

Documentation Essentials in Long-term Care

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Learning Objectives

1. Provide basic Medicare coverage guidelines for skilled therapy services
2. Understand RehabCare's documentation policies and procedures
3. Describe the elements of therapy documentation that support Medical Necessity
4. Understand the need for accurate and timely documentation to meet Medicare requirements
5. Review the general guidelines of documentation, including the importance of proper medical error corrections, approved abbreviations and point of service documentation

Target Audience

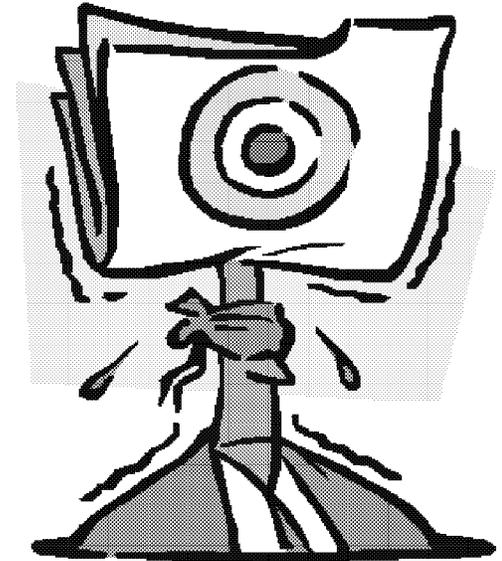
- All therapist and assistants providing patient care in the long-term care setting

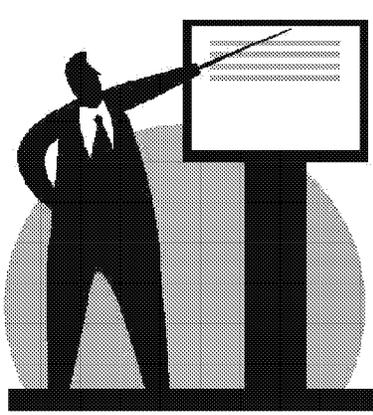
Who is your target audience??



Pre-test

1. It is unacceptable to state "continue as ordered" when writing a re-clarification order.
 - a. True
 - b. False
2. For Medicare Part A ICD-9 medical coding, all disciplines use the facility selected primary medical diagnostic code which will be used to bill Medicare for the skilled SNF services.
 - a. True
 - b. False
3. It is acceptable to indicate "poor" or "fair" for rehab potential when completing the Weekly Progress Note.
 - a. True
 - b. False
4. If the physician's signature has a history of marginal or questionable legibility, the therapist should PRINT the physician's first name, last name and credentials below the signature line PRIOR to submitting the document for signature.
 - a. True
 - b. False
5. Evaluation time recorded should be indicative of completion of a comprehensive evaluation (minimum of 15 minutes).
 - a. True
 - b. False





Introduction

Three Reasons to Document

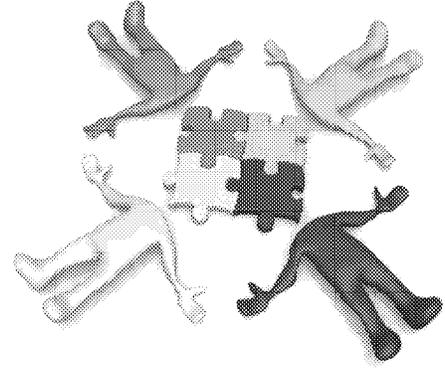
- CLINICAL
 - Required to support the services provided
 - Clinical description of the need for skilled services
 - Clinical description of the skilled interventions that address those needs
 - Clinical description and objective measurement of the outcomes of the skilled interventions
 - Communication with other healthcare professionals
- REGULATORY
 - Meet the requirements of CMS, Medicare Contractors and state practice acts for PT, OT, and ST
- COMPLIANCE
 - Ensure that services provided are properly documented to support billing as well as clinical and regulatory requirements

Medicare Coverage of Skilled Therapy

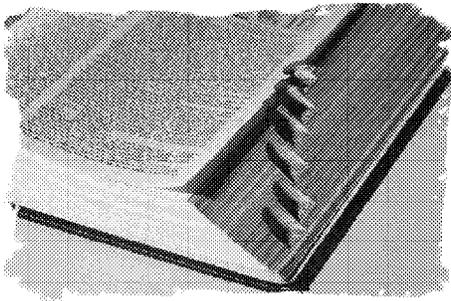
- Services must be considered under accepted standards of medical practice
- Services must be at a level of complexity and sophistication OR the condition of the resident must be of a nature that requires the judgment, knowledge and skills of a therapist
- Services must be related to an active written treatment plan designed by a physician
- The resident's condition should improve in a reasonable period of time OR the services are needed to set up a safe and effective maintenance program related to a specific disease state
- The frequency and duration of the therapy services must be reasonable for the treatment of the resident's condition



Documentation Essentials in Long-term Care



Overview of Medicare Requirements	
Medicare Part A Requirements	Medicare Part B Requirements
<ul style="list-style-type: none"> • Daily Treatment Notes <ul style="list-style-type: none"> ○ Best practice is to provide Daily Treatment Notes ○ Many Medicare Contractors require Daily Treatment Notes • Weekly Progress Report <ul style="list-style-type: none"> ○ RehabCare’s policy requires every 7 calendar days ○ Can be completed by a therapist or assistant • Discharge Note <ul style="list-style-type: none"> ○ RehabCare’s policy requires the therapist to write the Discharge Note, not the assistant • Include standardized tests in episode of care 	<ul style="list-style-type: none"> • Daily Treatment Notes <ul style="list-style-type: none"> ○ Required • Weekly Progress Report (Progress Reports) <ul style="list-style-type: none"> ○ RehabCare’s policy requires every 7 calendar days • Supervisory (10th Visit) Note <ul style="list-style-type: none"> ○ Must be written by a therapist (not assistant) ○ RehabCare’s policy is to write the Supervisory (10th Visit) Note on a Weekly Progress Note form • Discharge Note <ul style="list-style-type: none"> ○ Must be written by a therapist (not assistant) • Certifications/Recertifications <ul style="list-style-type: none"> ○ Required no less than every 90 calendar days for each treating discipline (or at the expiration of the previous POC) • Include standardized tests in episode of care • Complete the “Clinical Justification for Automatic Exception Form” for every resident that exceeds the cap and qualifies for an automatic exception



Treatment Intervention Definitions

Treatment Intervention	Definition
Individual treatment	<ul style="list-style-type: none"> • Treatment of one resident at a time with the resident receiving the full attention of one therapist/assistant
Concurrent treatment	<ul style="list-style-type: none"> • Treatment of two residents at the same time regardless of payer source • Residents are performing two different activities • Residents are in line of site of therapist/assistant • Medicare Part A <ul style="list-style-type: none"> ○ Report the total number of concurrent treatment minutes; MDS grouper will count 50% of the minutes for use in the RUG calculation • Medicare Part B <ul style="list-style-type: none"> ○ Not billable under Medicare
Group treatment	<ul style="list-style-type: none"> • Treatment of two-four residents at the same time regardless of payer source • Residents are under the supervision of one therapist/assistant who is not supervising any other individuals • Coding <ul style="list-style-type: none"> ○ 97150 – group therapeutic procedure utilized by OT, PT (& ST by some Medicare Contractors) ○ 92508 – group therapeutic procedure utilized for any ST services including dysphagia with two or more individuals; reference your Local Coverage Determinations for specifics on ST group coding • Medicare Part A <ul style="list-style-type: none"> ○ Group minutes are limited to 25% of the resident’s total therapy time per <i>discipline</i> per assessment/7-day look-back period ○ Report the entire unallocated group treatment minutes; MDS grouper will apply the 25% limitation for use in the RUG calculation ○ Residents are performing similar activities • Medicare Part B <ul style="list-style-type: none"> ○ All one on one treatment conducted with overlapping time is coded as group therapy ○ Exception is supervised (unattended) modalities (refer to: Utilizing Modality Interventions Using POC Device Technology) ○ Residents are performing similar or different activities
Co-treatment	<ul style="list-style-type: none"> • Treatment by two therapists, each from a different discipline, treating one resident at the same time • Minutes are split between each of the two disciplines as determined by the therapists • Split time may not exceed the actual total treatment time

Documentation Essentials in Long-term Care

Treatment Intervention Comparisons

Type of Treatment	Individual	Concurrent	Group
# Patients Allowed	1	2	2-4
Treatment Goals	N/A	Different	Medicare Part A <ul style="list-style-type: none"> ▪ Similar or different Medicare Part B <ul style="list-style-type: none"> ▪ Similar or different
Amount of Therapy	<ul style="list-style-type: none"> ▪ No limit ▪ Clinically appropriate 	Medicare Part A <ul style="list-style-type: none"> ▪ No limit ▪ Clinically appropriate ▪ Report the total number of concurrent treatment minutes; MDS grouper will count 50% of the minutes for use in the RUG calculation Medicare Part B <ul style="list-style-type: none"> ▪ Not billable under Medicare 	Medicare Part A <ul style="list-style-type: none"> ▪ Group minutes are limited to 25% of the resident's total therapy time per <i>discipline</i> per assessment/7-day look-back period ▪ Report the entire unallocated group treatment minutes; MDS grouper will apply the 25% limitation for use in the RUG calculation Medicare Part B <ul style="list-style-type: none"> ▪ Clinically appropriate ▪ Reimbursement is poor
HCPC Codes (individual or group)	Codes that most accurately describe the interventions and services provided	Follows individual therapy guidelines	<ul style="list-style-type: none"> ▪ 97150 (PT/OT/ST) ▪ 92508 (ST)
Part A?	YES	YES	YES
Part B?	YES	NO	YES
Other Payor Groups	YES	Check with Case Manager	Check with Case Manager
Type of Staff	<ul style="list-style-type: none"> ▪ Therapist ▪ Assistant 	<ul style="list-style-type: none"> ▪ Therapist ▪ Assistant 	<ul style="list-style-type: none"> ▪ Therapist ▪ Assistant
Requires <i>specific</i> clarification order?	Follow usual clarification order procedures	NO	YES
Requires <i>specific</i> documentation in POC?	Follow usual clarification order procedures	NO	YES
Frequency of Documentation	Per Medicare Contractor and RHB policy	Follows individual therapy guidelines	With each group intervention



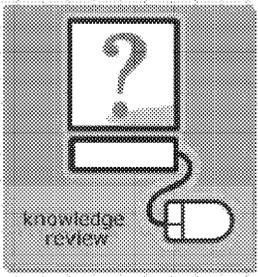
Medical Record Documentation Guidelines

- All original therapy documents should be placed in the resident's medical record in an organized fashion
 - Copies are not appropriate in the medical chart unless original is out for signature or misplaced and the copy is designated as a copy
 - Therapy documentation should be filed by discipline, in chronological order, newest to oldest
- All medical record entries must be legible
 - Use only black ink
 - Document in a clear, concise, direct manner
 - Use proper spelling and grammar
 - Use only approved medical terminology and abbreviations
- Always document facts and objective information about the resident's condition, status, and response to treatment
 - Describe signs and symptoms
 - Avoid expressing personal feelings about a resident
 - Do not argue with or disagree with other health care providers
 - Do not record any negative statements about the facility in which the resident resides
- Do not leave any blanks on documentation
 - Write not applicable (NA) or not tested (NT) as appropriate
- Correct errors with a single line through the error, then initial and date the correction
 - White out is not approved
- Do not document patient care or billing before it has been delivered
 - Unable to accurately reflect the resident's response to treatment
 - Potential error in billing if time or treatment changes

Documentation Essentials in Long-term Care

- Do not tamper with the medical record
 - Make entries in the medical record with the current date
 - All copies in a soft file and medical record should be marked COPY unless it is obvious it is a copy (NCR 2 part forms, for example)
 - Do not alter another person's documentation
- Late entries are appropriate if important information needs to be added to the medical record
 - Write "late entry" to demonstrate it is late and out of sequence
 - Record the current date and time of the late entry
 - Use a blank progress note to describe the information
 - An entry more than 30 days late is unacceptable
- Residents must be identified with full name, initials and Medicare number
 - Do not use nicknames in the medical record
- Document why treatments were not provided per the frequency identified on orders due to medical illness, refusals, etc.
- All documentation must be signed and dated by the therapist, including professional credentials
 - Students or therapists pending licensure must have all notes reviewed and co-signed by licensed therapist
 - Assistants must follow state practice acts for supervision and co-signature requirements
- *Key Point:* Document timely; file timely

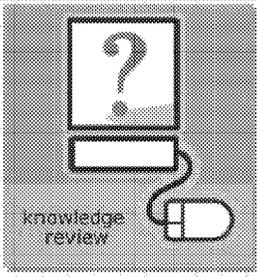




Knowledge Review – Introduction

1. Errors should be corrected with a single line through the error, then initial the error.
 - a. True
 - b. False

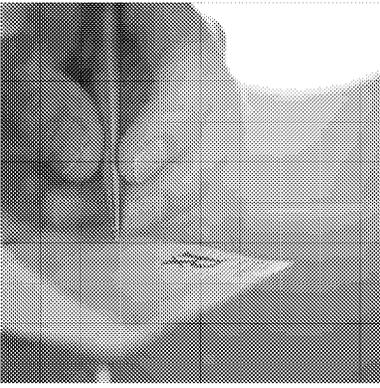
2. Which of the following is incorrect regarding medical record documentation?
 - a. All medical record entries must be legible
 - b. Document in a clear, concise, direct manner
 - c. Use only approved medical abbreviations
 - d. Use only blue ink
 - e. Use proper spelling and grammar
 - f. None of the above



Knowledge Review – Introduction – Answer Key

1. Errors should be corrected with a single line through the error, then initial the error.
 - a. **True**
 - b. False

2. Which of the following is incorrect regarding medical record documentation?
 - a. All medical record entries must be legible
 - b. Document in a clear, concise, direct manner
 - c. Use only approved medical abbreviations
 - d. **Use only blue ink**
 - e. Use proper spelling and grammar
 - f. None of the above



