Task Force Scenario: Documenting Therapy and Rehabilitation Services

The CERT A/B MAC Outreach & Education Task Force, a partnership of all A/B Medicare Administrative Contractors (MACs), created this guide to educate providers on common documentation errors for outpatient rehabilitation therapy services. These widespread errors contribute to Medicare's national payment error rate, as measured by the Comprehensive Error Rate Testing (CERT) program.

The leading cause of payment errors for therapy services is "insufficient" documentation in the medical records. Documentation is often missing the required elements as outlined in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Sections 220 and 230. (1.2 MB)

For example, a provider indicates in the medical record:"Plan of Care: We would like to see the patient three times per week to initiate exercises and modalities to decrease pain and increase range of motion, stretching, strengthening and function." This plan is missing key elements to support the medical necessity of the service, such as measurable long-term goals, the patient's diagnosis, the proposed type, duration and frequency of services required to achieve each goal, or anticipated plan of discharge.

Additional widespread issues that result in "insufficient" documentation errors include:

- Missing or illegible signature on the plan of care;
- Missing or illegible signature for physician's certification; and
- Missing legible signature and required treatment minutes in narrative or on flow sheet.
- The CERT A/B MAC Outreach & Education Task Force recommends providers carefully review the following documentation requirements and tips for ensuring complete and accurate medical records.

Contents of Plan of Care

The plan of care shall contain, at minimum, the following information as required by regulation (42CFR Section 424.24 and 410.61 and CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220.1.2[B]): (1.2 MB)

- Diagnoses.
- Long term treatment goals -- Should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care.
- Type -- May be physical therapy, occupational therapy, or speech language pathology, or when appropriate, the type may be a description of a specific treatment of intervention. When a physician or NPP establishes a plan, the plan must specify the type of therapy planned.

- Amount -- Refers to the number of times in a day the type of treatment will be provided. When amount is not specified, one treatment session a day is assumed.
- Duration -- Number of weeks or the number of treatment sessions for the plan of care.
- Frequency of therapy services -- Refers to the number of times in a week the type of treatment is provided. When frequency is not specified, one treatment is assumed.

The plan of care shall be consistent with the related evaluation. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

Signature and Certification of the Plan of Care

The legible signature and professional identity (e.g., MD, OTR/L) of the individual that established the plan, as well as the date it was established, must be recorded with the plan. A physician or NPP must certify (and date) the plan of care (*note: for CORF services, NPPs may not order or certify therapy services). Certification may be established in the patient's medical record through:

- Physician's or NPP's progress note
- Physician or NPP's order*
- Plan of care that is signed and dated by a physician/NPP*
- Documentation must indicate that the physician/NPP* is aware that the therapy service is or was in progress; and
- Agrees with the plan, when there is evidence the plan was sent to the physician/NPP, or is available in the patient's medical record for the physician/NPP to review.

Treatment Note

The purpose of treatment notes is to create a record of all treatments and skilled interventions that are provided and to record the time of the services to justify the use of billing codes and units on the claim. Documentation is required for every treatment day and every therapy service.

Documentation of each treatment note must include the following required elements:

- Date of treatment.
- Identification of each specific intervention/modality provided and billed (both timed and untimed codes).
- Total timed code treatment minutes and total treatment time in minutes.
- Signature and professional identification of the qualified professional who furnished the services; or, for incident to services, supervised the services, including a list of each person who contributed to the treatment.

Functional Reporting

Claims for therapy services that are required to contain the nonpayable G-codes and corresponding modifiers should include documentation of Functional Reporting in the medical record. Specifically, documentation of the nonpayable G-codes and severity modifiers regarding functional limitations reported on claims must be included in the

patient's medical record of therapy services for each required reporting interval as outlined in the CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220.4. (1.2 MB)

Documentation of functional reporting must be completed by the clinician furnishing the therapy services. Therapists must also document his/her clinical judgment in the assignment of the appropriate severity modifier.

Avoid CERT Errors: Tips to Improve Therapy Documentation

- Ensure the medical records submitted provide proof the service(s) was certified and rendered.
- Ensure the medical records provide justification supporting medical necessity and that skilled services were needed.
- Create a complete plan of care, making certain to include your legible signature, professional identification (e.g., PT, OTR/L) and date the plan was established.
- Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met.
- Confirm the plan of care is certified (recertified when appropriate) with physician/NPP legible signature and date.
- Clearly document, in minutes, the total time spent on timed-code treatment only and the total treatment time (including timed and untimed codes) in the patient's record.

Additional Resources

To find additional information regarding therapy and rehabilitation services, refer to the following resources on the CMS Web site:

- CORFs: CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 5 (391 KB) and CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 12
- Skilled therapy services provided in Skilled Nursing Facilities: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 8 (265 KB)
- Other guidance: the CMS Therapy Services Web page

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