Rancho Los Amigos National Rehabilitation Center

Communication Disorders Department
Policy and Procedure

SUBJECT: DOCUMENTATION TIMELINES FOR SPEECH PATHOLOGY

Policy No.: 520
Supersedes: May 1985
Revision Date: June, 2022

PURPOSE
To state documentation timelines for speech-language pathology services.

POLICY
The speech-language pathologist is to comply with Communication Disorders Department documentation timelines for all assigned patients.

PROCEDURES
1. Documentation timelines for patients who are seen on a rehabilitation treatment program are as follows:
   a. Inpatient: Within 48 hours of receipt of evaluation order, preliminary results of the assessment will be entered in the electronic medical record.
   b. Outpatient: Within 48 hours of the evaluation session, preliminary results of the assessment will be entered in the electronic medical record.
   c. Documentation of progress:
      1. Inpatients: A daily note is completed for each therapy session. The patient's progress for the week is summarized in the interdisciplinary team conference note, when applicable.
      2. Outpatients: A daily note will be completed for each patient visit. A progress note is required every 10 visits. For Medicare patients, a physician recertification is required every 90 days or when the Plan of Care must be revised, whichever comes first
   d. Documentation of discharge evaluation will be recorded in the Medical Record on discharge day or within 24 hours following discharge from program.
   e. Outpatient Discharge: After completion of discharge evaluation, the therapist will discharge the patient's encounter (FIN) within the PM Conversation solution by selecting Discharge Encounter.