PURPOSE AND POLICY

In order to ensure that our residents need skilled therapeutic intervention, and in order to meet all requirements of our CIA, and federal and state health care programs, it is the policy of Grace Ancillary Services ("GAS") and Grace Healthcare, LLC ("Grace") to ensure that all rehabilitation services and documentation support the need for the services provided and that our medical record documentation reflects the individual medical needs of our residents.

Specifically, it is the policy of Grace to ensure that therapy is provided to Grace residents pursuant to individualized Plans of Care which are formulated based upon residents’ individual needs, and that the care and therapy provided to our residents is consistent with the nature and severity of their individual presenting problems. Therapy services provided to Grace residents must be medically necessary and reasonable in terms of duration and quantity, and based upon an individualized Plan of Care pursuant to which the therapy will improve, maintain or slow deterioration of the resident’s condition. Furthermore, the services needed must be inherently complex to require the services of skilled therapists or other professionals. These requirements are not only requirements of Grace’s CIA, but also mandatory requirements/expectations of all Grace employees, contractors, and Covered Persons, irrespective of Grace’s CIA. If the individualized medical necessity of therapy and other services is not present as well as properly documented, then the claim is not properly billable to federal, state, or other payors.

It is the express purpose of the following procedures to ensure the medical necessity of therapy and therapy services provided to Grace residents by therapy contractors including, but not limited to, therapy by Covered Persons as that term is defined in Grace’s CIA.

Different therapy providers will have different roles in the process of providing therapy services to Grace’s residents. These different roles will result in different responsibilities, however, any employee, Covered Person, agent, or other provider of services must ensure, regardless of their job duties, that therapy and other services are reasonable, necessary, appropriately provided, and appropriately documented. Failure to do so can lead to severe compliance issues for both Grace and the individuals failing to so ensure.

Any questions pertaining to this policy and procedure should be first directed to a therapist’s supervisor, rehab service manager, and/or Grace or GAS’s Compliance Officer.

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1 The definition of Covered Persons is: (a) all owners, officers, directors, and employees of Grace; and (b) all contractors, agents, and other persons at the Ten Subject Facilities who (1) are involved in the delivery of therapy care, (2) make assessments of residents that affect therapy treatment decisions or reimbursement, or (3) perform billing or coding functions.
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Documentation and Medical Necessity

Necessity and Appropriateness of Therapy Services

Skill:
Utilization of standardized assessments and objective outcome measurement tools is recommended at the beginning of treatment and during and after treatment in order to quantify progress and evaluate and demonstrate the need for continued service delivery. The services must be provided by qualified personnel who are either a therapist or an assistant being actively supervised by a therapist as required by applicable federal and state law. The therapist must actively participate in the treatment of the resident during each Progress Note period. The therapist’s skill and the need for skilled services must be clearly documented. This documentation may include the therapist's descriptions of their skilled interventions, the changes made to a treatment due to the therapist’s ongoing assessment of the patient’s needs, or changes due to progress the therapist judged sufficient to modify the treatment toward the next, more difficult or complex task. Tasks requiring skill are not repetitive in nature, but ever changing and adjusting from continued assessment of the resident to help them progress toward greater independence. Demonstrating the need for skilled services in documentation requires the therapist to explain what is being done that cannot be done by an unskilled person.

Medical Necessity:
To be considered reasonable and necessary, the services must be considered an acceptable standard of practice to effectively treat the resident’s condition. The services must be of the level of complexity and sophistication that the skill of a therapist is required to deliver the services. There must also be an expectation that the resident’s condition will improve in a reasonable amount of time or that the therapy will maintain or slow deterioration of the resident's condition. Therapy services may also be considered medically necessary when establishing a safe and effective functional maintenance program, which can be established following an evaluation and the development of the plan of care performed by the therapist. If a resident is at his or her prior level of function but required skilled intervention, this must be clearly stated in the evaluation and the plan of care and the reason for the intervention must also be clearly documented. When documenting a resident's prior level of function, it is necessary to include practice areas related to those that will be addressed during the intervention. It should be descriptive and paint a vivid picture of how the resident was truly functioning in a variety of areas prior to this episode. The impairments the residents now have, when compared to the prior level of function, must lead to a functional limitation to demonstrate that services are medically necessary.

