



# ***SMART* Therapy Training Manual**

## **TX Resident Part 2**

## TABLE OF CONTENTS

<b>THERAPY ADMISSION</b> .....	<b>3</b>
THERAPY ADMISSION OVERVIEW .....	3
ADDING A NEW THERAPY ADMISSION .....	5
EDIT A THERAPY ADMISSION .....	10
DISCHARGING A THERAPY ADMISSION .....	10
<b>CLINICAL MEASURES</b> .....	<b>11</b>
BASIC MEASURES .....	12
ADVANCED MEASURES .....	13
ENTERING A DISCHARGE SUMMARY .....	14
PATIENT OUTCOME SUMMARY REPORT .....	15
<b>RUG ANALYSIS</b> .....	<b>17</b>
<b>COUNTER SIGN</b> .....	<b>19</b>
<b>RESIDENT REPORTS</b> .....	<b>21</b>
<b>RESIDENT TRACKING</b> .....	<b>22</b>
<b>DASHBOARD</b> .....	<b>24</b>

# THERAPY ADMISSION

## THERAPY ADMISSION OVERVIEW

The Therapy Admission screen allows the user to enter independent Start of Care Dates and End of Care Dates for each discipline. The discipline will default to the user's discipline. To select another discipline, press the OT, PT, or ST buttons. Other disciplines can be viewed in read only, but cannot be edited. Only users with Team Lead access in SMART can add or edit all 3 disciplines.

**What Do You Want To Do**

- 1. Facility Admission
- 2. Set up/Resident/VL
- 3. Therapy Admission**
- 4. PUG Analysis
- 5. Counter Sign
- 6. Resident Reports
- 7. Add New Resident
- 8. Resident Tracking

**Therapy Admission**

OT PT ST

Start of Care	End of Care
5/18/2009	

**Discipline: OT** First Activity Date: [ ] Last Activity Date: [ ]

SOC/Eval Date: 5/18/2009 Medical Diagnosis: 719.42-JOINT PAIN-UP/ARM Onset Date: 5/30/2007 EOC: [ ]

Order Date: [ ] Medical Diagnosis 2: [ ] Onset Date2: [ ] EOC Reason: [ ]

**Treatment Diagnosis** Add Delete

Code	Description
719.47	JOINT PAIN-ANKLE

**CPT Codes** Add Delete

Code	Description
97003	OT Evaluation
97110	Therapeutic exercise
97150	Group Therapy
97530	Therapeutic activities

Physician: Thomas, Dr.

Documented Medical necessity exists.

Save Delete

Selecting a Tab for a Discipline will display the history of that Discipline's admissions under the Therapy Admission area of the screen.

**Therapy Admission**

PT ST

Start of Care	End of Care
9/29/2004	10/4/2004
9/27/2004	9/28/2004

**Therapy Admission**

PT ST

Start of Care	End of Care
9/27/2004	

When the selected Discipline is not the Discipline of the currently logged in User, the screen will be 'Read Only'. The Header Information Bar will be gray and the Add and SAVE buttons are not available. No changes to any information will be allowed.

**What Do You Want To Do**

1. Facility Admission
2. Set Payor/RUG/ARD/LVL
3. Therapy Admission
4. RUG Analysis
5. Counter Sign
6. Resident Reports
7. Add New Resident

**Therapy Admission**

OT PT

Start of Care	End of Care
6/1/2009	

**Discipline:** PT    **First Activity Date:** 6/1/2009    **Last Activity Date:** 6/5/2009

**SOC/Eval Date:** 6/1/2009    **Medical Diagnosis:** 821.21-FX FEMORAL CONDYLE-CLOSE    **Onset Date:** 5/30/2009    **EOC:**

**Order Date:**    **Medical Diagnosis 2:**    **Onset Date2:**    **EOC Reason:**

**Treatment Diagnosis**

Code	Description
781.2	ABNORMALITY OF GAIT

**CPT Codes**

Code	Description
97001	PT Evaluation
97110	Therapeutic exercise
97116	Gait training
97150	Group Therapy

**Physician:** Thomas, Dr.

Documented Medical necessity exists.

**Buttons:** Split Tx

When the selected Discipline is the same discipline as the currently logged in User, the Header Information Bar is orange and the buttons are available.

**What Do You Want To Do**

1. Facility Admission
2. Set Payor/RUG/ARD/LVL
3. Therapy Admission
4. RUG Analysis
5. Counter Sign
6. Resident Reports
7. Add New Resident
8. Resident Tracking

**Therapy Admission**

OT PT ST

Start of Care	End of Care
6/1/2009	

**Discipline:** PT    **First Activity Date:** 6/1/2009    **Last Activity Date:** 6/5/2009

**SOC/Eval Date:** 6/1/2009    **Medical Diagnosis:** 821.21-FX FEMORAL CONDYLE-CLOSE    **Onset Date:** 5/30/2009    **EOC:**

**Order Date:**    **Medical Diagnosis 2:**    **Onset Date2:**    **EOC Reason:**

**Treatment Diagnosis**    **Add**    **Delete**

Code	Description
781.2	ABNORMALITY OF GAIT

**CPT Codes**    **Add**    **Delete**

Code	Description
97001	PT Evaluation
97110	Therapeutic exercise
97116	Gait training
97150	Group Therapy

**Physician:** Thomas, Dr.

Documented Medical necessity exists.

**Buttons:** Split Tx, Add New, Save, Delete

**TIP**

**\*\* If the user is marked as TEAM LEAD on the user screen, the user will be able to add/edit all three discipline's information on the Therapy Admission screen.**

## ADDING A NEW THERAPY ADMISSION

Select the patient name from the list and Select #3 Therapy Admission. Once the Therapy Admission window opens, click on the Add New button.

The SOC/Eval Date will automatically populate with today's date. The date can be changed using the calendar.

