Rehab Director Forum – Compiled Response
May 11, 2017

Query:

At "X" we see a fair number of patients who will bounce between IP and OP care – oncology kids, for example – where they receive therapy services in both settings: PT as an OP and PT as an IP, for example.

How do you deal with:

- Evaluation and development of plan of care when moving from one setting to another?
- Do you use the OP evaluation as the foundation for your IP goals?
- Do you reevaluate on the OP side when they are discharged from IP?
- How do you handle the documentation and billing piece?
- Do you require a resume therapy order on the OP side when a child has been admitted to the hospital.
    - If related to the reason for therapy.
    - If unrelated to the reason for therapy.

At "X", we have an established process for IP to OP transition where the IP therapist creates the POC and we use that evaluation/ last note / updated POC to obtain authorization for care on the OP side. For us this has decreased delays in accessing care. We don't, however, have a process for OP to IP movement of the patient.

Responses:

Facility	Evaluation and development of plan of care when moving from one setting to another?	Do you use the OP evaluation as the foundation for your IP goals?	Do you reevaluate on the OP side when they are discharged from IP?	How do you handle the documentation and billing piece?	Do you require a resume therapy order on the OP side when a child has been admitted to the hospital? If related to the reason for therapy. If unrelated to the reason for therapy.

A	As long as there has not been a change in medical status, the evaluation and plan of care set where the patient began services is continued throughout the IP/OP transitions.	Yes	Depends on the individual patient and situation.	Same requirements regardless of the setting.	No. As long as there has not been a significant change in medical status, the services and the plan of care are continuous. If there has been a change in medical status or different reason for therapy, we obtain a new order.
B	Our inpatient and outpatient therapists are generally separate. If older pediatric patients are hospitalized here, they generally do not receive therapy services while they are inpatient, unless it is critical to their discharge plan. In that case either one of the adult acute therapists will see the patient or one of our child therapists will go over to the hospital. Babies are sometimes seen by the developmental care specialists (PT or OT) from the NICU. Evaluations and plans of care are completely separate between the inpatient hospital and the outpatient setting.	I don't think so, the IP goals would be focused on immediate d/c needs.	Not unless the hospitalization was something that impacted or changed the OP plan of care. For example, if a child was hospitalized for an orthopedic surgery or a significant neuro event the PT would likely re-evaluate post discharge. If they were hospitalized for pneumonia or a stomach virus they would not.	Inpatient and outpatient documentation and billing are all separate. We would likely not do an outpatient evaluation on the same day as a hospital discharge to avoid trying to bill two services on one day, although to my knowledge this has never happened.	If related to the reason for therapy. Not required per departmental SOP, therapist preference if they want a re-start order that describes precautions If unrelated to the reason for therapy. No
C	Evaluation is done in each setting and then it may be a re-evaluation in each setting depending on time frame.	The OP may utilize some of the same goals or change them/update them, but not often are they the same. The OP goals are typically slightly longer in time frame and the IP are typically shorter term. It has happened that the IP therapist was also the OP on the day that the patient returned for OP therapy and they had an easier task of re-evaluation as they were already familiar with the patient. This therapist did complete a re-eval and updated	Yes.	We have a location for IP documentation and an OP documentation currently separate, but this is likely to change in the next 12 months as we upgrade the HER. Billing all occurs in one system, but is coded differently for us based on location IP versus OP.	No, the IP therapist recommends a note in the hospital dismissal summary that indicates whether or not continued OP therapy is warranted and this is signed by the physician to support continued OP therapy.

		changed goals appropriate to the setting and the current status and expected prognosis.			
D	If the patient is in active treatment and truly coming in and out frequently, I try to think of it as completely continuous. I typically meet kids inpatient (this model could and hopefully will change as our program grows and I can do pre-treatment evals etc) and do their eval there. When they discharge and OP follow up is needed, I typically keep the same goals and plan of care unless It is specific to being inpatient. As they come in and out for low counts, chemo induction, fever etc. I try to keep their therapy consistent. This is much easier when it's the same therapist.	Yes, if I have the opportunity to eval outpatient, I do keep the same goals. Obviously, as needs change based on medical status changes or if inpatient needs arise for a different communication setting, I certainly will add/change goals as needed. When appropriate, I try to maintain their OP plan of care to continue to make progress during inpatient stay.	Unless required by insurance or there is a significant change, I do not. I try to do diagnostic therapy as much as I can to avoid another eval charge. I know billing and requirements are different across disciplines.	I am still working on making the best documentation system myself. I believe PT and OT have made templates that contain needed info for both IP and OP than can more easily transfer to use template in either setting and contain the relevant info about their plan that is useful in both notes. Currently, I adjust the info needed in my template when switching from an IP to OP note. I don't want to speak to our billing because I am not sure the entire process. We have a team through our oncology clinic that helps with pre-auth once our OP appts are scheduled but not sure the specifics beyond that.	If related to the reason for therapy. No (I see my kids in our oncology clinic, it may be different for our regular outpatients but I personally have not heard of this) If unrelated to the reason for therapy. No
E	For a child that is not currently undergoing a transplant, we write a 3 month inpatient/outpatient plan of care (inpatient, usually at time of diagnosis) that allows them to bounce inpatient/outpatient without needing a new evaluation. If medical/functional status changes, we do re-evaluate (whether inpatient/outpatient). This is especially helpful for our brain tumor/bone tumor/leukemia population that are frequently	Our kids that are receiving chemotherapy are more like an outpatient that is seen inpatient (for convenience and decreasing OP appointments), so we do use OP evaluation/goals as appropriate. That being said, if a POC is written outpatient, we ALWAYS do a new plan of care inpatient (even if we don't fully re-evaluate) as the POC must be written from the higher level of care. So a POC written inpatient covers outpatient care but a POC written outpatient does not	If status changes but not always.	Documentation/billing corresponds to the most appropriate care given. Sometimes we write a POC but will charge a treatment (if we did more treatment than evaluation).	We only require a new outpatient PT order if the child's status changes. Otherwise we don't ask for a new order and they are scheduled for outpatient PT. The reason for therapy mostly doesn't change (weakness/deconditioning).

	inpatient/outpatient. We only write inpatient POC for a child undergoing transplant and then before they discharge, we try to reevaluate and write an inpatient/outpatient plan of care so they can follow up with outpatient. A child undergoing transplant gets evaluated outpatient at 80 days post transplant.	cover a child inpatient.			