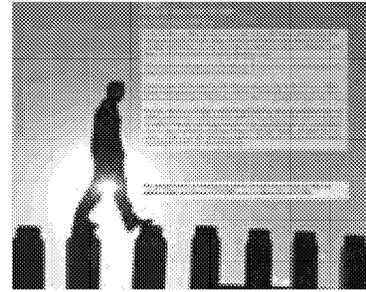
Physician Orders

Orders: Eval & Treat

- Therapist must obtain/verify a specific evaluation and treatment order prior to the initiation of the evaluation
- A new facility admit does not constitute an order for therapy
- Eval and treat orders must be separate and distinct from clarification orders
- Evaluations must be completed within 24-48 hours of notification of order
- Maintain a copy and place in soft file
- Only a therapist or a nurse can write an order
- An order written by a therapist must be for own discipline
- Physician signature must be legible and present within 30 days and dated timely

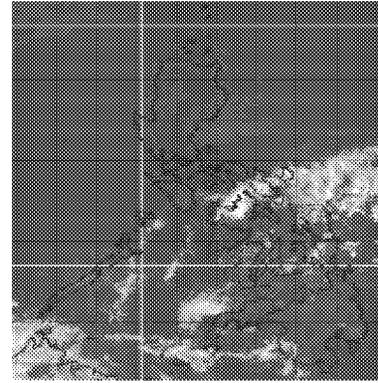
Orders: Initial Clarification

- Must be written and dated on day of evaluation for each discipline
- Must include the following components:
 - Specific procedures/modalities written in CPT code terminology, including group therapy, if appropriate
 - *Examples:*
 - ultrasound, therapeutic procedures, gait training
 - Frequency – the number of visits that will be conducted per week
 - Ranges of time are not appropriate (i.e., 2-3 times per week)
 - *Examples:*
 - PT services to be conducted 3 times per week for 30 days
 - OT services to be conducted 12 visits over 30 days
 - If initial week is a partial week, the following may be appropriate:
 - If a Medicare Part A resident is evaluated on Friday, the order can be written as *“PT services to be conducted 1 time this week and beginning the week of 11/14 the resident will be seen 5 times per week”*
 - If a Medicare Part B resident is evaluated on Wednesday, the order can be written as *“PT services to be conducted 2 times this week and beginning the week of 11/14 the resident will be seen 3 times per week”*
 - Treatments needed in excess of the current frequency must be conducted via an additional clarification order
 - Duration - the length of time the services are to be conducted in 30-day intervals
 - Duration should not exceed 30 days
 - Ranges of duration are not appropriate (i.e., 2-4 weeks)
 - Group therapy – a statement to indicate that a portion of the treatment may be conducted in a group setting
- Ensure clarification order matches frequency/duration/procedures/modalities checked on the initial POC
- Maintain a copy and place in soft file
- Only a therapist or a nurse can write an order
- An order written by a therapist must be for own discipline
- Physician signature must be legible and present within 30 days and dated timely



Orders: Reclarification

- Must be written on or before the due date, every 30 days
- Must be complete for all payor sources
- Must include the following components:
 - Specific procedures/modalities written in CPT code terminology, including group therapy, if appropriate
 - *Examples:*
 - ultrasound, therapeutic procedures, gait training
 - Frequency – the number of visits that will be conducted per week
 - Ranges of time are not appropriate (2-3 times per week)
 - *Examples:*
 - PT services to be conducted 3 times per week for 30 days
 - OT services to be conducted 12 visits over 30 days
 - Treatments needed in excess of the current frequency must be conducted via an additional clarification order
 - Duration - the length of time the services are to be conducted in 30-day intervals
 - Duration should not exceed 30 days
 - Ranges of duration are not appropriate (i.e., 2-4 weeks)
 - Group therapy – a statement to indicate that a portion of the treatment may be conducted in a group setting
- It is unacceptable to state "continue as ordered."
- Ensure reclarification order matches frequency/duration/procedures/modalities checked on the continued POC
- Maintain a copy and place in soft file
- Only a therapist or a nurse can write an order
- An order written by a therapist must be for own discipline
- Physician signature must be legible and present within 30 days and dated timely

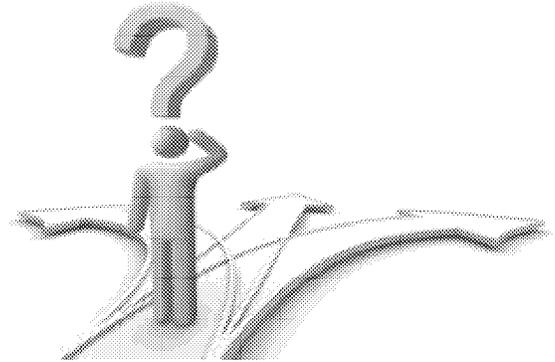


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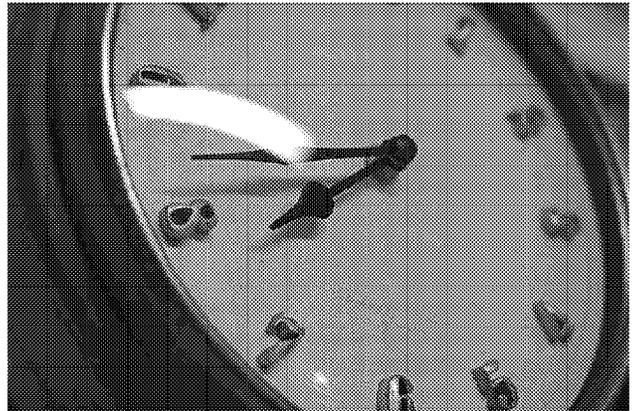
Orders: Discharge

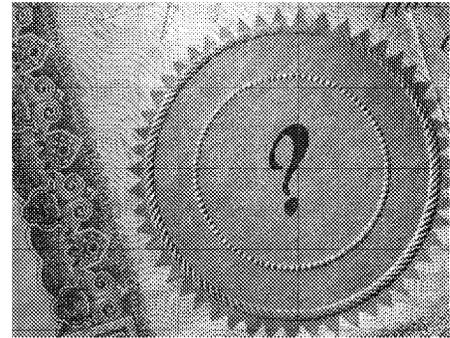
- Must be written at the end of care for each discipline unless the resident is discharged from the facility or expires
- Maintain a copy and place in soft file
- Only a therapist or a nurse can write an order
- An order written by a therapist must be for own discipline
- Physician signature must be legible and present within 30 days and dated timely



Orders: Late Entry

- If orders are noted to be absent:
 - If the medical record is closed the order will remain absent
 - If the medical record remains open and/or the medical record is available in the facility, the order will be written per facility policy
- Maintain a copy and place in soft file
- Only a therapist or a nurse can write an order
- An order written by a therapist must be for own discipline
- Physician signature must be legible and present within 30 days and dated timely





Medicare Part B Certification/Recertifications

- Medicare requires the Part B initial *certification/plan of care* be completed no less than every 90 calendar days by a therapist (clinician) and sent to the referring physician for signature and date
 - The initial *certification/plan of care form* must be signed and dated (certified) by the physician within 30 calendar days of the initial therapy treatment
 - Payment may be denied if the plan of care is not certified timely
 - The physician signature must be legible
 - The clinician can record, prior to obtaining physician signature, the full name of the physician below the signature line to ensure legibility
 - If the date is left blank by the physician a therapy staff member may record “received on” in order to record the date
 - The time frame cannot exceed 90 days
 - If clinical judgment of the evaluating therapist determines the certification needs to be for a lesser period of time, the timeline range can be less than 90 days
 - Some State Practice Acts require a 30 day certification for all patients therefore compliance to these practice acts will be upheld
- Once the initial *certification/plan of care* timeline has expired and the therapist (clinician) determines additional care is medically necessary, the treating therapist (clinician) will complete the *re-certification/continued plan of care form* and submit to the treating physician for review and subsequent signature and date
 - Input from the therapy assistant is acceptable, however the therapist (clinician) must complete the *re-certification/continued plan of care form*
 - The *re-certification/continued plan of care* must be completed and submitted for physician’s signature and date
 - The physician’s signature must be dated within 30 calendar days of completion of the *re-certification/continued plan of care*
- All initial and subsequent *re-certifications/continued plan(s) of care* are filed in the medical record with a copy filed in the soft file
- Evidence of the therapist’s (clinician’s) active participation in the therapy plan of care is required on the completion date of the *re-certification/continued plan of care*
 - This can be achieved by performing at least one unit of an intervention with the patient in order to gather critical data to determine current status of the patient

Documentation Essentials in Long-term Care

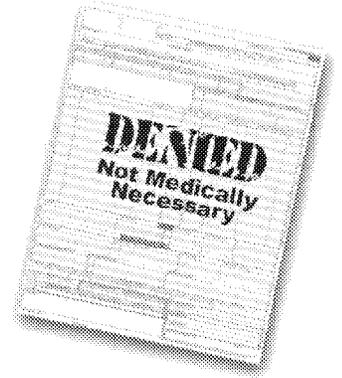
- Per Medicare and RehabCare guidelines, all entries on the initial *certification/plan of care* and *re-certification/continued plan of care* must be completed by the original licensed therapist, and later entries noted by initials and date
 - Any entries after signature of the physician to the *re-certification/continued plan of care* must be added by addendum on a blank therapy note

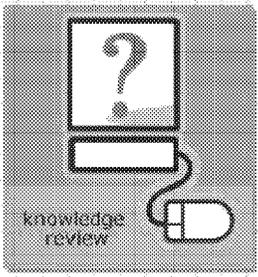
Medicare Recertification	
Medicare Part A	Medicare Part B
<ul style="list-style-type: none"> • Re-certification not required unless by the client or Practice Act • Recap order every 30 days repeating CPT interventions/modalities and specify frequency/duration 	<ul style="list-style-type: none"> • Re-certification must be completed no less than every 90 days by the therapist (clinician) and signed and dated by the Physician • Recap order every 30 days repeating CPT interventions/modalities and specify frequency/duration

Documentation Essentials in Long-term Care

Demonstrating Medical Necessity for Therapy Services - Physician Orders

- Do the services ordered require the skills of a therapist?

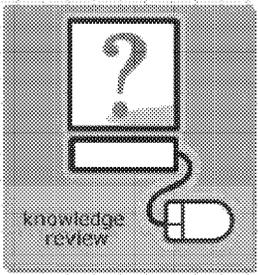




Knowledge Review – Physician Orders

1. Ranges of time are acceptable when writing clarification/re-clarification orders.
 - a. True
 - b. False

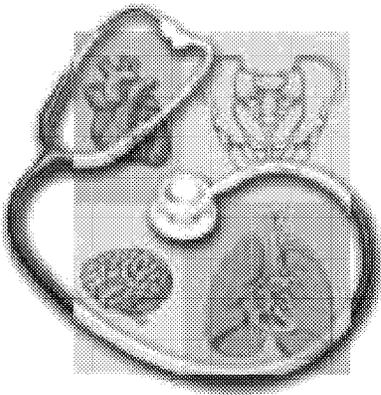
2. Eval and treat orders must be separate and distinct from clarification orders.
 - a. True
 - b. False



Knowledge Review – Physician Orders – Answer Key

1. Ranges of time are acceptable when writing clarification/re-clarification orders.
 - a. True
 - b. False**

3. Eval and treat orders must be separate and distinct from clarification orders.
 - a. True**
 - b. False



Evaluations

Evaluation: Basics

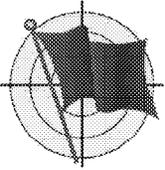
- Complete all blanks when completing the evaluation or write not tested (NT) or not applicable (NA) as appropriate
- Do not refer to another discipline for recording objective data
- Use standardized tests as indicated whenever possible
 - Reassess throughout the course of treatment to evaluate progress and help support services provided
- Avoid duplication of therapy services between disciplines
 - OT services provided should be distinct from PT services
 - If OT and PT are both involved in clinical care, it may be appropriate for OT to focus on specific ADL goals and PT to focus on bed mobility and transfers goals in order to best meet the resident's clinical needs
 - If it is necessary for OT and PT to share like goals, such as bed mobility and transfers, ensure consistency with expected outcomes and avoid variability
- Per Medicare and RehabCare guidelines, all entries on the initial POC/certification must be completed by the original licensed therapist, and later entries noted by initials and date
 - Any entries after signature of the physician to the initial POC/certification must be added by addendum on blank therapy note
- For Medicare Part B initial POC/certification, physician signature and date is required (certification statement at the bottom of the eval) to comply with Medicare regulations
 - For other payers, some state practice acts, facilities or Medicare Contractors may require the physician to sign and date the initial POC
- Evaluation only (with no further treatment recommended)
 - Medicare may pay for the evaluation if a complex medical condition exists and it is necessary for the establishment of a functional maintenance program
 - *Key Point:* It may be appropriate to provide at least a few follow up treatments to ensure that the recommendations made upon evaluation are appropriate and need no further modification
- The initial POC must be signed and dated by the therapist, including professional credentials, as required by state standards of practice for each professional organization
- The original initial POC must be placed in the medical record with a copy placed in the soft file
- SLP must perform and bill two separate evaluations for speech/language services and dysphagia



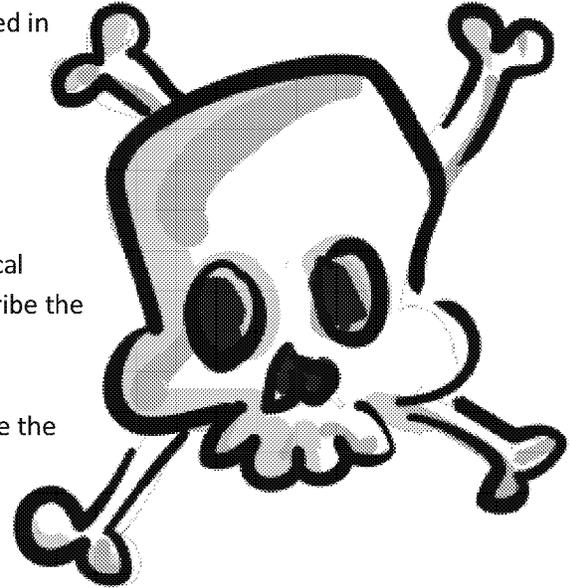
Evaluation: ICD-9 Coding

- Definition - International Classification of Diseases:
 - Describe the medical/clinical condition, disease and/or procedure into a 3, 4 or 5 digit number
 - Support and describe services provided
 - Support medical necessity
 - Used for analysis, indexing and medical review
 - Used for billing claims
- Always use the current year's ICD-9 codes
 - ICD-9 codes are updated annually with new codes or more specified codes
- Do not use codes that are no longer applicable to the resident's current medical status
 - Do not code medical conditions that were previously treated and are currently resolved
 - Ask your facility how they update a resident's ICD-9 codes
 - Codes can be updated via a clarification order if approved by your facility
- Code to the highest specificity
 - Many codes require a 5th digit to describe the specific anatomical area or the specific diagnosis
- The first diagnosis is primary, current or most serious and represents the medical condition that refers the resident to therapy
 - Use codes that describe the chief reason why therapy is being provided, such as osteoarthritis, late effects of a cerebrovascular accident (CVA), osteoporosis, etc.
- List supportive ICD-9 codes to help describe the reasons why the resident is receiving therapy services
 - Use multiple codes per discipline to fully describe the clinical complexity of the resident
 - Avoid patterns of using the same codes with all residents
- Don't use E codes (injury codes) which will place edits in secondary payor category
- Document both the code number and descriptor
- Know your FI's/MAC's Local Coverage Determination (LCD) for coding guidance





