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Pain Management Programming in Long Term Care

Todd Olson, OTR/L Director of Clinical Education
Brighton Rehabilitation

Learning Outcomes

After this course, participants will be able to:

- Define pain and describe 4 different classifications of pain
- Discuss 2 reasons why pain management is an essential component of assessment and care planning in the LTC setting
- Identify and describe 5 pain assessment rating scales that are effective with the LTC population and those with cognitive impairment.
- Independently list and recognize 6 common pain behaviors in cognitively impaired elderly persons
- Independently identify 5 skilled interventions to treat pain in the LTC population

Why Pain Management?

1. Minimize/eliminate pain so the resident is able to perform his/her daily activities at the highest level of independence

2. Educate residents and caregivers to compensatory and/or adaptive strategies that can help to minimize, if not eliminate, pain

F309 – Quality of Care

- "Effective pain recognition and management requires an ongoing facility-wide commitment to resident comfort, to identifying and addressing barriers to managing pain, and to addressing any misconceptions that residents, families, and staff may have about managing pain."

CMS, State Operations Manual, Pub 100-07, Appendix pp

Pain Myth Busters

- Aches and pains are a normal part of aging
- Patients with dementia are unable to report their pain
- Pain is largely an emotional or psychological problem
- Doctors, nurses, and therapists are the experts about pain
- It's important to be stoic about pain
- A similar injury suffered by two people will cause the same amount and type of pain in both people
- There's not much that can be done to relieve chronic pain

Definition of Pain

"An unpleasant sensory and emotional experience associated with actual or potential tissue damage."

International Association for the Study of Pain (IASP)

60% - 80% of nursing home residents have pain leading to decreased function and quality of life

Achterberg et al., 2013; Patel et al., 2013

Classification of Pain

- Acute
  - Well-localized
  - Lasts for the duration of the stimulus
  - Treatment aimed at resolving underlying cause
- Chronic
  - Persists for an extended period of time
  - Poorly localized
  - Treatment aimed at "controlling" pain, not curing it

Classification of Pain

- Somatogenic: Caused by organic diseases and disorders
- Psychogenic: Influenced by psychological factors, pain has no organic explanation or only a very weak one

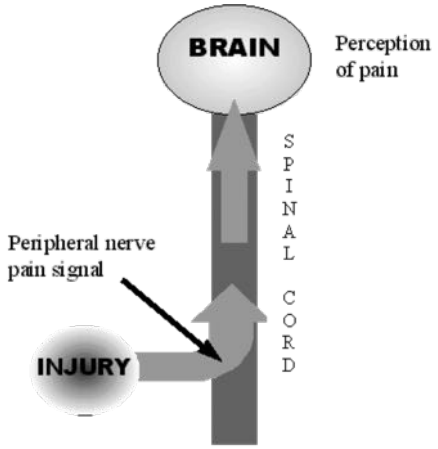
How the Body Feels Pain

- Nociceptors detect pressure, inflammation, toxic substance or other harmful stimulus
- Pain message travels from peripheral nerves to spinal cord
- "Gatekeepers" in spinal cord activate motor response, block message or release chemicals that ↑ or ↓ pain message on its way to the brain

How the Body Feels Pain

- In the brain, pain message relayed to the thalamus which transmits to:
  - Somatosensory cortex (physical sensation)
  - Limbic system (emotional response)
  - Frontal cortex (thinking and reasoning)
- Brain also causes ↑ blood flow to injured area for healing and releases serotonin, endorphins and enkephalins

How the Body Feels Pain



Nociceptive Pain Mechanisms

- Involves activation of the nociceptive system by noxious stimuli
- Consists of four processes:
  - Transduction: depolarization in reponse to noxious stimulus
  - Transmission: stimulus proceeds from PNS to CNS
  - Perception: brain recognizes impulse as “pain”
  - Modulation: dampening of pain impulse