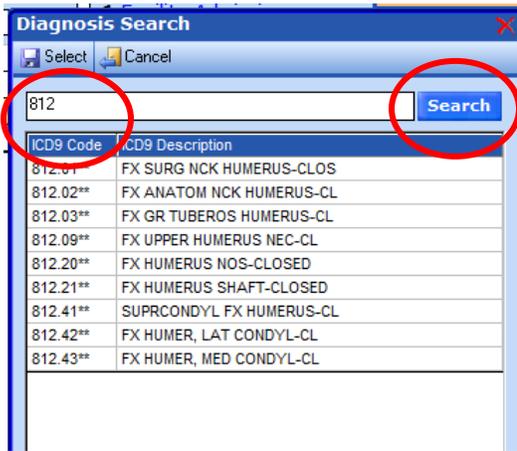
The screenshot shows the 'Smart Testing' software interface. On the left, there is a patient list with names like 'Davis Gina', 'McDougal Philip', 'Spring May', and 'Wilson John'. The 'Therapy Admission' section is active, showing a list of actions: 1. Facility Admission, 2. Set Payor/RUG/ARD/LVL, 3. Therapy Admission, 4. RUG Analysis, 5. Counter Sign, 6. Resident Reports, 7. Add New Resident, and 8. Resident Tracking. The 'Add New' button is circled in red. The main area displays fields for 'Discipline: OT', 'SOC/Eval Date' (6/14/2009), 'Medical Diagnosis', 'Onset Date', 'EOC', 'Order Date', 'Medical Diagnosis 2', 'Onset Date2', and 'EOC Reason'. There are also tables for 'Treatment Diagnosis' and 'CPT Codes'.

Use the Ellipsis to enter a Medical Diagnosis.

This is a close-up of the 'Medical Diagnosis' field in the 'Therapy Admission' window. The field contains an ellipsis button (three dots) which is circled in red. Other fields visible include 'Discipline: OT', 'First Activity Date', 'Last Activity Date', 'SOC/Eval Date' (6/14/2009), 'Onset Date', 'EOC', 'Order Date', 'Medical Diagnosis 2', 'Onset Date2', and 'EOC Reason'.

The Diagnosis Advanced Search window will open

The 'Diagnosis Search' window is shown, featuring a search input field and a 'Search' button. The window is currently empty, indicating that no search results have been returned yet.



Type in the ICD9 code that applies, and then click on the Search button.

A list of ICD9 Codes and ICD9 Descriptions will display. Choose a code and click on the Select button.

The ICD9 Code will then be inserted into the field.

Click on the Cancel button to close the screen without selecting the code.

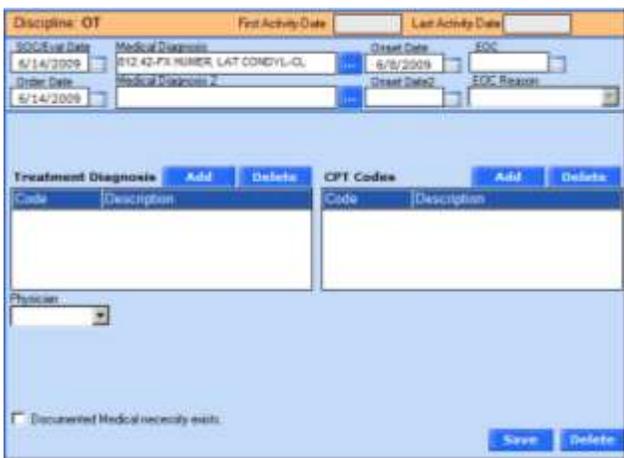
Enter the Medical Diagnosis Onset Date by clicking on the small calendar. **Note: The Onset Date cannot be after the SOC/Eval date.**



The EOC can also be added by clicking on the small calendar for its field. EOC Reason can be entered by using the dropdowns. The EOC will be entered later once the care has ended for the specific discipline, leave it blank for now.

The Order Date can be inserted using the calendar.

A secondary Medical Diagnosis and Onset date can be enter following the same steps used for the Primary Medical Diagnosis and Onset Date.



Next add the Treatment Diagnosis by clicking on the Treatment Diagnosis Add button.

**Note: At least one Treatment Diagnosis must be entered for each discipline.**

The screenshot shows a medical form with a 'Treatment Diagnosis' section. The 'Add' button is circled in red. The form includes fields for 'Medical Diagnosis', 'ICD9 Code', and 'Description'. There are also 'Add' and 'Delete' buttons for the 'Treatment Diagnosis' and 'CPT Codes' sections.

The screenshot shows the 'Diagnosis Search' window. The 'Search' button is circled in red. The window has a search input field and a 'Select' button.

The Diagnosis Advanced Search window will open. Type in the ICD9 code that is appropriate, and then click the Search button. A list of ICD9 Codes and ICD9 Descriptions will display. Choose a code and click on the Select button.

To add in a secondary treatment diagnosis code, repeat the process.

The screenshot shows the 'Diagnosis Search' window with search results for 'cva'. The search input field contains 'cva' and the 'Search' button is highlighted. The results table is as follows:

ICD9 Code	ICD9 Description
438.11**	LATE EFF CV DIS-APHASIA
438.12**	LATE EFF CV DIS-DYSPHSIA
438.19**	LATE EF-SPCH/LANG DF NEC
438.20**	LATE EF-HEMPLGA SIDE NOS
438.21**	LATE EF-HEMPLGA DOM SIDE
438.22**	LATE EF-HEMPLGA NON-DOM
438.81**	LATE EFF CV DIS-APRAXIA
438.82**	LATE EF CV DIS DYSPHAGIA
438.89**	LATE EFFECT CV DIS NEC

Published automatic or complexity ICD-9 codes are highlighted with an asterisk (\*) in the Diagnosis Search boxes. This is applicable for both Medical and Treatment Diagnosis searches.