- **Red Flag:** The following codes are NOT RECOMMENDED to be used on therapy claims:
 - 330-337 – Dementia or degenerative disease codes listed in the section 330-337 as a sole code on the claim form
 - 780.79 – Malaise and fatigue
 - 780.99 – Other general symptoms as chills, amnesia, generalized pain
 - 799.3 – Debility, unspecified
 - It is best to use a more specific diagnosis/medical condition and/or add supportive codes to describe the condition of the resident
 - Unspecified codes in any category (xxx.99)
 - Always use a more specific diagnosis to describe the resident's medical condition
 - Codes listed as non-covered in the Local Coverage Determinations (LCDs) of the Medicare Contractor will be denied



- Medical Diagnosis ICD-9 Codes
 - Should describe the medical condition which prompts the referral for therapy services
 - Medical diagnosis code should be taken from the diagnosis sheet or physician orders (unless V code)
 - Multiple codes can enhance reimbursement since it captures the medical complexity of the resident
 - Verify that these codes are approved by your Medicare Contractor through their LCDs

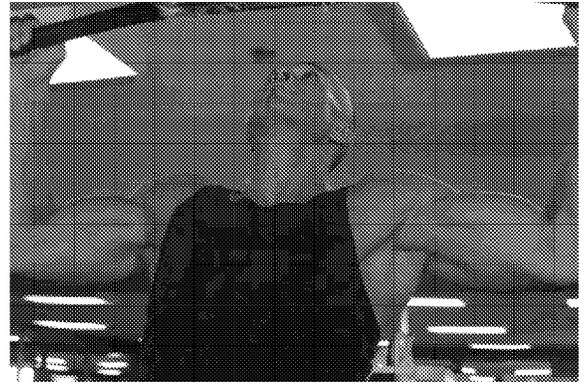


Medical ICD-9 Codes	
Medical ICD-9 Codes for Medicare Part A	Medical ICD-9 Codes for Medicare Part B
<ul style="list-style-type: none"> • All disciplines use the facility selected primary medical diagnostic code which will be used to bill Medicare for the skilled SNF services • Verify codes are approved by your Medicare Contractor through their LCDs • A variety of V codes are available for the facility to use • Each therapist should add any other pertinent medical ICD-9 codes which will be directly correlated with their skilled interventions • Are used to address the medical complexity of the resident • <i>Examples:</i> <ul style="list-style-type: none"> ○ Prior amputation ○ Parkinson's disease ○ Osteoarthritis ○ Prior CVA 	<ul style="list-style-type: none"> • Each discipline selects the medical diagnostic code which correlates with the need for skilled therapy services • Can be the same as the treatment diagnostic code • A medical diagnosis must be signed off by physician <ul style="list-style-type: none"> ○ Use codes which are found in the medical record if possible • Verify codes are approved by your Medicare Contractor through their LCDs • A variety of V codes are available for the facility to use • Each therapist should add any other pertinent medical ICD-9 codes which will be directly correlated with their skilled interventions • Are used to address the medical complexity of the resident • <i>Examples:</i> <ul style="list-style-type: none"> ○ Low vision ○ Diabetes ○ Dementia ○ Peripheral vascular disease • Therapists may utilize the automatic process for exception for any diagnosis for which they can justify services exceeding the cap

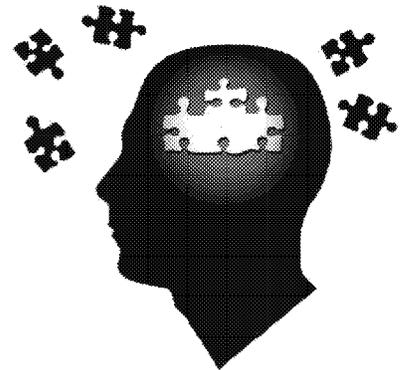


Documentation Essentials in Long-term Care

- Treatment Diagnosis ICD-9 Codes
 - Discipline-specific codes which describes the type of skilled interventions to be provided
 - Verify that these codes are approved by your Medicare Contractor through their LCDs



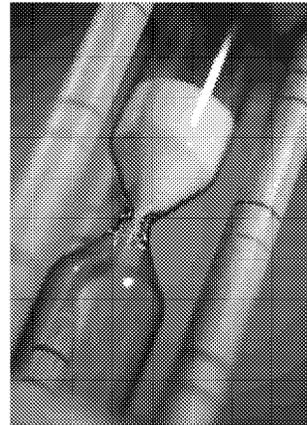
- V Codes
 - V codes are encouraged to support therapy services
 - Can be used when the purpose for the SNF admission and/or therapy encounter is based on the need for rehabilitation
 - V codes should not be used alone
 - Include other pertinent codes which provide more information on the clinical conditions of the resident
 - V codes can be used for both Medicare Part A and Medicare Part B



Quick Coding Reference	
Medical Diagnosis	Treatment Diagnosis
<ul style="list-style-type: none"> • Code the diagnosis which is closely related to therapy POC, condition for admission to SNF, condition for hospital services • Code the diagnosis which reflects over 50% of the therapy effort for that discipline • Hospital diagnosis may or may not be related to why rehabilitation is involved • Code several diagnoses (1-3) if the combination describes more clearly the medical condition • Record the number and description of the code 	<ul style="list-style-type: none"> • Code the diagnosis which describes the therapy intervention • Code the diagnosis which interrelates to the medical condition • Code several diagnoses (1-3) if the combination describes more clearly the therapy intervention • Record the number and description of the code

Evaluation: Onset Date

- Use the onset of the primary diagnosis and/or exacerbation of the illness or injury for which therapy services are being rendered
- If the exact onset date is unknown, use the first day of the month when onset is suspected



Evaluation: PLOF

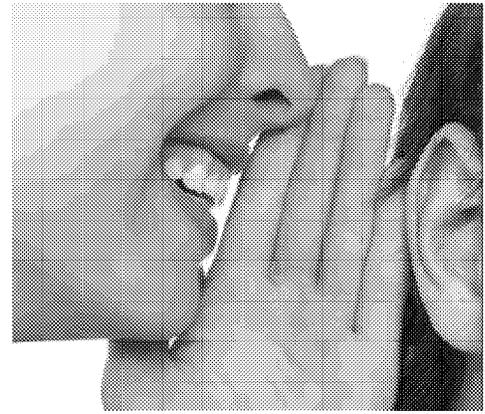
- Provides the “picture of the resident” prior to the admission to the facility or prior to the referral to therapy and as it relates to the current status and goals developed on the POC
- May need to be obtained from the family or from hospital records
- Establishes baseline for development of resident’s goals
 - PLOF should address each functional goal area
 - Justifies why a resident may need extended services prior to discharge
 - Writing “independent in ADLs” is not adequate to describe the abilities of the resident



- *Examples:*

- Resident independent in bed mobility; was independent in bed to wheelchair and toilet transfers; was ambulating independently to the dining room with wheeled walker without caregiver assist
- Resident lived alone in apartment with no support - independent in all ADLs and IADLs
- Resident was performing all ADLs and mobility activities independently at the assisted living environment prior to the hospitalization; no caregiver support required
- Resident was independent with upper body bathing, dressing, and hygiene, but husband provided assistance with lower body bathing, dressing, and toileting hygiene
- Resident was tolerating mechanical soft textures and nectar thick liquids with cueing for chin tuck in restorative dining program
- Resident has hx of aphasia and was using picture board and writing to augment verbal communication





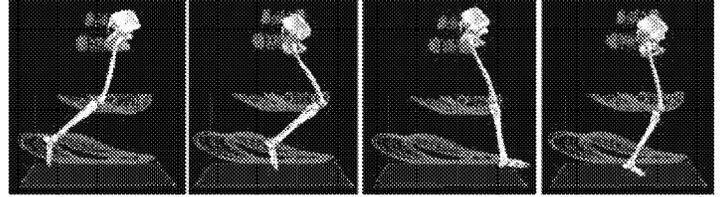
Evaluation: Reason for Referral

- Describe the significant functional change and/or need that has caused the resident to lose function and relate it to the primary or treating diagnosis
 - Why is therapy needed now?
 - Stating “decline in function” by itself does not adequately justify the initiation of therapy services
- *Examples:*
 - Resident has declined in ADLs since re-admission from hospital; is currently dependent in self cares due to right CVA with recent hospitalization
 - Resident has experienced numerous falls in the past week resulting in the loss of functional mobility in gait and transfers in the room



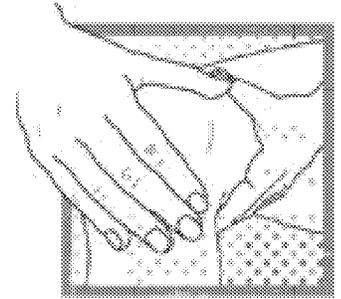
Evaluation: Extremity Function

- Must be completed in its entirety; focus on POC and discipline goals
- *Examples:*
 - PT should address UE function if pertinent to POC
 - Use of adaptive equipment requires UE function
 - OT should address LE function if pertinent to POC
 - Upright activities require LE function
- Do not refer to the other discipline



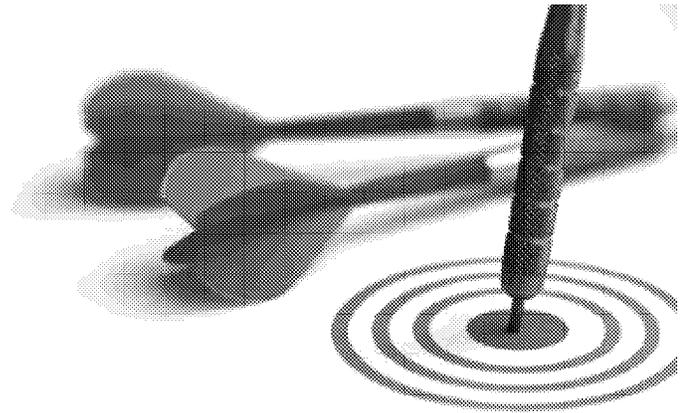
Evaluation: Plan

- Must include a list of the therapy procedures/ modalities appropriate for the condition of the resident
- Must include the frequency and duration of the therapy treatment
- Must match the clarification order



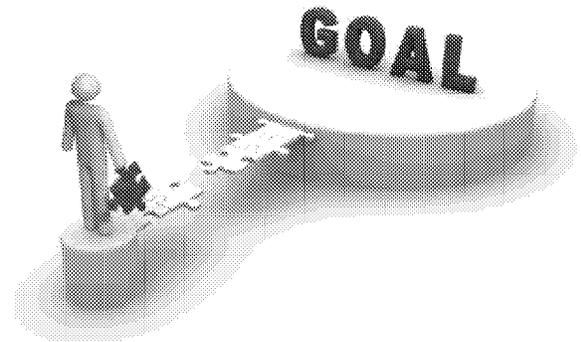
Evaluation: STGs

- Reflect the description of what the resident is expected to achieve as a result of therapy
- Should be segmented so that they can be reached in 1-2 weeks
- *Consider:*
 - Goals for caregiver education, including safety, when discharge home is anticipated
 - Goals for endurance, including energy conservation, work simplification, pacing, etc, when poor endurance has been identified as a barrier
 - Goals for balance when high risk for falls has been identified as a barrier
 - Goals for pain when pain is contributing to limited function



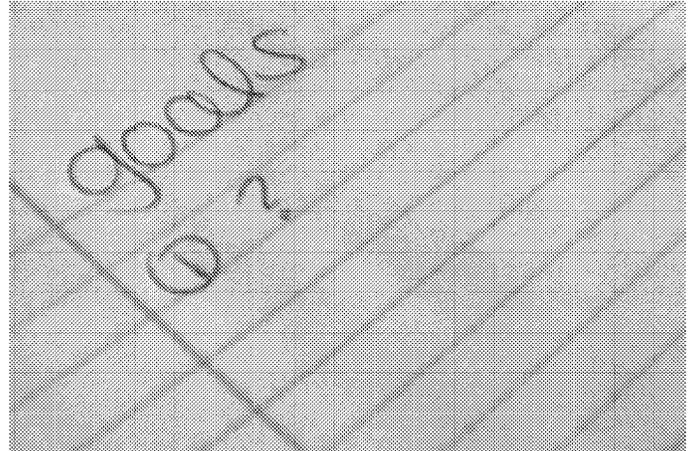
Evaluation: LTGs

- Reflect the final level the resident is expected to achieve
 - Should be developed for the entire episode of care
 - Should be realistic
- Have a positive effect on the quality of the resident's everyday functions
- *Consider:*
 - Medical condition
 - PLOF
 - Discharge destination
 - Anticipated length of stay
 - Resident/family priorities/goals
 - Family/Community support/resources
 - Physical functioning (including self-care, mobility, communication, cognition)
 - Resident tolerance/motivation/fall risk



