CAROLINA THERAPY SERVICES

Documentation Standards

In order to paid by Medicare and most other payor sources, therapy services "must be of a level of complexity that the judgement, knowledge and skills of a therapist are necessary to safely provide the services. There must be a reasonable expectation that the patient will improve in a reasonable and generally predictable period of time. Finally, the amount, frequency and duration of the services must be reasonable and necessary for the treatment of the patient's condition".

Medical Diagnosis

For Med A, the medical diagnosis must be the condition that was newly diagnosed or exacerbated by the most recent qualifying hospital stay. Previously diagnosed conditions not exacerbated by the hospital stay may be documented in the past medical history, but could be considered as pre-existing conditions if used alone as a medical diagnosis.

For Med B, the medical diagnosis must be a condition that has been diagnosed by the physician (not suspected or diagnosed by the therapist). It must directly relate to the treatment diagnosis and deficits the patient is experiencing.

Treatment Diagnosis

For all payors, the treatment diagnosis must be a condition included on the Local Coverage Determination (LCD) for that payor. The treatment diagnosis must be supported by evaluation baseline measures (ie: the patient's strength can't be WFL if muscle weakness is the treatment diagnosis) or by short term and/or long term goals.

Current/Past Medical History

List anything that will affect this patient's current episode of care, include past relevant medical history, existing co-morbidities, ability to follow directions and recall information, etc.

Reason for Referral

Check all that apply – the more thorough the patient's listed functional deficits, the more supportive this will be of therapy intervention.

Prior Living Situation

All therapy evaluations require a specific prior level of function for all goal areas. This will be established in the next section, but this section needs to include any other information not included there – patient lived with caregiver, number of steps, patient was independent with community mobility, etc.

Prior Level of Function

A prior level of function has to be documented on any area that goals are established for – including strength and ROM. It is inappropriate to leave this section blank or to say that prior level of function could not be established. Typically, the PLOF must be a lower functional level than the current functional level and goals should not exceed the PLOF.

Patient/Caregiver Goal

List any goals that the patient or their caregiver has set for themselves.

Objective Tests

Please complete any necessary sections to establish a current functional baseline for the patient. There are sections for specific standardized tests that can be completed when appropriate, as well as sections for specific skill areas such as positioning, activity tolerance, etc. At the very least, please make sure to report current evaluation baseline in functional skill areas. Evaluation baseline measures are typically a lower functional level than the prior level of function. Under no circumstances should this section be left blank.

CPT Codes

Select all possible CPT codes that can be used throughout the current therapy episode. CPT codes that are not listed on a POC or an updated UPOC cannot not be billed.

Frequency/Duration

Frequency must be set in terms of the number of visits that the patient will receive PER WEEK. Service dates delivered in excess would be considered out of compliance and are not payable without a clarification order signed by the doctor authorizing the additional treatment. Visits that are missed because the patient refused, was too sick to participate, or due to scheduling conflict must be documented. Every effort should be made to make up missed visits, if possible.

The duration refers to the period of time the patient will be seen before an updated plan of care/re-cert will be completed. An UPOC/re-cert must be completed at least every 90 days/12 weeks.

Rehab Potential/Prognostic Indicators

In order to best prove that the patient will benefit from this plan of care, the rehab potential should be good or excellent. This is only the potential that the patient will attain goals – not the potential that they will be fully independent and safe. Poor or fair potentials for progress may be problematic in a denial, especially if the patient is on caseload for long periods of time. Potential positive prognostic indicators include prior level of function, supportive caregivers, patient's ability to follow instructions, and patient motivation.

Long Term Goal

Must be measurable and include all short term goals. Ex: The LTG cannot ONLY be for the patient to dress themselves independently if there are also short term goals for bathing. The LTG is typically more general than the STG's. LTG also should not exceed the prior level of function and should be appropriate for the DC location. LTG's can only be updated by a therapist on an updated plan of care or re-evaluation.

Short Term Goals

Must be measurable. STG's should be specific to impairments or functional tasks and should not exceed the PLOF or LTG. Assistants or therapists can update STG's as long as the LTG is not exceeded. If assistants update STG's, they need to do so after the documented consultation with the supervising therapist.

DC Plans

In this section, do not just state that the patient is to be DC'ed when goals are met. Make sure you document the exact environment this patient will be DC'ed to (if you know it at the time of eval) and other factors you used to devise your goals. For example, even though patient is returning home with caregiver, he/she will still need to be completely independent with ADL's (rather than min assist or supervision) because the caregiver is unable to provide assistance, works out of the home, etc.

