

Checklist: Therapy and rehabilitation services documentation

This checklist is intended to provide health care providers with a reference for use when responding to medical documentation requests for therapy and rehabilitation services. Health care providers retain responsibility to submit complete and accurate documentation.

Note: To print and include this checklist with your medical documentation, click the print button at the end of this form. Documentation requirements.

Documentation requirements

- Documentation is for the correct date of service billed.
- Documentation is for the correct beneficiary billed.
- Documentation contains a valid and legible signature of performing provider
- Documentation should include signature logs or signature attestations if applicable
- Documentation must be legible, relevant and sufficient to justify the medical necessity of services billed.
- Documentation must include the Initial evaluation for the episode of treatment under review. That contains all the required components outlined in Pub 100-02, Chapter 15, Section 220.3C
- Documentation to support medical necessity including that the services are skilled, rehabilitative services, provided by clinicians (or qualified professionals when appropriate) with the approval of a physician/nonphysician practitioner (NPP), safe, and effective (e.g., progress indicates that the care is effective in rehabilitation of function).
- Documentation must indicate that the patient is under the care of a physician, nonphysician practitioner, or optometrist for the presenting diagnosis. (See comprehensive outpatient rehabilitation facility (CORF) guidelines specific to CORFs.)
- Documentation must include a plan of care that shall contain, at minimum the diagnosis, long term treatment goals; and the type, amount, duration and frequency of therapy services. Additional info as required by regulation may be found at 42 CFR 424.24, 410.61, and 410.105© (for CORFs) See Pub. 100-02, Chapter 15, section 220.3 for further documentation requirements.
- Documentation must contain long term goals and the goals should be measurable and pertain to identified functional impairments. Therapists typically also establish short term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care.
- Documentation should provide the type of treatment to be provided such as physical therapy (PT), occupational therapy (OT), or speech language pathology (SLP), or, where appropriate, the type may be a description of a specific treatment or intervention. Where a physician/NPP establishes a plan, the plan must specify the type (PT, OT, SLP) of therapy planned.
- Documentation must include a separate plan of care for each type of therapy discipline. When more than one discipline is treating a patient, each must establish a diagnosis, goals, etc. independently. However, the form of the plan and the number of plans incorporated into one document are not limited as long as the **required** information is present and related to each discipline separately.
- Documentation must include Initial certification and any applicable re-certification per requirements outlined in Pub 100-02, Chapter 15, Section 220.1.3 A-D and LCD
- Documentation of treatment encounter notes/treatment logs as outlined in Pub 100-02, Chapter 15, Section 220.3E. The purpose of these notes is simply to create a record of all treatments and skilled interventions that are provided and to record the time of the services in order to justify the use of billing codes on the claim.
- Documentation must include all applicable 10th visits progress notes written by the clinician. While only a specific date of service is under review remember if the note for that date of service cannot support medical necessity alone please include any documentation for prior dates that support the medical necessity of the service date billed.

- Documentation of time for time based codes including timed code treatment minutes and total treatment time.
- Documentation must include the discharge note (or discharge summary) if applicable for dates of service billed. The discharge summary is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required. The discharge note shall be a progress report written by a clinician, and shall cover the reporting period from the last progress report to the date of discharge. In the case of a discharge unanticipated in the plan or previous progress report, the clinician may base any judgments required to write the report on the treatment notes and verbal reports of the assistant or qualified personnel.
- Any applicable ABNs (advance beneficiary notice of noncoverage)
- Documentation must include the number of participants in group therapy if billing for Current Procedural Terminology (CPT®) code 97150

Disclaimer: This checklist was created as an aid to assist providers. This aid is not intended as a replacement for the documentation requirements published in national or local coverage determinations, or the CMS's documentation guidelines. It is the responsibility of the provider of services to ensure the correct, complete, and thorough submission of documentation.