POLICY AND PROCEDURE

SUBJECT: MEDICAL DOCUMENTATION FOR OCCUPATIONAL AND RECREATION THERAPY	**Policy No.: 401** **Revised: January 2016** **Supersedes: November 2014** **Page: Page 1 of 6**

PURPOSE

To communicate departmental standards regarding the types, content, timing and frequency of occupational and recreation therapy documentation for the patients' medical records.

POLICY

The following procedure for medical documentation shall be followed to meet the requirements of patient care, licensing, accreditation and reimbursement bodies. Only occupational, recreation therapists and occupational therapy assistants may document in the medical record. Students in these two categories may document, cosigned by preceptors.

PROCEDURE

Documentation Format:

In keeping with the Rehabilitation Center and Department regulations regarding medical documentation, the following are required:

1. Documentation is completed electronically on ORCHID. During system downtime, documentation maybe completed through word processor or written and should include the following components:

    a. **Date and tim**e all entries, including year. Date and time must be the date and time the service was rendered. If the date is not the same as the day or period for which the service was provided, the therapist must note "Addendum entry for (actual date)".

    b. **Heading**: Identify department.

    c. **Signature and Title;** All entries in the medical record must be electronically signed
    (first and last name) by the person responsible for the content of the note and license as applicable.

2. Countersigning: An OT and RT must countersign any notes written by students, or certification-eligible therapists. Daily notes written by an OTA will not need to be co-signed by the OT (either written or electronically). An OT must sign a progress note written by an OTA.

3. Abbreviations: Use only abbreviations and symbols approved by RLANRC.

Inpatient Rehabilitation Documentation:

1. Admission Note: The Occupational Therapy Evaluation Note must be completed within 24 hours from the day of admission to the unit and/or referral date through ORCHID. This includes the completion of the Initial Admission FIM scores. The day of admission is day #1. Content shall include:

   a. Summary of initial evaluation findings.

   b. Projected discharge destination and family or other social support.

   c. Major obstacles to achieving the goals, including pain issues addressed.

   d. Treatment Plan must include:

      i. **Program** must relate to the major problems, and reflect age-specific planning.

      ii. **Frequency and duration** of treatment. Frequency stated in terms of hours per day and days per week and duration in weeks.

   e. All admission notes must be countersigned by the physician to indicate approval of the treatment plan.

   f. If the patient has transferred to a different level of care and is seen again for OT or RT less than or within 3 days, therapist may resume inpatient rehabilitation program pending order from admitting physician/provider with medical clearance to resume inpatient therapy.

   g. If patient has transferred to a different level of care or out of the facility and is seen again for OT and RT for more than 3 days, therapist will need a new OT and RT evaluation order to initiate and complete the admission evaluation note for this new encounter

2. Daily Record of Treatment:

   a. Each day, the treating practitioners must record, for each patient seen, the amount of time for each procedure(s) provided in ORCHID. Therapist will need to ensure that the date and time of documentation reflect the date and time when the service was rendered (start of care).

   b. If treatment is not delivered as planned, the reason and the amount of treatment time that was cancelled must be recorded and will be documented in ORCHID using the appropriate Form (i.e. Time spent with Patient section or form).

3. Weekly Progress Note:

   a. Weekly Progress notes are due by the day of the team conference or as determined by the therapy team and will be documented in ORCHID.

   b. Content should show continuity from week to week and must contain:

      i. Major problems and status of each problem. Whenever possible, status should be stated as a change in functional level or, if not appropriate, as a measurable change in performance (e.g. time or frequency). Any problem interfering with progress should be discussed and recorded in team conference report.

      ii. Equipment and equipment changes, if any.

      iii. Measurable patient/family education goal, involvement, progress, and/or concerns since the previous note.

      iv. Short term goal stated as functional level to be achieved.

      v. Frequency and duration, if changed from admission note, is noted in comment section.

   Note: Any modifications to the initial Plan of care, Goals, and/or Frequency and Duration will require the therapist to forward completed Progress Note to the Primary Provider for signature.