Nociceptive Pain Mechanisms

- Can be acute or chronic
- Primarily involves injury to somatic or visceral tissue
- Can be referred

Somatic Pain

- Pain of muscles, bones, skin, etc.
- Activation of somatic primary afferent fibers
- Usually localized
- Aching, squeezing, stabbing

Visceral Pain

- Pain of the “viscera” or internal organs
- Most common form of pain produced by disease
- Often referred to other locations
- Usually diffuse and difficult to localize
- Cramping and gnawing or sharp and stabbing

Neuropathic Pain Mechanisms

- Direct injury or dysfunction of nerves in PNS or CNS
- Chronic
- Burning, shocking, paresthetic
- May be associated with referred pain, allodynia, hyperalgesia or hyperpathia
- Can result in abnormal nerve regeneration in the PNS

Biological Mechanisms of Chronic Pain

- Inflammatory (somatogenic/nociceptive):
  - Arthritis
  - Infection
  - Post-op pain
- Mechanical/Compressive (somatogenic/ nociceptive):
  - Compression fracture
  - Bulging discs
  - Ligament sprain
  - Bone tumor

Biological Mechanisms of Chronic Pain

- Neuropathic (somatogenic):
  - Sciatica
  - Peripheral neuropathy
  - Post-stroke pain
- Muscle dysfunction (somatogenic/nociceptive):
  - Fibromyalgia
  - Myofascial pain syndrome

Categories of Pain by Diagnosis

Nociceptive pain
- Arthropathies
- Myalgias
- Skin and mucosal ulcerations
- Non-articular inflammatory disorders
- Ischemic disorders
- Visceral pain

Neuropathic pain
- Post-herpetic neuralgia
- Trigeminal neuralgia
- Diabetic neuropathy
- Post-stroke pain
- Post-amputation pain
- Myelopathic or radiculopathic pain
- CRPS

Categories of Pain by Diagnosis

Mixed Pathophysiology
- Chronic recurrent headaches
- Migraine headaches
- Vasculopathic pain syndromes

Psychologically-Based Pain Syndromes
- Somatization disorders
- Hysterical reactions

Origin of Pain

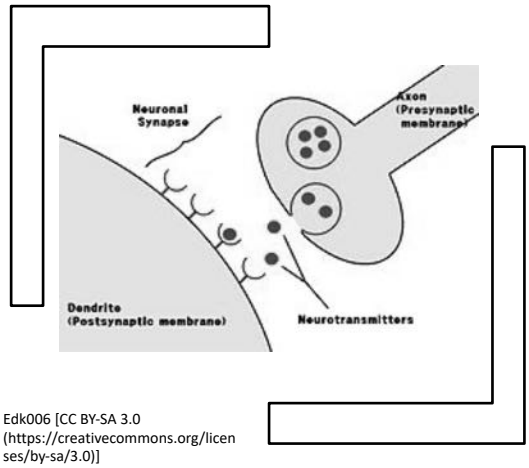
- Pain is often NOT where the problem is located
- Pain can be a symptom of various diseases and disorders:
  - Orthopedic
  - Cardiac
  - Pulmonary
  - Degenerative
  - Metabolic conditions

- Must find the ROOT OF THE PROBLEM

Complications of Pain

- ROM deficits
- Muscle weakness/atrophy
- Incontinence
- Decreased activity
- Behavioral/emotional changes
- Altered sensation
- Pain resulting from substitution of movement and protective posturing
- Proprioceptive/ kinesthetic deficits
- Impaired coordination

Pain Modulation



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- Gate Control Theory
- Endorphin Release Theory

Establishing a Pain Management Program

Establishing a Pain Management Program

- Establish resident identification & tracking mechanisms
  - At risk for weakness or atrophy due to pain
  - Functional decline in ADLs or mobility due to pain
  - Change in ROM, posture, standing ability, weight-bearing, or tone because of pain
  - Decreased participation in activities, decreased socialization, or exhibiting other behaviors due to pain
- Establish therapy communication systems