To add a CPT code, click on the Add button.

The screenshot shows a software interface for a medical discipline (OT). It includes fields for 'First Activity Date' and 'Last Activity Date'. Below these are fields for 'SOC/Eval Date', 'Medical Diagnosis', 'Onset Date', and 'EOC'. There are also fields for 'Order Date', 'Medical Diagnosis 2', 'Onset Date2', and 'EOC Reason'. The 'Medical Diagnosis' field contains '812.42-FX HUMER, LAT CONDYL-CL' and 'Medical Diagnosis 2' is empty. The 'Onset Date' is '6/8/2009'. The 'EOC' field is empty. Below these fields are two tables: 'Treatment Diagnosis' and 'CPT Codes'. The 'Treatment Diagnosis' table has one row with 'Code' '781.92' and 'Description' 'ABNORMAL POSTURE'. The 'CPT Codes' table is empty. Above the 'CPT Codes' table are 'Add' and 'Delete' buttons, with the 'Add' button circled in red. Below the tables is a 'Physician' dropdown menu. At the bottom left is a checkbox labeled 'Documented Medical necessity exists.' At the bottom right are 'Save' and 'Delete' buttons.

The CPT Code Search window opens. The codes that display in RED are the codes most commonly used with the Treatment DX code selected. Codes in BLACK can still be selected.

To see specific codes, type the first two digits of the code in the box. The search box will shorten the display window of codes.

Click on as many CPT Codes as appropriate and then click on the Select button to set the CPT Codes. At least one CPT Code must be added to a Therapy Admission.

The screenshot shows a 'CPT Code Search' window. It has a title bar with 'CPT Code Search' and a close button. Below the title bar are 'Select' and 'Cancel' buttons, with the 'Select' button circled in red. Below these buttons is a text box that says 'In order to see the list, type the first two digits of the code.' followed by an empty input field. Below the text box is a list of CPT codes with checkboxes. The list is as follows:

Code	Description
<input checked="" type="checkbox"/>	97003 OT Evaluation
<input type="checkbox"/>	97004 OT Re-evaluation
<input type="checkbox"/>	97024 Diathermy
<input type="checkbox"/>	97035 Ultrasound
<input checked="" type="checkbox"/>	97110 Therapeutic exercise
<input checked="" type="checkbox"/>	97112 Neuromuscular re-ed
<input type="checkbox"/>	97140 Manual therapy
<input type="checkbox"/>	97150 Group Therapy
<input type="checkbox"/>	97504 Orthotic fitting/training
<input checked="" type="checkbox"/>	97530 Therapeutic activities
<input type="checkbox"/>	97532 Cognitive Skills Development
<input checked="" type="checkbox"/>	97535 Self care training.
<input type="checkbox"/>	97542 Wheelchair management
<input type="checkbox"/>	29125 Static Forearm Splint
<input type="checkbox"/>	29126 Dynamic Forearm Spint
<input type="checkbox"/>	29130 Static Finger Splint

The CPT Code Search window opens. The codes that display in RED are the codes most commonly used with the Treatment

Code	Description
781.92	ABNORMAL POSTURE

Code	Description
97003	OT Evaluation
97110	Therapeutic exercise
97112	Neuromuscular re-ed
97530	Therapeutic activities

The CPT Codes and Treatment Diagnosis will display.

To add another CPT Code or Treatment Diagnosis, repeat the Add process.

To remove CPT Codes or Treatment Diagnosis select the code and click on the DELETE button.

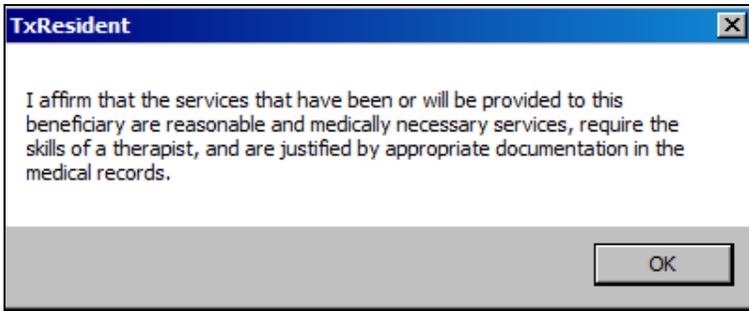
**Note: The CPT Codes that are added are the codes that will be used to add treatment in Tx Input.**

Physician: Thomas, Dr.

Documented Medical necessity exists.

Select the Physician by using the Dropdown Arrow button.

The 'Documented Medical necessity exists' checkbox will be selected when the services that have been or will be provided are reasonable and medically necessary services, require the skills of a therapist, and are justified by appropriate documentation in the medical records. This is used as part of the Medicare Part B exception process and KX modifier if the patient exceeds the cap.



When selected, an affirmation message displays.  
Click on: OK.

An optional field for ABN (Advanced Beneficiary Notice) date is also available. If medical necessity is not checked, SMART will require the therapist to insert the date the ABN was signed in order to Save. This setting can be set at the facility level.

Once all information is entered, click on SAVE at the bottom of the screen.

## EDIT A THERAPY ADMISSION

To edit or remove a therapy admission, select the admission date under Therapy Admission. Make any necessary edits and click the Save button. To remove the therapy admission, press the Delete button. If there are any treatments entered in the TX Input screen these will need to be removed before the therapy admission can be deleted.

## DISCHARGING A THERAPY ADMISSION

To discharge a therapy admission, select the open admission from the Therapy Admission screen. Enter the EOC date, select an EOC Reason from the drop down, and click on the Save button. The EOC Date must be equal to or greater than the Last Activity Date for the discharge information to save.

