DOCUMENTATION REQUIREMENTS
MEDICARE PART A VS MEDICARE PART B

ITEM	MEDICARE PART A	MEDICARE PART B	Your State Practice Act? Professional Association?
Where can regulations be found?	**Medicare Benefit Policy Manual Chapter 8: Section 30.2.2.1 – Documentation to Support Skilled Care Determinations** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf	**Medicare Benefit Policy Manual Chapter 15: Section 220 - Coverage of Outpatient Rehab Therapy Services Under Medical Insurance (PT, OT, SLP); Section 220.3 Documentation Requirements** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf	If your state restricts any of the following, then you must follow your Practice Act. However, if your Practice Act allows any of the following and Medicare does not, you must follow Medicare guidelines. (ie: Part B Progress Reports and DC Summaries cannot be written by a PTA or COTA even if your State Practice Act permits it.
MD Order for Evaluation	**REQUIRED** "Care in a SNF is covered if all of the following four factors are met: • The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); **are ordered by a physician** and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services"	**NOT REQUIRED** A physician order is not required. "Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan."	
MD Order for Treatment	**REQUIRED** "Skilled nursing and/or skilled rehabilitation services are those services, **furnished pursuant to physician orders,** that: • Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and • Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result."	**REQUIRED** An order for treatment is required in the form of a Plan of Care which must include: treatment amount (x per day), frequency (x per week) and duration (number of weeks)	
Therapy Plan of Care	**NOT REQUIRED.** THE FORMAL "PLAN OF CARE" IS REQUIRED FOR PART B. This is not to be confused with the need for a therapy treatment plan, which is required as part of the evaluation.	**REQUIRED:** A formal Plan of Care is required and must contain specific elements, including at a minimum, Diagnosis, LTG's that are measurable and function based, type, amount, duration and frequency of services. Optional but recommended are: STG's, treatment interventions and techniques that will be used, and a start date from which to measure the duration. "The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated). The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan."	
Certification / Re-Certification of the Plan of Care	**SPECIFIC THERAPY CERTIFICATION NOT REQUIRED.** SNF Part A Certification/Recertification's are required encompassing the whole stay (skilled care for .... nursing.... rehab). This is not a therapy plan of care and is typically prepared by the MDS Coordinator or Medicare Nurse and signed by the physician to certify the need for skilled care at specific required intervals. "Certification is obtained at time of admission or shortly thereafter; First recertification no later than the 14th day of inpatient extended care services. Then at intervals not exceeding 30 days."	**THERAPY CERTIFICATION REQUIRED AS PART OF PLAN OF CARE**: Certification requires a dated (physician) signature on the plan of care or some other document that indicates approval of the plan of care "The physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements noted above in §220.1 for the duration of the plan of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan. Recertification's that document the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan becomes evident, or at least every 90 days after initiation of treatment under that plan, unless they are delayed."	
Initial Evaluation	**REQUIRED. PERFORMED BY THERAPIST. "**The therapy services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist"	**REQUIRED. PERFORMED BY CLINICIAN / THERAPIST** "The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24, 410.61, and 410.105(c) (for CORFs)). (See §220.3 for further documentation requirements): • Diagnoses; • Long term treatment goals; and • Type, amount, duration and frequency of therapy services. Shall include: diagnosis specific to problem treated (impairment based dx), problem description to be evaluated/treated, results of objective tests and measures (NOMS, FOTO, AM-PAC or OPTIMA), and if not used then required objective functional testing data."	