Establishing a Pain Management Program

- Provide ongoing facility education re: therapy's role in pain management
- Train staff to identify impairments
- Training on techniques and strategies to be carried over after DC from therapy including positioning, exercise programs, coping mechanisms, use of adaptive equipment
- Schedule regular meetings/rounds
- Ensure supportive documentation

Candidate Identification

- Observation
- Ask residents questions
- Ask questions of the IDT
- Medical record/MDS
- Quality measures
- Facility lists
- Facility rounds

Observation

- Awkward postures/muscle guarding
- Disruptive behaviors
- Change in activity participation
- Vocalizations or grimacing
- Red areas, pressure, or skin breakdown
- Recent falls

Observation

- Muscular weakness, abnormal tone, and/or contractures
- Joint/weight bearing precautions
- Neurologic impairments
- Bed- or chair-bound
- Diagnoses known to cause pain

Ask Resident Questions

- Have you recently fallen?
- Are you comfortable in your chair?
- Do you have any pain or discomfort?
- Can you get around your room?
- Are you able to participate in activities?
- How much time do you spend in your chair?
- Have you noticed any changes or limitations in your ability to move?

Ask Staff Questions

Do you notice residents who:

- Have decreased ROM/increased weakness?
- Have declined in self-care ability/increased resistance to ADL?
- Have decreased activity participation?
- Complain of discomfort when in the bed or chair?
- Demonstrate tighter joints?
- Have repeated falls?
- Have increased complaints of pain or increased vocalizations or grimacing?
- Have increased isolation or are spending more time in their room?

Medical Records

- Nursing, CNA, and/or Restorative notes
- Activities and social services
- Medication lists
- MDS
  - Sections B, C, E, G – for communication, cognitive status, behavior, and function
  - Section I – active diagnoses
  - Section J – health conditions – PAIN, falls
  - Section M, N, P – skin conditions, medications, restraints

Quality Measures

- Percent of residents who:
  - Experienced one or more falls with major injury
  - Self-report moderate to severe pain
  - Were physically restrained
  - Need more help/assistance with ADL
  - Have depressive symptoms
  - Received an antipsychotic medication

Facility Lists

- Bed rest
- Wounds, pressure ulcers
- Decline in ADL
- Recent falls or at risk for falls
- Amputation and/or prosthesis
- Risk for contractures or have positioning needs
- Restraints

Facility Rounds

- Incorporate screening into facility activities
- Walking rounds
- “Round with a purpose” or a focus

Pain Assessment

Pain Assessment

- Multidisciplinary assessment is most successful
- No objective biological markers for the presence of pain
- Patients with mild to moderate cognitive impairment can be assessed

Initial Assessment

- Psychological function
  - Coping skills
  - Helplessness
  - Pain-related fears
  - Self-efficacy
- Social support
  - Caregivers/environment/relationships
- Cognitive function
- Pain through patient report

Pain History

- How the pain developed
- Description
- Location/nature
- Pattern
- Aggravating and relieving factors
- Effectiveness of pain medication
- Impact of pain on function

Initial Assessment

- Onset date and description of exacerbation or change
- Functional level prior to episode (PLOF)
- Past therapy services
- Previously attempted treatments
- Other medical complications that may affect therapy

Assessment: Non-verbal

- Negative verbalizations/vocalizations
- Facial expressions
- Changes in gait, skin color, vitals, perspiration
- Changes in behavior (e.g., resistance to care, pacing, irritability, depressed mood, decreased participation in activities)
- Loss of function, inability to perform ADLs, guarding a limb, rubbing a specific location
- Difficulty eating or loss of appetite
- Difficulty sleeping/insomnia

Pain Behaviors

(American Geriatric Society Panel)

