

Documenting Support for the Decision to Use Group Therapy



The Centers for Medicare and Medicaid Services (CMS) provides guidance for skilled nursing facilities (SNFs) on group therapy documentation:

*SNFs should include in the patient’s plan of care **an explicit justification for the use of group, rather than individual or concurrent, therapy.** This description **should include, but need not be limited to, the specific benefits to that particular patient** of including the documented type and amount of group therapy; that is, **how the prescribed type and amount of group therapy will meet the patient’s needs and assist the patient in reaching the documented goals.***

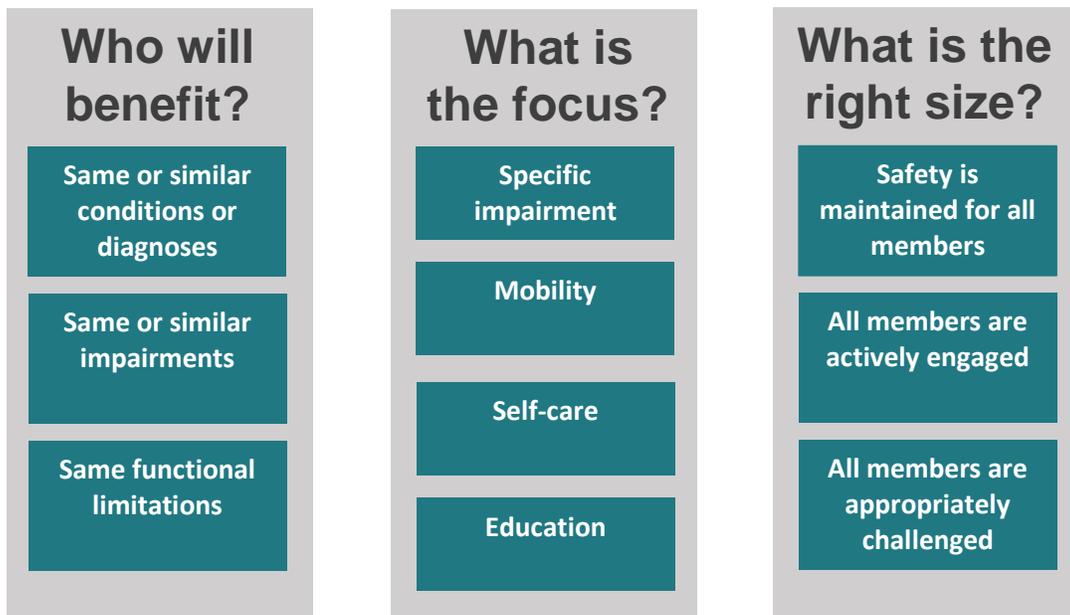
CMS’ guidance remains the same even with the revised definition of group therapy established in the Patient-Driven Payment Model, which became effective in October 2019. Here are some considerations for documenting support of your decision to use group therapy in a SNF.

What Constitutes Group Therapy: Medicare Part A, Part B, and Other Payers

Medicare Part A	Medicare Part B	All Other Payers
The treatment of <i>two to six</i> residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.	The treatment of <i>two or more</i> patients, regardless of payer source, at the same time.	Follow Medicare Part A descriptor unless otherwise directed per payer policy.

Source: CMS Resident Assessment Instrument Manual, V.1.17.1, October 19; Chapter 3, Section O

Considerations for Designing and Delivering Effective Group Treatment



How to Meet Documentation Expectations

The following are suggestions but not intended to be formal recommendations.

Plan of Care Justification

Provide language to support the rationale for including group therapy in the plan of care as an appropriate mode of intervention for the individual patient. Personalizing it to the patient, documentation language could convey that group therapy:

- Supports learning and carryover of tasks.
- Increases confidence and self-efficacy to promote sustainable carryover of functional tasks and safety strategies.
- Provides increased participation and engagement in therapy through peer interaction and support provided by the group format.

Documentation Example: Patient will benefit from [FILL IN THE BLANK] provided by the group format. (*Suggestions for filling in the blank:* peer interaction, peer support, modeling, increased engagement, a broader therapeutic alliance, shared experiences)