Evaluation: Writing STGs and LTGs

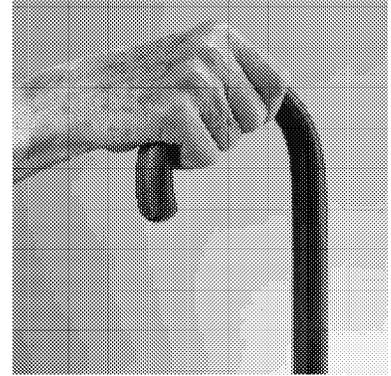
- Should answer “who will do what with how much assistance and the reason *why* this ability is important”
- Should be related to a functional activity
 - Strength, ROM, balance and pain by themselves are not functional, but can affect the resident’s ability to function
 - Without the connection to function, there will be a poor correlation between the written goals and established POC
 - Why does a resident’s knee strength need to increase by ½ grade?
 - Will the increased strength allow ambulation with a lesser assistive device, less assistance, or advance to uneven surfaces or stairs?
 - Goals for strength, ROM, balance and pain should have a *corresponding functional STG or LTG*
 - If the goal for increased strength or ROM is to improve gait, there should be a related goal for gait
- Should be measurable
 - Highest level of independence is NOT a measurable goal
- Should be patient centered
 - Establish a home exercise program is not patient centered, but therapist centered
 - Same goals for multiple patients are not patient centered
- Should be broken down into *specific* tasks
 - “Resident will be independent in all ADLs” should be broken down into individual tasks of bathing, dressing, eating, transferring, toileting, as appropriate
- Should be numbered in an organized format so they can be tracked throughout the episode of care (Medicare Benefit Policy Manual, Chapter 15, 220.3)
 - Any consistent method of identifying the goals may be used
 - Preferably, the LTGs may be numbered (1, 2, 3,) and the STGs that relate to the LTGs may be numbered and lettered 1.A, 1.B, etc.
 - The consistent method of identifying the goals on the POC may not be changed during the episode of care to which the plan refers
 - A therapist shall add new goals with new identifiers or letters and omit reference to a goal after it has been met
- *Example:*
 - STG Goal #1: “Resident will ambulate independently with a straight cane on multiple surfaces 25 feet from the kitchen to the bathroom within two weeks”



Goal Examples: "Resident will..."	
Balance/ Posture	<ul style="list-style-type: none"> • "Maintain balance/posture with (list level of assistance) for (time) when.... (list task)"
Cognition	<ul style="list-style-type: none"> • "How many cues does it take to perform safety precautions?" • "Family will demo/report independence with safety precautions"
Joint Status	<ul style="list-style-type: none"> • "Increase ROM (list joint) to/by (___ degrees) for (list task)" • "Increase flexibility to perform twisting / rotation movement required in job duties – 40 full upper body rotations per ½ hour" • "Increase ROM (list joint) to reach ___ inches for overhead cabinets"
Mobility	<ul style="list-style-type: none"> • "Ambulate / transfer (level of assistance) (distance/surface/height)" • "Ambulate 150 on uneven surface with SBA to retrieve mail daily" • "Safely/independently transfer on/off bed height of ___ inches" • "Be able to side step ___ inches to avoid obstacles in home" • "Step over ___ inches to for tub/shower stall transfers"
Muscle Status/ Conditioning	<ul style="list-style-type: none"> • "Decrease effects of atrophy on musculature for increased endurance (tolerate sitting in w/c ___ hrs, complete hygiene & grooming tasks in ___ min)" • "Increase inspiration/expiration breathing by demonstration of (blowing tissue, blowing ___# of bubbles, etc.)"
Pain reduction related to function	<ul style="list-style-type: none"> • "Reduce pain to 2/10 when picking up 10 lb. weight (infant weight/grandchild etc.)" • "Report only 3/10 pain when (stooping, bending, rotating, kneeling, etc.) (list activity)"
Safety	<ul style="list-style-type: none"> • "Demonstrate independence with THR /TKR precautions when (list task)..."
Self-Care	<ul style="list-style-type: none"> • "Increase ROM to ___ for full golf swing" • "Increase strength to ___ to pick up child from off floor" • "Increase grip strength to ___ to unscrew lids to jars" • "Increase shoulder internal rotation to ___ brush hair"
Skin Integrity	<ul style="list-style-type: none"> • "Decrease reddened areas while sitting in chair for minutes/hours" • "Decrease wound size to cm"
Strength	<ul style="list-style-type: none"> • "Increase strength to ___/5 for (list task)" • "Increase strength to ___/5 to pick up groceries from inside car trunk" • "Increase (list body parts) strength to ___/5 to lift iron skillet from low storage cabinet to stove level"
Wheelchair Assessment/ Positioning	<ul style="list-style-type: none"> • "Increase sitting tolerance to min/hrs while up in w/c with adaptive positioning equipment " • "Decrease effects of poor posture on resident's physiological status" • "Increase self-care skills of (eating, grooming, hygiene, dressing, etc.) to (level)" • "Increase transfer (bed to chair, chair to toilet, etc.) to (level)"

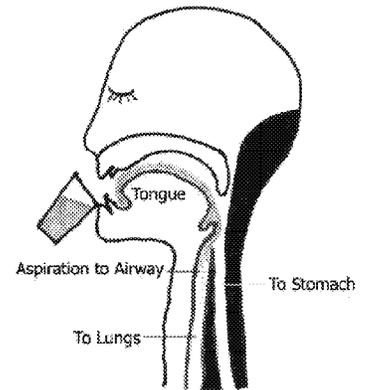
Evaluation: Rehab Potential

- Therapist's assessment regarding potential to meet goals, resident's ability to be trained, participation in care, and caregiver/family support and recency of acute illness
- Rehab potential should be good or excellent for stated goals
 - If not, goals may be unachievable and require modification



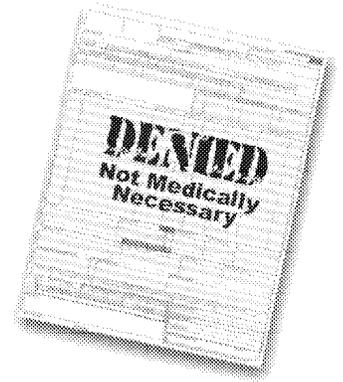
Dysphagia Medical Workup Form

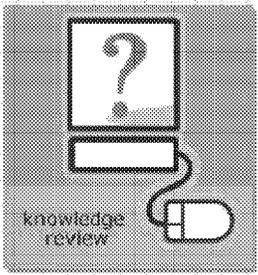
- Must be completed at the time a speech therapist completes a dysphagia evaluation if dysphagia is not listed as a diagnosis in the medical record
- Must be signed by the physician
- The SLP should include the specific dysphagia code on their clarification order to allow the facility to add it to the medical record
- Dysphagia is used as both a medical and treatment diagnostic code



Demonstrating Medical Necessity for Therapy Services - Evaluation

- What specifically was the recent change in condition that precipitated a physician order for a therapy evaluation?
 - Is this change documented by nursing/physician?
- What was the recent PLOF?
- What is the current level of function with objective measurements?
- Define the need for services that require the skills of a therapist
 - Why are the services needed now?
 - What further injury, deterioration can occur if therapy does not intervene?
 - Does the resident's condition require the skills of a therapist to safely and effectively carry out the proposed POC?
 - Could a member of the nursing staff or restorative provide the same activity or POC?
 - PROM is NEVER a skilled intervention
- Are the amount, frequency and duration of treatment consistent with the nature, extent, and severity of the illness or injury?
 - Justify the proposed treatment plan intensity
 - This includes the resident's needs and the accepted standards of practice as specific and effective treatment for the resident's condition
- Is the resident's expectation for functional improvement positive?
 - Can the resident follow simple and complex commands?
 - Is the resident motivated and cooperative?
 - Does the resident demonstrate the ability to attend to task?
 - Does the resident demonstrate progressive learning ability?
 - Can significant functional improvement in a reasonable period of time be expected?
- Are the goals functional?
 - The goals need to be related to a functional activity that is measurable
- Do the goals answer *who* will do what with *how much assistance* and the reason *why* this ability is important
- Does the admitting (primary) diagnosis support the therapy treatment diagnosis?





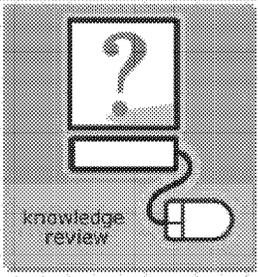
Knowledge Review – Evaluation

1. A physician's signature and date are required on the initial POC for all payor sources.
 - a. True
 - b. False

2. When completing the initial evaluation, if the exact onset date is unknown, leave it blank.
 - a. True
 - b. False

3. The PLOF establishes baseline for development of resident's goals.
 - a. True
 - b. False

4. Which of the following is not true about writing STGs and LTGs?
 - a. Should be broken down into *specific* tasks
 - b. Should be measurable
 - c. Should be numbered in an organized format so they can be tracked throughout the episode of care
 - d. Should be patient centered
 - e. Should be related to a functional activity
 - f. None of the above



Knowledge Review – Evaluation – Answer Key

1. A physician's signature and date are required on the initial POC for all payor sources.
 - a. True
 - b. False**

2. When completing the initial evaluation, if the exact onset date is unknown, leave it blank.
 - a. True
 - b. False**

3. The PLOF establishes baseline for development of resident's goals.
 - a. True**
 - b. False

4. Which of the following is not true about writing STGs and LTGs?
 - a. Should be broken down into *specific* tasks
 - b. Should be measurable
 - c. Should be numbered in an organized format so they can be tracked throughout the episode of care
 - d. Should be patient centered
 - e. Should be related to a functional activity
 - f. None of the above**

Daily Treatment Notes/Weekly Progress Report

Daily Treatment Note

Daily Treatment Notes: Basics

- *Best practice* to complete Daily Treatment Notes for all patient types for each treatment session
- Must be completed for Medicare Part B residents
- May be required by Medicare Contractor for Medicare Part A residents
- Purpose is to create a record of all treatment and skilled interventions that are provided and to record the time of the services in order to justify use of billing codes on the claim
- Requirements for Medicare Part B residents - include:
 - Date of treatment
 - Identification of each specific procedure/modality provided and billed, for both timed and untimed codes, using CPT code terminology
 - Total timed code treatment minutes
 - Total treatment time in minutes (includes the minutes for timed code treatment and untimed code treatment)
 - Signature and professional credentials
- The Daily Treatment Note must be signed and dated by the therapist or assistant, including professional credentials, as required by state standards of practice for each professional organization
- The original Daily Treatment Note must be placed in the medical record with a copy placed in the soft file



Therapy Weekly Progress Report

Physical Therapy

Occupational Therapy

Speech Therapy

Documentation Essentials in Long-term Care

Weekly Progress Report: Basics

- Address all blanks
- Must be completed at least every 7 calendar days
 - *Best practice* is to count the day of evaluation as day 1, then every 7 calendar days subsequently



Weekly Progress Note

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
			Day 1 Eval	Day 2	Day 3	Day 4
Day 5	Day 6	Day 7 Weekly Note	Day 8	Day 9	Day 10	Day 11
Day 12	Day 13	Day 14 Weekly Note				

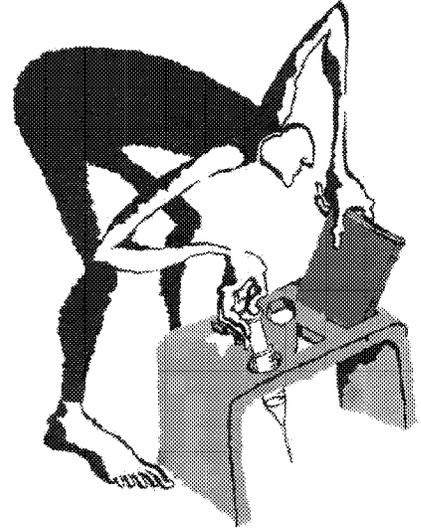
Weekly Progress Note
Service Dates Week 1
Day 1 – Day 7

Weekly Progress Note
Service Dates Week 2
Day 8 – Day 14

- Documents a comparison of progress in objective and functional terms (current level of function compared with previous level of function)
- Goals should be updated every 1-2 weeks
 - If not, note should discuss the reason for no or little progress
 - Recommend downgrading goals if they are not achievable in a 1-2 week period of time
- Report new information as it relates to the dates included in the Weekly Progress Note
 - Do not repeat same positive indicators, interventions or barriers week after week
 - Discuss any reason for decrease in status, i.e., illness, change in medication, falls
- Justifies need for continued skilled therapy services:
 - Why the skills of a therapist are necessary
 - The resident continues to have the potential for improvement
 - Therapy services are reasonable and necessary
- Justifies and describes the billed CPT interventions based on the treatment provided
- Justifies continued frequency, intensity, duration of treatment
- Discusses missed treatments and reason
- Discusses education provided to patient, family and caregiver
- Demonstrates carryover to the nursing floor of the learned activities
- Discusses any barriers to care, ability to learn
- Discusses the resident's response to the skilled care such as exercise, pain
 - Pain of grade 3-10 should be addressed (with pain grade level, location and effect on function) every week, per CMS quality standards
- Documents risk factors that will be eliminated with continued treatment
- Discusses discharge planning

Weekly Progress Report: Summary of Significant Progress

- List the STGs you are addressing at the beginning of the progress period
- Give the objective status of each goal
 - Met/Not Met is not adequate
- List updated, new or revised goals
- STGs should be written for a 1-2 week time frame
 - If goals are not met in this time frame, goals need to be broken down further
- Do not put “continue” in box
 - State specifics as they relate to the goals



Weekly Progress Report: Positive Indicators for Achieving Goals

- Positive indicators for achieving goals should be listed
- Be specific to that treatment period
 - Do not repeat the same comment week to week
- *Examples:*
 - Resident is motivated to return to PLOF
 - Resident participates fully in all treatment sessions
 - Resident self-initiates preliminary exercise program on the nursing floor and would benefit from skilled intervention for further gains and establishment of a finalized program
 - Resident is compliant to preliminary exercise program and would benefit from skilled intervention for further gains and establishment of a finalized program
 - Resident demonstrates safety awareness during functional activities
 - Resident exhibits ability to learn and retain new information for achievement of goals
 - Resident is able to follow directions
 - Resident is benefiting from treatment and making progress toward goals



example
the way forward ...