1. Facial expressions
   - Slight frown/sad, grimacing, wrinkled forehead, closed eyes, rapid blinking
2. Verbalizations/vocalizations
   - Sighing/moaning/groaning, grunting/chanting, calling out, noisy breathing, asking for help, verbally abusive
3. Body movements
   - Rigid/tense, fidgeting, ↑ pacing, rocking, gait/mobility changes

Achterberg et al., 2013

Pain Behaviors

(American Geriatric Society Panel)

4. Changes in interpersonal interactions
   - Aggressive/combative/resisting care, ↓ social interactions, socially inappropriate/disruptive, withdrawn
5. Changes in activity patterns or routines
   - Refusing food/appetite change, ↑ rest periods, sleep pattern change, cessation of common routine, ↑ wandering
6. Mental status changes
   - Crying/tears, ↑ confusion, irritability, distress

Achterberg et al., 2013

Pain Rating Scales

- Numeric Rating Scale (NRS)
- Visual Analog Scale (VAS)
- Verbal Descriptor Scale
- Wong-Baker Pain Rating Scale
- Pain Assessment in Advanced Dementia (PAINAD) Scale

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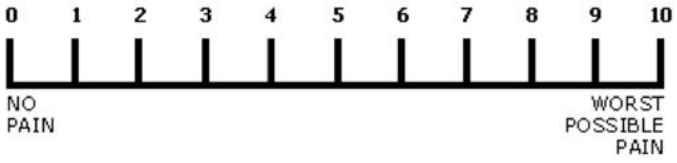
Numeric Rating Scale (NRS)



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Wong-Baker Pain Rating Scale

Tips for Assessing Older Adults

- Use a variety of terms synonymous with pain
- Note nonverbal pain behavior, vocalizations, and recent changes in function
- Seek caregiver reports

Barriers to Pain Assessment: Older Adults

- Reluctant to report pain
- Expect pain with aging
- Don't necessarily use the term "pain"
- Fear the need for diagnostic tests

Barriers to Pain Assessment: Older Adults

- Fear medication side effects
- Believe pain is metaphor for serious disease or death
- Believe suffering is atonement for past actions
- Poor communication skills

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Pain Treatment Strategies

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Pain Treatment Strategies

Consider…

- Resident's needs and goals
- Etiology, type, severity of pain
- Treat underlying cause, where possible
- Use medication judiciously
- Monitor for effectiveness/adverse consequences
- Modify approaches as necessary

Pharmacological vs. Non-pharmacological Intervention

- Ever-increasing focus on use of pain medications in today's culture
- Consider non-pharmacological interventions when possible
- Often will need a combination approach

Medications

- Follow a systematic approach – may require repeated attempts
- Consider…
  - Administering lower doses initially, slowly titrating dose upward
  - "Round the clock" vs. PRN
  - Combining longer-acting medications w/ PRN meds for breakthrough pain
  - Use of adjuvant medication or multiple analgesics
- DOCUMENT the rationale for treatment, modifications/assessment, risks, etc.

Non-pharmacological Interventions

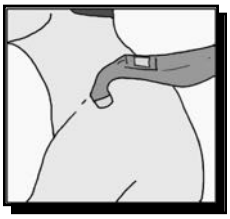
- Altering the environment for comfort
- Positioning/pressure relief
- Moist heat/warm blanket, ice packs
- Relaxation techniques
- Education

Non-pharmacological Interventions (PT/OT)

- Modalities
- Exercise
- Manual therapy
- ADL/mobility training
- Orthotics
- Cognitive-behavioral strategies
- Education

Modalities

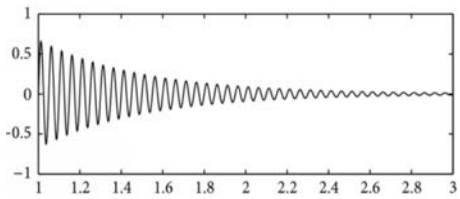
- Electrical stimulation - TENS/IFC
- Ultrasound
- Diathermy
- Paraffin
- Fluidotherapy
- Moist heat
- Cryotherapy