Appropriateness:
Skilled intervention is appropriate to treat residents who have conditions resulting in impairments or limitations documented by an evaluation and establishment of an individualized plan of care. The concept of rehabilitative therapy includes recovery or improvement in function, and when appropriate, restoration to the prior level of function as well as maintaining or slowing deterioration of the resident’s condition. All rehabilitation therapy must be consistent with the nature and severity of the resident’s individual illness, injury and needs, and must comply with accepted Standards of Medical Practice. The continual assessment of the resident’s progress, maintenance, or slowing deterioration should be documented in each Weekly Progress note, utilizing objective information to be compared from one week to the next to demonstrate improvement in function, a decrease in severity, or deterioration, or rationalization for an optimistic outlook to justify continued delivery of services. There must be continual assessment and analysis of functional progress throughout the course of treatment. CMS states "improvement is evidenced by successive objective measurements", indicating objective measurements must be provided when possible. All rehabilitation therapy must be based on an individual resident’s
needs and must be reasonable and necessary in both duration and quantity given the individual resident's needs and plan of care.

Also note, the fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve a resident's condition. The deciding factor is whether or not the services are considered reasonable, effective intervention for the resident's condition and require the skills of a physical, speech, or occupational therapist to provide the stated interventions. Rehab therapy which does not require a skilled professional's services is not medically necessary.

Appropriateness of care and services is also demonstrated by the resident's individual need for services. A need must be present and documented in order for Medicare to determine the medical necessity. Along with the need for services is the resident's potential for improvement, maintenance, or slowing of deterioration. The resident must have a good rehab prognosis for services to be needed and appropriate.

Evaluation and Individualized Plan of Care Requirements
The initial evaluation should demonstrate that the clinician, referring to the Occupational Therapist, Physical Therapist, or Speech Language Pathologist, completed a hands-on assessment. The evaluation should provide documentation to support the necessity for the current course of treatment based on the subjective and objective findings of the clinician and the individual needs of the patient.

- It should state a baseline of function, such as the prior level of function the resident was practicing at before this spell of illness.
- Upon completion of the evaluation, a picture should be clearly painted of how the resident was able to function prior to the current condition and how he or she is currently functioning in objective terms.
- The documentation should include the history and onset date of the current disorder, as well as any relevant medical history to support the current episode of care.
- There should also be a listing of other conditions and complexities, as well as an explanation of the impact these will have on the resident's ability to participate and make progress with skilled intervention. The explanation should be detailed in nature and objective in terms. In order to initiate treatment, the evaluating therapist must expect the resident to make progress as a result of intervention.

Please note, if a resident is evaluated and services are not deemed appropriate or reasonable and necessary, but a functional maintenance program is needed, the evaluating therapist may develop the program after the completion of the evaluation, and caregivers can be educated as needed.

Elements of Evaluation:
- A diagnosis that reflects the specific reasons the resident requires skilled intervention is required. A clinician should choose the most relevant medical diagnosis from the resident's medical record. A relevant and specific treatment, or impairment based, diagnosis should also be chosen using the Grace Ancillary Services Billing and Coding Program. If the applicable diagnosis does not indicate the necessity of skilled intervention, the rehabilitation services should not be provided.
- Objective findings indicating measurable physical functioning of the resident should be included in the evaluation. The use of functional assessment measures should be utilized as appropriate to indicate measurable progress toward identified goals, as stated in the plan of care. These goals should be written directly in response to the areas of limitation identified by the evaluation. The types of assessments used should be listed.
- The clinician's professional judgment and subjective impressions, which describe the resident's current functional status, should be clearly stated at the conclusion of the evaluation. The amount, type, and duration of therapy should be based on the clinician's professional judgment,
and the individual needs of the patient. Any therapy not meeting this requirement should be reported to the Compliance Officer immediately.

- The reason for the referral or treatment and the referral source should be included.
- Proper and complete documentation is essential to demonstrate medical necessity. Care can be reasonable, appropriate, and medically necessary, but if the care provided is not fully and accurately documented, then it cannot be justified to reviewers. “If the care is not documented, it did not happen.” Additional documentation requirements include:
  - Reason for Referral and specific interventions to be performed
  - Diagnosis (medical and treatment) and functional condition/limitation, which is being addressed and the onset date (treatment diagnosis onset date). The medical diagnosis must be a current medical condition that is currently being addressed.
  - Medical history, co-morbidities, precautions, pertinent medications. Listing these medical complexities will assist in demonstrating the appropriateness of the level of intensity of intervention.
  - Primary subjective complaint
  - Mechanism of injury
  - Any previous diagnostic testing results (x-rays, MRI, CT scans, blood work)
  - Prior level of function with specific information regarding household activities, community interaction, mobility, etc. There must be a prior level of function noted in order to compare with the resident’s current level of function. This will also properly indicate progress as the resident receives intervention and demonstrates improvement.
    - The prior level of function should be a guide for developing the long-term goal. The general goal is to provide the appropriate care in order to assist the resident in returning to the prior level of function or the highest level of function possible which may include maintenance or slowing of deterioration.
  - Any previous therapeutic interventions
  - Baseline data, which is objective and measureable in all applicable areas listed on the evaluation. Some examples include: cognition, perception, sensation and proprioception, edema, posture, AROM, PROM, strength, coordination, pain, bed mobility, balance transfers, ambulation, assistive devices, DME, activity tolerance, wound measurements, safety, and special testing
  - Problem list