Daily Treatment Notes	**REQUIRED** "The patient's medical record must document as appropriate: • The history and physical exam pertinent to the patient's care, (including the response or changes in behavior to previously administered skilled services); • The skilled services provided; • The patient's response to the skilled services provided during the current visit; • The plan for future care based on the rationale of prior results. • A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences; • The complexity of the service to be performed"	**REQUIRED** The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim. Documentation is required for every treatment day, and every therapy service. Documentation of each treatment shall include the following required elements: • Date of treatment; and • Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding. Record each service provided that is represented by a timed code, regardless of whether or not it is billed, because the unbilled timed services may impact the billing; and • Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See Pub. 100-04, chapter 5, section 20.2 for description of billing timed codes; and • Signature and professional identification of the qualified professional	
Daily Billing Entries / Minutes / Units	**REQUIRED** (TOTAL MINUTES). Billing occurs using the UB-04 claim form which outlines the total # of days that each discipline provided services and the RUG score. CPT Codes are not used for Part A on the claim.	**REQUIRED** (TOTAL DIRECT CONTACT TIME): Billing occurs using the UB-04 claim form which lists each date of service, the CPT code billed and units for each.	
Progress Report	**NOT REQUIRED:** A formal progress report is not required. However, all Medicare Part A services require "sufficient documentation to convey to a reviewer that the services were skilled, reasonable and necessary..."	**REQUIRED:** The progress report provides justification for the medical necessity of treatment. For Medicare payment purposes, information required in progress reports shall be written by a clinician that is, either the physician/NPP who provides or supervises the services, or by the therapist who provides the services and supervises an assistant. The minimum progress report period shall be at least once every 10 treatment days. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, reevaluation or treatment. Regardless of the date on which the report is actually written (and dated), the end of the progress report period is either a date chosen by the clinician or the 10th treatment day, whichever is shorter. Content of Clinician (Therapist, Physician/NPP) Progress Reports."The progress report of a clinician shall also include: • 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 should be documented in the clinician's progress report; and • Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment. • Functional documentation is required as part of the progress report at the end of each progress reporting period. It is also required at the time of discharge on the discharge note or summary, as applicable. The clinician documents, on the applicable dates of service, the specific nonpayable G-codes and severity modifiers used in the required reporting of the patient's functional limitation(s) on the claim for services, including how the modifier selection was made. See subsection C of 220.4 below for details relevant to documentation requirements." Assistant's Participation in the Progress Report. PTAs or OTAs may write elements of the progress report dated between clinician reports. Reports written by assistants are not complete progress reports. The clinician must write a progress report during each progress report period regardless of whether the assistant writes other reports. Verification of the clinician's required participation in treatment during the progress report period shall be documented by the clinician's signature on the treatment note and/or on the progress report	
Progress Note	**NO FORMAL FORMAT OR FREQUENCY REQUIRED - see statement above**	**NOT REQUIRED IN ADDITION TO THE FORMAL PROGRES REPORT**	

Functional Limitation Reporting: G-Codes / C-Modifiers	**NOT REQUIRED**	**REQUIRED:** "The functional impairments identified and expressed in the long term treatment goals must be consistent with those used in the claims-based functional reporting, using nonpayable G-codes and severity modifiers, for services furnished on or after January 1, 2013."	
Re-Evaluation	**NO FORMAL REQUIREMENT**	**REQUIRED ONLY WHEN MEDICALLY NECESSARY.** "A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued. A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation. The minutes for re-evaluation are documented in the same manner as the minutes for evaluation. Current Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code"	
Discharge Summary	**NOT REQUIRED**	**REQUIRED AS A PROGRESS REPORT:** "The Discharge Note (or Discharge Summary) is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The discharge note shall be a progress report written by a clinician, and shall cover the reporting period from the last progress report to the date of discharge." "In the case of a discharge anticipated within 3 treatment days of the progress report, the clinician may provide objective goals which, when met, will authorize the assistant or qualified personnel to discharge the patient. In that case, the clinician should verify that the services provided prior to discharge continued to require the skills of a therapist, and services were provided or supervised by a clinician. The discharge note shall include all treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge"	
General Documentation Requirements	"When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be provided by nonskilled personnel."	"Services are or were required because the individual needed therapy services (see 42CFR424.24(c),§220.1.3); • A plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP* (see 42CFR424.24(c), §220.1.2); • Services are or were furnished while the individual is or was under the care of a physician* (see 42CFR424.24(c), §220.1.1); • In certifying an outpatient plan of care for therapy a physician/NPP is certifying that the above three conditions are met (42 CFR 424.24(c)). Certification is required for coverage and payment of a therapy claim."	
	"If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service"	"Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to Medicare requirements. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all requirements applicable to Medicare claims."	
	"Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether— • Skilled involvement is required in order for the services in question to be furnished safely and effectively; and • The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals"	"Only a clinician may perform an initial examination, evaluation, re-evaluation and assessment or establish a diagnosis or a plan of care. A clinician may include, as part of the evaluation or re-evaluation, objective measurements or observations made by a PTA or OTA within their scope of practice, but the clinician must actively and personally participate in the evaluation or re-evaluation. The clinician may not merely summarize the objective findings of others or make judgments drawn from the measurements and/or observations of others."	
	"It is expected that the documentation in the patient's medical record will reflect the need for the skilled services provided. The patient's medical record is also expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatment, and training performed. Taken as a whole, then, the documentation in the patient's medical record should illustrate the degree to which the patient is accomplishing the goals as outlined in the care plan. In this way, the documentation will serve to demonstrate why a skilled service is needed. Thorough and timely documentation with respect to treatment goals can help clearly demonstrate a beneficiary's need for skilled care in situations where such need might not otherwise be readily apparent, as when the treatment's purpose changes (for example, from restoration to maintenance), as well as in establishing the efficacy of care that serves to prevent or slow decline—where, by definition, there would be no "improvement" to evaluate. "		