Ultrasound

Physics of Ultrasound

- Reverse piezoelectric effect
- US waves generated and transmitted
- Collimation
- Attenuation in tissues



Important US Terms/Concepts

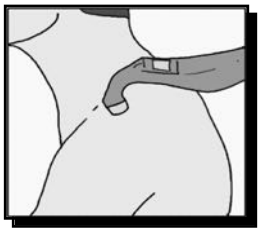
- Ultrasound Calibration
- Beam non-uniformity ratio
- Refraction of energy
- Continuous Vs Pulsed
- Effective Radiating Area (ERA)

Ultrasound

Therapeutic US produces high frequency sound waves for thermal and sub-thermal effects in tissues

Clinical efficacy based on:

- Machine itself
- Application technique



Ultrasound Collimation Depth and Energy

- 1 MHz – 4 cm deep
- 3 MHz – 2-3 cm deep
- 3 MHz delivers 3X the energy for given period of time

Absorption of US Energy

- Blood – 3%
- Fat – 13%
- Muscle – 24%
- Skin – 39%
- Tendon – 59%
- Cartilage – 68%
- Bone – 96%

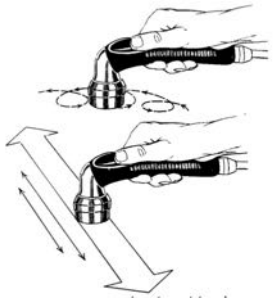
Thermal Physiological Effects

- Thermal – US or Hot Packs
  - Increased molecular kinetic energy
  - 1 Degree C – Increased metabolic rate
  - 2-3 Degreed C – Reduced muscle spasm and increased blood flow
  - 4 Degrees C – increase tissue extensibility

Thermal Effects on Muscle

	Intensity	T2.5	T5.0	T7.5	T10
1MHz	0.5	* (~0.5)	*	*	0.5 C
	1.0	*	1.0 C	1.25 C	1.0 C
	1.5	1.0 C	1.75 C	2.5 C	1.0 C
	2.0	1.25 C	2.25 C	3.25 C	1.0 C
3MHz	0.5	0.75 C	1.5 C	2.0 C	1.0 C
	1.0	2.5 C	3.5 C	5.0 C	5.75 C
	1.5	2.75 C	5.0 C	** (Pain)	**
	2.0	4.0 C	**	**	**

Proper Application Technique



Soundhead glides over surface; contact only thru gel

Treatment area no greater than 2 X ERA

Ultrasound Application

- Treatment area = 2 X the ERA
- Applicator should be flush to skin or perpendicular from skin
- It is ok to remove applicator from skin, or briefly tilt the applicator – move gel
- Keep applicator moving about 1 inch/sec
- Patient should feel gentle warmth

Ultrasound Indications

THERMAL

- Pain reduction, increase circulation
- Muscle spasm
- Collagen remodeling
- Reabsorption of calcium deposits
- Muscle tone reduction

Ultrasound Indications

THERMAL

- ✓Low back pain due to muscle spasm
- ✓Trigger points in upper traps
- ✓Decreased shoulder ROM (adhesive capsulitis)
- ✓Shoulder pain due to chronic bursitis or tendonitis

Appropriate use of Ultrasound

- Heat tissue prior to soft tissue mobilization or stretching
- Perform stretching or mobilization within the stretching window – 4 Degrees Celsius

Ultrasound Indications

SUB-THERMAL

- Acute soft tissue trauma, edema reduction
- Tissue healing
- Pain reduction – from edema reduction
- Arthritis
- Muscle tone reduction

Ultrasound Indications

SUB-THERMAL

- ✓Carpal tunnel syndrome
- ✓Acute ankle sprain
- ✓Rotator cuff tendonitis
- ✓Open wounds