- Supporting documentation and information should also include:
  - Identification of other healthcare providers participating in the resident's care and in demonstrating the severity of the illness and medical complexity. This includes PT, OT, ST, Social Services, Nursing, Dietician, Psychologist, and Physician.
  - A listing of current durable medical equipment the resident needs.
  - The number of medications the resident is currently taking
  - Complicating factors that will affect the treatment provided and an explanation of the impact
  - Multiple conditions the resident has, in addition to the medical conditions being addressed by skilled therapy intervention.
  - Mental or cognitive state of the resident, which may significantly impact the response to treatment and the rate of recovery.
  - Indication of other skilled intervention provided prior to the current episode, therapy services provided during the current episode in the same or different setting, or previous intervention by the same discipline over the past year.
  - Other relevant factors, such as resident’s age, cause of current condition, time lapsed since onset, medical stability, and predictability of progress or maintenance or slowing of deterioration.
• The discharge plan for the resident, including location, who will be living with or caring for the resident at discharge, and possible recommendations for continued services at discharge if known.

• The resident’s priorities and desired outcomes should also be listed.

• The time spent completing the evaluation will not be billed as treatment time. Evaluation minutes are untimed minutes and are part of the total treatment minutes but minutes of evaluation shall not be included in the minutes for time code reports in the treatment notes.

• If treatment is provided on the same day as the evaluation, a treatment encounter note must be completed, as per the guidelines stated in the Daily Treatment Encounter section later in this guide.

Elements of the Individual Plan of Care (POC)

• The Individual Plan of Care must be established prior to providing treatment. It is appropriate to initiate treatment on the same day the Plan of Care is established.

• The Plan of Care must be signed and dated by the person who has established the plan. Measurable treatment goals must be included in the Plan of Care. These goals must pertain to the impairments and limitations identified by the evaluation. The goals must also remain consistent throughout the course of treatment, unless they have been modified and noted appropriately.

• These goals should be written directly in response to the areas of limitation identified by the evaluation. Also note if there are goals written to address dysphagia, there must be a dysphagia evaluation completed.

• A consistent method of identifying goals must be used throughout the course of treatment.

• Short-term goals must be specific and should be a sub-goal of the stated long-term goals.

• If the resident is being treated for different conditions, there may be two separate plans or the information can be combined into one plan, including goals to address all areas of limitation.

• The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcomes with the appropriate resources.

• Long-term goals should be established for the entire episode of care.

• The clinician should estimate the duration of the entire episode of care when listing it on the POC. For Medicare B residents, there is a 90-day certification limit on the POC, but if it is anticipated the resident will need services beyond the 90-day period, the clinician should state the total length of the current episode of care on the plan.

• If significant changes are made to the plan of care, the therapist must make the changes in writing, and it must be signed by the therapist of the appropriate discipline. The certifying physician must also sign the updated plan.

• An example of a significant change would be changing the long-term goals for the resident’s condition.

• An insignificant change would be a change in the frequency and duration, or a modification in the short-term goals to reflect improvement toward the initially stated long-term goals.

• The physician must sign the plan of care within 30 days of it being established.

• If the plan of care is certified for a duration of 30 days and the resident is making progress and in need of continued skilled services, an updated plan of care must be completed and signed by the certifying physician.

Physicians’ Orders

Evaluation Orders

• Must be obtained prior to initiating a therapy evaluation

• May be included with admission orders on the admission or transfer sheet or on a Telephone Order

• All written orders must be signed and dated by the physician
Clarification Orders

• Must be obtained prior to initiating a therapy plan of care and must include the following:
  o Date the order is requested
  o Patient’s name
  o Medical diagnosis description
  o Treatment diagnosis, with specific numerical code
  o Summary of treatment approaches to be used in POC
  o Frequency and duration, should be definite, not variable
  o Signature of therapist

• Must be obtained for a change in the rehabilitation POC during the course of treatment. The change includes any of the following:
  o Change in modalities
  o Change in frequency
  o Change in payer
  o Upon expiration of previous order
  o Upon change or addition of medical diagnosis

Discharge Orders

Discharge orders must be obtained when the patient is discharged from therapy and will remain in the facility beyond the discharge date.

Daily Treatment Encounter Note Requirements

The Daily Treatment Encounter Note is meant to be a record of all the treatment and skilled interventions that are provided to a resident, as well as a record of time the services were provided to justify the billing codes listed on the claim form. Documentation is required for each treatment day and should include information regarding each therapy intervention provided. Specific information should be included if it is not mentioned in the treatment plan or if it has changed from what is documented in the treatment plan.

