Rehabilitation and Durable Medical Equipment: Obtaining goods and services for patients

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DESERT SKY SPINE AND SPORTS MEDICINE

Goals of this Presentation

- Be able to describe the levels of rehabilitative care, as per CMS
- Identify what level of care is most appropriate for patients
- Understand the roles of nursing, physical therapy, occupational therapy, speech language pathology, and vendors in rehabilitation
- Understand basic principles of prosthetic and orthotic prescriptions
- Know how to prescribe the appropriate gait aide for patients with mobility impairment
- Understand basic principles of the power mobility prescription

Scope of this presentation

- Each of these topics can be very extensive
- A basic understanding of navigating the CMS system is presented
- The principles described are, when possible, presented in accord with World Health Organization terminology, but understand that the framework described here is somewhat contrived and arbitrary
- Nevertheless, this is how you get patients what they need

What is Rehabilitation Medicine?

- Diagnosing and treating functional impairments that limit patients' ability to perform their vocational and avocational activities
- Improve quality of life by increasing their ability to perform ADLs and I-ADLs
- Identifying the structural limitations that inhibit a patients ability to function
  - (That sounds familiar. Maybe an Osteopathic principle?)

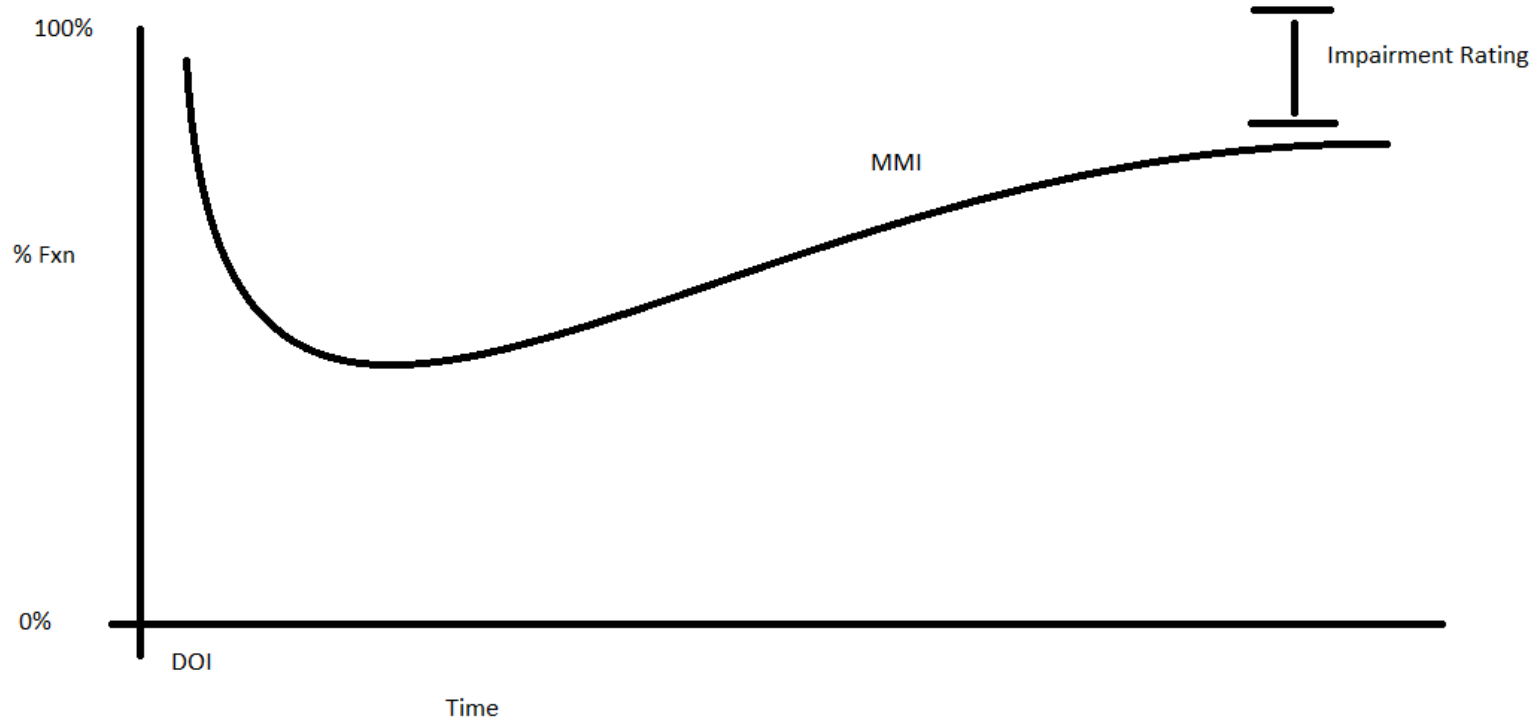
- Rehabilitation medicine is not complex neurosurgery, but it does require thinking about things differently