Ultrasound Parameters

Thermal

- Frequency: 1 or 3 MHz
- Duty Cycle: 100%
- Intensity: 0.5-1.5 W/cm^2
- Duration: 7-10 min
- 3x/week

Sub-thermal

- Frequency: 1 or 3 MHz
- Duty Cycle: 20%
- Intensity: 0.5 W/cm^2
- Duration: 5-8 min
- Daily

Appropriate use of Ultrasound

- Studies indicate at least 4 – 6 treatments are needed to patient to receive full effects
- If no effects after 6 treatments it is time to move on to other interventions
- If patient is demonstrating objective, positive effects from use of ultrasound, continue as medical necessary, but document objective findings, continued medical necessity, and required skills of the therapist.

Ultrasound Contraindications

- Malignant tumor
- Pregnancy (over abdomen, low back, pelvis)
- CNS tissue (spinal cord, carotid sinus)
- Joint cement, plastic implants
- Pacemaker
- DVT
- Over the eyes
- Over the reproductive organs
- Use caution in areas of acute inflammation, over growing epiphyseal plates, fractures

Shortwave Diathermy

Subthermal SWD Pain Application

- Post traumatic/surgical
  - Post Op Pain Reduction
  - Post traumatic pain and edema reduction
- Increase circulation to improve tissue healing
- Osteoarthritis pain reduction
- Trigger point pain

Thermal SWD Pain Application

- Pain reduction
  - Sub-Acute
  - Chronic
- Increasing ROM

Dosage Parameters

- Due to wide variety of outputs from various Diathermy machines, it is suggested to consult with the manufactures information regarding dosing.
- Acute Conditions
  - Mean power of less than 3 watts, greater acuity – less power
  - Shorter duration pulses and higher repetition rate
  - Treatment time = 10 minutes

Dosage Parameters

- Chronic Conditions
  - Mean power more than 5 watts required to achieve tissue heating response
  - Pulses of longer duration
  - Treatment time- 15 – 20 mins
  - Need to be mindful of heating effect

Diathermy Contraindications

- Pregnant patients
- Open wounds, hemorrhage, or ischemic tissue
- Acute Infections
- Decreased sensation
- Proximity to active cancer
- Within 10 feet of those with cardiac pacemaker or implanted defibrillators
- Any implanted systems that may contain a lead or a removed implant that may have contained a lead

Ultrasound Vs Diathermy

- Diathermy provides a larger treatment area (drum head vs 2x ERA of US transducer) and is less labor intensive
- Ultrasound has slight advantage in depth, focal heating – trigger points
- Ultrasound can heat tissues faster (5-8 Mins vs 10-15 mins with SWD)
- Ultrasound has faster heat decay providing less time for mobilization
  - US = 5 min mobilization window
  - SWD = 10 min mobilization window

Moist Heat – Hot Packs

- Vasodilation: Increases blood flow and removes waste products/inflammatory compounds that activate nociceptors
- Decreases muscle spasm via vasodilation
- Increases pain threshold
  - Inhibit gating effect on transmission of pain sensation at spinal cord level – Gate Theory
- Increase ROM and decrease joint stiffness

Moist Heat – Hot Packs

- Have the patient wear a timer!!
- Highest rate of lawsuits in physical medicine
- Check for contraindications and precautions
- Inspect skin prior
- Test for sensory discrimination
- Educate patient, goals, communicate discomfort
  - Give patient a bell, make sure they can use it
- 6-12 layers of towels
- Beware of bearing weight on hot pack

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Electrical Stimulation

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Electrical Stimulation

The use of alternating or direct current applied through electrodes to the body for

- Pain management
- Muscle re-education
- Tissue healing

Electrical Stimulation Parameters

- Type of current
- Frequency
- Pulse duration
- On/off time
- Ramp time
- Amplitude
- Modulation
- Burst mode
- Proper electrode placement