Elements of the Daily Notes:

• Date the treatment is provided
• Identification of each specific intervention and modality provided and billed, as well as an explanation of services delivered to support each code being billed daily. A portion of the daily narrative need to address each HCPC billed each day.
• The resident’s response to treatment and participation should be noted, as well as any training or consultation provided during the treatment.
• The total timed code treatment minutes and the total treatment time in minutes is required and is documented by entering billing into AHT each day. For each day there is billing in the system for a resident, there should also be a Daily Treatment Encounter Note.
• Start and Stop times for each resident treatment will be entered by the therapist in real time on the mobile device used for point of service documentation. Start and stop times for therapy sessions entered on any device other than in real time point of service must be approved in writing by Grace Corporate Compliance.
• Unbillable time should also be represented, as it will assist in providing an accurate description of the treatment.
• Signature and professional identification of the clinician who provided the services billed, as well as a list of each person who contributed to that treatment session. For example, if a PTA delivered the services but consulted with the supervising PT, the PTA would sign the note and would list the PT as a consultant.
• If, during the daily treatment, an intervention is added or changed under the direction of the supervising therapist and it is between the time frame of the weekly notes, the change must be documented in the medical record. These changes or adjustments also may aid in demonstrating
that the services being delivered require the skill of a therapist. If such services do not require the skill of a therapist, they are not medically necessary.

- Each stated short-term goal should be addressed in some manner daily to sufficiently address the goal in the Weekly Progress Note.
- Optional items can be documented in the Daily Treatment Encounter Note as deemed relevant by the clinician, and include:
  - Patient self report
  - Adverse reaction to intervention
  - Communication or consultation with other members of the interdisciplinary team
  - Significant changes in clinical status
  - Any equipment provided, along with education and understanding of the resident.
  - Environmental modifications
  - Any additional information relevant to the intervention

- The short-term goals listed on the plan of care should be the map for the course of treatment. These goals should be referred to by the treating therapist on an ongoing basis.
- If a resident refuses treatment, the reason for the refusal should be documented, as well as the attempts to be made to see the resident. The resident's response should also be clearly documented. If the resident is treated by therapy services after the initial refusal, the therapist should explain in the daily note why the resident received therapy after the initial refusal. The daily note should then be completed as it typically would.
- Please refer to the Grace Billing and Coding Guidelines for specific documentation requirements for each HCPC code provided during intervention.

**Weekly Progress Note Requirements**

The weekly progress note is a summary of the intervention process from week to week and documents the resident's progress toward the goals stated on the Plan of Care. This is the portion of documentation, which provides the justification for the medical necessity of treatment and the need for continuation of services. Please note a therapist must be directly involved in the care of each resident, providing supervision to the assistant and treatment to the resident at least every 30 days.

**Elements of the Weekly Progress Note:**

- An explanation of the frequency of services provided as well as the length of time services have been provided since the evaluation should be included (i.e. 5 times a week this week and 8 weeks since the initial evaluation). The date must also be included.
- Techniques, interventions and strategies used to make the stated progress should be stated, as well as any environmental modifications or therapy equipment provided.
- The resident's response to treatment over the past week should also be noted.
- The resident's progress toward the stated goals should be documented. This should be objective information and descriptive of changes in functional status should be noted to address each goal stated.
- The goals to be addressed must be consistent from week to week unless the goals have been appropriately modified or updated.
- Verification of the participation of the clinician's involvement in the Weekly Progress Note is required and should be documented by his or her electronic co-signature on the Progress Note.
- The signature and professional credentials should be included on all Weekly Progress Notes. An electronic signature meets this requirement.
- Objective reports of the patient's subjective statements should also be documented if relevant.
- Assessment of resident improvement toward each goal, or lack of progress should be documented for each goal.
- It should be noted that assistants should not make clinical judgments regarding why progress was or was not made each week but the progress can be reported objectively.
• Progress notes can be used to add, change or delete short-term goals. Assistants may make changes to the goals with the direction of the supervising therapist. The therapist should verify these changes by providing a co-signature on the report.
• Recommendations and rationale for continued treatment as well as the resident’s input regarding the current treatment plan should be included.
• Treatment plan revisions should also be documented by the therapist on the Weekly Progress Note.
• Attention must be given in the weekly note to ensure the provided documentation justifies the medical necessity of continued skilled intervention. If continued skilled intervention is reasonable and necessary, it must be appropriately documented. The justification for treatment should include objective evidence or a clinically supported statement of expectation that:
  o The resident’s condition has the potential to improve or is improving in response to therapy or that therapy is necessary to maintain the resident’s condition or to slow deterioration
  o That maximum improvement is yet to be attained
  o There is an expectation that the anticipated improvement is attainable in a reasonable and predictable period of time or that therapy is necessary to maintain or slow deterioration.
• It is the ultimate responsibility of the therapist to continually assess the appropriateness of goals. If progress is taking place rapidly or if a lack of progress is noted, the therapist should assess whether the current goals are still appropriate. Goals may be adjusted as necessary throughout the course of treatment to ensure optimum progress is made toward the stated long-term goals.
• If progress has not been achieved, clinical reasons should be clearly stated, especially if care is going to continue. Regressions and plateaus may happen during treatment but the reasons for the lack of progress must be noted and there should be justification documented for continued intervention if the treatment continues after the regression or plateau.
• If there are functional regressions, declines or plateaus, these may also be addressed in the daily treatment encounter notes.