## CLINICAL MEASURES

Clinical Measures is an optional module in Smart. This screen can be used to collect outcome measures for the patient. Clinical Measures measure the resident's performance at the beginning of care and the end of care.

Click on Clinical Measures button on the Therapy Admission screen.

The screenshot shows the Therapy Admission screen. At the top, there are fields for Discipline (OT), First Activity Date, and Last Activity Date. Below that, there are fields for SOCCal Date (5/14/2009), Medical Diagnosis (R12 42-FX HUMER, LAT COMEVL-CL), Create Date (6/8/2009), EOC, Start Date (5/14/2009), Medical Diagnosis 2, Create Date 2, and EOC Reason. There are two tables: 'Treatment Diagnosis' with columns Code and Description, and 'CPT Codes' with columns Code and Description. The 'CPT Codes' table lists 97003 OT Evaluation, 97110 Therapeutic exercise, 97112 Neuromuscular re ed, and 97530 Therapeutic activities. At the bottom, there is a checkbox for 'Documented Medical necessity' which is checked, and a 'Clinical Measures' button circled in red. There are also 'Save' and 'Delete' buttons.

The Measurements window will open.

The '**Measure Name**' drop down refers to the item being measured.

The '**PreMorbidity Value**' drop down refers to the pre hospitalization value/ Patient's pre SOC value.

The '**Goal Value**' is the value anticipated at EOC.

The '**SOC Value**' is the rating at the beginning of treatment.

The '**Interim Value**' is the value the patient achieved at some point during treatment. Typically this value would be entered when the resident is reassessed.

The '**Interim Value Date**' is the date the resident was reassessed for the Interim Value score.

The '**EOC Value**' is the score at the end of treatment.

The '**Prior Living Arrangements**' indicates where the resident was admitted from.

The '**Anticipated DC Living Arrangements**' indicates the resident anticipated discharge location.

The screenshot shows the Measurements window. It has a 'Measure Name' dropdown, 'PreMorbidity Value' dropdown, 'Goal Value' dropdown, 'SOC Value' dropdown, 'Interim Value' dropdown, and 'EOC Value' dropdown. There are also fields for 'Prior Living Arrangements' and 'Anticipated DC Living Arrangements'. Below these are fields for 'Measure Description' and 'Measure Value Description'. At the bottom, there are 'Add' and 'Save' buttons.

**NOTE: The Prior Living Arrangements as well as Anticipated Living Arrangements should be supplied to your Casamba representative to be entered into a table in the database. [L\\_MeasuresLivingArrangements](#)**

## BASIC MEASURES

Enter the information by using the dropdown Arrow buttons. Then click on the SAVE button.

To clear the Clinical Measurements dropdown and add a new one, click on the ADD button.

To delete an already saved indicator, select the item from the list and click on the DELETE button.

Value	Description
10	Patient needs 100% assistance of one or two caregivers to complete task. Patient is unwilling or unable to participate in activity.
20	Patient needs 75-99% assist to complete task and needs maximal cueing for safety.
30	Patient requires 50-74% assist to complete task and needs moderate cueing for safety.
40	Patient requires 25-49% assist to complete task and needs minimal cueing for safety.
50	Patient does not require physical assist but caregiver needs to be close enough to provide steadying if needed. Caregiver may provide set up of assistive device or environmental modification and/or cue.
60	No physical assist or supervision needed but extra time or assistive device required.
70	No assistive device or extra time required.

Continue adding until all the measures evaluated are listed in the Resident Measurements box.

To close the window without saving, click on the Close button.

At end of care-click on the appropriate measurement in the box and enter the EOC measurement and Save.

Value	Description
10	Patient needs 100% assistance of one or two caregivers to complete task. Patient is unwilling or unable to participate in activity.
20	Patient needs 75-99% assist to complete task and needs maximal cueing for safety.
30	Patient requires 50-74% assist to complete task and needs moderate cueing for safety.
40	Patient requires 25-49% assist to complete task and needs minimal cueing for safety.
50	Patient does not require physical assist but caregiver needs to be close enough to provide steadying if needed. Caregiver may provide set up of assistive device or environmental modification and/or cue.
60	No physical assist or supervision needed but extra time or assistive device required.
70	No assistive device or extra time required.

**Note:** This area is completed by the Evaluating Therapist and the Therapist who completes the discontinuation of therapy.

## ADVANCED MEASURES

Measures can also be set using the Advanced Tab. Individual Measures can be grouped.

Measurements

Resident Name: May Spring SOC: 6/14/2008 EDC: Discipline:OT

Tab: Advanced

Measure Group: ADL Total Start Score: 30 Total End Score: 3

Group	Name	Start Score	End Score	Gain
ADL	Self-Hygiene	30		
ADL	Bathing / Showering	30		
ADL	Dressing Lower Body			
ADL	Dressing Upper Body			

Measure Description:

Measure Value Description:

ValueID | Description

Save

Choosing a Measure Group from the dropdown will display all measures associated within the group.

Click on the Start Score and a dropdown will appear. Select the appropriate score. Repeat for each measure.

End Scores will be entered the same way. Click on Save.

Measurements

Resident Name: May Spring SOC: 6/14/2008 EDC: Discipline:OT

Tab: Advanced

Measure Group: ADL Total Start Score: 30 Total End Score: 3

Group	Name	Start Score	End Score	Gain
ADL	Bathing / Showering	30		
ADL	Dressing Lower Body			
ADL	Dressing Upper Body			

Measure Description:

Ability to safely don and doff clothing to lower extremities including underclothes, pants, shoes and socks as desired.

