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SPEAKER:
You are listening to the AOTA podcast. Here is your host, Matt Brandenburg.

MATT BRANDENBURG:
Our presenting sponsor for the AOTA podcast is New York University Steinhardt's Department of Occupational Therapy. A quick show note, since the recording of this interview, Katie has been announced as the incoming Executive Director of the American Occupational Therapy Association. She will begin her new role in August of 2024. Back to the interview. Alright. Today, we are joined by Katie Jordan. Thank you so much for sharing your time and being on the show today, Katie.

KATIE JORDAN:
Thanks, Matt.

MATT BRANDENBURG:
As a way of introduction, Katie, you are the Chief Administrative Officer at University of Southern California Clinical Services and the Associate Chair of Clinical Occupational Therapy Services. You have experience as a practitioner, educator, administrator, and leader, and you have expertise in quality improvement, risk management, reimbursement, policy and advocacy, which truly makes you the perfect guest for our topic today as we will be discussing coding and billing as it relates to caregiver training services. How are you feeling?

KATIE JORDAN:
I'm feeling great. Thank you so much for having me. I'm really excited to talk about this, so thank you for doing the show.

MATT BRANDENBURG:
Absolutely. It's such an important topic, and one that I think the everyday practitioner could use a little brushing up on as it's not always at the forefront of our minds as we're preparing intervention and direct one-on-one treatment. But before we dive in, could you tell us a little bit about your background and occupational therapy and what motivates you to work to support and expand clinical occupational therapy services?

KATIE JORDAN:
I serve currently as the advisor on behalf of AOTA to the American Medical Association on the Healthcare Professional Advisory Committee and many other subcommittees like, currently, I serve on the practice expense committee as well. Volunteer leadership to me has always been a way to serve the association and the profession. And as an administrator, early in my career, I was frustrated really by the opaqueness and complexity of coding and billing, and I didn't really understand the system that financed a lot of occupational therapy practice. So, I wanted to learn more and I wanted to be able to advocate effectively for change. Engagement in this process on behalf of AOTA has helped me to do that, and it's given me the experience and expertise to create change and also to teach others and share with the broader occupational therapy community.

MATT BRANDENBURG:
That's wonderful, and it takes a lot of skill to work on a subject or a topic that, as you mentioned, might be opaque and complex and make it clear and simple and applicable to people who are affected by that policy or that topic. How would you begin to describe the importance of documentation, coding, and billing in occupational therapy?

KATIE JORDAN:
Yeah, that's a great question. None of those things are reasons why anyone became an occupational therapy practitioner. So, sometimes it's not the easiest topic, but each of them are critical to occupational therapy practice being recognized as an essential and distinct service for the patients and clients that we serve and that benefit from our skilled services. If we can't communicate to payers speaking a language that they understand through documentation, coding, and billing, then our services aren't effectively covered and reimbursed, which hurts consumers, practitioners, referring providers, researchers, really everyone in our broader community. So, it's vital that OT practitioners and students learn to speak in payer language so that we can clearly and effectively communicate the value of what we were doing to those that fund the services.

MATT BRANDENBURG:
Absolutely. We know it's important to be able to communicate effectively with patients, with caregivers, and also with those within the medical system, with payers, with insurance companies, important to learn that language as well. Could you introduce us to maybe one of the most important aspects or vocabulary terms within that language, which is current procedural terminology, code sets, what really are CPT codes? And how are these codes developed?

KATIE JORDAN:
Yeah, so for over 50 years, the American Medical Association Board of Trustees has been responsible for maintaining and updating current procedure terminology. They own and operate the code book that's recognized by the US Department of Health and Human Services as the primary medical language used to communicate across functions in healthcare. And that would be from practitioners to payers. But it also covers things like quality and risk and research and more. Every year, the CPT code book is edited, revised and released with over 10,000 codes in six different sections in three different categories. Most of the codes that OT practitioners use live in the physical medicine and rehabilitation section. AOTA does a really fantastic job of releasing a frequently used CPT code guide annually, and this is a really great resource for members to help you learn and expand your CPT coding knowledge and utilization. The codes are developed, deleted, and revised through the CPT editorial panel, and that's really the first step in the process of CPT.

