Home State Health and Allwell from Home State Health Physical Medicine Tip Sheet/Checklist

Patient Name: _____ Evaluation Date: _____ Surgery Date: _____

1. ICD10: a) _____ b) _____ c) _____ d) _____
2. Cause for therapy: Traumatic, Repetitive, Work Related, Motor Vehicle, Unspecified (choose one)
3. Select the type of service being rendered.
    a. Physical Therapy (PT)
    b. Occupational Therapy (OT)
    c. Speech Therapy (ST)
4. Type of therapy being rendered: Rehabilitative | Habilitative | Neuro Rehabilitative
5. Authorization start date (if different from the evaluation date)
6. Date of onset/injury
7. Planned number of sessions: 1, 2 or 3+ visits
8. Body regions being treated, quantity: 1, 2, or 3+
9. Body regions being treated, location(s): Head/neck, Upper Extremity, Spine, Lower Extremity, Wound, Vestibular, Balance/Falls
10. Functional Tool used to assess the patient and score expressed as a percent of function (25% disability = 75% functional)

Questions will vary depending on the condition being treated. As you proceed to the additional clinical questions, here are some general guidelines.

Additional Clinical Questions:

- Identify the level of functional deficit the patient exhibits and objective findings:
    - Functional deficits being addressed in therapy
        - Type: mobility, language, memory, feeding, etc.
        - Severity: Mild, Moderate or Severe functional limitations
    - Location of symptoms (focal vs. disperse, proximal vs. distal)
    - Objective findings (ROM limitation, pain, strength, etc.)
    - Is there a fall risk?
    - Are there equipment needs? What level of assistance is required?
    - Has there been a decline in status?
    - Do home programs need to be updated?

- Habilitative Care
    - Standardized testing scores (percentiles, and/or standard deviations below the norm)
    - Has there been a functional decline? To what extent?
    - Recent medical interventions such as Botox injections, surgeries, etc.
    - Are there equipment needs?
    - Functional deficits being addressed in therapy – type, severity, and impact on ability to perform activities of daily living (ADLs)

Recommended Documentation

This is a guide for recommended documentation submission AFTER you have received and accepted immediate authorization through the initial intake at the Algorithm level and is assuming no previous documentation has been submitted for the case in question.

Documents needed for Rehabilitative Cases:

1) Within 3 visits of Initial Evaluation
    a. Only **Initial Evaluation** is needed
2) After 4 visits from Initial Evaluation
    a. Initial Evaluation + Recent Daily note
3) After 30 days from Initial Evaluation
    a. Initial Evaluation + Recent Progress note

Documents needed for Habilitative Cases:

1) Within the 1st 30 days from Initial Evaluation
    a. **Initial Evaluation** showing Standardized Testing
2) Within the 30-90 days from Initial Evaluation
    a. **Initial Evaluation + Updated Progress Note OR Recent Daily note(s)** with indications of objective and functional progress with therapy
3) Within 3-12 months of Initial Evaluation
    a. Initial Evaluation + Updated progress note(s)
4) After 12 months from Initial Evaluation
    a. Initial Evaluation + Re-Evaluation

Documentation should include the following details:

- Initial Evaluation:
    - ✓ Subjective History (Date of injury, Mechanism of injury, Chronicity, Patient perceived deficit)
    - ✓ Objective measures, Functional Outcome scores or Standardized Testing Scores
    - ✓ Assessment (Detailed clinician interpretation of findings and expected progress of care)
    - ✓ Detailed Plan of Care
        - Include treatment interventions intended to utilize
        - Frequency of visits intended for care
    - ✓ Goals
        - Functional goals matched to identified deficits
        - Time frame on goals helps authorization match needs
- Progress Note
    - ✓ Update on objective measures, Functional Outcome scores
    - ✓ Update to Plan of care, and goals if appropriate
- Re-Evaluation
    - ✓ Should demonstrate level of improvements through repeating testing from Initial evaluation.
    - ✓ Updated Treatment plan noting interventions intended to utilize for care.
    - ✓ If change in Plan of Care then documentation should support this change in patient presentation.