Measure Value Description:

ValueID	Description
10	Patient needs 100% assistance of one or two caregivers to complete task. Patient is unwilling or unable to participate in activity.
20	Patient needs 75-99% assist to complete task and needs maximal cueing for safety.
30	Patient requires 25-75% assist to complete task and needs moderate cueing for safety.
40	Patient requires 1-25% assist to complete task and needs minimal cueing for safety.
50	Patient does not require physical assist but caregiver needs to be close enough to provide steadying if needed.

Save

## ENTERING A DISCHARGE SUMMARY

Each discipline can enter a Summary per Discipline. This Summary will display on the Outcome Summary Report.

Discipline: OT      First Activity Date: [ ]      Last Activity Date: [ ]

SOC/Eval Date	Medical Diagnosis	Onset Date	EOC
6/14/2009	812.42-FX HUMER, LAT CONDYLA-CL	6/8/2009	[ ]
Order Date	Medical Diagnosis 2	Onset Date2	EOC Reason
6/14/2009	-	[ ]	[ ]

Treatment Diagnosis		CPT Codes	
Code	Description	Code	Description
781.92	ABNORMAL POSTURE	97003	OT Evaluation
		97110	Therapeutic exercise
		97112	Neuromuscular re ed
		97530	Therapeutic activities

Physician: [ ]

Documented Medical necessity exists.

**Clinical Measures**      **DC Summary**      **Save**      **Delete**

Click on DC Summary and the Discharge Summary window appears. Enter in the Summary information, then click on SAVE.

**DC Summary**

Save      Close

Resident Name: May Spring      SOC: 6/14/2009      EOC:      Discipline: OT

[ ]

PATIENT OUTCOME SUMMARY REPORT

The Patient Outcome Summary Report is created from the data entered in the Measures and DC Summary Screens.

**Report Example:**



### Patient Outcome Summary

**8/1/2006 - 8/31/2006**

**8989 - Angelica Manor**

**Patient:** Jane Smith  
**DOB:** Jan 10, 1945  
**Medical Record Number:**  
**Admission Date:** Nov 29, 2005  
**Onset Date:** 9/26/2005  
**Diagnostic Group:**

**Payer:**  
**Rehab LOS:** 276  
**Physician:** Trol Frida  
**Referral Source:** Marys Hospital  
**Rehab Discharge Date:** Sep 02, 2006  
**Discharge Destination:** Acute Hospital

	PT	OT	ST
<b>Medical Dx:</b>	342.02 - FLCCD HMIPLG NONDMNT SDE	342.02 - FLCCD HMIPLG NONDM SDE	191.2 - MAL NEO TEMPORAL LOE
<b>Treatment Dx:</b>	719.45 - JOINT PAIN-PELVIS	719.45 - JOINT PAIN-PELVIS	333.1 - TREMOR NEC
<b>Start of Care:</b>	Nov 30, 2005	Nov 30, 2005	Aug 28, 2006
<b>End of Care:</b>	Sep 01, 2006	Sep 01, 2006	Sep 01, 2006
<b>Length of Stay:</b>	276 Days	276 Days	5 Days
	Admit D/C	Admit D/C	Admit D/C
<b>Scores:</b>	Ambulation 2.0 5.0	Hygiene/Grooming 2.0 5.0	Self Feeding 2.0 3.0
	Step Negotiation 5.0 5.0	Self Feeding 3.0 4.0	Hygiene/Grooming 2.0 4.0
	Self Feeding 3.0 5.0	Toileting 5.0 3.0	Words Pronunciation 5.0 4.0
	Toileting 2.0 5.0		Swallowing 0.0 7.0
	Hygiene/Grooming 5.0 4.0		

OT - Patient significantly demonstrated progress in rehab and met all goals

PT - Demonstrated significant progress in all areas. All goals met and ready to go home with care giver.

Patient will be followed up with home care services.

\*\*\*\*Report example is shown with the DC Summary information.



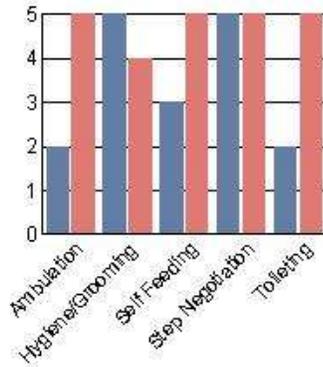
# Patient Outcome Summary

8/1/2006 - 8/31/2006

8989 - Angelica Manor

Patient: Jane Smith

## PT



■ Admission ■ Discharge

### Ambulation

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

### Hygiene/Grooming

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

### Self Feeding

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

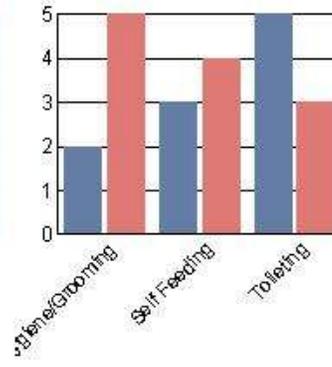
### Step Negotiation

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

### Toileting

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

## OT



■ Admission ■ Discharge

### Hygiene/Grooming

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

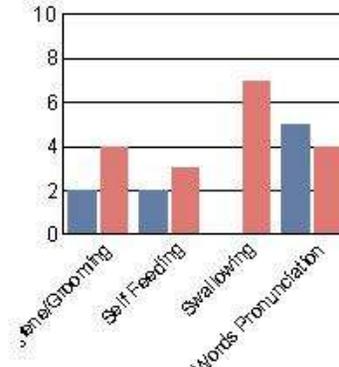
### Self Feeding

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

### Toileting

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

## ST



■ Admission ■ Discharge

### Hygiene/Grooming

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

### Self Feeding

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

### Swallowing

- 0 Dependent
- 1 Maximum
- 2 Moderate
- 3 Minimal
- 4 Standby
- 5 Independent
- 6 test1
- 7 test2

