PT Documentation Considerations

http://ncptboard.org/

North Carolina Board of Physical Therapy rules: 21 NCAC 24C .0102 (l) and (m) and NCAC 24C .00102 (f)

21 NCAC 48C .0102 RESPONSIBILITIES

(a) The physical therapist must determine the patient care plan and the elements of that plan appropriate for delegation.
(b) The physical therapist must determine that those persons acting under his or her supervision possess the competence to perform the delegated activities.
(c) The physical therapist may delegate responsibilities to physical therapist assistants. The supervising physical therapist must determine that the PT or PTA student is working under supervision at all times.
(d) The physical therapist must enter and review chart documentation, reexamine and reassess the patient and revise the patient care plan if necessary, based on the needs of the patient.
(e) The physical therapist must establish the discharge plan.
(f) For each date of service, a physical therapist must provide all therapeutic interventions that require the expertise of a physical therapist and must determine the use of assistive personnel who provide delivery of service that is safe and effective for each patient.
(g) A physical therapist's responsibility for patient care management must include first-hand knowledge of the status of each patient and oversight of all documentation for services rendered to each patient, including awareness of fees and reimbursement structures.
(h) A physical therapist must be immediately available directly or by telecommunication to a physical therapist assistant supervising a physical therapy aide or student engaging in patient care.
(i) A physical therapist must be limited to clinically supervising only that number of assistive personnel, including physical therapists assistants, physical therapy aides, and students completing clinical requirements, as is appropriate for providing safe and effective patient interventions at all times.
(j) If a physical therapist assistant or physical therapy aide is involved in the patient care plan, the patient must be reassessed by the supervising physical therapist no less frequently than every 30 days.
(k) A physical therapist who is supervising a physical therapy aide or student must be present in the same facility when patient care is provided.
(l) The physical therapist must document every evaluation and intervention/treatment, which must include the following elements:
    (1) Authentication (signature and designation) by the physical therapist who performed the service;
    (2) Date of the evaluation or treatment;
    (3) Length of time of total treatment session or evaluation;
    (4) Patient status report;
    (5) Changes in clinical status;
    (6) Identification of specific elements of each intervention/modality provided. Frequency, intensity, or other details may be included in the plan of care and if so, do not need to be repeated in the daily note;
    (7) Equipment provided to the patient or client; and
    (8) Interpretation and analysis of clinical signs and symptoms and response to treatment based on subjective and objective findings, including any adverse reactions to an intervention.
(m) At least every 30 days, the therapist must document:
    (1) The patient's response to therapy intervention;
    (2) Progress toward achieving goals; and
    (3) Justifications for continued treatment.

History Note: Authority G.S. 90-270.24; 90-270.26; 90-270.31; 90-270.34;
Eff. December 30, 1985;
Amended Eff. November 1, 2006; August 1, 2002; August 1, 1998; January 1, 1991.

Physical Therapy Documentation of Patient/Client Management

Selected sections of *Physical Therapy Guide to Practice*

*Physical Therapy Prognosis and **Plan of Care***

Interventions from *Physical Therapy Guide to Practice*

Patient/client Related Instruction
Therapeutic Exercise
Functional Training in Self-Care and Home Management
Functional Training in Work, Community, and Leisure
Prescription, Application, and as Appropriate, Fabrication of Devices and Equipment

Please note that the *Anticipated Goals and Outcomes* are listed in general terms but your patient goals should be objective, measurable, and time limited as stated in the *Physical Therapy Prognosis and Plan of Care* document.

There are additional Intervention sections relating to respiratory, electrotherapy, manual therapy, skin care, and physical agents available in the Physical Therapy Guide to Practice.

OT Documentation Considerations

The standard for documentation of a therapy session is set by the licensure board/professional standards of the practitioner.

For OT, the OT Board rule states:
(5) Documentation:
(a) The occupational therapy practitioner shall document each evaluation, intervention and discharge plan recognizing the unique requirements of specific practice settings, payors, and service delivery models. Documentation shall include the following elements:
(i) Client name or identifiable information;
(ii) Signature with occupational therapist or occupational therapy assistant designation of the occupational therapy practitioner who performed the service;
(iii) Date of the evaluation, intervention or discharge plan;
(iv) Objective and measurable description of contact or intervention and client response; and
(v) Length of time of intervention session or evaluation.

SLP Documentation Considerations

For SLP, the SLP Board Rule states:
21 NCAC 64 .0209 ADEQUACY OF RECORDS
(a) The definition of "adequate records of professional services" required to be maintained by Rule .0303(4) shall include:
(1) The full name of the patient;
(2) The nature of the service provided;
(3) The date services were provided;
(4) The identification of the person providing the service;
(5) The identification of the person preparing or signing the record if not by the person providing the service.
(b) Corrections shall be made by drawing a single line through the error without obliterating the error and shall be initialed
by the person making the correction.
(c) Records of professional services rendered shall be maintained for a minimum period of three years.