And we have AOTA has an advisor, Leslie Davidson, that sits on that committee as well as an alternate advisor, Tippi Geron, and staff, including Kim Karr who work on that, on that committee on behalf of the association and representing occupational therapy practice. Once the codes are finalized, then they go to the relative value update committee. And that's where I serve as the AOTA advisor, along with our alternate advisor, Mary Walsh-Sterup and Kim Karr as AOTA staff. The relative value update committee is sometimes called the RUC is a specialty, multi-specialty group that provides expert recommendation to the federal government and really helps CMS understand the resources that are required to provide that clinical service that is represented by that CPT code. The RUC has to consider the work of the practitioner, the support staff, the time supplies, equipment, professional liability, and many other factors that make up the cost and value of providing a clinical service. The RUC is not required to advise the Centers for Medicare and Medicaid Services or CMS.

And CMS isn't required to accept the recommendation, but the process that the American Medical Association runs in partnership with CMS helps to ensure that there is input from the healthcare professional that's considered to help the government adopt policies that reflect our contemporary practice.

MATT BRANDENBURG:
It's really interesting to kind of hear you describe this, what's typically happens behind the scenes, but how you're helping be a voice for the practitioner and really connect those CPT code sets to day-to-day and to the intervention activities and what practitioners are doing and clinical settings. It makes it a little more clear to see how an awareness of how these CPT codes are developed and where they come from can improve someone's approach to practice and intervention, and obviously be a part of that uniform language for coding medical services and procedures that streamlines reporting and increases accuracy and efficiency. The current terminology code set that became effective on January 1st, 2024 includes some new codes, three new codes related to caregiver training without the patient present. Can you describe these new codes for us kind of what are they and how did they get developed and approved?

KATIE JORDAN:
Yes. We are so excited to roll these codes out and to educate practitioners on how to use these codes and why they exist. And this was many years in the making. I think that's the other piece of it that may be behind the scenes, as you said, that there's a lot of collaboration and work that goes on just to get to the point where we can get these codes approved and across the finish line for practitioners to be able to utilize them. So, there's three new codes in this family. It's a caregiver training family of codes. The first one is 97550, and this is caregiver training for one or more unpaid caregivers of an individual patient in strategies and techniques to facilitate the patient's functional performance in the home or community. So, that can include things like ADLs, IADLs, functional mobility, communication, feeding, problem-solving, safety practices, and this is without the patient's presence. It's a timed code face-to-face with the caregiver for an initial 30 minutes. There can be more than one caregiver present, but they're representing one patient.

And then there's an add-on code 97551. That gives you an additional 15 minutes beyond the first 30 minutes of individual caregiver training if you need more time. And then finally, there's a group caregiver training code, which is 97552. And this is where caregivers for one patient receiving training at the same time as caregivers for other patients, because the patients have similar goals or needs or the caregivers have similar training needs.

MATT BRANDENBURG:
So, these three codes 97550 to 97552, how would you say interventions associated with these codes differ from traditional caregiver education that occurs with the patient present?

KATIE JORDAN:
Usually, caregiver education means providing general information about the patient and their potential needs. There may be handouts involved or resources that are shared. When we provide caregiver education and the patient is present, we're able to currently capture those services under the CPT code that most closely matches the topic that we're educating on. So, that could be self-care, therapeutic activities, therapeutic exercise, for example, these new codes, this family of codes about providing caregiver training with functional skill training that they need to facilitate the therapy plan of care and the patient's functional performance are able to be provided when the patient's not present for the training or they're not able to participate.

MATT BRANDENBURG:
I love that this is included in the new code set. As a pediatric practitioner, myself, I've often thought, "Man, I wish I could just design a full-hour intervention session, just to work with the parents and with this kid that I have and just to train, you know, some of these strategies that we've been working on implementing at home or across environments. And it's nice to see that this is established and included in coding and billing now to encourage more collaboration. How do you think that the inclusion of these codes will reduce caregiver burden and support patients'functional performance in ADLs, and in life in general?

KATIE JORDAN:
Matt, I'm so happy that you shared that about pediatric practice. When we presented these codes, they were initially presented to CMS, and so the patient vignette was initially a stroke patient. And I'll talk more about that in a little bit, but I actually really think that this is going to be used very often, if not most often, in pediatric practice environments, working with caregivers and parents on their goals. The best practice for most patients would be caregiver training with the patient present, but for some patients with medical complexity or conditions that impact their ability to participate actively in that training, caregivers without the patient present offers an opportunity at, like you talked about, to directly engage caregivers to ensure safe transition of care or safe performance of care tasks in a manner that will encourage working with the patient or client to reach their goals and encourage engagement of the caregivers with those goals and participating in that training.