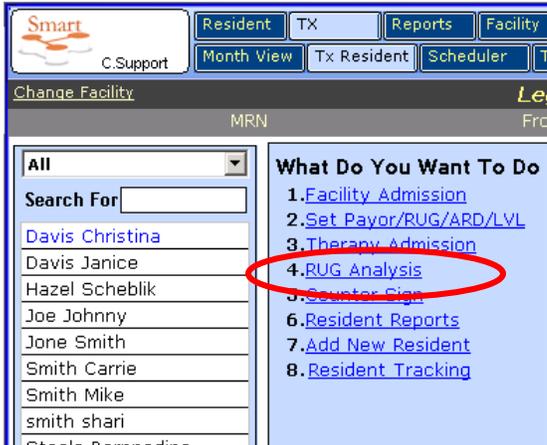
### Words Pronunciation

- 2 Total
- 3 Maximum
- 4 Moderate
- 5 Minimum

## RUG ANALYSIS

The RUG Analysis screen displays the 7 day look back minutes and calculated RUG category for each day of the residents' Facility Admission.

Begin by clicking on RUG Analysis- option4



The RUG Analysis screen will display.

RUG Analysis									
Tuesday May 19 2009 - Monday May 25 2009									
Day	Tue 5/19	Wed 5/20	Thu 5/21	Fri 5/22	Sat 5/23	Sun 5/24	Mon 5/25		
Payor Day/RUG	MedA(2)-M	MedA(3)-M	MedA(4)-M	MedA(5)-M	MedA(6)-M	MedA(7)-M	MedA(8)-M		
PT	55	51	55	60			50		
OT	55	55	56	60			50		
ST	50	51	50	51			51		
Total	160	157	161	171			151		
Eval		51							
Group		55							
Individual	160	51	161	171			151		
<b>Look Back</b>									
PT Min/Days	70 2	121 3	176 4	236 5	236 5	236 5	271 5		
OT Min/Days	85 2	113 3	188 4	256 5	256 5	256 5	276 5		
ST Min/Days	66 2	66 2	116 3	167 4	167 4	167 4	202 4		
Total Min/Days	221 6	300 8	480 11	659 14	659 14	659 14	749 14		
SectionT	0/0	0/0	0/0	0/0	0/0	0/0	0/0		
ARD							5 Day		
RUG Level	M	M	M	V	V	V	U		
<p>Minutes displayed in Red were reduced because Group Therapy for the Look Back was greater than 25% of the Total Minutes for the Discipline. In these cases the Minutes are reduced until no more than 25% Group Therapy is reached.</p>									

This is a read only screen and data cannot be entered into it. The current week will be displayed with today as the last day. The dropdown arrow allows the screen to be moved by month, day, or week using the Forward/Backward buttons.

RUG Analysis															
Day		Tuesday May 19 2009 - Monday May 25 2009													
		Tue 5/19	Wed 5/20	Thu 5/21	Fri 5/22	Sat 5/23	Sun 5/24	Mon 5/25							
Payor Day/RUG		MedA(2)-M	MedA(3)-M	MedA(4)-M	MedA(5)-M	MedA(6)-M	MedA(7)-M	MedA(8)-M							
PT		55	51	55	60			50							
OT		55	55	56	60			50							
ST		50	51	50	51			51							
Total		160	157	161	171			151							
Eval			51												
Group			55												
Individual		160	51	161	171			151							
<b>Look Back</b>															
PT	Min/Days	70	2	121	3	176	4	236	5	236	5	236	5	271	5
OT	Min/Days	85	2	113	3	188	4	256	5	256	5	256	5	276	5
ST	Min/Days	66	2	66	2	116	3	167	4	167	4	167	4	202	4
Total Min/Days		221	6	300	8	480	11	659	14	659	14	659	14	749	14
SectionT		0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
ARD															5 Day
RUG Level		M	M	M	V	V	V	V	U						

**Minutes displayed in Red were reduced because Group Therapy for the Look Back was greater than 25% of the Total Minutes for the Discipline. In these cases the Minutes are reduced until no more than 25% Group Therapy is reached.**

The screen displays the Payor day and actual RUG level for the patient that was entered on the ARD screen.

The top area of the screen displays the actual minutes delivered for the day from the TX Input screen. This is separated by discipline with a total for the day. Eval and individual minutes are then separated on the next rows.

Look Back area displays totals for the previous seven days. If any of the Discipline totals were reduced due to the total group being greater than 25% for the previous seven days, then the total displays in RED.

Section T displays the estimated minutes and days from the 5 day ARD screen.

ARD displays the ARD type for the date the ARD is set.

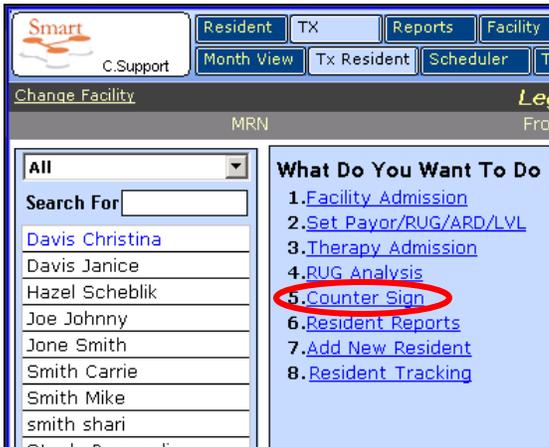
The RUG Level is calculated for each Look Back day as if that day were an ARD day.