10th Visit/Supervisory Note Elements:
• The Part B 10th visit note must be completed by the supervising therapist. This may be completed at intervals less than every 10th visit but it must not exceed this time frame.
• It should be noted that a recertification does not affect the dates required for 10th visit notes.
• This note should state the therapist’s guidance to the assistant(s) involved in the course of treatment during the reporting period.
• The PTA or the OTA may write elements of the progress note dated between the clinician’s notes but these may not be used as a complete note. The therapist does not need to recopy information documented in the assistant’s notes, as their documentation is also part of the complete medical record.
• Please note the guidelines outlined for the progress notes listed above all apply to the completion of the 10th supervisory visit note.

Discharge Summary Requirements
A Discharge Summary is required at the conclusion of each episode of therapy and should be completed by each discipline involved. A Discharge Order must also be written if the resident will be remaining in the facility after therapy discharge. Clinicians should consider the Discharge Summary as the final opportunity to aid in demonstrating medical necessity of the entire treatment episode. Medically appropriate therapy which is not appropriately documented cannot be justified.

Elements of the Discharge Summary:
• It should contain information similar to a Progress Note and must be completed by a therapist.
• The information included in the Discharge Note should summarize objective information from evaluation through discharge, and include a narrative explanation of the progress made over the course of treatment. This includes writing the listed goals and providing the level of function at both the evaluation and at discharge, as well as the interventions utilized to address the goals.
• The date of the evaluation and the date of discharge should be documented in the Summary.
• The Discharge Summary may also justify why treatment extended beyond the initially expected time frame for the resident’s condition.
• A clear picture of the discharge disposition should be painted at discharge. Is the resident going home with family? How often will there be help available? Can the family help with transfers?
• In the event the discharge is unexpected, the therapist can base any judgments on the Daily Treatment Encounter notes written in the time period since the last Weekly Progress Note.
• Any recommendations for post-discharge should be clearly documented in the Discharge Summary.

Development of a Maintenance Program:
• The goals of developing a maintenance program are to maintain the current level of function and/or prevent a functional decline.
• While the skill of a therapist may not be required to carry out a functional maintenance program (FMP), it may be required for the development of a FMP. The therapist can design and establish the FMP, train the resident and other caregivers, and make infrequent re-evaluations of the plan.
• The development of a FMP should be completed prior to the discontinuation of skilled therapy services.

Discharge Guidelines:
The course of treatment for a resident involves a continual assessment of the resident and his or her participation and progress on a daily basis. The course of treatment, which is planned at the initial evaluation, may change, based on the response of the resident to the intervention provided. It requires the skills of a therapist to ensure the resident is able to continually benefit from services. There are three areas, which should be considered when determining an appropriate discharge:

• Status of patient
• Potential to demonstrate improvement
• Gap between current level and the anticipated level of function at discharge

The course of treatment should also involve interaction between the resident and the therapist to determine whether services continue, or to proceed with discharge. If the resident has not demonstrated progress toward stated goals, even after the plan of care has been adjusted or modified, or can no longer benefit from skilled intervention, a plan for discharge should be developed and communicated with the interdisciplinary team as appropriate.