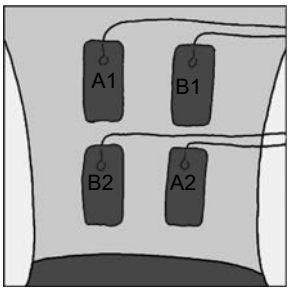
Pain Modulation

Sensory

- Conventional, high-rate TENS
- Interferential current

Motor

- Low rate, “acupuncture-like” TENS

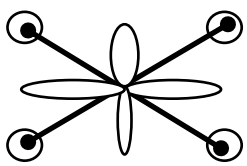


Pain Modulation - Indications

- ✓Acute or chronic low back or neck pain (muscle strain/spasm, trigger points, disc problem, stenosis)
- ✓Shoulder pain (bursitis, rotator cuff tendonitis, arthritis)
- ✓Knee pain (arthritis, post-op TKA)

Interferential Current (IFC)

- Superimposition or interference of two or three medium frequency sinusoidal currents by independent oscillatory circuits incorporated into the interferential devices
- Use quadripolar electrode set up with target area in center



quadripolar

bipolar

Transcutaneous Electrical Nerve Stimulation (TENS)

- Portable biphasic asymmetric electrical stimulation at sensory or motor levels providing analgesia

- Application technique: over the local site of pain or bilateral bipolar or bilateral crisscross at the involved segmental levels with distal acupuncture or trigger points appropriate for treatment of the painful area

TENS	Conventional	Acupuncture-like
Pulse duration	Short, 50-80 us	Long, 100-200 us
Frequency	High, 100-150 pps	Low, 2-10 pps
Amplitude	Comfortable, tingling	Tolerable, visible muscle contraction
Nerve fibers depolarized	Sensory	Sensory, motor
Onset of analgesia	Rapid, w/in minutes	Slow, w/in hours
Duration of analgesia	Short, < few hours	Long, > hours

Cognitive/Behavioral Strategies

Cognitive Strategies
- Distraction
- Relaxation
- Biofeedback
- Hypnosis

Behavioral Strategies
- Positive reinforcement
- Behavior modification

Cognitive/Behavioral Strategies

- Promote self-management
- Relaxation skills training
- Goal setting and pacing skills
- Problem-solving skills training
- Communication skills training
- Family interventions
- Habit reversal
- Relapse prevention

Cognitive/Behavioral Strategies

- Cognitive restructuring
- Behavioral goal setting
- Rational thinking
- Assertiveness training
- Pacing/activity journal
- Coping
- Relaxation

Exercise

- ROM
- Stretching/flexibility
- Strengthening
  - PRE
  - Isometrics
- Endurance
- Posture
- Body mechanics

Exercise

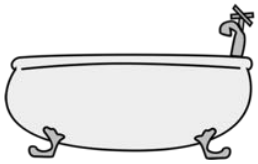
- Individualized programs
- Skilled therapy intervention as indicated
- Consider a group exercise program
- Program must be carried out long-term

Manual Therapy

- Myofascial release
- Soft tissue mobilization
- Joint mobilization
- Positional release

Activities of Daily Living/Mobility

- Compensatory strategies
- Energy conservation techniques
- Joint protection
- Adaptive equipment



Orthotics

- Reduce pain and inflammation
- Immobilize joints for rest and proper positioning
- Support joints during functional activities

Education

- Cause of pain
- Treatment plan
- Goals of treatment
- Factors that aggravate/alleviate pain
- Methods of pain relief
- Address fears, barriers to pain management, misconceptions about pain

Documentation

Documentation

- Prior Level of Function
- Reason for Referral
- Goals
- Plan of Care

Therapy Documentation

Goals (must be FUNCTIONAL)

- Minimize/eliminate pain in order to…
- Enhance ability to perform ADL/IADL
- Facilitate functional mobility

Treatment Interventions

- Skilled, medically necessary
- Progress toward goals
- Resident/caregiver/staff education