**TIP: RUG Analysis can also be viewed on the TX Planner Screen.**

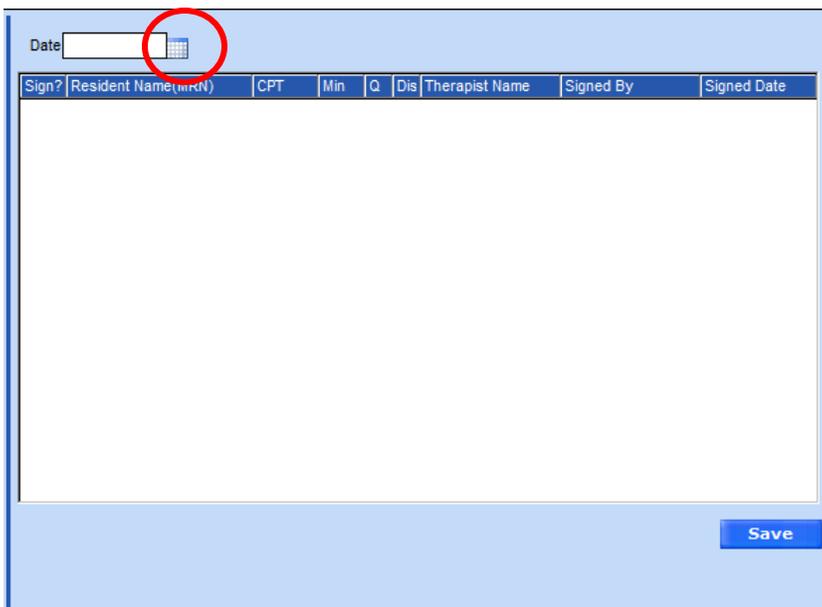
## COUNTER SIGN

This screen is used to confirm the minutes/ daily notes that Therapist Assistants or any staff member who requires supervision, documented with the residents.

Begin by clicking on Counter Sign- option5



The Counter Sign screen will open.



Click on the Calendar button to select the day to review for counter sign.

Once the user selects a date, a list of residents who had treatment rendered within the same discipline as the user will display.

Date: 5/20/2009

Sign?	Resident Name(MRN)	CPT	Min	Q	Jis	Therapist Name	Signed By	Signed Date
<input type="checkbox"/>	George Bush(1234)	97110	30	2	PT	PT Test		
<input type="checkbox"/>	George Bush(1234)	97112	15	1	PT	PTA Test		
<input type="checkbox"/>	Gina Davis()	29126	16	1	PT			
<input type="checkbox"/>	Gina Davis()	29505	15	1	PT			
<input type="checkbox"/>	Phillip McDougal(345)	97110	51	3	PT			
<input type="checkbox"/>	Phillip McDougal(345)	97542	15	1	PT			

Pt seen for therapeutic exercise to develop strength, endurance, ROM and flexibility.

Save

The CPT column will display daily notes in BLUE. CPT codes without a daily note written on the TX Input screen will display in BLACK.

Hovering the mouse over CPT Notes in BLUE will display on the screen for easy review before countersigning.

Date: 5/20/2009

Sign?	Resident Name(MRN)	CPT	Min	Q	Jis	Therapist Name	Signed By	Signed Date
<input checked="" type="checkbox"/>	George Bush(1234)	97110	30	2	PT	PT Test	Casamba Support	6/21/2009
<input checked="" type="checkbox"/>	George Bush(1234)	97112	15	1	PT	PTA Test	Casamba Support	6/21/2009
<input checked="" type="checkbox"/>	Gina Davis()	29126	16	1	PT	PTA Test	Casamba Support	6/21/2009
<input checked="" type="checkbox"/>	Gina Davis()	29505	15	1	PT	PT1 Test	Casamba Support	6/21/2009
<input checked="" type="checkbox"/>	Phillip McDougal(345)	97110	51	3	PT	PT Test	Casamba Support	6/21/2009
<input checked="" type="checkbox"/>	Phillip McDougal(345)	97542	15	1	PT	PT Test	Casamba Support	6/21/2009

Save

Check the Sign? boxes of the treatment supervised, and click on the SAVE button.

The signed by field and date will be inserted.

The counter sign appears on the service logs for the patient.

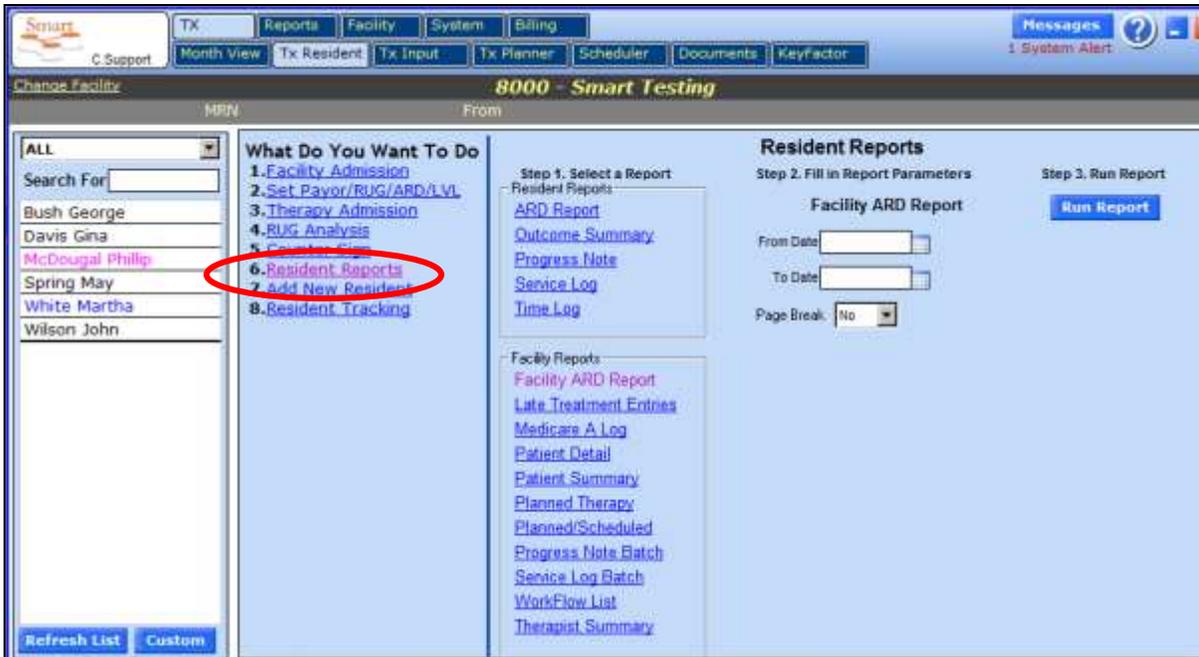
Counter signing any treatment will lock the TX Input screen so that changes can't be made to any treatment which has been counter signed.