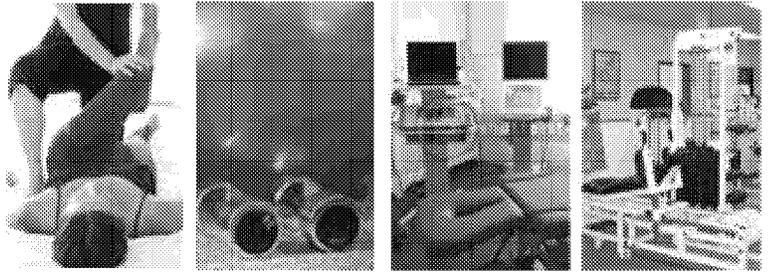
Weekly Progress Report: Rehab Potential

- Should be good or excellent for stated goals if the resident continues to be appropriate for therapy
 - Do not write poor or fair in the box



Weekly Progress Report: Detail of Skilled Interventions

- Discuss skilled services provided for the Weekly Progress Note period
- Do not just list procedures/modalities but rather the details of the intervention including the skilled components
- *Examples:*



- Resident continues to receive skilled OT for dressing/grooming/bathing activities with a focus on discharge to home safety issues. Now mod A LB dressing & bathing, min A UB dressing & bathing, min A grooming. Requires min verbal cues for sequencing of activities and utilization of AE for LB dressing & bathing. Notable improvement with the ability to transfer (mod A) from wheelchair to tub bench during bathing activities. Next week focus on continued sequencing of activities and use of AE and safety of bathroom transfers.
- Focus on gait training provided and fall recovery activities in preparation for safe discharge home. Now SBA ambulation with quad cane 150' from room to dining room, CGA up/down stairs with quad cane and 1 rail, and min A fall recovery. Requires occasional verbal cue for sequencing/placement of quad cane during gait & stairs, and minimal verbal cues for sequencing of steps during fall recovery. Greatest gains this week have been in the ability to climb stairs without pain upon descent. Next week to focus on strengthening of B dorsiflexors to prevent foot drag and falls during gait, B quads for up/down stairs.
- Provided neuromuscular re-education including quad facilitation technique allowing resident to transfer sit to stand with minimal assist and allow safe discharge home.



Documentation Essentials in Long-term Care

Clinical areas to describe in detail	
ADL/ Self care	<ul style="list-style-type: none"> • Describe the reduced ability to perform self-care activities which requires skilled OT to teach compensatory strategies • Describe the barriers to performance of self-care/ADLs. • Describe the previous loss of function in ADL categories • Describe the patient and/or caregiver training required for continued ADL performance • “Resident requires skilled OT intervention for functional training, observation, assessment, and environmental adaption due to impaired strength of the right upper extremity, abnormal muscle tone in the left hand, and lack of awareness of safety hazards in daily grooming activities”
Communication	<ul style="list-style-type: none"> • Describe the inability of the resident to communicate basic physical needs, self care needs, and emotional needs • Describe the communication level required for discharge to the planned discharge location • Describe the resident’s inability to name objects or conduct conversational language • Describe patient and/or caregiver education required to continue care after therapy discharge
Discharge Planning	<ul style="list-style-type: none"> • Describe the patient and/or caregiver training required prior to discharge • Describe the functional mobility level and ADL performance level required for safe discharge to the planned discharge location • Describe the environmental or equipment necessary prior to discharge • Describe the patient and/or caregiver training and education provided
Gait training	<ul style="list-style-type: none"> • Describe the current gait pattern with deficits/barriers (neurological, muscular, or skeletal abnormality) which affect safe ambulation • Describe the need for and training with an assistive device • Describe the training required for the assistive device • Describe the cardio/respiratory response to gait training and the need for continued skilled oversight

Documentation Essentials in Long-term Care

Clinical areas to describe in detail	
Orthoses, Prostheses, Adaptive Equipment	<ul style="list-style-type: none"> • Describe the functional deficit and reason for the device which require continued skilled services • Describe the outcome which will be obtained by using the orthoses/adaptive equipment • Describe the patient and/or caregiver training required for continued skilled therapy intervention
Pain	<ul style="list-style-type: none"> • Address whenever significant pain has been identified in initial POC • Describe the effect of pain on functional abilities • Describe pain intensity, type, change patterns, location • Describe how the pain limits self care, mobility and safe performance of activity • Describe patient and/or caregiver training and education provided
Swallowing	<ul style="list-style-type: none"> • Describe the swallowing impairment which has been responsible for reduced dietary intake and weight loss • Describe the risks to the resident if this impairment is not improved • Describe the techniques necessary for the resident to use to have a safe swallow • Describe patient and/or caregiver education required for continued care post therapy discharge
Therapeutic Exercise	<ul style="list-style-type: none"> • Describe the type of exercise provided and why it needs to be continued • Describe the muscle groups involved • Describe the resident's loss in self-care, mobility, and safety awareness and how strengthening will improve functional performance • Describe the progression of the exercise program • Describe the resident's response to exercise in terms of improved endurance, heart rate, blood pressure • Describe patient and/or caregiver training and education provided
Transfer Training	<ul style="list-style-type: none"> • Describe the monitoring and instructions provided for safety and completion of functional tasks • Describe the resident's response to training • Describe patient and/or caregiver training and education provided

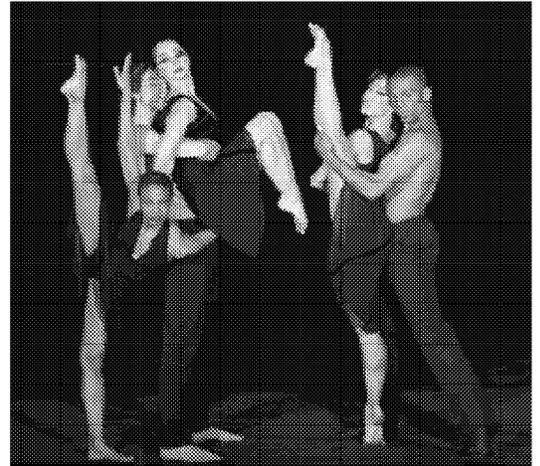
Weekly Progress Report: Patient/Caregiver Education

- The goal of teaching and training is for the resident to transition newly achieved skills to his/her discharge environment and to ensure the safety and care of the resident post discharge
- Documentation of these teaching and training activities demonstrates an essential skill provided by a therapist and serves as a record that comprehensive discharge planning activities were completed with the resident and caregiver
- List any education provided to family, nursing caregivers, or resident during the weekly note time frame
- Discuss any communication or consultation provided
- List equipment issued and education associated with the equipment and include success with return demonstration and carryover



Weekly Progress Report: Reasons for Continued Skilled Therapy

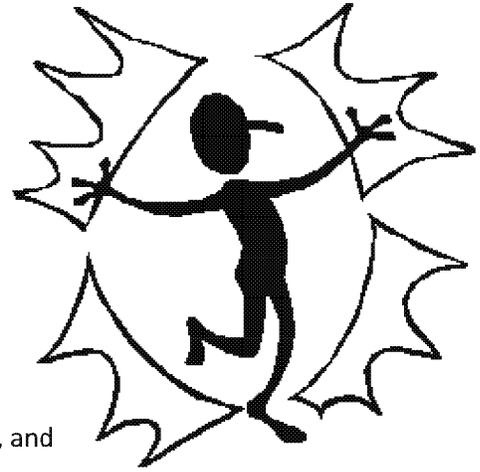
- Discuss any functional issues remaining that are related to the resident's current impairments
- Use skilled terminology and be specific on why the resident needs to continue therapy into following week
- Do not just relist the procedures/modalities in the POC - be more specific
- Relate skills to discharge location, burden on caregiver, PLOF
- *Examples:*
 - Skilled services are necessary for performing progressive resistive exercises to the bilateral triceps/quads to improve stability and safety in transfers/gait and allow safe return home at PLOF
 - Skilled services are necessary to provide soft tissue stretching/manipulation to facilitate full function ROM to the right shoulder to allow UB dressing and allow safe return home at PLOF
 - Skilled services are necessary to maximize transfer abilities at PLOF and decrease the burden on the caregiver



example
the way forward ...

Weekly Progress Report: Barriers to Progress

- Documenting barriers to progress helps explain why a resident might take longer to achieve his/her goals
- State all barriers to progress, especially as it relates to future treatment
- Be sure to document what you are doing to overcome these barriers.
- *Consider:*
 - managing pain through pre-medication, modalities, and manual techniques
 - managing issues with blood pressure/pulse/O2 saturation/acute illness/medication change through continuous monitoring, rest periods, consultation with nursing and physician
 - managing poor activity tolerance through monitoring vital signs and rest periods
 - managing skin integrity through frequent skin checks and positioning
 - managing refusals through approaching the patient at different times of the day, utilizing different therapists, asking for assistance from facility staff and family
 - managing non-compliance through facility and family assistance, education, and care conferences
 - managing inconsistent performance or safety awareness through learning strategies and repetition, breaking components into small steps
 - managing cognition and confusion using verbal and visual cueing, spaced retrieval, utilizing OT and SLP to assist with improved cognition
 - managing agitation and combative by changing manner of approach or modifying environment
- Negative behaviors
 - Documenting negative behaviors, such as resident “confused”, “agitated”, “noncompliant”, etc., are often cited as denial reasons
 - Consider whether recoding a negative behavior is essential to the medical record
 - *Key Point:* State positive prognostic indicators despite these barriers to function



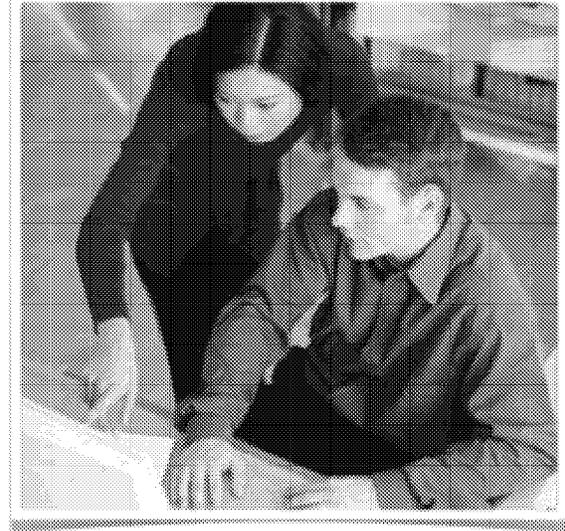
Weekly Progress Report: Patient Response to Care

- Discuss patient's response to care specifically as it relates to the treatment provided in the current week of care
- *Examples:*
 - Resident is motivated to return to PLOF and is actively participating in therapy
 - Resident states "The tub bench really works, I feel safer getting into the tub"
 - Resident cooperates with all treatment provided, participated in 5/5 sessions offered
 - Resident participates in all treatment sessions and understands the precautions for the total hip
 - Resident and family are actively engaged in therapy goals
 - Resident states bathroom transfers are becoming easier
 - Resident desires to return to her home and remains an active participant in her therapy program
 - Resident cooperates thoroughly in treatment and is compliant with hip precautions
 - Resident is motivated to return to PLOF
- Reviewers of a medical record need to determine how a resident is responding to the medical treatment provided
- Reviewers look for recorded signs and symptoms that indicate a resident is improving



Weekly Progress Report: Supervisor (10th Visit) Note

- For Medicare Part B residents the Centers for Medicare & Medicaid Services (CMS) requires the therapist demonstrates his/her involvement, re-assesses the resident, makes clinical judgments regarding the resident's condition and/or continued care, makes updates to the POC and goals , documents medical necessity, and provides supervision of the assistant at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less
 - The therapist must personally perform or actively participate in one treatment session every 10 treatment days and write a Weekly Progress Note (Progress Report)
 - Verified by one billable intervention
 - Should be completed on a Weekly Progress Note Form
 - The Weekly Progress Note Form includes all of the required components and provides for a standardized format
 - Daily Treatment Notes do not suffice as a Supervisor (10th Visit) Note
 - The Supervisor (10th Visit) Note must be signed and dated by the therapist only (not the assistant), including professional credentials, as required by state standards of practice for each professional organization
 - The original Supervisor (10th Visit) Note must be placed in the medical record with a copy placed in the soft file

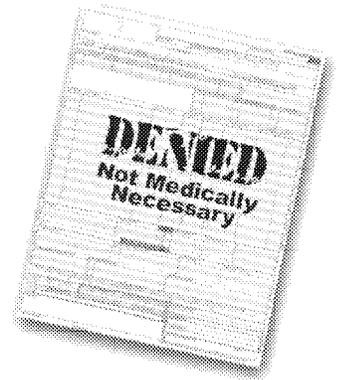


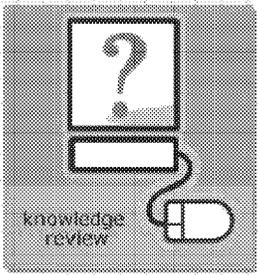
Documentation Essentials in Long-term Care

Clinician (Therapist, Physician/NPP) Progress Reports (Medicare Benefits Policy Manual, Chapter 15, 220.3 - Documentation Requirements for Therapy Services)	Assistant's Participation in the Progress Report
<ul style="list-style-type: none"> • Date of the beginning and end of the reporting period • Date that the report was written • Signature and professional identification • Objective reports of the resident's subjective statements, if relevant • Objective measurements or description of changes in status relative to each goal currently being addressed • Assessment of improvement, extent of progress (or lack thereof) toward each goal • Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions • Changes to LTGs or STGs, discharge or an updated plan of care that is sent to the physician/NPP for recertification • Justification of the necessity of the services provided • Justification for treatment must include, for example, objective evidence or a clinically supportable statement of expectation that: <ul style="list-style-type: none"> ○ Resident's condition has the potential to improve or is improving in response to therapy ○ Maximum improvement is yet to be attained ○ There is an expectation that the anticipated improvement is attainable in a reasonable and predictable period of time ○ Objective evidence consists of standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome • Guidance and supervision provided to the assistant 	<ul style="list-style-type: none"> • Date of the beginning and end of the reporting period • Date that the report was written • Signature and professional identification • Objective reports of the resident's subjective statements, if relevant • Objective measurements or description of changes in status relative to each goal currently being addressed • Assistants may not make clinical judgments about why progress was or was not made, but may report the progress objectively

Demonstrating Medical Necessity in Documentation – Weekly Progress Report

- Has the resident made significant functional improvement? Is this improvement being made in a reasonable period of time?
 - Reduction in level of assistance needed to perform functional tasks
 - Change in the type of assistive device used
 - Improvement in reported rating of pain and resultant improvement in ability to perform functional tasks
 - Gains in strength, ROM, endurance, communication, swallowing ability which result in measurable functional gains
 - Compensatory strategies used to increase resident's functional level
- What is the current level of assistance needed for functional tasks and how does it compare with last week's level?
- Has measurable progress toward STGs or LTGs been made?
- If progress has not been made, what are the reasons for this lack of progress? Should the goals be revised or should rehab services be discontinued?
- Are continued therapy services expected to result in significant functional improvement? Is there a positive expectation that further progress will be made?
- Is further functional improvement necessary to be able to be discharged safely to the proposed discharge location?
- Does the resident still require the supervision of a skilled therapist to continue to make progress based on the skilled nature of the program and/or the medical complexity of the resident?
- Could a restorative nurse provide this service?
- Is there carryover of the skills learned in therapy to the resident's living environment?
- What are the risk factors that are reduced or eliminated by the provision of rehab services?
- Is the frequency, intensity, duration of treatment justifiable?