Late Entries
The use of late entries should be a rarity in medical documentation. However, there are circumstances that may require a late entry. In such circumstances, the following should be observed:

• The entry must be made within 48 hours
• The entry should be clearly labeled “late entry”
• Only a licensed clinician may make a late entry
• Late entries should contain the date the entry should have been made in addition to the date the late entry is being made; for example “05/14/12 late entry for 05/12/12…”
General Guidelines

- To determine scheduling and frequency of the delivery of services, the therapy week for each facility will be Sunday through Saturday for all payors and disciplines.
- The therapy documentation must clearly convey the medical necessity of the services provided; be based upon an individualized plan of care; be consistent with the nature and severity of the resident’s individual illness or injury; comply with accepted standards of therapy practice; be necessary given the resident’s individual needs, condition, and plan of care; and demonstrate the need for skilled therapy intervention.
- Documentation needs to be clear, concise and legible.
- Review the Cahaba Local Coverage Determinations to understand the difference between what the therapists are able to do and what the fiscal intermediary will cover with payment.
- CMS prefers the long term goals on the plan of care be written for the episode, not just a different version of the short term goals.
- A new plan of care should be written for resident's who experience a significant change in his or her condition or if the long term goals are modified.
- In the daily treatment note, there must be justification of each therapy code billed during the treatment session (clear identification of each specific therapeutic intervention and service provided). This should accurately reflect skilled services provided and should include only objective information.
- The progress notes should paint the picture not of what we did but how we did it.
- When choosing a treatment and medical diagnosis, the therapist should choose the one which most accurately reflects the condition or the reason the patient is receiving skilled services. It is recommended that V codes not be used for the medical or treatment diagnosis.
- Documentation must reflect the skill of the service provider. What did the therapist do that an unskilled person cannot do?
- The reason for referral section of the evaluation should be the last thing the evaluating therapist completes. It should be determined when the therapist identifies the areas of deficit.
- The evaluation should be referenced frequently, not just at the time of evaluation. It provides the road map to guide the treating therapists on the road the plan needs to follow.
- Within Functional Limits (WFL) should only be used in reference to range of motion. The abbreviation should not be used to describe the resident’s ability on any other part of the evaluation as it is not an objective measure.
- Goals should be set with the intention of doing everything possible to achieve them. They need to guide the treatment and the interventions provided with and for the resident. If the goals are not being met, they need to be revised and changed as appropriate. Modifying goals shows that the therapist is watching and continuously evaluating the resident.
- Avoid using ranges when writing goals, both short and long term.
- Use outcome measures and objective testing as frequently as possible and include the outcome measure scores in the goals.
- When documenting the use of verbal cues, be specific with the information provided in the note to reflect the type and level of cueing necessary for that session. Consistently use the same type of measure and descriptors in the documentation. The amount of cues must be objectified. The use of cues helps to separate us from non-skilled persons. Remember that a reduction in cues shows that the resident is learning and improving.

Part B Information

- With Medicare Part B residents, the therapist must provide hands on services for a minimum of one unit on or before the 10th treatment day.
- A new plan of care must be written when the duration expires. Clarification orders should also be written when the duration expires.
- The plan of care and the evaluation must be written within 24 hours of treatment being provided. The therapist prior to an assistant providing treatment services must complete these.
Functional Limitation/G Codes

CMS has implemented new claims based data collection requirements for outpatient therapy services by requiring reporting with 42 new non-payable functional G codes and seven new modifiers on claims for Physical Therapy, Occupational Therapy, and Speech Language Pathology services.

These G-codes and modifiers are required on all Part B claims, regardless of whether or not the beneficiary has exceeded the cap or not. Only one functional limitation shall be reported at a given time for each related therapy plan of care. However, functional reporting is required on claims throughout the entire episode of care; so there will be instances where two or more functional limitations will be reported for one beneficiary's plan of care, just not during the same time frame. In these situations, where reporting on the first reported functional limitation is complete and the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes.

These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at:

- The initial evaluation and re-evaluation
- At least once every 10 treatment days—the functional reporting is required on the claim for services on the same DOS that the services related to the progress note are furnished.
- Upon discharge
- On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary

Function-related G-codes

The following Healthcare Common Procedure Coding System (HCPCS) G-codes are used to report the status of a beneficiary's functional limitations:

**Mobility G-code set:**
- G8978, Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals.
  - Short descriptor: Mobility current status
- G8979, Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.
  - Short descriptor: Mobility goal status
- G8980, Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting.
  - Short descriptor: Mobility D/C status

**Changing & Maintaining Body Position G-code set:**
- G8981, Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals.
  - Short descriptor: Body pos current status
- G8982, Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
  - Short descriptor: Body pos goal status
- G8983, Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting.
  - Short descriptor: Body pos D/C status

**Carrying, Moving & Handling Objects G-code set:**
- G8984, Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals
  - Short descriptor: Carry current status
• G8985, Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
  o Short descriptor: Carry goal status
• G8986, Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting
  o Short descriptor: Carry D/C status

Self Care G-code Set:
• G8987, Self care functional limitation, current status, at therapy episode outset and at reporting intervals
  o Short descriptor: Self care current status
• G8988, Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
  o Short descriptor: Self care goal status
• G8989, Self care functional limitation, discharge status, at discharge from therapy or to end reporting
  o Short descriptor: Self care D/C status

