

## Quantifying Function: Status Critical

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### MeSH TERMS

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- recovery of function



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During a recent commencement address extolling the work of health profession disciplines, a prominent physician, congratulating the graduates of the University of Texas Health Science Center at San Antonio, remarked the following about occupational therapy:

Your role in restoring autonomy, self respect and quality of life to our friends and neighbors is critical. You need to be involved in patient care sooner and longer than currently recognized. Your position on the healthcare team is secure and will increasingly be recognized for the critical role you have. In the future, OT will not be an afterthought, but a first thought in the care of patients. (Holly, 2013).

His statements are sharply perceptive and intuitive as well, given the imminent health care changes and new federal reimbursement policies now being implemented. Although occupational therapy does not singularly own the concept of function, restoring health through meaningful, purposeful activity with a focus on occupation is historically and personally ours; we are uniquely and more appropriately trained for this task than any other discipline. Our role in restoring autonomy to people with injury or disease has now become critical.

### New Emphasis on Function in Medicare Reimbursement

Case in point: The Center for Medicare and Medicaid Services (CMS) has undergone an epiphany and now understands that therapy services should be driven by a

person's ability to return to purposeful activities, and not solely based on improvement of physical impairment—thus the recent mandate of using task-based G-codes and modifiers on all claims submitted for outpatient Medicare Part B recipients as of July 1, 2013. CMS reviewed previous fee schedule rules and researched past utilization of outpatient therapy services in developing the functional reporting system:

Although there is widespread agreement that beneficiary condition and functional limitations are critical to developing and evaluating an alternative payment system for therapy services, a system for collecting such data does not exist. Diagnosis information is available from Medicare claims. However, we believe that the primary diagnosis on the claim is a poor predictor for the type and duration of therapy services required. (Medicare Program, 2012)

This is an important indication that CMS now recognizes the critical nature of functional skill learning and independence in daily activities, the mainstay of our profession. The purpose of the new reporting system is to track functional changes that occur in patients over time; the coding is also a means for CMS to manage the rapid rise in Medicare expenditures and prevent provision of medically unnecessary services (Medicare Program, 2012). The original system was proposed in July 2012, and the American Occupational Therapy Association (AOTA) was diligent in giving analysis and feedback on the initial product (Hitchon, 2012). Although the codes do not directly drive payment and

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are in no way a perfect product at this time (AOTA emphasized the lack of attention to environment and context), the process provides basic task-specific information on patient status at the onset of therapy, at interim points throughout, and at discharge.

G-codes are the offspring of the basic components of the *International Classification of Diseases (ICD)* taxonomy developed by the World Health Organization (WHO; 2011). Currently in its 10th revision (*ICD-10*), the original purpose of the *ICD* was to classify diseases and provide standard diagnostic nomenclature in epidemiology and health management. However, the *ICD* was deficient in that it did not provide a mechanism to describe and report functional abilities from the patient's perspective; the *International Classification of Functioning, Disability and Health (ICF; WHO, 2001)* was then developed as a supplement precisely to describe and report human function. The *ICF* defines health conditions by specifying the body functions and body structures involved; the abilities associated with the health conditions are classified as activities and participation, and all components interact with environmental and personal factors.

The new G-codes are alphanumeric codes that describe the primary functional limitation being addressed by therapy services. The code that is chosen as primary by the reporting practitioner is based on the functional area (1) of greatest clinical relevance, (2) that will potentially resolve the most rapidly, or (3) of greatest priority for the patient (AOTA, 2013a). Of the 42 G-codes that are available for use by all disciplines, the codes typically used by physical and occupational therapy include

- Mobility: walking and moving around
- Changing and maintaining body position
- Carrying, moving, and handling objects
- Self-care.

Additional codes typically used by speech-language pathologists include

- Swallowing
- Motor speech
- Spoken language comprehension
- Spoken language expression
- Attention

- Memory
- Voice.

However, AOTA strongly encourages occupational therapy practitioners to use the codes of swallowing, attention, and memory to comprehensively report the full scope of the services they provide (AOTA, 2013b). Practitioners can also use supplementary codes labeled *other* to describe other services not defined by the current codes.

In addition to the codes, a scale of modifiers in percentage increments of 20 (1%–19%, 20%–39%, 40%–59%, and so forth) is used to quantify the percentage amount of impairment, limitation, or restrictions of the patient. This new coding system is a *mélange* of CMS encryptions used to report basic functional abilities and the amount of restriction or limitation involved. An additional resource available from the rehabilitation software company MediServe is a Claims-Based Outcome Reporting (CBOR) tool. The tool is on the MediServe Web site and allows the user to input a score from a selected assessment and obtain the appropriate modifier for impairment reporting (MediServe, 2013).

## Increasing Importance of Objective Measures

The G-code mandate presents occupational therapy with a tremendous opportunity; in the unforgettable words of Wendy Wood (1998), it may once again be “jump time” for occupational therapy. Why? Because not only do we have the precise tools and expertise to quantify and objectively measure functional performance, but we also are expertly skilled at restoring function in our clients through purposeful and meaningful occupations. AOTA has compiled a list of functional measures that provide data and information for G-code reporting (AOTA, 2013c). The tools on the Web site are a few suggested assessments, not an exhaustive list or the organization's mandate on which evaluations should be used. However, the list is a valuable resource for practitioners working with Medicare Part B beneficiaries and may help ensure that outdated, subjective measures that have become a part of many practitioners' assessment regimen are discarded and that use of some of the remarkable tests developed for (and, in

many cases, by) occupational therapists to quantify function is encouraged.