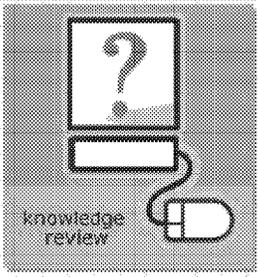
Knowledge Review - Daily Treatment Notes/Weekly Progress Report

1. When completing the Weekly Progress Note, STGs should be written for a 1-2 week time frame, and if goals are not met in this time frame, goals need to be broken down further.
 - a. True
 - b. False

2. Do not just list procedures/modalities but rather the details of the intervention including the skilled components when completing the Weekly Progress Note.
 - a. True
 - b. False

3. When documenting reasons for continued skilled therapy, which is correct?
 - a. Use skilled terminology and be specific on why the resident needs to continue therapy into following week
 - b. Do not just relist the procedures/modalities in the POC - be more specific
 - c. Relate skills to discharge location, burden on caregiver, PLOF
 - d. All of the above

4. For Medicare Part B residents, the therapist must personally perform or actively participate in one treatment session (verified by one billable intervention) every 10 treatment days and write a Weekly Progress Note (Progress Report).
 - a. True
 - b. False



Knowledge Review - Daily Treatment Notes/Weekly Progress Report – Answer Key

1. When completing the Weekly Progress Note, STGs should be written for a 1-2 week time frame, and if goals are not met in this time frame, goals need to be broken down further.
 - a. **True**
 - b. False

2. Do not just list procedures/modalities but rather the details of the intervention including the skilled components when completing the Weekly Progress Note.
 - a. **True**
 - b. False

3. When documenting reasons for continued skilled therapy, which is correct?
 - a. Use skilled terminology and be specific on why the resident needs to continue therapy into following week
 - b. Do not just relist the procedures/modalities in the POC - be more specific
 - c. Relate skills to discharge location, burden on caregiver, PLOF
 - d. **All of the above**

4. For Medicare Part B residents, the therapist must personally perform or actively participate in one treatment session (verified by one billable intervention) every 10 treatment days and write a Weekly Progress Note (Progress Report).
 - a. **True**
 - b. False

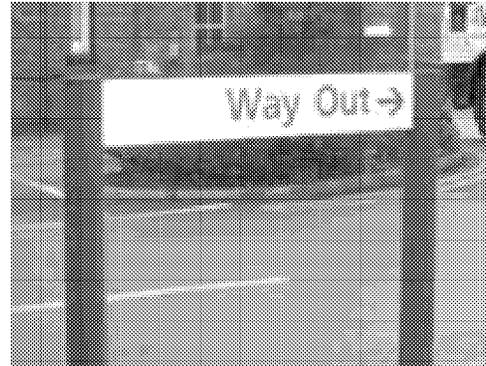
Therapy Discharge Note

Physical Therapy

Occupational Therapy

Speech Therapy

Discharge Notes



Discharge Notes: Basics

- *Key Point:* The Discharge Note is the last opportunity to justify medical necessity of the therapy services provided in the episode of care
- The Discharge Note is a summary of the resident's functional outcome as a result of rehabilitative services
 - Document specific objective discharge status as it relates to goal
 - Not sufficient to state goal Met/Not Met
- The Discharge Note is a summary of discharge instructions, equipment provided, and restorative program developed, or home program/training provided
- The Discharge Note should be completed within 5-7 days of discharge or earlier
- The Discharge Note must be completed, signed and dated by the therapist (not assistant per RehabCare policy), including professional credentials, as required by state standards of practice for each professional organization
- The original Discharge Note must be placed in the medical record with a copy placed in the soft file



Discharge Notes: Summary of Significant Functional Status in Last Week of Care

- The top portion of the Discharge Note provides a description of the patient interventions, functional progress, functional goals and skilled services provided within the last week of care
- Complete like any other Weekly Progress Note for the date from the last Weekly Progress Note through the last treatment day
- MET or NOT MET should not be the only comment in the “current status” box – list specific objective status
- This section *only* can be written by the assistant
 - Signature and credentials must be included



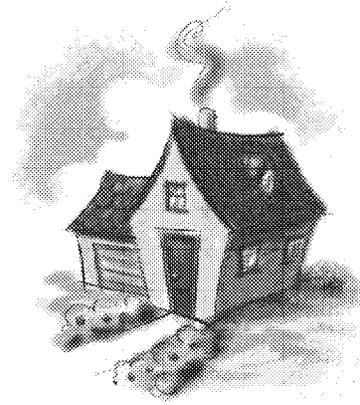
Discharge Notes: Summary of Care Provided from Evaluation to Discharge

- The lower portion of the Discharge Note provides a summary of care and functional gains related to treatment interventions from initiation to discharge
- LTGs should be taken from evaluation (unless changed during the episode of care) and the discharge outcome should be stated
- MET or NOT MET should not be the only comment in the “discharge status” box– list specific objective status
- Do not refer to the top section of goals
- This section must be completed by the therapist only
 - Signature and credentials must be included



Discharge Notes: Discharge Reason/Discharge Location

- State the discharge reason and discharge location
- Ensure that discharge location is consistent if multiple disciplines provided care



Discharge Notes: Discharge Recommendations

- The discharge recommendations provide a summary of discharge instructions, equipment provided, and restorative program developed, or home program/training provided



Documentation Essentials in Long-term Care

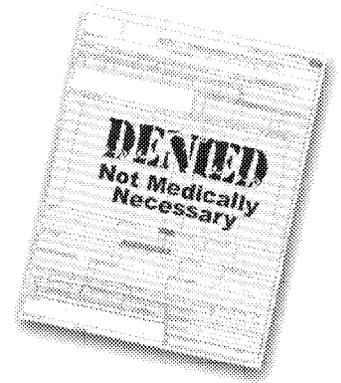
Discharge Notes: Patient/Caregiver Education and Response

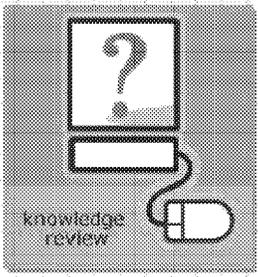
- Document the education given to the resident and/or caregiver



Demonstrating Medical Necessity in Documentation – Discharge Notes

- The Discharge Note is the last opportunity to justify medical necessity of the therapy services
- Did the therapist adequately document a summary of the resident's functional outcome as a result of rehabilitative service?

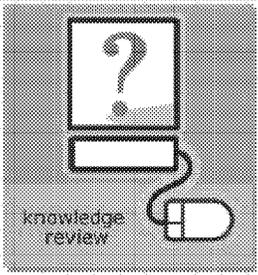




Knowledge Review – Discharge Notes

1. The Discharge Note can be completed, signed and dated by the therapist or assistant.
 - a. True
 - b. False

2. MET or NOT MET should not be the only comment in the “current status” or “discharge status” box of the Discharge Note.
 - a. True
 - b. False



Knowledge Review – Discharge Notes – Answer Key

1. The Discharge Note can be completed, signed and dated by the therapist or assistant.
 - a. True
 - b. False**

2. MET or NOT MET should not be the only comment in the “current status” or “discharge status” box of the Discharge Note.
 - a. True**
 - b. False



Signature Requirements

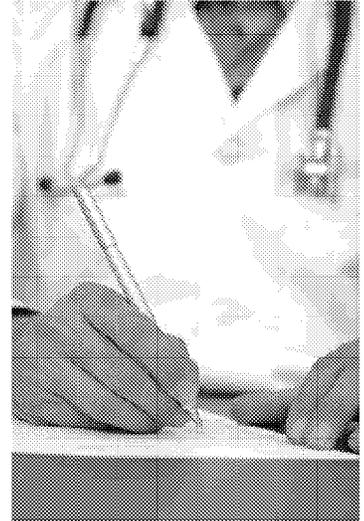


- *Key Point:* MISSING or ILLEGIBLE signatures can result in DENIAL of the claim
- THERAPIST'S HANDWRITTEN SIGNATURES
 - Must be present on all necessary documents
 - Must include first and last name (or first initial and last name) and professional credentials
 - Must be legible
 - If the signature has marginal or questionable legibility, the therapist should PRINT his/her full name and credentials below the signature
 - Medicare states the legible signature requirement is met when an "illegible signature" appears "over a typed or printed name"
 - A signature log is another option to clarify an illegible therapist signature
 - A signature log "lists the typed or printed name of the author associated with initials or an illegible signature" and "the signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document"
 - Medicare recommends the individual's credentials be included on the signature log
 - The signature log may be created at any point but must be signed by the author of the signature and no one else
 - Stamped signatures are never acceptable

Documentation Essentials in Long-term Care

- PHYSICIANS' HANDWRITTEN SIGNATURES ON THERAPY PLANS OF CARE/CERTIFICATIONS AND UPDATED THERAPY PLANS OF CARE/RE-CERTIFICATIONS

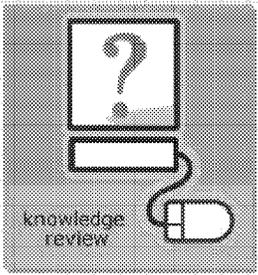
- Must be present and dated timely
- Must be legible
 - If the physician's signature is illegible, the letterhead, addressograph or other information on the page may identify the signator
- If the physician's signature has a history of marginal or questionable legibility, the therapist should PRINT the physician's first name, last name and credentials below the signature line PRIOR to submitting the document for signature
 - Medicare states the legible signature requirement is met when an "illegible signature" appears "over a typed or printed name"
- If the POC does not contain a legible signature and the therapist failed to print the physician's name below the signature line prior to sending it for signature, a signature log or signature attestation statement may be obtained from the physician
 - A signature attestation statement:
 - May be obtained at any time and can be used to clarify the identity associated with an illegible signature
 - Can only be signed by the author of the signature and no one else
- Stamped signatures are never acceptable
- If a physician's signature is missing from *an order*, the order will be disregarded during review
- If a physician's signature is missing from *any other medical documentation*, reviewers must accept a signature attestation statement from the author of the medical record
 - This does NOT include therapy plans of care/certifications or other documents that must be signed by the physician within a specific time frame
 - If the physician's signature is missing from the therapy plans of care/certifications, within certain guidelines a delayed certification will meet Medicare requirements
 - A signature attestation statement will not be accepted



Documentation Essentials in Long-term Care

- DATES OF PHYSICIANS' HANDWRITTEN SIGNATURES ON THERAPY PLANS OF CARE/CERTIFICATIONS AND UPDATED THERAPY PLANS OF CARE/RE-CERTIFICATIONS
 - If a physician certifies a therapy plan of care/certification and the date on the physician's signature is illegible or missing all or part (i.e., physician fails to include the year), the therapy department may add "Received Date" in writing or with a stamp
 - If the date on the physician's signature is illegible or missing all or part or the therapy department failed to provide a timely "Received Date" on the document, a delayed certification will be necessary
 - Signature logs or signature attestation statements *cannot* be used to "back date" a certification or re-certification

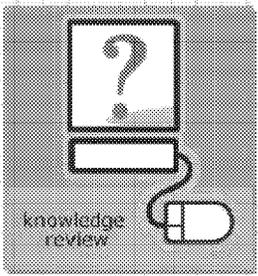




Knowledge Review – Signature Requirements

1. A signature attestation statement lists the typed or printed name of the author associated with initials or an illegible signature.
 - a. True
 - b. False

2. Stamped signatures are acceptable
 - a. True
 - b. False



Knowledge Review – Signature Requirements – Answer Key

1. A signature attestation statement lists the typed or printed name of the author associated with initials or an illegible signature.
 - a. True
 - b. False**

2. Stamped signatures are acceptable.
 - a. True
 - b. False**

Smart Service Log

Smart Service Log: Basics

- Smart service log is our only documentation source for what services were provided on any given day
 - For Medicare Part A, supports how we achieved the RUG levels
- Smart service log is completed for all payor types
 - Each discipline (OT, PT and SLP) will complete a separate Smart service log for each resident being treated
 - The month and year are documented
 - The date of service, the CPT codes, and the delivered minutes and units of evaluation and treatment are recorded
 - Each therapist or therapist assistant who treats the resident during the month will be listed
- Smart service log supports documentation of the therapy services provided
 - Evaluation time recorded is indicative of comprehensive evaluation (minimum of 1 unit/15 minutes)
 - Treatment minutes recorded are supported by discharge location, cognition, activity tolerance, ability to participate, medical diagnosis, etc.
- Smart service log supports the minutes of therapy delivered and the CPT codes billed for each day
 - Therapy services are provided as ordered (procedures/modalities/frequency/duration)
 - CPT codes recorded are documented in clarification/reclarification orders and initial POC/continued POC
 - CPT codes recorded are documented in daily/weekly notes
 - CPT codes recorded match invoice
- Smart service log supports treatments delivered point of care
 - Minutes on Smart service log fluctuate to avoid pattern of unit rounding (15, 20, 25, 30)
 - Minutes on Smart service log fluctuate to avoid pattern of recurring minutes (53, 53, 53, 53)
 - Minutes on Smart service log avoid a pattern of over delivery of minutes at low end of 8-minute unit limit (23, 38, 53, 68) for Medicare Part B residents
- Smart service log supports MDS
 - Minutes/days documented on the MDS match the Smart service log for all assessment reference periods
 - Minutes documented on Smart service log corresponds with RUG category on MDS
 - Group therapy minutes are limited to 25% of the resident's total therapy time per **discipline** per assessment period/7-day look back period
- Smart service log is placed in the medical record monthly following verification



