SMART GUIDELINES for ONLINE

I. **Login** – Refer to ***"Quick Card" pg.1***

a. Login

b. Verify correct facility is loaded.

c. Change location by clicking on the upper left in green to select the location. If you are in a new location that isn't on your list: Dave L will give you access

d. Privacy awareness: don't leave the computers up and unattended

e. Logout when leaving computer

f. Smart Help Desk Phone number (on screen and quick card). Call for technical questions of using the program. *How do I? It's not working right.* (i.e. cannot remember how to enter minutes, find patient, print schedule etc.) Hours are 6 am to 6 pm

g. Rehab Director/Regional Help. Call for procedural questions. *Should I . . . ? Am I supposed to . . . ?* (i.e. am I supposed to adjust the schedule myself)

II. **Schedules** - ***Refer to "Quick Card" pg 13*** – Print your schedule upon arriving to see patients to see.

a. Select on scheduling tab

b. Click on your name on the right side window. (double check all pts with min are assigned for someone to see)

c. If you need to add patients to the schedule to print, use the pull down tab to choose your name.

d. Print your therapy schedule from bottom of the screen

e. **BOLD** print indicates residents in assessment. Everyone on Med A is in reference unless they are leaving during the next few days. Thus, the minutes must be met.

f. Note the expected treatment minutes for the day may be different from the scheduled minutes. **Please follow those minutes in the parenthesis,** which are the actual numbers that upload by the computer at midnight to assure we meet the RUG category, based on the minutes completed prior.

g. You may use the schedule to note your treatment minutes on the printed schedule. Turn the schedule into the RD or designated area. This helps if someone forgets to document or enter minutes as there is no other paper to go back and check.

III. ***Add/Enter Patient Charges and Daily Documentation***– *Refer to* ***"Quick Card" pg 8***. ***Note:*** *As* you enter your treatments minutes, at the bottom of the screen, you will see if you have treated according to the plan.

a. Input tab

b. Input **all** minutes (individual and concurrent minutes) for each treatment code provided. Enter group minutes under the group code. (Units number will automatically populate into the Qty box)

   i. When concurrent minutes have been delivered, please enter **again** the number of minutes that were concurrent in the concurrent field. NOTE: These minutes should have been also entered above under the treatment codes.

   ii. Concurrent Example: A resident was in the department and performed 30 minutes of therapeutic ex (97110). However, the first 15 minutes were 1:1 time, but during the second 15 minutes you had another resident performing a dissimilar activity. You will enter 30 minutes under 97110 and then again place 15 minutes in the "concurrent" field. This will tell the computer that 15 of the above 30 minutes were concurrent.

   After you enter your minutes (this must be done for each code) click on the word note. Enter your treatment documentation to support that billing code and minutes of treatment. You may select from the automatic phrased documentation, or type your own note at the bottom. All areas in red must be filled in before you can complete and save the note.

c. BID Treatment – Refer to ***"Quick Card" pg 10***. The majority of our sessions are split treatments, even when it is divided between two session. These treatments are entered as above. However, when a true BID treatment is performed (2 identical sessions with an MD order for BID), you may add codes a second time to reflect the BID treatment.

d. Shared Treatment - Refer ***to "Quick Card" pg 9*** . If another therapist from your discipline has already entered minutes for the same day, the box will appear gray. You will need to select the "people" icon present to enter your time. (Enter your own time, but review that the total time falls within the 8 min rule for total time, as not to miss by a few minutes).

e. Withheld, Refused, Non-bill Treatment – ***Refer to "Quick Card" pg 9***

   i. Patient on hold – Enter "W" in Qty box for withheld. May enter note for reason.

   ii. Patient refused - Enter "R" in Qty box. Only enter "R" when the patient has refused the discipline session entirely. May enter note for reason.

iii. Non-bill/Note - Enter "X" in Qty box. May enter note. For instance, maybe a resident refused to perform ADL training for dressing but participated in their Ex. You would **NOT** enter R for refused but could enter "x" in quantity of ADL training and make a note that he refused that part of the recommended treatment. If you enter an X, then another person is able to go back later and still bill the patient. If an R or W is entered, it locks billing for that patient for the day

f. Always "Save" between patients.

g. Click on the next patient and enter the billing, as well as the daily documentation for each billing code completed.

h. If you work in more than one facility, be sure to change facility in green , in upper left, to get to the correct list of patients.

IV. **Time/Payroll** – Refer ***"Quick Card" pg. 11*** – (Complete after all charges have been entered for the day.)

a. Click on Monthly View

b. Click on the Time box in the upper right of today's date

c. All the patient billing that is entered will appear from the input tab as a total in the timecard. Group time is not noted but is factored "on the backside" in the productivity.

d. Review that all patients seen have billable time listed on the left hand side of the screen

e. Click on the blue box at the bottom/middle of the screen. Enter your time worked in and out in military time

f. Click save

g. If you have worked at more than one building, enter the travel and mileage in the building you are going TO. Click on the correct facility (or if this is the first time in a period of time, add facility at the bottom left and add facility). Enter time in and out for this facility as well.

h. Click save. It will tell you how much non-patient time to enter. Scroll down in the list and enter all extra time (even group) in nonbillable.

i. Total time paid for the day will be listed as facility time. Total patient time is listed in minutes, number of patients listed and productivity for the day.

j. Enter PTO/Sick time by clicking open request on left side, open new request, fill out screen and save. Ask the manager to approve time for it to appear on the calendar. (Time must be approved in eservices before entering into SMART)

V. **Productivity** – Shows on calendar for that day. There is not a cumulative productivity that each therapist can access. The Rehab Director can do this from the reports

TIPS

Resident Tab:

1. Counter sign: this has not been used yet as we do not cosign all of the notes
2. Resident reports
    a. **Progress Note Batch:** This prints the weekly documentation with the billing for each discipline or all at the same time. We should be doing this each Monday, to print the prior week's documentation to put on the hard chart. You do not need any of the parameters, they can all stay no. To print all disciplines all at once, print from the facility progress note batch.
    b. **Resident Pathway:** this is the planner for the month on paper

Input:

1. Assure there is a note done for each charge by clicking on the word Note in blue after entering a charge. This is essential for the eval and all charges, as they align directly with the charge for documentation.
2. If there is a W, X or R, you must write the detail of why the patient is not being seen
3. Visit note numbers are at the bottom, and now will correlate better with needed notes and updated by therapist.
4. In the daily documentation, you can see the last note written on the bottom
5. Goals are in the right side to know what you are documenting toward.

Scheduler:

1. Progress notes show up on your schedule the day they are due. They do not stay there until done though, so if it isn't done (for example by a prn filling in that day), you must keep an eye on the due dates in the documentation tab.
2. For the documentation schedule, have the RD print this off weekly. It is a report under resident, documentation schedule. It lists progress notes and UPOC to plan ahead for the schedule.

Planner:

1. Frequency shows up on the bottom right for the planner after the evals are done.
2. Use the unplanned tab to assure all the residents on caseload are on the planner