Therapist SMART Guideline
Evaluations, Discharges, Update POC and Progress Notes

If the resident is not in the system for the evaluation, you must enter them first. If they are already in the system, you can skip to the documentation instruction.

I. **Add Resident to Patient Database** – Refer to ***"Quick Card" pg 1***

a. Search for name in system under "all" to see if they are already in database. Always check to assure that the patient has not been there before entering as a new patient.

b. Add new resident if not in system (Warning: If you duplicate a resident in the system and document on that duplication**, the documentation must be deleted and re-entered.)**

c. "Location" is Room number, or outpatient, ALF Room. You may include bed. (i.e. 311-b)

d. Enter Social Security Number, Medicare number , Gender, DOB. All this must be filled in before end of month billing can be completed. If you do not complete this at eval, be sure to notify the RD (or aide if applies) to complete for full accurate billing.

II. **Facility Admission** – Refer to ***"Quick Card" pg 2***

a. Add: add the date of the facility admission and the location (inpatient, outpatient, ALF)

b. Cap amounts: Enter a therapy dollar amount for the services provided in the current year **outside** of the facility therapy department. Casamba will remember this for the future and add it to our therapy dollar amount. You are informed of the dollar amounts via your facility's payor verification process

III. **Initial Set of Payor Info/Change of Payor** – Refer to ***"Quick Card" pg 4***

a. Click on the date that the patient came to the facility (not necessarily the day of the eval)

b. Click set payor source (middle)

c. Click on the appropriate payor (if you are not sure, be sure to inform the aide or RD to double check this asap)

IV. **Therapy Admission (Evaluation)** –

Click on the documentation tab: Initiate POC

a. Eval date: defaults to today

b. Medical Diagnosis: assure it is acceptable and matches the facility. If you are the second person evaling, it will default to what was done first…be sure it is appropriate, as there may be a ST diagnosis in there, for example, that doesn't meet PT requirements.

c. Order Date: fill in if known

d. Onset Date: must be filled in

e. Hospitalization (select NA if no hospitalization)

f. MD: must be filled in

g. Check statement – "Documented Medical necessity Exists"

h. Check statement of informed consent

i. Fill in each area on the first page, all areas in RED are mandatory. If you are the second person doing an eval, you can copy those areas completed by the other area by clicking on the area that looks like a copy machine. You can select from what is there, copy and add or change. This is particularly helpful in the area of PMHX. In addition, each area has a list of suggested statements, which can be used by clicking on the paper with a finger in the upper right of that section. Certification will default from the frequency entered on the last page.

j. The second tab is Functional deficits. Fill in all areas that are noted as a problem for the resident. You must list prior level and current level. You can only select from the drop down list. Anything additional can be added in writing at the bottom of the page. Be sure to use the scroll area to see all selections.

k. The third tab is Underlying impairments. Although it states to just list problem areas, please fill in all areas that were assessed, to assure you are painting a clear picture of the patient to insurance, physicians and other clinicians. Just as you would state ROM is WFL on a written eval, please include online (please note: if strength is 4/5, then they really do not need ther ex or a goal for strength. This means that they would not be billed or documented on for strengthening. Thus, be sure you are stating what problems they have. You will have a general tab for strength; be sure to write on the bottom what areas are weak. For example if you state strength is 4/5 but they are mod assist to transfer, is that accurate…or is there a muscle group that are weak?)

l. The last tab: Functional Areas

a. Goals: click on the green + to enter goals. Enter one long term goal and 2-3 short term goals. Short term goals show up on the daily documentation to guide treatment. Goals are chosen by the functional area or problem to be addressed. They also coinside with what billing codes should be used to reach that goal.

b. Goals must have a current level and an anticipated /goal level. No red areas can be left or it will not print.

c. Short term goals must have a goal date entered, for 2 weeks.

d. Treatment Diagnosis : start filling in the word partially and select and matching words will appear to choose from.

e. CPT codes: Add ALL codes that you could possibly use for this patient, as if you forget one, a full recert needs to be completed to enter another code to be used.