Primary G-code Set:
• G8990, Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals
  o Short descriptor: Other PT/OT current status
• G8991, Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
  o Short descriptor: Other PT/OT goal status
• G8992, Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting
  o Short descriptor: Other PT/OT D/C status

Other PT/OT Subsequent G-code Set:
• G8993, Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals
  o Short descriptor: Sub PT/OT current status
• G8994, Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
  o Short descriptor: Sub PT/OT goal status
• G8995, Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting
  o Short descriptor: Sub PT/OT D/C status

Swallowing G-code Set:
• G8996, Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Swallow current status
• G8997, Swallowing functional limitation, projected goal status, at initial therapy treatment/episode outset and at discharge from therapy
  o Short descriptor: Swallow goal status
• G8998, Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation
  o Short descriptor: Swallow D/C status

Motor Speech G-code Set: (Note: These codes are not sequentially numbered)
• G8999, Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Motor speech current status
• G9186, Motor speech functional limitation, projected goal status at initial therapy treatment/episode outset and at discharge from therapy
Short descriptor Motor speech goal status
- G9158, Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation
  o Short descriptor: Motor speech D/C status

Spoken Language Comprehension G-code Set:
- G9159, Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Lang comp current status
- G9160, Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
  o Short descriptor: Lang comp goal status
- G9161, Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation
  o Short descriptor: Lang comp D/C status

Spoken Language Expressive G-code Set:
- G9162, Spoken language expression functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Lang express current status
- G9163, Spoken language expression functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
  o Short descriptor: Lang express goal status
- G9164, Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation
  o Short descriptor: Lang express D/C status

Attention G-code Set:
- G9165, Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Atten current status
- G9166, Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
  o Short descriptor: Atten goal status
- G9167, Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation
  o Short descriptor: Atten D/C status

Memory G-code Set:
- G9168, Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Memory current status
- G9169, Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
  o Short descriptor: Memory goal status
- G9170, Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation
  o Short descriptor: Memory D/C status

Voice G-code Set:
- G9171, Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Voice current status
- G9172, Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
  o Short descriptor: Voice goal status
• G9173, Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation
  o Short descriptor: Voice D/C status

Other Speech Language Pathology G-code Set:
• G9174, Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
  o Short descriptor: Speech lang current status
• G9175, Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
  o Short descriptor: speech lang goal status
• G9176, Other speech language pathology functional limitation, discharge status at discharge from therapy/end of reporting on limitation
  o Short descriptor: speech lang D/C status

For each of the non-payable G-codes, a modifier must be used to report the severity/complexity for that functional measure. The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the therapist, physician, or NPP furnishing the therapy services. The beneficiary's current status, the anticipated goal status, and the discharge status are reported via the appropriate severity modifiers. The seven modifiers are:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Impairment Limitation Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>0 Percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CI</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CJ</td>
<td>At least 20 percent but less than 40 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CK</td>
<td>At least 40 percent but less than 60 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CL</td>
<td>At least 60 percent but less than 80 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CM</td>
<td>At least 80 percent but less than 100 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CN</td>
<td>100 percent impaired, limited or restricted</td>
</tr>
</tbody>
</table>

The functional reporting coincides with the progress reporting frequency, which, according to the new requirement, is for services related to the progress reports to be furnished on or before every tenth treatment day.

Evaluative Procedures

The presence of an HCPCS/CPT code on a claim for an evaluation or re-evaluation service listed as follows requires reporting of functional G-code(s) and corresponding modifier(s) for the same date of service:

**HCPCS/CPT Codes requiring Functional G-code(s) and Corresponding Modifier(s)**

<table>
<thead>
<tr>
<th>92506</th>
<th>92597</th>
<th>92607</th>
<th>92608</th>
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<td>96125</td>
<td>97001</td>
<td>97002</td>
<td>97003</td>
<td>97004</td>
</tr>
</tbody>
</table>

When functional reporting is required on a claim for therapy services, two G-codes will generally be required. Two exceptions exist:

1. Therapy services under more than one therapy POC. Claims may contain more than two non-payable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.
2. One-Time Therapy Visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim
for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

Each reported functional G-code must also contain the following essential line of service information:

- Functional severity modifier in the range CH - CN
- Therapy modifier indicating the discipline of the POC - GP, GO or GN - for PT, OT, and SLP services, respectively
- Date of the corresponding billable service
- Nominal charge, e.g., a penny, for institutional claims submitted to the FLs and A/MACs. For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

In addition, claims containing any of these functional G-codes must also contain another billable and separately payable (non-bundled) service.

**Billable Treatment Guidelines**

**Minutes of Therapy (RAI Manual Chapter 3 Section O)**

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.

- If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted.

- The therapist's time spent on documentation or on initial evaluation is not included.

- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.