Lots of Vocabulary and Terminology

- Medical Diagnosis – What is the name of their disease?
  - Peripheral neuropathy, CHF, rotator cuff disorder, degenerative spinal arthritis
- Impairment – A problem with the function of an organ system
- Disability – The inability to perform a function that would be considered normal for a human being peer
- Handicap – Limitations in a person's ability to perform a role

- Restrictions – Limitations placed by a professional on what is recommended for a patient to do / not do given their medical diagnosis

Theoretical framework for Workers Compensation Cases



Translating to CMS

- My patient was doing well, until X event happened. Now, they are unable to A, B, and C functions. Therefore, they have identifiable rehabilitation needs

- My patient was doing well until their CHF exacerbation. Now, they are unable to ambulate household distances, get to a commode safely, or stand long enough to cook a meal. Therefore, they need rehabilitation.

Levels of Rehabilitation – Outpatient

- Outpatient therapy
  - Can be PT, OT, speech therapy
  - Usually 2-3 times per week, per discipline
  - Patient is well enough be away from the house safely
  - **Grossly oversimplified** rule of thumb – hospital-based therapy for neuro or general medical needs, private practice therapy for ortho or MSK needs
    - Ex: COPD, post-abdominal surgery, Guillen-Barre → hospital-based
    - Ex: Sports injury, auto collision, workers comp → private practice based
  - In AZ, patients have direct access to PT. However, Medicare (and others) do not pay the therapist without a valid Rx
  - A provider Rx is usually sufficient, as long as they still have visits left, per their plan

Levels of Rehabilitation – Home Health

- Home Health Care
  - A patient is unable to safely leave their home. Doing so would cause an undo burden to them medically
  - Transportation alone is not a justification for home health care.
  - If a patient can go to their hair appointment or the mall, they do not qualify for HHC
  - PT, OT, Speech Therapy, RN, MSW
  - Can be limited by geographic availability
  - Requires a face-to-face encounter, documenting medical necessity, and the fact that the patient is medically unable to go to an outpatient facility

Levels of Rehabilitation – Subacute Rehab Facility (SNF)

- Medicare actually makes a distinction between Subacute Rehab and a Skilled Nursing Facility
- However, the vast majority of subacute facilities are in SNFs.
- Therefore, most patients associate going to subacute with going to a "nursing home"
- **My opinion**: Margins for these facilities are razor-thin. Often patients will have to choose between variables – clean facility, great nursing, great therapy. Choose two. If a facility has all three, they are probably very particular about who they accept. I recommend patient families tour the facilities *without giving the facility prior notice*.

- Requirements include needing 24 hour nursing, and two of the three disciplines (PT, OT, SLP)
- Patients are admitted to an attending physician, but need not be seen daily

Levels of Rehabilitation – Inpatient Rehabilitation Facility

- IRF – hospital-based rehabilitation facility
- Admission, discharge, length of stay and payment to the facility work conceptually much more like a psychiatric unit admission than an acute hospital admission
- Requires 24 hour nursing, a rehabilitation physician to oversee the care, medical necessity (we'll get to this later), 2 of the 3 disciplines, AND an estimated expectation of going home after the stay (NOT to SNF)
- PT, OT, speech, rehab nursing, MSW, dietician, rehab physician
  - Most of the team will meet weekly to discuss progress and estimate/update length of stay
- Each week, a patient would be expected to increase their overall function by one unit on the FIM score

- In Pima County, the IRFs are – St. Joseph's, St. Mary's, Healthsouth RIT, Healthsouth SARA, Northwest Hospital, and Oro Valley

Functional Independence Measure

- Eating
- Grooming
- Bathing
- Upper body dressing
- Lower body dressing
- Toileting
- Bladder management
- Bowel management
- Bed to chair transfer
- Toilet transfer
- Shower transfer
- Locomotion (ambulatory or wheelchair level)
- Stairs
- Cognitive comprehension
- Expression
- Social interaction
- Problem solving
- Memory

Measuring Independence

- 7 – Completely independent
- 6 – Modified independent (uses a cane for walking, an alarm reminder to take medications, etc.)
- 5 – Supervision (requires someone present to watch and remind, but not touch)
- 4 – Minimal assistance (needs <25% help)
- 3 – Moderate assistance (needs 25-50% help)
- 2 – Maximal assistance (needs 50-75% help)
- 1 – Total assistance (needs 75-100% help)

