

# Complete Healthcare Compliance Manual Resource: Rehabilitation Documentation Checklist

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## Rehabilitation Documentation Review

|                          |                      |                        |
|--------------------------|----------------------|------------------------|
| Facility:                | Date:                | Reviewed by:           |
| Patient:                 | Therapist:           | Disc. OT PT ST         |
| Key: (+) = Present/Meets | (N) = Not Applicable | (■) = Criteria Not Met |

|          |   | Areas to Review   |  | Comments |
|----------|---|---|--|----------|
| MD Order | 1 | Referral / order is current?  |  |          |
|          | 2 | Referral / order signed & dated by the physician?                           |  |          |
|          | 3 | Extension or other required order is in the chart?                          |  |          |
|          | 4 | Evaluation is complete and documented timely?                               |  |          |
|          | 5 | Plan of Care signed and dated by physician within 30 days of Start of Care? |  |          |
|          | 6 | Reason for referral is clearly stated and supports therapy intervention?    |  |          |

|                |    |   |  |  |
|----------------|----|---|--|--|
| Evaluation/POC | 7  | Medical & treatment diagnoses are clearly stated and support Plan of Care?  |  |  |
|                | 8  | Prior level of function supports treatment?   |  |  |
|                | 9  | Medical history is comprehensive and relates to reason for treatment?   |  |  |
|                | 10 | Functional testing completed and limitations clearly stated?  |  |  |
|                | 11 | Therapist's clinical assessment/impression documented?  |  |  |
|                | 12 | Goals are specific, measurable, functional, and have time frames?   |  |  |
|                | 13 | Plan of Care includes interventions/procedures related to the goals?  |  |  |
|                | 14 | Frequency and duration are appropriate and specific?  |  |  |
|                | 15 | Daily / treatment encounter notes present for all dates therapy delivered, including treatment rendered on day of evaluation? |  |  |
|                | 16 | Progress reports completed by therapist as required by payer and applicable state practice acts?                              |  |  |
|                | 17 | Number of treatments is supported by the frequency/duration?  |  |  |

|                        |    |  |  |  |
|------------------------|----|--|--|--|
| Progress Notes         | 18 | Goals are addressed in encounter notes and progress reports?                           |  |  |
|                        | 19 | Encounter notes reflect skilled interventions and time billed?                         |  |  |
|                        | 20 | Patient's response to treatment is documented?   |  |  |
|                        | 21 | Education of patient, staff, caregiver, or family is clearly documented?               |  |  |
|                        | 22 | Progress reports support need to continue treatment?                                   |  |  |
|                        | 23 | Active participation by therapist at least every 10 visits for Med B?                  |  |  |
|                        | 24 | Co-signatures are recorded as required by practice act?                                |  |  |
| Updated POC/DC Summary | 25 | Updated Plan of Care/ Recertification signed and dated by the physician?               |  |  |
|                        | 26 | Discharge summaries are filed in the medical record and completed by clinician timely? |  |  |
|                        | 27 | Discharge recommendations & referrals are made as appropriate?                         |  |  |
|                        | 28 | Progress clearly documented? Comparison made from initial status?                      |  |  |
|                        | 29 | Goals are addressed with explanations for goal(s) not attained?                        |  |  |

|  |    |  |  |  |
|--|----|--|--|--|
|  | 30 | Need for medically necessary, skilled service is documented? |  |  |
|--|----|--|--|--|

Total # Correct \_\_\_\_\_ / \_\_\_\_\_ = \_\_\_\_\_ %

Action Plan Recommended  Yes  No

Comments/Recommendations:

Reviewer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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