General Medicare Documentation Requirements for PT/OT

Medicare pays for therapy services when the medical record and the information on the claim form accurately report covered therapy services. That means your documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to the requirements in Medicare manuals. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all legal/regulatory requirements applicable to Medicare claims. Also remember that CPT instructs that there must be appropriate documentation to support a given CPT code.

Note: Medicare documentation guidelines identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program. State or local laws and policies, or the policies of the profession, the practice, or the facility may be more stringent.

Additional documentation not required by Medicare is encouraged when it conforms to state or local law, or to professional guidelines of the American Physical Therapy Association or the American Occupational Therapy Association.

Medicare carriers will consider the entire record when reviewing claims for medical necessity so that even if you leave out a piece of documentation, it does not mean the medical necessity of the service will be denied. Services are medically necessary if the documentation indicates they meet the requirements for medical necessity, including that they are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/NPP, safe, and effective (i.e., progress indicates that the care is effective in rehabilitation of function).

Documentation Required – What you need to have for all your records

Medicare requires documentation of therapy services in several formats. They include:

- **Evaluation/Plan of Care** (may be one or two documents) includes the initial evaluation and any re-evaluations relevant to the episode being reviewed. This would be setting up what type of therapy, how long a given patient needs therapy and why.
- **Certification (physician/NPP approval of the plan) and recertifications of the need for treatment and therapy plan of care.** Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due. (See Section 220.1.3 and Appendix C)
- **Progress Reports** (including Discharge Notes, if applicable). This is a summary of treatment notes for a given period of time and also provides the medical necessity.
- **Treatment Notes** for each treatment day documenting what was done, how patient tolerated, and time spent performing therapy services. (May also serve as Progress Reports when required information is included in the notes.)

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Knee Therapy Treatment

Pt#:								
Name:								
DATE	11/9/10		11/12/10		11/14/10		11/20/10	
THERAPIST	Susan, PT		Mary, PT		Susan, PT		Susan, PT	
# of visits	1		2		3		4	
	Reps	Time (min)	Reps	Time (min)	Reps	Time (min)	Reps	Time (min)
THERAPUTIC EXERCISE (97110)		25						
Bike (seat @)		5						
Treadmill								
Quad Sets								
Heel Slides								
SLR								
Hip ADD								
Hip ABD								
Hip Ext.								
Ball Squeeze								
Bridge								
TKE								

OCCUPATIONAL THERAPY REFERRAL

Date:___ /____ / _____ Patient: __________________________ _______________ DOB:____ /____ /_____

Diagnosis: ____ ________________ ❐ RT ❐ LT ❐ BOTH

Surgery: ____ DOS/DOI: ____ /____ /_____

Duration: _______x/week for _______weeks or _______ # visits Insurance ___________________________

❐ Evaluate and Treat

Therapy Interventions:

- ❐ Joint mobilization
- ❐ Myofascial Release/Massage
- ❐ ROM
  - ❐ Active/assisted ❐ Active ❐ Passive
- ❐ Strengthening (P.R.E.)
  - ❐ Theraband ❐ Putty
- ❐ Isometric
- ❐ Muscle Re-education
- ❐ Modalities per pt. response
- ❐ E-Stim/TENS
- ❐ Paraffin
- ❐ Edema control
- ❐ Scar management
- ❐ Iontophoresis
  - ❐ Dexamethasone ❐ Saline
- ❐ Functional Conditioning Program
- ❐ Ergonomics Education
- ❐ Home Exercise Program
- ❐ ____________________________________

Protocol:

- ❐ Distal biceps tendon repair
- ❐ Epicondylitis
- ❐ Distal radius fx, pinning
- ❐ Distal radius fx, ORIF
  - ❐ Phase II ❐ Phase III
- ❐ Dupuytren's
- ❐ Extensor tendon repair
- ❐ Flexor tendon repair
- ❐ RSD
- ❐ Sensory re-education
- ❐ ____

Supplies:

- ❐ Digisleeve ❐ K-tape ❐ Coban ❐ Tensogrip
- ❐ Scar pad ❐ Silipos sleeve/pad ❐ Buddy splint
- ❐ Oval 8 ❐ Silver Ring
- ❐ Ulnar nerve pillow splint
- ❐ ____

Splints

❐ Custom ❐ Prefab ❐ Static ❐ Static Progressive ❐ Dynamic ❐ Dynamic Stretch

Position: ❐ Intrinsic Plus ❐ Functional ❐ Extension ❐ ____________________________

❐ Long arm ❐ include hand ❐ Munster ❐ Forearm ❐ include wrist ❐ include hand

❐ Hinged Elbow ❐ Fracture brace ❐ Orfit wrist fracture brace

❐ Thumb spica IP ❐ in ❐ out

❐ Forearm based ❐ Hand based

❐ Ulnar Gutter ❐ Radial Gutter include digits 5 / 4 / 3 / 2 IP ❐ in ❐ out

❐ Forearm based ❐ Hand based

❐ MP Block ❐ Digit(s)

❐ ____

Specific Instructions/Restrictions:

____

____

____

Physician Name (print) ____________________________________ **Physician Phone** ______________________

Physician Signature: ____ **Date** ________________________

The item(s) being dispensed to you today may be determined by your insurance company or Medicare to be a non-covered item(s).

BENEFICIARY DELIVERY NOTICE

By signing this form I acknowledge receipt of the listed item(s).

Patient Signature: ____ Date: _________________

Created by Twin Cities Orthopedics, P.A. in Minnesota

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