Examples of Documentation to Support Group Therapy as a Skilled Service

Impairment(s)	Patient treatment included skilled group intervention with focus on:	Participation in this group session of [#] people supports skills needed to address patient-specific goals related to [FILL IN THE BLANK]. <i>Suggestions related to each impairment are below.</i>
Patient demonstrates lower extremity weakness that contributes to functional limitations.	<ul style="list-style-type: none"> • Progressive LE resistance exercises, tailored to challenge each patient. • Education about the benefits of strengthening as part of a regular physical activity program to maintain or improve function. • Education regarding LE weakness as a modifiable contributor to fall risk. 	<ul style="list-style-type: none"> • Increased independence in transfers. • Decreased risk for falls. • Increased lower extremity strength for improved muscle performance and mobility. • Gait speed for home and community mobility.
Patient demonstrates impaired balance that contributes to functional limitations.	<ul style="list-style-type: none"> • Improving anticipatory postural adjustments, such as the ability to carry out an intended action at the appropriate future moment. • Executing the necessary direction, force, and sequence of actions for safe functional mobility. • Improving core and LE strength required for balance reactions. • Progressive static, dynamic, and ambulatory postural control training, tailored to challenge each patient. 	<ul style="list-style-type: none"> • Decreased risk for falls. • Increased ability to respond to perturbation. • Increased safety during multi-task ADL/IADL.
Patient demonstrates limitations in aerobic capacity that contribute to functional limitations.	<ul style="list-style-type: none"> • Progressive exercise/activity to increase aerobic capacity, tailored and monitored to challenge each participant. • Education about the benefits of aerobic training as part of a regular physical activity program to improve and sustain function. • Education in normal physiologic responses to aerobic activity, and training in self-monitoring heart rate and perceived exertion. 	<ul style="list-style-type: none"> • Increased safety and independence in limited community mobility. • Increased confidence in self-management of progressive walking program post discharge.

Impairment(s)	Patient treatment included skilled group intervention with focus on:	Participation in this group session of [#] people supports skills needed to address patient-specific goals related to [FILL IN THE BLANK]. <i>Suggestions related to each impairment are below.</i>
Patient demonstrates decreased function and/or safety related to transfers.	<ul style="list-style-type: none"> • Weight shift for transitions to and from sitting. • UE and LE strengthening for initial stance and return to sit. • Education and training regarding floor to and from stand transfers. • Demonstration and training regarding strategies for managing transfers from a variety of surfaces, such as low, soft surfaces with or without armrests. 	<ul style="list-style-type: none"> • Transfer independence with reduced risk for falls. • Return to independent living environment.
Patient demonstrates decreased function and/or safety related to gait.	<ul style="list-style-type: none"> • Dynamic balance in all planes of movement. • Bilateral LE strengthening. • Speed of weight shift and return to bipedal support. • Assistive device management training, all surfaces. • Dual-task gait activities and safety strategies in complex situations, tailored to the abilities of each participant. 	<ul style="list-style-type: none"> • Increased gait quality and speed for safety on level and uneven surfaces.
Patient demonstrates decreased function and/or safety related to wheelchair mobility and management.	<ul style="list-style-type: none"> • UE motor coordination for wheelchair parts management and mobility in everyday environments. • UE strengthening. • Cervical mobility for environmental scanning. • Progressive training in wheelchair management and mobility skills on a variety of surfaces, tailored to the needs and abilities of each participant. 	<ul style="list-style-type: none"> • Increased safety and independence in wheelchair management and mobility on even and/or uneven terrain. • Increased ability to access community environments for social, recreational, and/or vocational activities.
Patient demonstrates increased risk for falls.	<ul style="list-style-type: none"> • Identifying hazards in the home that increase risk for falls. • Safety procedures to call for help. • Learning how to recover from a fall, including floor to mat, bed, and chair transfers. • Education regarding risk factors, with focus on management of LE strength and balance, and need for program postdischarge for ongoing risk management. 	<ul style="list-style-type: none"> • Safe discharge home with nighttime caregiver support only. • Safe floor to bed and chair transfers. • Increased confidence in self-management of fall risk.
Patient demonstrates increased risk for impaired skin integrity.	<ul style="list-style-type: none"> • Instruction in skin inspection and pressure reduction for active self-management and prevention. • Foot inspection and education on proper hygiene to reduce risk of neurotropic ulcer. 	<p>Decrease risk of changes in skin integrity due to impaired sensation.</p> <ul style="list-style-type: none"> • Demonstrated ability to perform skin self-inspection and identify areas of pressure. • Increased confidence and engagement in chronic diabetes self-management and skin safety.
Patient demonstrates increased risk for hospitalization and/or unsuccessful transition to next level.	<ul style="list-style-type: none"> • Patient and, as needed, caregiver education regarding “red flag” signs and symptoms that indicate condition or chronic disease worsening, in need of medical attention. • Home safety checklist for emergencies and medication management. • Use of transition notebook or journal to follow home exercise program, medication routine, etc. • Importance of ongoing plan for physical activity, and strategies for sustained engagement. 	<ul style="list-style-type: none"> • Safety and improved confidence in chronic disease self-management strategies. • Independence in home program and safety strategies to reduce risk of decline and/or hospitalization. • Independence in recognizing signs and symptoms of medication intolerance. • Independence in recognizing changes in condition needing medical attention.