For All

Medicaid requirement was drawn from the licensure board standards. Medicaid is not the final dictator of documentation standards; the licensure boards are.

A SOAP note format is not required. However, every treatment must include what's in the rule quoted above. How you define "nature of service provided" is probably the key—if you're an LEA hoping for Medicaid reimbursement of the service, you may want to use the Medicaid standard to describe the nature of service provided.

The DPI memo was really intended to highlight the need for a plan of care (POC) that is separate from and developed after the IEP. The POC is not an IEP document and it is not an NCDPI requirement. It is a required

component of documentation under some of the licensure board rules and all best practice standards. While DMA Medicaid LEA Policy 10-C states the IEP *may* serve as the plan of care, it does not state the IEP *must* serve as the plan of care for school-based claims. Recent audit findings suggest the IEP does not (and should not) contain all required components of a complete therapy plan of care.

When using any documentation template, it remains the responsibility of the IEP team to create school participation-based goals. After the IEP is developed, the practitioner will document treatment approaches and outcomes that are evidence-based, measurable and accurate.

Use of these templates is the personal choice of the practitioner; please feel free to adapt as would suit your individual practice.

Medicaid Documentation

MEDICAID POLICY and ADDITIONAL INFORMATION

DPI Medicaid website:
http://www.ncpublicschools.org/ec/medicaid

Medicaid Policy 10C: Local Education Agencies
http://www.ncdhhs.gov/dma/mp/8h.pdf

All policies state that Medicaid accepts the medical necessity for beginning, continuing and terminating treatment as published by the professional guidelines of each discipline.
Policy includes documentation requirements:

7.1 Documenting Services

Each provider must maintain and allow DMA to access the following documentation for each individual:

a. The patient name and Medicaid identification number.

b. A copy of the treatment plan. (IEP accepted for LEAs.)

c. A copy of the MD, DO, DPM, CNM, PA, or NP's order for treatment services. Date signed must precede treatment dates.

d. Description of services (intervention and outcome/client response) performed and dates of service.

e. The duration of service (i.e., length of assessment and/or treatment session **in minutes**).

f. The signature of the person providing each service.

g. A copy of each test performed or a summary listing all test results, and the written evaluation report.

h. For medication administration under nursing services, a flow sheet or equivalent documentation must be used by the nurse or delegated individual. The documentation must show the nurse's/delegated individual's full name and title. The date and time administered as well as nurse's/individual's initials and title must be written after each medication given. A narrative note summarizing the medication administered must be completed at least weekly by the RN with (if appropriate) input from the delegated person administering medication. This note should document results from the medication, side effects of the medication, and any other pertinent data.

i. Other nursing services outlined in the plan of care require the same documentation as all IEP services.

j. For delegated services there must be documentation of training and validation of competency by the RN of the person who will be performing the procedure. In addition, documentation, at a minimum monthly, that the RN monitors the care of the student to ensure that the procedure is being performed safely and effectively. The documentation usually is a form in which the school nurse and the assistant sign and date that the procedure is being done correctly.

k. All services provided "under the direction of" must have supervision provided and documented according to the Practice Act of the licensed therapist. If group therapy is provided, this should be noted in the provider's documentation for each child receiving services in the group. For providers who provide services to several children simultaneously in a classroom setting, the documentation should reflect this and the duration of services noted in the chart

should accurately reflect how much time the provider spent with the child during the day. Such documentation ensures that an adequate audit trail exists and that Medicaid claims are accurate.

Because services provided in schools may be unique and differ from those provided in other settings, documentation to justify medical necessity could be more like progress notes identifying the services provided with an assessment of results and goals for the next treatment. Such documentation does not have to be lengthy and can be accomplished in a couple of sentences. It does, however, have to be clear to a reviewer to support the services billed.

The student's IEP, which is generally only revised once a year, does not serve as documentation sufficient to demonstrate that a service was actually provided, to justify its medical need, or to develop a Medicaid claim. The IEP represents a plan of care showing what services are to be provided and at what frequency. It does not document the provision of these services.

Practitioners/clinicians should keep their own records of each encounter, including the date of treatment, time spent, treatment or therapy methods used, progress achieved, and any additional notes required by the needs of the student. These notes should be signed by the clinician and retained for future review by state or federal Medicaid reviewers.

Records must be available to the Division of Medical Assistance (DMA) and its agents and to the U.S. Department of Health and Human Services, and CMS upon request. Lack of appropriate medical justification may be grounds for denial, reduction or recoupment of reimbursement. LEAs are responsible for ensuring that salaried and/or contracted personnel adhere to these requirements.