Sometimes the caregivers lack competence or confidence to complete care tasks in a safe and effective manner. And these codes offer an opportunity to train those caregivers that need a chance to build confidence and build skills before they work with their loved ones on those skills. This would increase the confidence and also reduce risk for injury of both the caregiver and the client as the caregivers learn new skills.

MATT BRANDENBURG:
I love that so much. I we emphasize so much client centered care and including caregiver training without the client present to me is a way of providing caregiver centered care, which in a way increases our scope as therapists and the impact that we can make on our clients and people that we work with. What settings and practice areas of occupational therapy will be first impacted by the changes in these codes?

KATIE JORDAN:
All settings, I think the sky's the limit. We know there are applications for hospital settings, skilled nursing facilities, long-term care facilities, outpatient clinics, private practice, and pediatric practices. In fact, I think that's, as I mentioned, where we will see this code set utilized the most is with caregivers for children who can benefit from this specialized training to reach their goals. It's really dependent on which payers those settings accept, and whether the payer has included this new family of codes as billable in that setting. In settings where payers have not added this service to what occupational therapy practitioners can do, it may take advocacy by practitioners to ask payers to consider reimbursement of these services.

MATT BRANDENBURG:
I love that. I love that. What would advocacy look like? Or what would you recommend to a clinician who maybe wants to increase their scope and collaborate with a payer to have this type of service approved? Would they be writing letters, reaching out to people? How would they go about that process?

KATIE JORDAN:
So, if you find out that this code set this family is not included in the list of billable services for you as a practitioner for a particular payer, I would recommend reaching out directly to that payer either through email or phone call to inquire about including this code set. I think one of the things that we have in our favor is that this family was approved as we presented it with the language that we presented to the Centers for Medicare and Medicaid. So, Medicare approved this code set, including the relative value of the code sets. And that gives you a lot of strength in talking to commercial payers and others to be able to say, look, this is a Medicare approved service. Here are the three codes that went into effect in January, and it's listed in the CPT code book, and Medicare approves and reimburses for these services. So, once Medicare does that, commercial payers tend to follow suit, but they're not fast enough. Sometimes they may not have it on their books as of January 1.

So, I think sometimes it's educating payers, it's alerting them to these code changes, and it's letting them know the full scope of occupational therapy and how this service will support their beneficiaries.

MATT BRANDENBURG:
I love that. I love that. And it's clear to see how establishing communication with payers and agencies in this way can help grow. The scope of occupational therapy can add new relationships and new approaches to a clinician's toolbox. And on top of that, it's going to be very important to prepare to provide skilled intervention in caregiver education and caregiver training. What are some of the criteria or qualifications for skilled intervention that can be billed using these codes?

KATIE JORDAN:
As with any skilled intervention, medical necessity is critical. So, being able to demonstrate that medical necessity for providing caregiver training without the patient present needs to be established in the medical record. It needs to be... Because of the patient's medical condition or cognition or the caregiver skill level, so not for scheduling convenience, but because of the medical necessity, that's why you need to do this caregiver training. The code should be identified in what you plan to do in that plan of care. So, when you do your initial evaluation and you write your plan of care, if you're planning on doing caregiver training, that should be part of your plan of care. The patient's best practice would be for them to consent to providing each caregiver training without them present, and that should be documented in the record. Training needs to address the patient's goals, like what you mentioned earlier, the patient-centered plan. The caregiver training should clearly align with the goals and outcomes for that patient and should focus on the skills that the caregiver needs to reach those goals.

And then for Medicare at least, and maybe for other payers as well, we don't know yet, but caregivers are defined as unpaid family or friends who have significant relationship with the patient and provide assistance in daily tasks. So, this may be defined differently by other payers, but that's the definition of caregivers that we're working from right now.

MATT BRANDENBURG:
I love that. That's such a wonderful guideline and emphasizes the importance of addressing caregiver training through every step in the OT process. It's not just an aspect of care to be tacked on after you've been working with a patient, but it should be deliberate and purposeful from the moment you initiate the plan of care to be thinking about how to incorporate caregiver training to increase carryover and overall wellbeing. That's sustainable. Our presenting sponsor is New York University Steinhardt's top ranked Department of Occupational Therapy, which now offers an entry-level OTD for aspiring occupational therapists. NYU additionally offers advanced degrees for practicing therapists that can be completed in person or online, study and work with leading educators, researchers, and master clinicians in the vibrant setting of New York City, and have access to a diverse patient population and extensive healthcare system. Learn to deliver exceptional patient care or deepen your knowledge and practice as you focus on applied scientific inquiry and clinical areas such as pediatrics, developmental disabilities, mental health, and assistive rehabilitation technologies.

