1. Certification/Recertification
   
a. **Certification** – Include a certification statement signed and dated by the physician, physician’s assistant, clinical nurse specialist or nurse practitioner upon admission or as soon as is reasonable and practical. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services. There must be a separate signed statement indicating that the patient will require SNF covered care on a daily basis.

   Only physicians may certify outpatient physical therapy and outpatient speech-language pathology services.

   **Note:** The certification and recertification statements may be entered on forms, notes, or records that are signed by the appropriate individual.

   b. **Recertifications** – The first recertification should be obtained by the 14th day after admission. Subsequent recertifications should be obtained at no later than 30 day intervals. Recertifications should be signed and dated by the physician, physician assistant, clinical nurse specialist or nurse practitioner. A reason for the recertification and any plans for discharge should be included (i.e. home care, long term care placement)

   c. **Delayed Certification or Recertifications** – Include an explanation for the delay as well as medical or other evidence that is relevant for the explanation of the delay. A delayed certification and recertification may appear in one statement. The facility may determine the format and method by which it is obtained.

2. Therapy Documentation
   
a. **Plans of Treatment** – For all therapies involved including occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP), include a written therapy plan of treatment established by the physician after consultation with the therapist to support each Minimum Data Set (MDS) Resource Utilization Group (RUG-IV) code billed and for all of the dates of service on the claim.

   b. **Log of Therapy Minutes** – Include a log of all actual therapy minutes that were provided during the dates of service submitted on the claim as documented on a log/grid or in the clinical documentation to support the minutes recorded on the MDS. Include documentation for “change of therapy” periods. This information is needed to support each MDS therapy RUG-IV code billed for the dates of service on the claims, and to support the timeliness of any Other Medicare Required Assessments (OMRAS) completed. The 5-day MDS requires the first 15 days of therapy minutes on a log for verification of a therapy RUG level.

   Subsequent MDS must have minutes to support each look back period, which is 7-days from the Assessment Reference Date (ARD) for each MDS. Include any documentation for look forward periods. For example, if your facility is billing for the month of July but the Change of Therapy (COT) goes through August, include the documentation for August. COT days in July will be denied for lack of documentation if the August documentation is not sent with the July claim.

   c. **Progress notes to support the look back period of each MDS RUG – IV code billed.** Include documentation for the ‘look back period(s).’ This may include up to 30-45 days prior to the dates of service under review.
d. Diagnosis for which the treatment is provided, the patient’s prior level of function, and the date of onset for the diagnosis for which treatment is being provided. Always include the initial evaluation and any updated functional assessments. Therapy documentation should include the functions level at admission, prior level of function, restorative potential, short and long term goals including time frames, types of services/modalities provided, documentation of expectation for significant progress, change in condition, and ongoing progress including gains in independence.

3. Supporting Documentation to Support RUG-IV Code Billed to be Included:

a. Nurse’s notes 30 days prior to the ARD of each MDS RUG-IV code billed and for the dates of service (DOS). This documentation may fall outside the dates of service under review. (For all assessments, other than the initial 5-day assessment, determination of the continued need for, and receipt of, a skilled level of care will be based on the beneficiary’s clinical status and skilled care needs for the dates of service under review.)

b. Hospital Information – Include the discharge summary, history and physical and transfer sheet.

c. Each MDS for every RUG-IV code billed for the dates of service.

d. Physician orders and progress notes to support each MDS RUG-IV code billed – These provide support for RUG-IV code billed and services provided during the DOS.

e. Dietary Documentation – Include documentation to support each MDS RUG-IV code billed and care provided during dates of service.

f. Complete medication, treatment and wound care records.

4. Signature

a. Timeliness – If the timeliness of a physician signature is being confirmed, a visible and readable fax date documenting the return from the physician’s office is acceptable.

b. Date Missing – If the physician, clinical nurse specialist or nurse practitioner does not date their signature; the facility should not enter a signature date. Instead stamp or handwrite the date when the signature was received. This applies to the certification and recertifications for skilled care and physician signing of therapy orders.

Resources


Hints for Submitting Medical ADR or Appeal Requests http://www.cgsmedicare.com/parta/pubs/news/2013/0113/872.html