Documentation

Goals for Pain Management

- Minimize/eliminate pain
- Enhance ability to perform ADL/IADL
- Facilitate functional mobility

- SMART – Specific, Measurable, Attainable, Realistic, Timely

Sample Goals

LTG: By discharge, pt will be able to perform LB dressing from seated position using proper body mechanics with no c/o LBP

STG: In 2 weeks, pt will:

- Perform LB dressing using long-handled shoe horn and reacher with min (A) and LBP < 4/10
- Demonstrate proper body mechanics during bed mobility and sit<>stand transfers with < 3 VCs to maintain neutral spine

Sample Goals

LTG: By discharge, pt will ambulate 500 ft with standard cane and reciprocal gait with equal WB on carpet, tile, cement and gravel surfaces

STG: In 2 weeks, pt will:

- Report ↓ (L) buttock/post thigh pain to ≤ 4/10 to facilitate equal WB & step length during gait
- Ambulate 100' on tile & carpet with RW and step-through gait pattern with SBA and < 3 VCs for safety with RW

Documentation

Treatment Encounter Notes

- Justification for services billed
- Skilled interventions
- Patient/caregiver education
- Barriers to treatment/progress toward goals

Sample Treatment Notes

- Strain-counterstrain to (R) upper trap, (R) lateral cervical segments 2-4 followed by occipital release to ↓ neck pain and headache
- Pt received IFC to (R) lumbar paraspinals (L2-L5) @ 80 bps (sensory level stimulation) to ↓ pain and muscle spasm x 15 min prior to initiating lumbar stabilization exercises

CPT Codes

- 97012 Mechanical traction
- 97018 Paraffin
- 97022 Whirlpool (fluidotherapy)
- G0283 Unattended e-stim
- 97032 Manual e-stim (each 15 min)
- 97033 Iontophoresis (each 15 min)

CPT Codes

- 97035 Ultrasound (each 15 min)
- 97110 Ther ex (each 15 min)
- 97124 Massage (each 15 min)
- 97140 Manual therapy (each 15 min)
- 97530 Ther act (each 15 min)

Modalities – Billing: RAI Manual, Chapter 3, Section O

- "…only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS…The use and rationale for all therapy modalities, whether skilled or unskilled, should always be documented as part of the resident's plan of care."

RAI Manual v1.14, Chap 3, pg O-27

Modalities – Billing: Noridian

- The portion of time that can be recorded on the MDS includes:
  - Proper electrode placement
  - Establishing proper settings
  - Removal of electrodes
  - Examining the skin before and after treatment
- Documentation should be sufficient for the medical reviewer to determine when:
  - Skilled staff involvement/attendance is necessary
  - Services are reasonable and necessary for treatment and to promote the goals of therapy

Noridian, 2015

Documentation

- Documentation is key to supporting all skilled interventions no matter the procedure – including all modalities
- The presence of a modality on a POC or in a daily note does not justify the procedure or deem it skilled
- All regulatory language concerning skilled therapy delivery and documentation applies to modalities

Key components of documenting skill with modalities

- The modality must be clarified as part of an active written treatment plan including the location to be applied, frequency, and anticipated duration
- The reason for the modality must be clearly described
- Modality must be supported by the rest of the documentation within the chart
- Documentation should highlight the necessity and complexity of performing the procedure
- Relate modality to goals with objective scale- Pain, edema
- Document modification/adjustments and patient response

Modalities Documentation Checklist – Daily Note

- Type of modality
- Purpose
- Duration of treatment
- Parameters:
  - Current type
  - Waveform
  - Frequency and intensity
  - On/Off, Ramp up/down
- Skin Condition
- Patient response
- Functional correlation

In Summary…

- Key Points
- Pain is an individual experience
- Pain can severely impact quality of life
- A thorough IDT assessment is critical
- A comprehensive treatment plan is most effective
- Document medical necessity, patient response, adjustments, objective functional improvement, and patient caregiver education.

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Questions?