Take the next step by visiting steinhardt.nyu.edu/ot to learn more. What would you say are some additional considerations that practitioners should keep in mind when working with caregivers and designing these types of caregiver training interventions?

KATIE JORDAN:
Like you just stated, I think that's really the key. This needs to be intentional. It needs to be part of the plan. It should be a scheduled interaction. The services should be based on your clinical judgment. As a clinician, you can decide if caregiver training is needed and it should be, and whether that training should be with or without the patient present during the course of treatment, and when that should occur in your plan of care. The OT practitioner needs to determine whether the caregiver would benefit best from either individual training or from group training. And that would depend on the patient's condition, the goals that they have, the skill level and confidence of the caregiver, as well as the specific training that's required in order to develop those skills.

MATT BRANDENBURG:
I love that. What type of strategies would you share for how to kind of assess that? How can practitioners begin to assess what type of training they should be incorporating, assess kind of the collaboration and relationship between caregivers and their patients? What recommendations do you have for how to design and implement these, these types of trainings?

KATIE JORDAN:
It's really great to start at the beginning, I would say. So, when you do your initial evaluation, that's a perfect time to assess caregiver support, which I know a lot of practitioners do because that's an important part of thinking about what kinds of goals are feasible and where the patient and client needs to get to at the end of your care, at the end of your treatment plan. So, assessing the caregiver's skill, confidence, and availability to provide support is going to be an important part of your initial evaluation. And then that would help you to guide the types of goals that you're including in your plan of care, including caregiver training, if that's appropriate for that, for that client. Caregiver support is a really big initiative from Medicare, and they're putting out a lot of resources that practitioners can use to think about how to design effective caregiver training. There's a lot of literature about the positive impact of caregiver training. In fact, that's what really prompted this whole project was looking at how critical caregiver training is to the entire unit, the family.

And when we presented these codes to CMS to advocate for their inclusion, we shared that evidence about what this could do for caregivers and for families in order to support the patients and clients that we work with.

MATT BRANDENBURG:
And I love that perspective. And I want to thank you again for all the work you and the team members you've mentioned have put into advocating for these codes and occupational therapists' role in using these codes. I love that focus of not just looking at the individual and the patient, but looking at them and how they operate within their own family unit. How would you kind of summarize some of that research and evidence that you presented? How does including caregivers across the care continuum help patients maintain progress in the long term?

KATIE JORDAN:
Well, it's really critical to carryover, carryover of treatment plans. That's a critical piece of long-term progress, especially once you've discharged the patient from your care, their ability to maintain those skills that they've learned is, is also dependent on the support that they have from caregivers and others in their environment. So, training caregivers in those strategies really helps the patient to continue or maintain to improve their skills after they've completed their episode of care with us. And proper caregiver training also helps caregivers to reduce the risk of falls injury and potential rehospitalization. So, engaging caregivers in all stages across the continuum of care helps to ensure that patients are safe and able to enjoy a better quality of life when they continue to engage in meaningful occupations in their community. And I would also add that it helps to... We've talked about confidence and competence with caregivers, but I think it also helps keep them safe too.

And especially things like body mechanics and how they're going to provide cueing for patients, it helps them to really understand the challenges and also the opportunities and capacity of the people that they're caring for.

MATT BRANDENBURG:
Thank you, Katie. The benefits are clear and it really emphasizes the importance of being intentional of on caregiver training. You mentioned earlier that you had a case vignette or a case study prepped for us today. Can you present this case study or clinical experience of how these codes could be used and what kind of procedures could be followed in their application?

KATIE JORDAN:
Yeah. When we presented this set of codes, we actually had to present a case. It's part of the process when you present a new code to the CPT editorial panel, and it's also part of the process of determining the right value for the code that you're presenting. So, we created a vignette, and we use the example of a stroke patient. And I should also share that this family of codes was a partnership, a collaboration between AOTA, ASHA, which is the Speech Language and Hearing Association, and APTA, physical therapy. So, the vignette that we created had to work across all three associations and three professions. So, we had examples of how we would each engage with a stroke patient, with their family for utilization of these codes. So, from the occupational therapy perspective, we would work with caregivers to ensure that they know how to support the patient to successfully navigate in their environment, working on things like functional mobility and adaptive equipment, if that's needed. So, teaching the caregivers how to adjust different equipment for different situations.

