 1 | 3 | 3 | 1 | 1 | 1 | 1 | 1 | 1 | 3 |
| Falls Risk Assessment, >65 yo, at EVAL | 1 |  |  |  |  |  |  |  |  |  |
| Falls F/u plan in place >65 yo, at EVAL | 1 |  |  |  |  |  |  |  |  |  |

1. Now put in the date of your evaluation (example is 10-31-14), and later you will put your subsequent visit dates. If you can get the client to sign that’s wonderful but not mandatory.

 **SIGNATURE of Patient: \_\_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_\_ \_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TREATMENT: | date | date | date | date | date | date | date | date | date | date |
| *ADD UNITS/day 15 minutes = 1 unit* | \* 10-31-14 |  |  |  |  |  |   |  |  | \* |
| **97001, 2, 3 or 4:PT/OT Eval / Re-eval** | **x** |  **Put**  | **check** | **In**  | **box** |  |  |  |  |  |

1. The eval does not have minutes attached so just put a check in the first box (see X above) under date.
2. Add your time, by CPT code used, in **15 minute intervals** down the rest of the

Column for each date of service. Medicare clients shouldn’t have more than 1.25 to 1.5 hour visits. Insurance only ONE hour! Any extra I pay you from my own pocket. Using more CPT codes is better than doing all one type of CPT code. In the example below, five (5) fifteen minute intervals = 1.25 hours.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **97110 Therapeutic Exercise** |  |  |  |  |  |  |  |  |  |  |
| Strength and Endurance, ROM, Muscle Flexibility (for specific skill) | **2** |  |  |  |  |  |  |  |  |  |
| **97112 Neuromuscular Reeducation** |  |  |  |  |  |  |  |  |  |  |
| Balance, Coordination, Posture, Kinesthetic sense, Proprioception for sitting and standing (for Re-Ed) | **1** |  |  |  |  |  |  |  |  |  |
| **97116 Gait Training** |  |  |  |  |  |  |  |  |  |  |
| Stair Climbing, Balance and Wt shift | **2** |  |  |  |  |  |  |  |  |  |
| Bilateral Coordination |  |  |  |  |  |  |  |  |  |  |

AND THAT’S IT, FOLKS! After your first or second time, you will be able to toss the above sheet and just use the PQRS Cheat Sheet below. Call if you have questions or suggestions, please. Know that when I started this business in 1998 one of my goals was that you would be able to write your note on any piece of paper, add the company name and be finished at the end of the visit. That was before emails, and before Medicare got complicated. I still want to keep your life simple, get therapy to as many people as possible who would miss out otherwise, and get you paid for the full amount of time you spend for your patients. Thank you for your patience. Now I am off to translate all this data onto 1500 forms for Medicare to decipher.

Julie

Julie Groves, OTRL

**PQRS CODES CHEAT SHEET**

Functional Outcome Assessment and follow up plan for people 18 yo and up at EVAL. And each visit, document #3, below, that you already did test.

1. Documented using standardized tool and have related POC
2. Documented using standardized tool, no problem, no POC
3. Documented using standardized tool in last 30 days
4. Documented using standardized tool, no care plan, not eligible
5. Not documented, patient not eligible
6. Not documented, reason not given
7. Documented but no POC, reason not given

Pain Assessment and follow up plan EVERY VISIT for people 18 years and up

1. Pain assessment AND follow up plan documented
2. Pain assessment documented as negative, no follow up required
3. Patient not eligible for assessment for documented reasons
4. Pain assessment not documented for unspecified reasons
5. Pain assessment documented as positive but follow up not documented for unspecified reasons

Medications documented in visit note EACH VISIT for people 18 yo and up. Document *current meds with names, dosage, frequency and route*

1. Documented
2. Not documented, patient not eligible
3. Not documented, for reason not specified

Falls Risk Assessment = Assess Balance and gait AND one or more of *postural BP, vision, home assessment, related meds*

1. Falls Risk Assessment completed AND patient screened for future fall risk
2. Unable to assess for mobility issues BUT at risk of falls in the future
3. No fall history, no anticipation of falls
4. Patient not eligible, unspecified reason AND fall status not documented
5. No fall risk assessment competed for other reasons AND still at risk of falls.

Plan of Care for falls (use only if #1, #2 or #5 is used in Fall Risk Assessment)

1. Includes assess for assist device and balance, strength, gait training
2. Not documented for Medical reasons
3. Not documented for reasons not specified

(END FOR PT, OT has three more questions on next page)

Depression Screen and Follow up (OT ONLY) for people 12 years and up

1. Positive screen for depression and follow up documented
2. Negative screen and follow up not required
3. NO screen due to patient not eligible/appropriate
4. NO screen for unspecified reasons
5. Screening performed but no follow up plan for reasons not specified

Elder abuse screen and report for people over 65, by OT at eval, using one of three tools to assess physical, emotional, psychological or sexual abuse; neglect, abandonment, financial or material exploitation and unwarranted control. Also note self-neglect.

1. Screen positive and follow up to APS documented
2. Screen negative and no follow up
3. Screen not documented, patient not eligible – refused or emergency
4. Screen positive, follow up documented but not eligible for followup plan
5. Screen not documented, reason not given
6. Screen positive, follow up not provided, reason not given

Tobacco use screen and counseling for people 18 and over by OT at EVAL

1. Screened, is a user and is not counseled
2. Screened and counseled if a user
3. Screened and not a user
4. Not screened for medical reasons such as end of life
5. Not screened for reason unspecified