3 Documentation Requirements for Therapy Services

American Therapy Administrators of Florida

1. Plan Of Care

- Establishes a rehabilitation diagnosis
- Individualized plan for each patient based on the evaluation/examination
- Establish a treatment program — Specific interventions to be used to treat the patient's needs (i.e. Therapeutic exercise, functional training, manual therapy techniques, adaptive devices/equipment needs, modalities)
- Establish anticipated goals, expected outcomes, any predicted level of improvement — Short term goals (optional), Long term goals, Determine the intensity, frequency and duration for care
- The plan of care includes the anticipated discharge plans
- If there is a change in the frequency, length or duration of therapy within the current treatment period, a POC modification order must be completed and you MUST submit the modification order to the referring provider for signature approval. Please keep the physician signed POC modification order in the member's clinical documentation record.

2. Daily Visit Note

Treatment Encounter Note — It is a record of all treatment. Documentation is required for every treatment day, and every therapy service, it must record the:

- Date of treatment
- Treatment, intervention, or activity
- Total timed code treatment minutes and total treatment time minutes (Includes timed codes and untimed codes)
- Signature and professional identity of the qualified professional furnishing the treatment
- Additional information may be included (response to treatment, changes)

If a member or parent is non-compliant or no show for appointments this should be documented within the clinical medical record. Services should be appropriate type, frequency, intensity, and duration for the individual needs of the patient:

- The fact that services are billed is not necessarily evidence that they were appropriate
- Documentation of objective measures
- Needs of the patient (Contributing factors i.e. motivation, cognition, onset, psychological stability, social stability)

Consistent and clear documentation is essential to providers' demonstrating their compliance

3. Therapy Service Discharge

When therapy services have ended due to the achievement of patient goals:

- A discharge summary must be created
- Send it to the referring physician for signature
- Place a copy of the physician signed discharge summary in patient chart as confirmation/attestation that the physician was notified of patient's therapeutic success.

For more information on requirements and acceptable practices for Therapy Services, please visit:

American Physical Therapy Association (APTA)
http://www.apta.org

American Occupational Therapy Association (AOTA)
http://www.aota.org

American Speech and Hearing Association (ASHA)
http://www.asha.orgi/default.htm

If you have any further questions, please contact us at 1 (888) 550-8800 Option 2, or email us at: atafl@ healthnetworkone. com.