CMS-13 Qualifying Diagnosis

- 1) Stroke;
- 2) Spinal cord injury;
- 3) Congenital deformity;
- 4) Amputation;
- 5) Major multiple trauma;
- 6) Fracture of femur (hip fracture);
- 7) Brain injury;
- 8) Neurological disorders, including:
  - Multiple sclerosis; Motor neuron diseases; Polyneuropathy; Muscular dystrophy; and Parkinson's disease;
- 9) Burns

CMS-13 Qualifying Diagnosis

- For the three qualifying conditions listed below, the severity/complexity can vary significantly. For this reason, additional clinical criteria were established to require evidence that other less intensive treatments were attempted and failed to improve the patient's condition before admission to the IRF:
- 10) Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living;
- 11) Systemic vasculidities with joint inflammation resulting in significant functional impairment of ambulation and other activities of daily living;
- 12) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more weight bearing joints (elbow, shoulders, hips, or knees but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, and significant functional impairment of ambulation and other activities of daily living;

CMS-13 Qualifying Diagnosis

- Knee or hip joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria: The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care hospital admission immediately preceding the IRF admission; The patient is extremely obese with a Body Mass Index of at least 50 or The patient is age 85 or older at the time of admission to the IRF.

Rule of Thumb for a CMS-13 qualifying diagnosis

- Has there been a sudden change to their neurologic or musculoskeletal system?
- IRF are required to maintain a certain % compliance with CMS-13
- Your patient with CHF exacerbation can still come, if the facility is in compliance with CMS-13, they meet medical necessity, and they require 2 of the 3 disciplines

PT, OT, Speech

- Physical therapy – mobility, transfers, ambulation, wheelchair propulsion
- Occupational therapy – grooming, bathing, toileting
- **Gross and incorrect oversimplification** – PT works with the legs, OT works with the arms
- Speech Language Pathology – communication, cognition, swallow

I understand the levels of rehab, but I'm still not sure what my patient needs

- How about a rehabilitation medicine consultation?
  - History
    - Social – Who do they live with? Do they have help at home? What kind of house? Stairs?
    - Functional – What were they able to do prior?
  - Physical
    - Particular focus on the neuromusculokeletal system
  - Assessment
    - What level of rehab would benefit them?
    - Would any changes to their medical plan of care increase their estimated functional capacity?

Prosthetics and orthotics

- P&O is a Master's Degree level field of expertise
- Certified practitioners combine knowledge and skill in translating the medical diagnoses to what might advance a patient's functional ability
- Often, they then fabricate the device in their own facility

Prosthetics

- A prosthetist, physical or occupational therapist, and physician, working in concert, provide the best functional outcomes
- The best thing a physician can do is trust in their team, and “get out of the way”, offer any medical assessment/plans, and sign the complex rx generated by the prosthetist and therapist
- Very rare is the physician who knows more about prosthetics than the prosthetist. Much more common is the physician who thinks they know more about prosthetics than the prosthetist.

Off-the-shelf Orthotics

- Very common way of adding revenue to your practice.
- Lumbar orthoses and knee orthoses are paying VERY WELL these days

- Be careful about prescribing orthoses for a diagnosis of “pain”. By bracing a joint, you reduce the need for the surrounding musculature to “do the work”. The muscles get weaker, then joint takes on more force, the pain gets worse, and the patient gets “addicted” to the brace.

Gait Aides

- Here is the rule:
  - If you are falling without a cane, you need a cane. If you are falling with a cane, you need a walker. If you are falling with a walker you need a wheelchair. There should be zero tolerance for falling.
- Identifying why someone is falling can be difficult. Ambulation is a very complex action of "controlled falls", requiring the neurologic, musculoskeletal, vestibular, visual, auditory, proprioceptive, and tactile systems.
- Possible diagnoses – Vascular dementia, BPV, peripheral neuropathy, painful arthritis of a weightbearing joint
- Utilize a physical therapist to help identify what gait aide would work best

Teach your patients how to properly use a cane

A Final Word on Power Mobility

- Do NOT sign any rx for a patient for power mobility without a physical therapist's assessment.
- There are very few patients that are appropriate for a power scooter.
  - What are the odds that the patient in the scooter will need a power wheelchair in the next 5 years?
- If a patient has diminished sensation in their back, buttocks, legs, feet, or back of their head, a proper seating evaluation is critical to lowering the risk of developing pressure ulcers.

- Learn something new all the time: A power mobility Rx requires a wet signature (not electronic)