7.2 Post-Payment Validation Reviews

Medicaid or agents acting on behalf of Medicaid will perform reviews for monitoring utilization, quality, and appropriateness of all services rendered. Post-payment validation reviews will be conducted using a statistically valid random sample from paid claims. Overpayments will be determined using monthly paid claims data. Written notice of the finding(s) will be sent to the provider who is the subject of the review and will state the basis of the finding(s), the amount of the overpayment, and the provider's appeal rights. Case reviews may also show the need for an educational notification to the provider. While services provided by LEAs are excluded from prior authorization, they will be subject to post-payment review.

Information Regarding Post-payment Reviews by DMA/CCME

North Carolina's Department of Medical Assistance (DMA) has contracted The Carolinas Center for Medical Excellence (CCME) to conduct post-payment reviews of claims for outpatient services, which includes school-based services provided by LEAs. At this time post-payment validations do not include nursing services.

Detailed information about post-payment reviews can be found at:
www.medicaid programs.org/nc/therapyservices

Questions about the post-payment review process or specific questions can be emailed to: priorauth@thecarolinascenter.org

To get access to information regarding selection for post-payment review, providers (LEAs) must register at www.medicaid programs.org/nc/therapyservices

The first review period will be from 7/1/09-11/30/09. Selection will be random with distribution matched to submitted claims (number of claims), therapy type and provider type. DMA/CCME may also select claims as prompted by concern. LEAs are not subject to prior approval (PA) reviews as our IEP process serves as or prior approval.

Review selections will be made on the first business day of the month and CCME will send out a request for information by email if the provider (LEA) is registered on the CCME website as outline above or by mail if not registered. Every provider (LEA) has 15 calendar days to provide documentation to CCME. There is no exception for school closures or holidays. If the provider is not able to provide the requested documentation to CCME, they will be contacted by CCME. Usually an extension can be arranged. DMA/CCME will not reimburse providers for cost associated with copies or shipping. Documentation can be faxed to CCME at 800-228-1437 or electronic documentation can be mailed via CD using Word or PDF files to CCME at 100 Regency Forest Dr., Suite 200 Cary, NC 27518

Information about DMA requirements for documentation can be found in section 7.0 of Medicaid policy for LEAs (there is a link from www.ncpublicschools.org/ec/medicaid

Also available on the DPI Medicaid website is a documentation checklist and a self audit tool to review your own documentation. Often mistakes can be caught and remedied by implementing a self audit process.

Each review will result in one of three outcomes:

- pass,
- fail (failing one or more validations) or
- closed (no documentation received)

Reviews resulting in fail or closed outcomes are subject to recoupment. Recoupment will be required only for the claims resulting in fail or closed outcomes, not all claims for that provider. Payment will be due to DMA within 30 calendar days of the outcome decision.

Providers have three options for reconsideration within 15 calendar days of the outcome decision:

- Written/paper submission (additional documentation is accepted)
- Personal via telephone
- Personal meeting

Providers may also formally appeal within 60 days to the Office of Administrative Hearings (www.oah.state.nc.us)

Please note, the appeal process does not negate the payment due to DMA for recoupment.

If you have any questions please review the information available on line at www.medicaidprograms.org/nc/therapyservices or email priorauth@thecarolinascenter.org

If you cannot find the answer to your question using the resources above, contact Lauren Holahan: lauren_holahan@med.unc.edu or 919/843-4466 or Laurie Ray: laurie_ray@med.unc.edu or 919/636-1827.

Carolinas Center for Medical Excellence (CCME)

Resources available on their website http://www.thecarolinascenter.org/

Helpful hints: Goal Pitfalls and Modifications
PPV Outpatient Specialized Therapies – Documentation Standards
PPV Review _ Helpful Hints

Reported Issues:
Insufficient documentation of medical necessity
Illegible notes and signatures
Insufficient Plan of Care
Visit notes: session length not recorded **in minutes** (regardless of the billing code)
Visit notes: **skilled intervention** provided during this session not documented
Visit notes: patient's response to treatment not documented

DATA COLLECTION RESOURCES:

National Center on Student Progress Monitoring:
http://www.studentprogress.org

http://www.speakingofspeech.com/
(click on data forms)

National Research Center on Learning Disabilities:
http://www.nrcld.org

National Center on RTI:
http://www.rti4success.org

Intervention Central:
http://www.interventioncentral.org

Chris Riley-Tillman's site on Evidence Based Interventions
http://core.ecu.edu/psyc/rileytillmant/rileytillman.html

For tally counters: http://tallycounterstore.com/?gclid=CNzKoYzH550CFRwhnAodLRDpMQ

MOVEMENT BASED INSTRUCTION:
http://jc-schools.net/Health/K-5-Energizers.pdf

http://www.ncpe4me.com/pdf_files/MS-Energizers-Music.pdf

Courageous Pacers
http://www.southpawenterprises.com/%2FThe-Courageous-Pacers-Program-P24.aspx