Guidelines for using Timed and Un-timed CPT Codes

- Medicare Part B residents are subject to the 8-minute rule
- When using the procedural CPT Codes, which are based in 15-minute units of direct patient contact, the clinician must spend 8 to 22 minutes with a resident to bill the code as one unit of time
 - If treatment intervention is < 8 minutes, the treatment cannot be billed as one unit of time
 - The expectation is that the time for each unit will average 15 minutes in length
- The time intervals for additional units are:
 - 1 unit – 8 minutes to 22 minutes
 - 2 units – 23 minutes to 37 minutes
 - 3 units – 38 minutes to 52 minutes
 - 4 units – 53 minutes to 67 minutes
 - 5 units – 68 minutes to 82 minutes
 - 6 units – 83 minutes to 97 minutes
- When using more than two procedural CPT codes, the codes cannot exceed the total treatment time
 - *Examples:*
 - If during an 8:30-9:00 treatment session, the therapist did 10 minutes of 97110 (therapeutic exercise) and 10 minutes of 97116 (gait training) and 10 minutes 97542 (wheelchair management), for a total of 30 minutes, only 2 units can be billed (2 units – 23 minutes to 37 minutes)
 - The therapist would assign the time to the 2 codes that represent the greatest therapeutic effort and/or time
- The time involved in the skilled delivery of a treatment is billable time
 - This time may include those professional activities in the presence of a resident such as observation, assessment, teaching and training as well as the direct delivery of specific therapeutic interventions
- Medicare accepts pre-service and post-service activities associated with all physical and occupational therapy procedural CPT Codes
 - These pre-service and post-service activities are skilled component activities included in the time associated with procedural CPT Codes
- CPT Codes which are not time-based, such as evaluation, supervised modalities and many codes related to speech therapy, are listed as a one unit, no matter the time spent in delivery of skilled interventions; these codes can only be provided 1x/day
- Selecting the most appropriate CPT code for treatment is imperative to describing the treatment that we provide to our residents

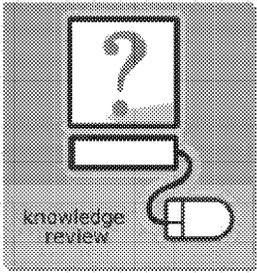


Utilizing Modality Interventions Using Point of Care (POC) Device Technology

Supervised (unattended) Modality	
<p>Supervised (unattended) Modality requires the application of the modality with the majority of the treatment supervised (unattended) by the therapist/assistant. However, the therapist/assistant must be present in the treatment room.</p> <ul style="list-style-type: none"> • Modality(ies) must be listed on the clarification order or added during updates to the plan of care • Modality(ies) must be documented to: <ul style="list-style-type: none"> ○ Show the rationale for the use of the modality, i.e., promote healing, relieve muscle spasm, improve circulation, decrease inflammation/edema and provide analgesia for pain ○ Show the parameters/settings of the modality ○ Indicate response of the resident to the modality ○ Indicate area of body treated ○ Indicate pain descriptors, medication and dosage information • The use of modalities as standalone treatment is rarely therapeutic and is not indicated as a sole treatment approach • One code per day can be billed with a supervised (unattended) modality, regardless of the number of areas treated • Billable time included within the one unit code is the entire time spent with the resident in pre-and post-treatment care and the delivery of the modality • When using a supervised (unattended) modality with a resident, a therapist/assistant can be treating another resident as the supervised modality does not require the direct attention of the therapist/assistant 	
Medicare Part B	Medicare Part A
<ol style="list-style-type: none"> 1. Enter the START time (punch in) on the POC when performing resident positioning and pre-treatment assessment; apply modality. Pre-treatment includes application of electrodes, adjusting parameters, etc. 2. Enter the END time (punch out) once the modality has been successfully applied. 3. By stopping the initial treatment this allows the therapist to treat another resident while the first resident is receiving the supervised (unattended) modality. 4. Enter the START time (punch in) on the POC when returning to the resident to remove the modality and assess the outcome of the treatment (such as observation of the skin, joint range, post-treatment interview, etc.) 5. Enter the END time (punch out) on the POC when the treatment has been completed. 6. The minutes recorded on the Smart service log include the time spent in the initial application and post-treatment. 7. Hot packs are not billable to Medicare, so these minutes cannot be counted on the invoice. 	<ol style="list-style-type: none"> 1. Enter the START time (punch in) on the POC when performing resident positioning and pre-treatment assessment; apply modality. Pre-treatment includes application of electrodes, adjusting parameters, etc. 2. Enter END time (punch out) when the pre-treatment session is completed. 3. During the unattended treatment session, the resident will remain under the direction of the therapist, however, treatment minutes will not be counted on the MDS. 4. Enter START time (punch in) at the end of the treatment session to reassess the outcome of the treatment (such as observation of the skin, joint range, post-treatment interview, etc.) 5. Enter the END time (punch out) on the POC when the post-treatment review has been completed. 6. Record all the minutes which were spent in the skilled treatment of the resident with the supervised (unattended) modality: the pre-and post-service efforts and any time during the treatment which required the skills of a therapist. 7. The POC will allow concurrent treatments to be performed when billing for any pre service, intra service and post service skilled time when another resident is receiving treatment while the second resident is receiving the supervised (unattended) modality. 8. Hot packs are not billable to Medicare, so these minutes cannot be counted on the MDS.

Documentation Essentials in Long-term Care

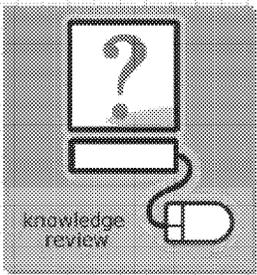
Constant Attendance Modality	
<p>Constant Attendance Modality –require one-on-one constant attendance. The therapist must remain with the resident throughout the treatment to perform the modality and/or supervise the resident and observe the procedure and response by the resident.</p> <ul style="list-style-type: none"> • Modality must be listed on the clarification order or added during updates to the plan of care • Modality(ies) must be documented to: <ul style="list-style-type: none"> ○ Show the rationale for the use of the modality, i.e., promote healing, relieve muscle spasm, improve circulation, decrease inflammation/edema and provide analgesia for pain ○ Show the parameters/settings of the modality ○ Indicate response of the resident to the modality ○ Indicate area of body treated ○ Indicate pain descriptors, medication and dosage information • The use of modalities as standalone treatment is rarely therapeutic and is not indicated as a sole treatment approach. • Constant Attendance Modality(ies) are subject to the 8 minute rule: <ul style="list-style-type: none"> ○ 1 unit –8 minutes through and including 22 minutes ○ 2 units –23 minutes through and including 37 minutes • Activities associated with billable time may be positioning, application of gels and electrodes, palpation and observation of the skin. Interviewing of the resident to obtain response, pre-and post-modality delivery. 	
Medicare Part B	Medicare Part A
<ol style="list-style-type: none"> 1. Enter the START time (punch in) on the POC when performing resident positioning and pre-treatment assessment; apply modality. 2. The POC device remains running throughout the treatment session and/or delivery of the modality. 3. At the end of treatment session assess the outcome of the treatment (such as observation of the skin, joint range, post-treatment interview, etc. 4. Enter END time (punch out) on the POC device when the post-treatment review has been completed. 5. Record the entire treatment session time, including the time that the resident was receiving the constant attendance modality, on the DTR/ Service Log. 	<ol style="list-style-type: none"> 1. Enter the START time (punch in) on the POC when performing resident positioning and pre-treatment assessment; apply modality. 2. The POC device remains running throughout the treatment session and/or delivery of the modality. 3. At the end of treatment session assess the outcome of the treatment (such as observation of the skin, joint range, post-treatment interview, etc.) 4. Enter END time (punch out) on the POC when the post-treatment review has been completed. 5. Record the entire treatment session time, including the time that the resident was receiving the constant attendance modality, on the Smart service log. 6. All of the time spent with the resident in pre-and post-treatment and treatment delivery is recorded on the MDS.



Knowledge Review – Smart Service Log

1. Treatment minutes recorded on the Smart service log should be supported by discharge location, cognition, activity tolerance, ability to participate, medical diagnosis, etc.
 - a. True
 - b. False

2. Which of the following is not evidence of Point of Service documentation on the Smart service log by:
 - a. Minutes on Smart service log fluctuate to avoid pattern of unit rounding (15, 20, 25, 30)
 - b. Minutes on Smart service log fluctuate to avoid pattern of recurring minutes (53, 53, 53, 53)
 - c. Minutes on Smart service log avoid a pattern of over delivery of minutes at low end of 8-minute unit limit (23, 38, 53, 68) for Medicare Part B residents
 - d. Group therapy minutes are limited to 25% of the resident's total therapy time per *discipline* per assessment period; any group minutes delivered in excess of the 25% are not applied to the RUG level

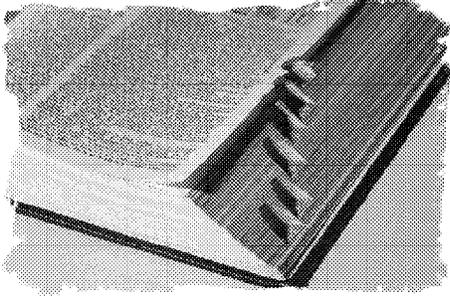


Knowledge Review – Smart Service Log – Answer Key

1. Treatment minutes recorded on the Smart service log should be supported by discharge location, cognition, activity tolerance, ability to participate, medical diagnosis, etc.
 - a. **True**
 - b. False

2. Which of the following is not evidence of Point of Service documentation on the Smart service log by:
 - a. Minutes on Smart service log fluctuate to avoid pattern of unit rounding (15, 20, 25, 30)
 - b. Minutes on Smart service log fluctuate to avoid pattern of recurring minutes (53, 53, 53, 53)
 - c. Minutes on Smart service log avoid a pattern of over delivery of minutes at low end of 8-minute unit limit (23, 38, 53, 68) for Medicare Part B residents
 - d. **Group therapy minutes are limited to 25% of the resident's total therapy time per discipline per assessment period; any group minutes delivered in excess of the 25% are not applied to the RUG level**

Red Flag Practices



Red Flag

- A warning signal
- Something that demands attention
- An indicator of potential problems

A red flag can be any undesirable characteristic that stands out to an analyst. There is no universal standard for identifying red flags; the method used will depend on the investment methodology being employed.

Medicare requires that patient services be provided point-of-care, with the exact times reported. Minutes should reflect the actual skilled/billable time with the resident.

Medicare Part A/Medicare Part B Residents: Unit Rounding

Unit rounding rounds to the nearest 5th minute. Not only are the exact times not reported, but delivery of services point-of-care is questionable.

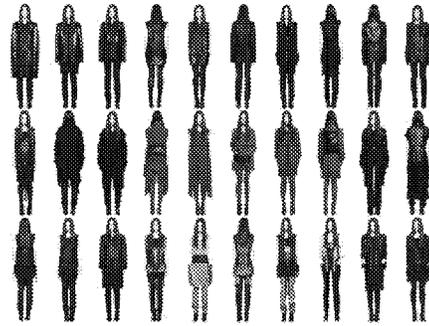


CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18
97001	30																	
97110	10	15	10	15	10			15	15	10	10	20			10	15	15	10
97112	10	20	20	15	10			20	15	20	10	20			10	20	15	20
97116	10	15	20	10	10			15	10	20	10	20			10	15	10	20
Total Min	60	50	50	40	30			50	40	50	30	60			30	50	40	50

Documentation Essentials in Long-term Care

Medicare Part A/Medicare Part B Residents: Recurring Minutes

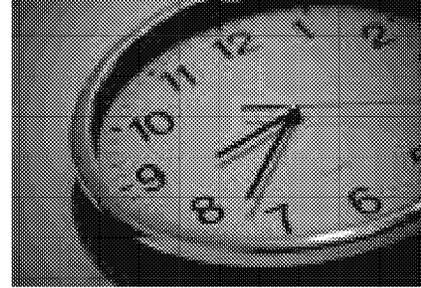
When recurring minutes are noted, not only are the exact times not reported, but delivery of services point-of-care is questionable.



CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18
97001	30																	
97110	15	25	20	15	25			15	25	20	15	25			25	20	15	25
97112	20	20	25	20	15			20	20	25	20	15			20	25	20	15
97116	25	15	15	25	20			25	15	15	25	20			15	15	25	20
Total Min	90	60	60	60	60			60	60	60	60	60			60	60	60	60

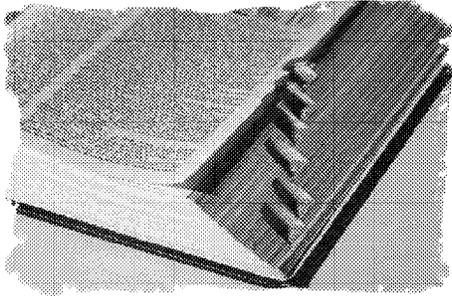
Medicare Part B Residents: Over Delivery of Minutes at Low End of the 8-Minute Rule Limit

A pattern of over-delivery of minutes at the low end of the 8-minute rule limit (23, 38, 53, 68, 83) indicates a practice of maximizing financial reimbursement rather than delivery of care to meet the needs of the resident.



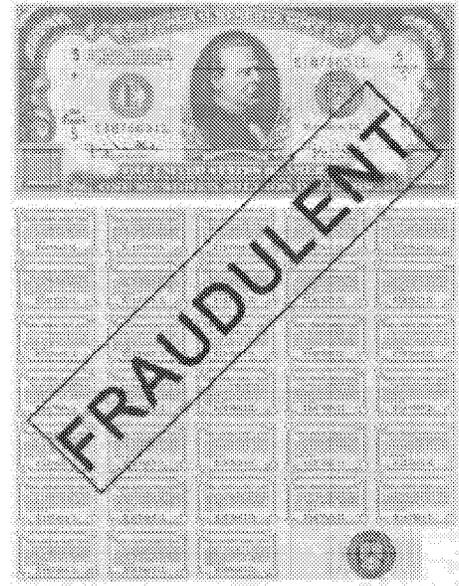
CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18
97001	30																	
97110	10	10	18	10				10	10	18	10				10	10	18	
97112	18		10	10	10			18		10	10	10			18		10	10
97116	10	13	10	18	13			10	13	10	18	13			10	13	10	13
Total Min	68	23	38	38	23			38	23	38	38	23			38	23	38	23

Fraudulent Practices



Fraud

- A deception deliberately practiced in order to secure unfair or unlawful gain



In law, fraud is the deliberate misrepresentation of fact for the purpose of depriving someone of a valuable possession or legal right. Any omission or concealment that is injurious to another or that allows a person to take unconscionable advantage of another may constitute criminal fraud.