f. Enter frequency and duration (if you want 5x week for 2 weeks, then 3 times a week…you have to enter only 5x for 2 weeks, then a UPOC will need to be done to change frequency)

g. Save (you have to save before you can do outcomes)

m. Complete outcomes

a. Click on outcomes

b. Select the area that you are addressing in your goals (for example if you are seeing for PT for mobility: you must select all areas of mobility: ambulation, transfers, bed mobility. If you select incontinence, you just do that one tab)

c. Select premorbid level

d. Select goal level

e. Select SOC level

f. Select prior living arrangement

g. Save

n. Save entire document

o. Print 3 copies: If it says DRAFT, then there is something in RED in one of the tabs to fix

print one for facility, one for soft chart for staff to review and one for MD to sign.

p. when saved and completed, cancel to get back to main screen.

V. Progress Note:

a. A Therapist must complete the progress note.

b. Click on the progress note in the documentation tab

c. Click edit at the bottom

d. Assure the date is the correct date, if doing on a different date than listed

e. Complete all areas/tabs in red

f. Goals: to address goals, click on the paper to review the last two weeks notes. Complete the note by clicking on the drop downs, or erase from the top line and enter your own information

g. If the goal was met, click on the red X and discharge the goal.

h. If the goal is not met, change the calendar date and continue with the goal, however you must update where you are on that goal today

i. To modify the goal, click on the piece of paper to the way left under goals, change the information and save. It will ask you way such as upgrade, downgrade, etc.

j. Be sure to scroll to make sure you have all of the goals addressed

k. Save

l. Print: print for the facility file, if in the first 2 weeks this can be the 2 week note. If there are any areas in brackets, they were not completely filled out.

m. Missed visits will auto populate, but you have to look back and explain why missed

n. Goals can be changed. It is recommended to write the words, goal met, in progress, etc.

VI. Updated Plans of Care:

a. Complete the same as a progress note, except add CPT codes, change frequency. Similar to the eval, there are suggestion and fill in boxes . You must justify why you are doing a UPOC, add rehab potential and readdress frequency/duration

b. Leave the date of activity (upper left) so it stays with the correct certification time. The date of completion by the therapist will be on the form, which is OK to be different. The cert dates have to coinside exactly.
c. An updated POC must be completed to add a modality or change information as you are changing a plan of care. We have not printed the evaluation until the primary person (PT or RD) can look at the eval and assure all areas are addressed. Then it can be added and printed. However, after it's printed and the physician signs, it cannot be added and a new POC must be completed.

d. Save
e. Print: assure it looks correct, print one for facility, one to be signed by MD, and one for staff to review to assure they know the updated POC.

VII. Therapy Discharge:

a. Add Extra & choose DC Summary

b. Edit DC Summary with proper discipline DC date/information

c. Complete all red areas. Goals must be all discontinued/met or addressed. Use unsuitable if not met and explain the level that achieved and add statements. Can erase and write current level in the top area of goals.

d. The long term goal is addressed only by the reason for discharge. All information is listed below. Please do a detailed summary to justify all treatment.

e. Complete the outcomes

    a. Click on outcomes on the bottom of the discharge screen

    b. Address the areas that were picked on eval, as they appear in the top box

c. Select the EOC value/level

d. enter prior living arrangement

b. Enter discharge living arrangement

c. Save

d. improvement score will appear: if -, then you forgot to enter living arrangement information

f. Save

g. Print: be sure all areas are complete. Print one for facility only

VIII. DC Facility Admission – *Refer to Quick Card pg 2 This is done if the patient is leaving the facility*

a. Click on resident

b. Click edit under facility admission

c. Enter discharge date if they are leaving the facility, on the date they left the facility

d. Enter location of discharge (take out other which some default to)

e. If they do not discharge from the facility, be sure Med A is changed to Med B the day they come off Med A. Med B can stay open.

TIPS

If the documentation title is in purple, it is not complete. Always try to check this. For evals, always print to assure DRAFT in not on the page, also indicating you missed something.

If it is red, you are overdue.

Goals are a bit confusing, take time to review and enter. They correlate with diagnosis and codes, so there are times when you cannot use a goal that is selected.