### TIP

Only a licensed therapist can counter sign. This page is read only if you are not licensed.

## RESIDENT REPORTS

Resident reports are reports which are used the most frequently by the therapy staff. Begin by clicking on Resident Reports.



The Resident Reports screen displays.

- Reports under the Resident Reports will display data only for the selected resident.
- Reports under the Facility Reports will display data for all residents for the parameter the report is run.

To run a report, select the report, enter the requested parameters for the report, and select Run Report. The report will calculate and automatically pull up in Adobe PDF.

### TIP

\*\*Refer to the TX Resident Report Manual for details on the reports in this section.

## RESIDENT TRACKING

Resident Tracking is used to prompt the Therapy team for periodic screening of Facility Residents. It is also used to track the progress of the screen process. Additionally, screening forms are available for each discipline.

Residents are triggered for a screen based on one of the following events:

- New Admission or Re Admission to the Facility
- Two weeks after discharge off of Medicare
- Three weeks prior to when the next OBRA assessment is due

Screens can also be added by the Therapy team for non triggered reasons.

An alert is also available that can display residents who are due for screening.

Select the Resident from the list and select Resident Tracking. The screen will display.

Screen Reason		Screen Result	Screen Date	Order Date	SOC	
Admit	OT					
	PT					<a href="#">Print</a>
	ST					

Add Line Save

'Screen Reason' displays the trigger reason.

'Screen Result' allows the Therapist to document whether the screen was Negative (no further action required) or Positive (deficit was identified that could benefit from skilled Therapy services).

'Screen Date' is used to indicate the date of the screen.

'Order Date' is used to indicate the date the Eval was ordered.

'SOC' is the Therapy Start of Care Date.

'Print' will print the therapy screening form which can be completed for the resident.

The screenshot shows a software interface with a sidebar on the left and a main table area. The sidebar is titled "What Do You Want To Do" and contains a list of actions: 1. Facility Admission, 2. Set Payor/RUG/ARD/LVL, 3. Therapy Admission, 4. RUG Analysis, 5. Counter Sign, 6. Resident Reports, 7. Add New Resident, and 8. Resident Tracking. The main table has columns for Screen Reason, Screen Result, Screen Date, Order Date, and SOC. The table contains three rows of data, with the second row having a "Print" link. At the bottom right of the interface are "Add Line" and "Save" buttons.

Screen Reason	Screen Result	Screen Date	Order Date	SOC	
Admit	OT Positive	6/1/2009	6/13/2009	6/14/2009	
	PT Positive	6/1/2009	6/12/2009	6/15/2009	<a href="#">Print</a>
	ST Negative	6/2/2009			

## DASHBOARD

The Dashboard is located at the bottom of the Tx Resident screen.

This screen allows the user to view messages and alerts for the facility logged into.

The message dashboard will display any SMART update information for the facility. These messages can be from the Corp office, manager or from Casamba support.

The alerts dashboard will display any alerts on missing information for residents in the facility. Refer to the Smart Quick Cards for more information on specific alerts.

All ▼

Search For

- Smaet Mary
- Smart Adam
- Smart Mary
- Smit Mike
- Smith Bill
- Smith David
- Smith Gable
- Smith Jane
- Smith Kim
- Smith Mary
- Smith Ron
- Smithy John
- Smithy Mary
- Smoltston Beirut
- Snett Mary
- Snickers Mary
- Spring Jerry
- Stoic Jim

Refresh List Custom

**What Do You Want To Do**

1. [Facility Admission](#)
2. [Set Payor/RUG/ARD/LVL](#)
3. [Therapy Admission](#)
4. [RUG Analysis](#)
5. [Counter Sign](#)
6. [Resident Reports](#)
7. [Add New Resident](#)
8. [Resident Tracking](#)

**Facility Admission**

Admit Date	Discharge Date
6/1/2005	

Correction Add Edit

**Resident Information**

First Name  MI  Last Name  Birth Date  Tx Location

Gender  SSN  MRN  Medicare #  Save Delete

**Current/Latest Facility Admission**

Admit Date  Admitted From   Inpatient  Outpatient

Discharge Date  Discharged To  Admission ID

Last update to this screen was on 11/12/2005 at 09:58 PM by Casamba Support

For non-urgent questions email [Support@Casamba.net](mailto:Support@Casamba.net)

Casamba Help Desk  
818.991.9111

< > 1/1 From: Ofir Weisberg

**Important Smart Update**

A new field called **Admission ID** has been added to the Facility Admission Screen. This Admission ID should contain the Health Med X Admission ID that is created with each new Facility Admission.

Every Resident admitted from October 1 forward must have this ID entered for each new Facility Admission.

Please reference the Smart Release Notes from 11/1/2005 for more information.

**Alerts As of Nov 23 2005 8:35PM**

Missing Payor (2) | Missing RUG (27) | Missing ARD (64) | Missing Treatments (81) | P >

Start Date	Resident Name	Admit Date	Discharge Date
09/01/2005	Ashton, Anna	11/01/2005	
09/01/2005	Fonda, Jane	10/05/2005	

24