For several years, there has been a resounding call to use standardized, reliable, and valid instruments as part of clinical practice (Bowker, 1984; Managh & Cook, 1993; Russek, Wooden, Ekedahl, & Bush, 1997). Consistent measurement of outcomes is needed to validate the intervention effectiveness (Gutman, 2010), guide treatment planning (Veloza & Woodbury, 2011), and improve the quality of health care. However, occupational therapists continue to demonstrate resistance to the use of standardized measures (Robertson & Blaga, 2013); some of the reported reasons for the nonacceptance are time required to perform the tests, lack of training in test administration, lack of familiarity with the measures, and inability to interpret scores or results (Abrams et al., 2006).

No longer can therapists use these excuses. A variety of assessments are available ranging from simple 5-min checklists to complex 2-hr analyses of individual behaviors. Objective measurement and functional outcome reporting are not going away; we need this component of our practice to accurately define abilities and limitations for translation to G-codes today, and we will potentially face more extensive requirements tomorrow as reimbursement of medical services continues to change.

Consider a few of the powerful instruments available to specifically measure functional task performance. The Assessment of Motor and Process Skills (AMPS; Fisher & Bray Jones, 2010) is an exceptional tool for quantitatively measuring not only motor function but also the behavioral (process) components of completing a task. The client selects from more than 100 functional tasks he or she would like to perform (e.g., making a peanut butter and jelly sandwich, potting a small plant). The AMPS software program creates informative and comprehensive printouts of scores with meaningful explanations of results. Testers need to be certified to administer this tool, but it may be the model assessment for occupational therapy because it can quantify individual performance in selected occupations.

Another assessment that is invaluable for measuring task-based skills after stroke is the Functional Test for the

Hemiparetic Upper Extremity (Wilson, Baker, & Craddock, 1984). This assessment, unfortunately, has not had widespread exposure, but it is another useful battery for evaluating task performance. The stroke survivor is timed in a series of increasingly difficult tasks that begin with placing the hemiplegic hand in the lap and progress to using the weakened extremity to insert a light bulb into a socket using an overhead reach. The Canadian Occupational Performance Measure is a perfect tool for true client-centered intervention and can clearly prioritize the most meaningful activities of our clients (Law et al., 1990).

Practitioners working with people who have cognitive limitations may consider the Routine Task Inventory–Expanded (Katz, 2006), which contains both a self-report checklist and a performance-based checklist that the practitioner scores while observing the client in a variety of routine functional tasks over the course of several days or sessions. The Kitchen Task Assessment (Baum & Edwards, 1993) is another tool for clients with cognitive dysfunction that scores performance on a simple cooking task and quantifies specific cognitive abilities such as task initiation, planning and organization, safety, and appropriate task completion.

Other measures specific to activities of daily living (ADLs) include the Klein–Bell ADL Scale (Klein & Bell, 1982) and the Modified Barthel Index (Mahoney & Barthel, 1965). Still other tests, such as the Functional Reach Test (Duncan, Weiner, Chandler, & Studenski, 1990) and the Five-Repetition Sit to Stand Test (Bohannon, 2006), can be quick screenings that provide robust correlations with falling or overall functional ability. Other task-based assessments that can assist in G-code translation include the Arnadóttir OT–ADL Neurobehavioral Evaluation (Gardarsdóttir & Kaplan, 2002), the Test of Grocery Shopping Skills (Hamera & Brown, 2000), the Kettle Test (Hartman-Maeir, Harel, & Katz, 2009), the Wolf Motor Function Test (Wolf et al., 2001), and the Comprehensive Occupational Therapy Evaluation Scale (Brayman, Kirby, Misenheimer, & Short, 1976).

Although these are only a few of the many assessments available, they illustrate

the types of instruments we should be using as part of standard practice and to assist in G-code functional outcomes reporting. Currently, the G-code requirement is limited to Medicare Part B recipients; however, CMS mandates tend to drive the actions of private insurers, and therefore other payers may potentially require functional outcomes as part of standard claims submissions in the future. We must be prepared, and we can begin now by incorporating more of these assessments into our daily practice.

Perhaps most important, what we extract from the standardized assessments can provide even greater meaning to others when we do what we do best as occupational therapy practitioners: Marry these findings with the qualitative, contextual, and personal components of assessment that truly describe the essence of occupational performance. Doing so will give payers a full understanding of the impact that the condition has had on the person and his or her abilities, needs, and daily life.

## Conclusion

The move toward function-based reporting may finally educate beneficiaries, insurers, consumers, legislators, other medical personnel, and payers about the value of functional skills and the instrumental role occupational therapy practitioners play in returning clients to productive activity. At a minimum, it should begin to transition our thinking about standardized assessments and the importance of using objective, valid measures in our practice.

Occupational therapy is at a critical juncture. A closing thought from an *American Journal of Occupational Therapy* column written in 1998 remains timely today: “The time has never been greater for the profession to demonstrate through scientific methods what occupational therapists have always known intuitively: that occupational therapists hold unique expertise in the domain of function” (Gutman, 1998, p. 687). ▲

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