- Family education when the resident is present is counted and must be documented in the resident's record.

- Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.

- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.

- Set-up time shall be recorded under the mode for which the resident receives initial treatment when he/she receives more than one mode of therapy per visit.
  - Code as individual minutes when the resident receives only individual therapy or individual therapy followed by another mode(s);
— Code as concurrent minutes when the resident receives only concurrent therapy or concurrent
therapy followed by another mode(s); and

— Code as group minutes when the resident receives only group therapy or group therapy followed by
another mode(s).

- For Speech-Language Pathology Services (SLP) and Physical (PT) and Occupational Therapies (OT)
include only skilled therapy services. Skilled therapy services must meet all of the following conditions
(Refer to Medicare Benefit Policy Manual, Chapters 8 and 15, for detailed requirements and policies):

  — for Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a
  physician following the therapy evaluation;

  — the services must be directly and specifically related to an active written treatment plan that is
  approved by the physician after any needed consultation with the qualified therapist and is based on an
  initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;

  — the services must be of 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;

  — the services must be provided with the expectation, based on the assessment of the resident’s
  restoration potential made by the physician, that the condition of the patient will improve materially in
  a reasonable and generally predictable period of time, or the services must be necessary for the
  establishment of a safe and effective maintenance program or to slow deterioration;

  — the services must be considered under accepted standards of medical practice to be specific and
  effective treatment for the resident’s condition; and,

  — the services must be reasonable and necessary for the treatment of the resident’s condition; this
  includes the requirement that the amount, frequency, and duration of the services must be reasonable
  and they must be furnished by qualified personnel.

- Include services provided by a qualified occupational/physical therapy assistant who is employed
by (or under contract with) the long-term care facility only if he or she is under the direction of a
qualified occupational/physical therapist. Medicare does not recognize speech-language pathology
assistants; therefore, services provided by these individuals are not to be coded on the MDS.

- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the
definitions and coding for Medicare Part A.

- Record the actual minutes of therapy. Do not round therapy minutes (e.g., reporting) to the nearest
5th minute.

- When therapy is provided staff need to document the different modes of therapy and set up minutes
that are being included on the MDS. However, the therapy aide set-up time is not included for billing
purposes on a therapy Part B claim.

- When a resident refuses to participate in therapy, it is important for care planning purposes to
identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying
to persuade the resident to participate in treatment is not a skilled service and shall not be included in
the therapy minutes.
• Services provided by therapy aides are not skilled services

Individual Treatment
This is the treatment of one resident at a time. The resident is receiving the therapist's or the assistant's full attention. Treatment of a resident individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count.

When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals and he/she is able to immediately intervene/assist the student as needed.

Co-Treatment
Co-Treatment occurs when two or three disciplines simultaneously work with the same patient under discipline-specific plans of care. For Medicare A, when two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited. Justification for the need of a co-treatment must be clearly conveyed in the daily encounter note for the resident. For Medicare B, therapists, or therapy assistants, working together as a "team" to treat one or more patients cannot each bill separately for the same or different service provided at the same time to the same patient. CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s).

Group Therapy
Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. The number of group therapy minutes to be counted toward the reimbursable treatment minutes will be the number of therapy minutes delivered in a group setting divided by 4, regardless of the number of participants. The total number of minutes provided will be entered in Section 0.

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:
- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.
- When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:
  - The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
  - The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.
There is a 25% cap per discipline on the amount of group therapy, which can be completed in a 7-day period, regardless of payor.

**Concurrent Treatment**

**Medicare A:** Treatment of 2 or more residents, who are not performing the same or similar activities, at the same time, regardless of payor, both of whom are in the line of sight of the treating therapist or assistant. The total number of minutes provided in a concurrent setting will be entered on the MDS and the software will divide the minutes by 2, resulting in the amount of reimbursable treatment minutes.

When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy.; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

**Medicare B:** The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment.

**Modalities**

Only skilled therapy time spent with a resident during the delivery of physical agent modalities should be counted as reimbursable treatment minutes. In most situations with modalities, there will be some skilled and some unskilled treatment time. Only the time spent as skilled intervention should be included in the MDS. As instructed in the RAI manual, the following example is given: "the portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS."

Another example from the RAI manual is "the application of a hot pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS." The use of physical agent modalities and the rationale for use should always be included in the resident's discipline specific plan of care and clarification orders.

**References:**

- Cahaba LCD for PT, OT and ST
- CMS Benefit Policy Manual, Chapter 15
- CMS Transmittal 63
- Grace Healthcare Billing and Coding Guidelines Program
- Guidelines for Documentation of Occupational Therapy
- Resident Assessment Instrument Manual Chapter 3
- Medicare Learning Network Matters Number MM8005