Progress Notes

Must be completed by a therapist (not an assistant) at least every 10^{th} visit. This note must also be accompanied by at least one billable service by the therapist. NC PT licensure rules require a PT to re-assess each patient every 14 visits/30 days, whichever comes first. Progress notes should include progress made towards each goal, skilled services provided, and the plan and justification for further treatment. If no progress is being documented, goals need to be updated or the patient should be discharged.

DC Summary

Must include a summary of skilled services provided during the entire episode of care, progress towards goals, and post-DC plan (ie: will the patient remain in the facility on restorative nursing, is the patient independent with their own exercise program, are they returning home with home health PT, etc).

Daily notes

Daily notes must be a summary of the skilled service provided that supports the billing of each CPT/HCPCS code. (ie: Ther ex note must document instruction/training/other skill provided during ther ex, gait must document instruction/training/other skill provided during gait, etc). Just documenting assistance provided does not typically justify skilled services, as untrained staff could safely be trained to provide this assistance.

Services that are repetitive or could be completed by non-therapy staff (ex: restorative nursing) are not skilled or billable to most payors. *Under no circumstances should the daily note be copy/pasted or contain exactly the same information as the prior day or another CPT code delivered on the same day.*

Timeliness of Documentation

CMS requires that all forms, including the DC summary, be completed within 7 days. Documentation time-stamped after that time can be thrown out in an appeal. Plans of care and updated plans of care must be signed and dated by the physician within 30 days.

Screens

The purpose of a screen is to identify the need for further evaluation by therapy ONLY. Recommendations such as equipment application, positioning devices, diet texture change, restorative nursing, etc. require a full evaluation and usually a couple of visits by the discipline to insure that the plan will be effective. Functional changes experienced by the patient that are reported to therapy by nursing, dietary, administration, etc should usually be full evaluated by therapy – not screened.

Eval-only

The purpose of an evaluation-only is to document the patient's function at that period of time or to establish that the current plan/equipment/etc is appropriate. Patients should also receive a few therapy visits beyond the evaluation whenever recommendations are made or a new plan/piece of equipment is put into place. The extra visits should insure that the patient will be safe with the new plan and that the patient and/or caregivers have been trained and are proficient with carryover.

Billing/Units

Billed minutes must be a true reflection of the skilled time spent with the patient. Under no circumstances are minutes to be rounded or include non-skilled tasks such as documentation, meetings, patient transport, or rest breaks.

Individual/Group/Concurrent Biling

Most inpatients and outpatients are treated on a one-on-one basis. If more than one patient is seen at any given time, individual minutes cannot be billed. Please use one of the following, making sure we are adhering to billing requirements:

- Concurrent: 2 patients (no more) that are performing different activities. Staff enters full treatment minutes. Concurrent therapy cannot be billed under Med B.

- Group: Up to 6 patients who are performing the same or similar activities. Staff enters full treatment minutes.

CoTreatments:

There are times when a patient requires treatment from more than one discipline during a single therapy session. During a co-treatment, each discipline must be providing a skilled service. For example, SLP may be addressing sequencing and PT is addressing gait training or an activity in which OT is addressing an ADL goal and PT is addressing balance for mobility.

- Co-treatment is appropriate when coordination between two disciplines will benefit the patient, not simply for scheduling convenience.
- It is required that documentation clearly indicate the rationale for co-treatment and state the goals that are being addressed through this method of intervention.
- Co-treatment should be documented by each practitioner.
- Co-treatment should be limited to two disciplines providing intervention during a single treatment session.

Modalities

The use of modalities (e-stim, ultrasound, etc) require a daily note indicating location, type, intensity, and parameters of treatment – even if the modality code is not billed (ie: VitalStim treatments therapy delivered under the swallowing treatment code). ***Run-time of unattended e-stim (G0281 and G0283) is not billable time!!! Only bill skilled time setting up machine, determining intensity, applying electrodes, patient ed, etc.**

The above will be considered the minimal documentation and billing requirements, based on CMS policy and NC state licensure. Anything exceeding these requirements is considered best practices and should be used whenever possible.

For questions, contact your Clinical Specialist:

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References:

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- https://www.apta.org/uploadedFiles/APTAorg/Payment/Medicare/Coding_and_Billing/SNF/JointCotreatmentGuidelinesUnderMedicare_ASHAAOTAAPTA.pdf