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Audit Tool to Help Evaluate Compliance With Therapy Documentation Requirements

With physical, occupational and speech therapy under review by Medicare auditors, it's important to ensure the medical necessity of your services ("With Payment Changes and Medicare Audits, Therapy Services Are Ripe for Monitoring," *RMC* 28, no. 24). This audit tool was developed by Holly Hester, senior vice president of compliance and quality at Casamba, and Yolunda Dockett, corporate compliance officer at Lorien Health Services. Contact Dockett at ydockett@lorienhealth.com and Hester at holly.hester@casamba.net.

Rehabilitation Documentation Review

Facility:	Reviewer:	Date of Review:
Patient:	Discipline:	Therapist:

Areas to Review	Meets Expectations: Y/N/NA	Comments
Physician Order/Referral		
Referral/order is current?		
Referral/order signed & dated by the physician?		
Extension or other required order is in the chart?		
Evaluation/Plan of Care		
Evaluation is complete and documented timely?		
Plan of Care signed and dated by physician/NPP within 30 days of Start of Care?		
Reason for referral is clearly stated and supports therapy intervention?		
Medical & treatment diagnoses are clearly stated and support Plan of Care?		

Prior level of function supports treatment?		
Medical history is comprehensive and relates to reason for treatment?		
Functional testing completed and limitations clearly stated?		
Therapist's clinical assessment/impression documented?		
Goals are specific, measurable, functional, and have time frames?		
Plan of Care includes interventions/procedures related to the goals?		
Frequency and duration are appropriate and specific?		
Progress Notes		
Daily/treatment encounter notes present for all dates of therapy delivered, including treatment rendered on day of evaluation?		
Progress reports completed by therapist as required by payer and applicable state practice acts?		
Number of treatments is supported by the frequency/duration?		
Goals are addressed in encounter notes and progress reports?		
Encounter notes reflect skilled interventions and time billed?		
Patient's response to treatment is documented?		
Education of patient, staff, caregiver, or family is clearly documented?		
Progress reports support need to continue treatment?		
Active participation by therapist at least every 10 visits for Med B?		
Co-signatures are recorded as required by practice act?		
Updated POC/DC Summary		
Updated Plan of Care/Recertification signed and dated timely by the physician/NPP?		
Discharge summaries are filed in the medical record and completed by clinician timely?		
Discharge recommendations & referrals are made as appropriate?		

Progress clearly documented? Comparison made from initial status?		
Goals are addressed with explanations for goal(s) not attained?		
Need for medically necessary, skilled service is documented?		

Compliance Percentage:

Action Plan Recommended? Y / N