Medicare expects that:

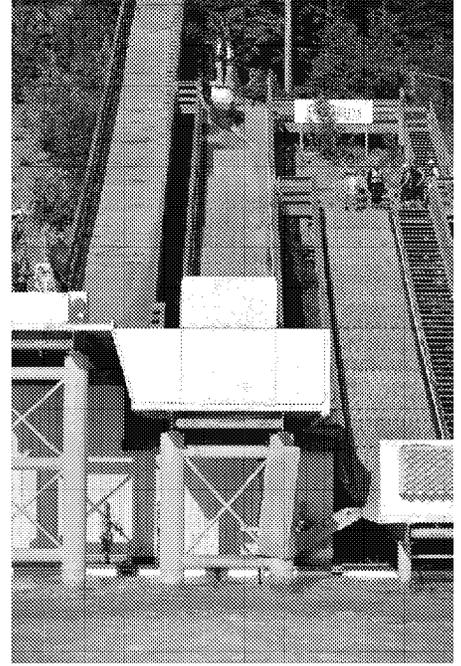
- Residents should receive services based on medical necessity. Manipulating therapy minutes based on financial gain rather than the resident's needs is considered fraud.
- Patient care practices during non-assessment periods should be consistent with patient care practices during assessment periods.

Documentation Essentials in Long-term Care

Medicare Part A Residents: Ramping To Affect Minutes During Assessment/Non-Assessment Periods

Ramping is the practice of significantly:

1. Increasing minutes during an assessment period to achieve a higher RUG category and greater reimbursement
- OR
2. Decreasing minutes during a non-assessment period once a RUG category has been achieved and reimbursement determined



*Off cycle minutes drop
by up to 20 min/day*

CPT Codes	5-DAY MDS ARD Day 5																	14-DAY MDS ARD Day 18	
	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	
97001	30																		
97110	16	19	20	19	15			8	12	11	10			16	19	20	19	15	
97112	18	16	14	16	15			10	10	10	8			18	16	14	16	15	
97116	17	15	15	17	16			8	12	11	10			17	15	15	17	16	
Total Min	81	50	49	52	46			26	32	32	28			51	50	49	52	46	

Documentation Essentials in Long-term Care

Medicare Part A Residents: Adding Minutes after the Fact to Achieve a Higher RUG Category

Making corrections to the eDTR/service log after the fact to add minutes not provided in order to achieve a higher RUG category and greater reimbursement is fraudulent.

In this example, OT increased the minutes from 45 to 55 on the eDTR/service log on Day 8, bumping up the RUG category from RV to RU on the 14-day MDS.



Day	Time	HCPC	Min	Units	HCPC	Min	Units	HCPC	Min	Units	Total Min	Total Units
Day 8	8:00 am – 8:55 am 1/8/2010	97110	20	1	97530	25	1				45	2
Day 8	8:00 am – 9:05 am 1/13/2010	97110	20	1	97530	25	1	97112	10	1	55	3

14-DAY MDS
ARD Day 13

CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18
97003	15																	
97110		26	26		24	26	14	20	22		22	12	16	8		16		16
97112		17	18		26	18	17	10	18		8	8	17	10		17		17
97530		24	24		18	24	26	25	12		10	10	22	12		22		22
Total Min	70	67	68		68	68	57	55	52		40	30	55	30		55		55

CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18
97001	15																	
97110	11	17	26			24	15	14	22	12			22	14	16	14	16	
97112	14	24	18			26	36	17	18	22			8	26	17	17	17	
97116	10	26	24			18	24	26	12	18			10	18	22	26	22	
Total Min	50	67	68			68	75	57	52	52			40	58	55	57	55	

CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18
92506		30																
92507		35	31			30	23	31	38	40			32	32	37	30	38	
Total Min		65	31			30	23	31	38	40			32	32	37	30	38	

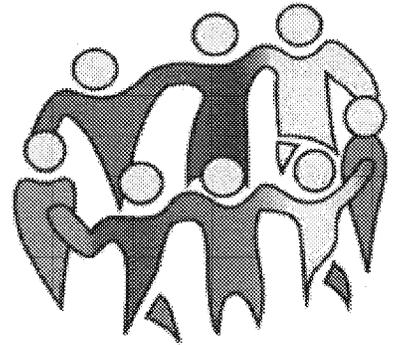
ORIGINAL EDTR		
Discipline	Days	Minutes
ST	5	164
OT	6	279
PT	5	276
		719 = RV

CHANGED EDTR		
Discipline	Days	Minutes
ST	5	164
OT	6	289
PT	5	276
		729 = RU

Documentation Essentials in Long-term Care

Medicare Part A Residents: Providing Group Minute Greater Than 25% of the Resident's Total Therapy Time Per Discipline during Non-Assessment Periods

Delivery of group therapy minutes should be no greater than 25% of the resident's total therapy time per discipline for any 7-day look back period.



5-DAY MDS
ARD Day 5

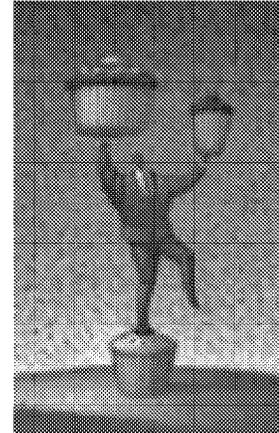
14-DAY MDS
ARD Day 18

CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18
97001	30																	
97110	16	19	20	19				19		20					19	20	19	15
97112	18	16	14	16				16		14					16	14	16	15
97116	17	15	15	17				15		15					15	15	17	16
97150					46				50		50			51				
Total Min	81	50	49	52	46			50	50	49	50			51	50	49	52	46

Documentation Essentials in Long-term Care

Medicare Part A Residents: Increasing Concurrent Minutes During Non-Assessment Periods

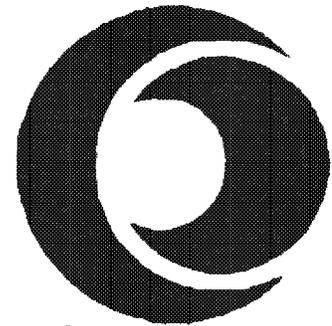
Delivery of concurrent minutes during non-assessment periods should remain consistent with delivery of minutes during assessment periods.



5-DAY MDS
ARD Day 5

14-DAY MDS
ARD Day 18

CPT Codes	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	
97001	30																		
97110	16	20	20	19				30	30	30					19	20	19	15	
97112	18	16	14	16				16	16	14					16	14	16	15	
97116	17	15	15	17				15	19	15					15	15	17	16	
97150					46						50			51					
Total Individual	81	51	49	52	46			31	35	29	50			51	50	49	52	46	
Total Concurrent								30	30	30									
Total Group					46						50			51					



Medicare Part B Residents: Making Corrections on the eDTR/Service Log to Reflect Individual Treatment Rather than Concurrent Treatment/Co-Treatment

Example 1: Concurrent treatment (1 therapist, 2 patients)

Jimmy John, PT provides concurrent treatment with two residents (Jane Doe and John Brown). At a later date, Jimmy John, PT makes a time correction change for resident Jane Doe in order to show individual rather than concurrent treatment.

Physical Therapy – Resident Jane Doe

Day	Time	HCPC	Min	Units	HCPC	Min	Units	HCPC	Min	Units	Total Min	Total Units
1/1/2010	8:30 am – 9:15 am	97110	30	2	97530	15	1				45	2
1/1/2010	9:15 am – 10:00 am	97110	30	2	97530	15	1				45	2
1/15/2010												

Patient Care Time – Therapist Jimmy John, PT

Patient Name	Time	Total Min	Group Min	Total Units	HCPC Code	Units	Min
Jane Doe	9:15 am – 10:00 am	45	0	3	97110	2	30
					97530	1	15
John Brown	8:30 am – 9:15 am	45	0	3	97112	2	30
					97116	1	15

Example 2: Co-treatment (2 therapists, 1 patient)

Jimmy John, PT provides co-treatment with Bobby Joe, OT. At a later date, Jimmy John, PT, makes a time correction change in order to show individual rather than co-treatment.

Physical Therapy – Resident Jane Doe

Day	Time	HCPC	Min	Units	HCPC	Min	Units	HCPC	Min	Units	Total Min	Total Units
1/1/2010	8:30 am – 9:00 am	97110	30								30	2
1/1/2010	8:30 am – 9:30 am	97110	30	2	97530	30	2				60	4
1/15/2010												

Patient Care Time – Therapist Jimmy John, PT

Patient Name	Time	Total Min	Group Min	Total Units	HCPC Code	Units	Min
Jane Doe	8:30 am – 9:30 am	60	0	4	97110	2	30
					97530	2	30

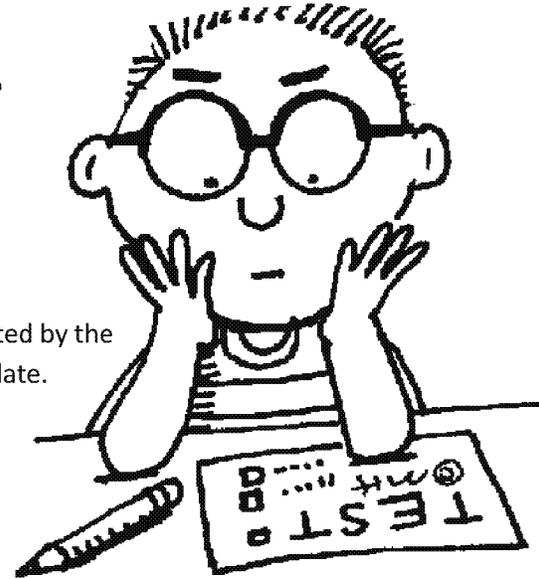
Patient Care Time – Therapist Bobby Joe, OT

Patient Name	Time	Total Min	Group Min	Total Units	HCPC Code	Units	Min
Jane Doe	9:30 am – 10:30 am	60	0	4	97110	2	30
					97530	2	30



Post-Test

1. Which of the following are not permitted to write therapy orders?
 - a. Assistant
 - b. Nurse
 - c. Therapist
 - d. None of the above
2. All entries on the *Re-certification/Continued POC* must be completed by the original licensed therapist, and later entries noted by initials and date.
 - a. True
 - b. False
3. Which of the following is incorrect regarding ICD-9 coding?
 - a. Always use the current year's ICD-9 codes
 - b. Code to the highest specificity
 - c. Do not use codes that are no longer applicable to the resident's current medical status
 - d. E codes are encouraged
 - e. Use multiple codes per discipline to fully describe the clinical complexity of the resident
 - f. All of the above
4. Dysphagia Medical Workup Form must be completed at the time a speech therapist completes a dysphagia evaluation if dysphagia is not listed as a diagnosis in the medical record.
 - a. True
 - b. False
5. Daily Treatment Notes must be completed for all payor types.
 - a. True
 - b. False
6. Which of the following is not true about documenting patient/caregiver education on the Weekly Progress Note?
 - a. List any education provided to family, nursing caregivers, or resident during the weekly note time frame
 - b. Discuss any communication or consultation provided
 - c. List equipment issued and education associated with the equipment
 - d. It is not necessary to documentation of patient/caregiver education each week



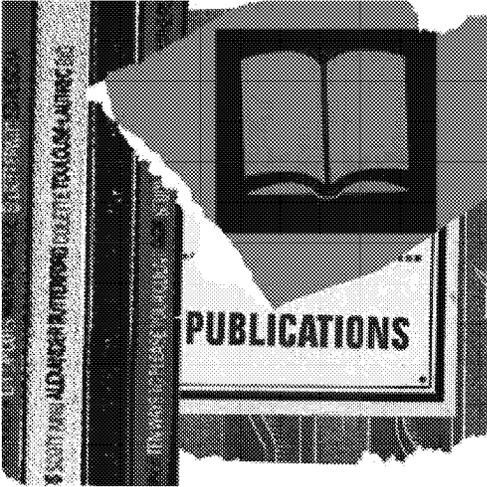
Documentation Essentials in Long-term Care

7. If the signature has marginal or questionable legibility, the therapist should PRINT his/her full name and credentials below the signature or use a signature log.
 - a. True
 - b. False

8. If a physician's signature is missing from *an order*, the order will be disregarded during review
 - a. True
 - b. False

9. Smart service log supports which of the following:
 - a. Documentation of the therapy services provided
 - b. The minutes of therapy delivered and the CPT codes billed for each day
 - c. Treatments delivered point of service
 - d. MDS
 - e. All of the above
 - f. None of the above

10. When using more than two procedural CPT codes, the codes cannot exceed the total treatment time.
 - a. True
 - b. False



Resources

- Pub 100-02 Medicare Benefit Policy Manual - Chapter 8
- Pub 100-02 Medicare Benefit Policy Manual - Chapter 15
- Pub 100-04 Medicare Claims Processing Manual - Chapter 5
- Pub 100-04 Medicare Claims Processing Manual - Chapter 6
- Pub 100-07 State Operations Manual - Appendix PP
- Pub 100-08 Medicare Program Integrity Manual - Chapter 3
- Pub 100-08 Medicare Program Integrity Manual - Chapter 13
- Pub 100-08 Medicare Program Integrity Manual - Transmittal 327, March 16, 2010
- Title 42 - Public Health - Part 483
- SRS Goal Manual
- SRS listing of Current CPT Codes and ICD-9 Codes
- SRS Med B Q & A
- SRS Policy & Procedure Manual - Chapter 3
- SRS PPATT Tool
- SRS PPS Informational Notebook for Rehabilitation Staff - Section III

Need Help?

Contact your:

- Program Services Consultant
- Compliance Department