We'd teach the caregivers on using adaptive tools or cueing effectively in an activity like meal preparation. And we'd demonstrate how to use safe toileting and bathing strategies to protect them through proper body mechanics and also ensure safety with the patient that they're caring for while also providing the least restrictive environment possible for that patient.

MATT BRANDENBURG:
I love that. And how were you able to present this case and tie the positive outcomes to the one-on-one caregiver training or group caregiver training that clinicians were providing?

KATIE JORDAN:
Yeah, I'll start with the group. So, for the group, we focused on the ability to move around to different modules or stations, so that caregivers could see how different types of equipment or strategies could be used for patients that they're caring for. And the other benefit of having a group caregiver training is that they create a peer network and support, and they can share strategies with each other that may or may not be included in the skilled service that the practitioner is providing, but helps them to create a community with each other and share tips and strategies and resources that have worked for them. For the individual one-on-one, we're really focused on meeting the goals of that individual patient helping them get from point A to point B, and also creating opportunity to continue to improve and expand on the goals even beyond discharge. So, what are the things that are goals for that family going into the future? When we presented the vignette, when we presented the code set, we also focused on things like reducing cost, reducing utilization, reducing rehospitalization, falls, and other negative quality and safety outcomes that could come about if caregivers weren't prepared, and if the patient didn't have an environment where there was a lot of support and understanding of what's needed for them.

So, that's what we use when we presented the codes, and also when we talk to CMS about why they should fund and support these codes, because ultimately, it's going to help people stay safe in their home and their communities and live a high quality of life together with their family.

MATT BRANDENBURG:
What more could we ever ask for our patients? (LAUGHS)

KATIE JORDAN:
Right. Yes, exactly.

MATT BRANDENBURG:
I love that creative application of these codes in a group setting, especially in designing modules or stations to provide that, that group training. Do you have any additional recommendations or tips of how clinicians could begin to incorporate these codes into their day-to-day?

KATIE JORDAN:
Start early. And often, I would say, as we've talked about, think about it in your evaluation and how you might incorporate this in your plan of care. If you were working with older adults, as I mentioned, CMS has a lot of resources on caregiver training and support that can help you think about designing effective caregiver training. aota.org has a web article on caregiver training services that you can access. And there also is a really great free webinar at the AOTA store that you can access. If you have questions, I would encourage you to reach out to regulatory at aota.org and they can always help you troubleshoot, especially the billing and coding aspects.

MATT BRANDENBURG:
Thank you. Those are some wonderful resources. We'll definitely encourage listeners to check out more. Katie, this has been such an informative and important interview and I really appreciate your recommendations on how clinicians can begin to implement more caregiver training into their day-to-day. We're now at the golden nugget segment. And I want to ask you if you could share one piece of knowledge or one recommendation to practitioners, what would you say?

KATIE JORDAN:
I mentioned earlier that this was a multi-year process. It was also a collaboration between AOTA, ASHA, APTA, and ultimately AMA and the Centers for Medicare and Medicaid Services. So, it took a long time and a lot of resources and a lot of effort to get to this point. And I would just say keep advocating for our full scope as occupational therapy practitioners. Getting this code set was an example of what's possible. Through years of collaborations, meetings, lots of hard work from our dedicated AOTA staff and volunteer leadership, and we did it. We got this amazing family of codes that is really going to make a difference in the lives of patients and clients that we serve. So, it's possible to make change. And we really need people to continue advocating so that we can continue working together as a community to enact the change that will improve the lives of the clients we serve.

MATT BRANDENBURG:
That is so wonderful. Thank you so much again for all the work that you've done along with your team in advocating for a profession. And like you mentioned, it truly is so beautiful and wonderful to see how these new codes are really a representation of an OT lens and OT centered, you know, practice and care. That's included by AMA and by CMS, so that it truly is wonderful to see.

KATIE JORDAN:
Thank you, Matt. It's been really great to share. We're so excited to have this finalized and rolled out and really anxious for people to use the codes and give us feedback and ask questions as you see trends happening in your practice.

MATT BRANDENBURG:
I love it. Well, thank you so much for your time, Katie. It's been wonderful speaking with you today.

KATIE JORDAN:
Thank you so much, Matt. It's been nice to get to know you and thanks for featuring this.

MATT BRANDENBURG:
Thank you listener for tuning in and thank you to NYU Steinhardt Program and Occupational Therapy for sponsoring this episode.

SPEAKER:
Thanks for listening to the AOTA podcast. Tune in again next time. (MUSIC PLAYS)