4. Discharge Notes:

   a. Discharge notes are due before 4 p.m. on the day of patient's discharge from program, including transferring off rehabilitation program without being discharged.

   b. Note form and format should be the same as that used for the admission.

   c. Note should contain:

      i. OT patient's occupational performance level and any pertinent physical status at discharge.

      ii. Status of remaining major problems at discharge.

      iii. Statement of goal achievement.

      iv. Patient/family discharge instruction, discharge destination and with whom.

      v. Equipment Issued

      vi. Follow-up plans (e.g. outpatient OT at Rancho, referral to Home Health).

d. All discharge notes must be countersigned by the physician.

5. Consultation Requests:

   a. Consultation requests from physicians for patients admitted to services not covered by occupational therapy must be within the following time requirements:

      i. Urgent: within 24 hours

      ii. Routine: within 48 hours

   b. Enter the original Consult Request in the patient's medical record followed by findings, action taken, and recommendations.

   c. Any note containing recommendations or changes made in meeting the consult request must be countersigned by the physician.

   d. Daily documentation is required to document OT services provided and patient response to treatment.

Outpatient Documentation:

1. There must be a signed physician's order (includes MD, PA or NP) for each patient who receives OT services in the Ambulatory clinics or the OT outpatient treatment area. One of the following methods can be used.

   a. For in-patients referred for continued occupational therapy at Rancho, therapist will proposed order for OT Day Rehab Evaluation and Treatment and identify the Program type to route to the appropriate Scheduling queue. For patients that will not be seen in OP Day Rehab Program, therapist will propose OP OT Evaluation and Treatment Order for outpatient OT. For services not using the above workflow, an Out-patient Therapy Referral form or consult request form can be used.

   b. For patients seen in the Ambulatory Clinic locations, a physician’s order for Outpatient OT evaluation/treatment must be present on the patients’ Orders profile for the date the therapist sees the patient in clinic.

   c. For patients referred from Ambulatory clinics, an Outpatient OT Evaluation and Treatment Order may be utilized and must be current within the requirements of the medical insurance/payer.

   d. A community physician is to provide his/her customary written referral and must be current within the requirements of the medical insurance/payer.

2. Patients seen in central outpatient clinic:

   a. Documentation is required each time a patient is seen by OT in the Ambulatory clinic locations. Content should include, but not be limited to, diagnosis, reason patient was seen, what services were provided and follow-up plan.

   b. Physician must countersign the note if changes or recommendations are made (e.g., changes in equipment).

3. Patients seen in OT outpatient treatment area:

   a. Initial evaluation is to be completed in the first visit (for complicated cases no more than two visits).

      i. On completion of evaluation, admission note should include diagnosis, reason for seeing patient, summary of findings including any pain management issues, patient/family goals, long and short term goals, treatment plan, frequency and duration of treatment.

      ii. Physician must approve/countersign the initial treatment plan and any time there is a change in the treatment plan.

      iii. If patient has been referred for a single follow-up visit only, findings are summarized. If further treatment is indicated, treatment plan must be approved by physician.

      iv. Initial evaluation notes are to be completed within 3 days of visit.

      v. Patients with Medicare insurance will require completion of the OT Functional G Code and Modifier section of the evaluation to complete the initial evaluation documentation

   b. Daily Note:

      A daily note must be written for each visit a patient visit. Daily notes are to be completed within 24 hours of visit.

   c. Progress Note:

      Must be completed every 10 visits. Progress notes must include a summary of the patient's functional status, extent or lack of progress toward each of the goals, ongoing problems and treatment plan. Physicians' signature is not required. Patients with Medicare require the therapist to update the OT Functional G-code and modifier section of the Progress Note.

d. Recertification Note:

Must be written for patients with medical insurance (such as Medicare) who require it. Note must include improvement, in functional level, problems impeding progress and specific care plan. Physician signature is required. Recertification note must be completed every 90 days.

e. Discharge Note:

i. Must be written within 5 days of discharge from an outpatient program.

ii. Content is the same as for inpatients.

f. Community Referrals:

i. All notes must be completed electronically

ii. All initial evaluation, recertification notes, as well as any note that contains a major change in program, require the signature of the physician.

iii. The therapist or treatment area clerk will fax the note with an appropriate cover sheet to the physician. Once returned, the clerk will forward the signed note to the physician.

References: (Administrative Policy and Procedure No. B820, “Interdisciplinary Care Plan”.)
(Departmental Policy and Procedure No. 310)
(Departmental Policy and Procedure No. 402)

Director, Occupational Therapy and Recreation Therapy Department

Signature (s) On File