A Medical Review
Approach to Medicare
Outpatient
Documentation

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health, reimbursement • Medicare •
reimbursement mechanisms

Blue Cross of California has recognized the problem of reimbursement delays due to Medicare claims that have been returned or denied. The information in this article applies to the medical review process and suggests an interpretation of the new Medicare outpatient guidelines used by the Blue Cross of California Medicare reviewers. As a solution to the problem of delayed reimbursement, medical reviewers—who are also practicing occupational therapists—offer an explanation of the Medicare review process and suggestions for correcting technical billing errors. Methods for keeping complete and timely medical records are discussed, with the suggestion that clinicians follow these methods from the start of care. A process for documentation is presented that will clearly prove to the medical reviewer the need for the special skills of an occupational therapist. This article also proposes reasons for noncoverage because of insufficient medical necessity. It is important to note, however, that variance between fiscal intermediaries’ interpretations and requirements exists nationwide. This article, therefore, represents only one fiscal intermediary’s approach to reviewing claims and medical records.

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After a patient has received occupational therapy services and the provider has sent the bill for services to the fiscal intermediary (an insurance company that contracts with the federal government to process Medicare claims), a medical review may take place to ensure that the services provided are covered under Medicare regulations. At the beginning of 1989, the Health Care Financing Administration (HCFA) introduced new guidelines for these occupational therapy reviews, called “Outpatient Occupational Therapy Medicare Part B Guidelines” (see Appendix A). These guidelines speed the process of reimbursement, yet also require that providers complete their Part B bills (UB-82 forms) with 100% accuracy.

The purpose of the present article is to explain the medical review process via a focus on occupational therapy claims and an outline of what medical reviewers must have before providers can be reimbursed for services. A documentation example that includes the elements to establish medical necessity is also provided.

The Importance of Proper Documentation

As Medicare medical reviewers for Blue Cross of California and practicing occupational therapists, we have an opportunity to observe the medical review process from both perspectives. We understand the problems involved when a claim is denied or sent back to the provider for further information, and we have found that thorough documentation is the key to successful reimbursement.

Documentation requirements may seem trivial when compared with the complex and, at times, overwhelming degrees of disabilities that patients present. However, responsibility for proper documentation of services is no less important than the selection of the most effective treatment approach or the provision of the best clinical care. Documentation is the only tangible evidence of the critical link between the therapist’s clinical reasoning and the patient’s functional performance outcome. Improper documentation can result in a claim being denied or returned to the provider for additional information, thus jeopardizing the patient’s access to further treatment.

When a claim is denied for technical reasons, the billing office and the beneficiary receive a claims correction notice, which provides basic information concerning the denial. When the claim is denied for medical necessity, a Medicare denial letter is sent. The occupational therapist should review denied cases individually and determine if an additional technical requirements review or a medical necessity review is warranted.
Clerical Errors

Many technical errors can be traced to improper coding for diagnosis and treatment; perhaps the billing clerk responsible for completing the claim has misunderstood an occupational therapist's notes or has had little experience in proper coding. Common errors at this level include the following:

- The diagnosis on the bill differs from the diagnosis of concern to the occupational therapist. For example, the diagnosis code on the bill may indicate that the diagnosis is urinary incontinence, but the diagnosis that caused the referral to the occupational therapist is cerebrovascular accident. It is essential to specify the diagnosis used to establish the occupational therapist's goals.
- The number of treatment units is mistaken for the number of visits, thereby causing the number of visits to appear excessive for the billing period.
- The start-of-care date and the onset date are the same. Except for an emergency room visit, the start-of-care date typically occurs after the onset date. For example, the date of the onset of multiple sclerosis would be prior to the date of the first day of therapy.

These clerical errors cause a delay in claim processing because additional or corrected information is required before the final review of the claim. The occupational therapist can reduce these delays by making sure that the billing office has accurate information (Blue Cross of California provides a form for recording such information).

Education to increase billing accuracy can be provided through workshops, printed materials, audiotapes, and computer programs. One such computer program, PT Medicode+, developed by Blue Cross of California (1989), addresses the billing problems specifically cited by the American Occupational Therapy Association ("Update on Medicare," 1988). Although originally designed to assist in physical therapy billing, this software program also pertains to occupational therapy billing and is available in two versions: 1500 for private practices and UB-82 for hospitals, rehabilitation facilities, nursing homes, and home health care agencies.

Request for Medical Records

When a claim falls outside the norms established by Level I review for the fiscal intermediary, the third-party payer may request that the provider supply medical information for further investigation into the claim. This request does not indicate an automatic denial, it simply represents a reviewer's desire for further clarification to ensure a fair and objective decision on the case.

For a complete, fair, and accurate review, these medical records must include documentation of (a) the patient's medical history (supplied by a physician or through an interview with the therapist), (b) a physician's referral, (c) physician certification, (d) an initial evaluation, (e) daily documentation from the start-of-care date, (f) weekly and monthly progress notes, and (g) an itemized financial ledger showing daily charges. The third-party payer's medical reviewer then uses the concurrent review form (see Appendix B) to ascertain that technical requirements have been met and to determine if the therapy provided is at a covered level of care.

A request for medical records is initiated well after services have been provided. The following is a guideline for the provision of complete documentation of services and for the avoidance of deficient records.

Patient's medical history. These records, which are supplied by the physician or through an interview with the therapist, should provide supportive information to substantiate the need for the stated intervention.

Physician's referral. A physician's referral should include (a) the occupational therapy treatment diagnosis, (b) the onset date of the treatment diagnosis, (c) the actual or estimated date of any recent change in level of function, (d) a request for evaluation or specific orders, and (e) the date and the physician's signature. If the physician has ordered an evaluation, the therapist should establish a treatment plan (including the type of activity or procedure and the frequency and duration of treatment) at the time of the initial evaluation and sign and date this plan. Any
changes or additions to this plan should be in writing and should be signed and dated by the occupational therapist. If the physician has ordered a specific occupational therapy plan, the specific orders must be followed unless the therapist suggests or receives a change in orders from the physician. All telephone orders must be documented and then signed by the physician as required by state law and by facility and occupational therapy department procedures. Common errors in the physician’s referral that cause delays or technical denials include incomplete or nonspecific orders (e.g., PRN orders), orders with a span of frequency and duration (e.g., two to three times a week for 4 to 6 weeks), and orders that do not state a specific type of treatment (e.g., activities as needed).

Physician certification. Certification for outpatient services is a statement written by the physician at the time treatment is begun indicating that the patient needs occupational therapy services. This certification is good for 30 days from the date of the initial evaluation or the start-of-care date.

Blue Cross of California accepts the initial physician’s referral as the first certification. On or before the 30th day of treatment, and every 30 days thereafter, recertification must be obtained in writing and signed and dated by the physician. The use of a stamp for the physician’s signature on orders, certification, or recertification is not valid. The original certification and recertifications with the physician’s signature should be kept on file.

Certification or recertification may be in any form, but must contain the following key elements:

- A statement that the physician has seen the patient during the 30-day period
- A statement of the need for continuing outpatient occupational therapy
- A statement estimating the length of time services will be needed to achieve the treatment goals
- A statement of the physician's intention to review the case every 30 days

Initial evaluation. These records must contain baseline data—both subjective and objective—that measure the relevant recovery factors for that patient’s treatment diagnosis. Goals must be clearly stated and must relate directly to the baseline recovery factors.

Daily documentation from the start-of-care date. At a minimum, daily documentation should state the date of treatment, the type of treatment, the length of the treatment session if the therapist billed by time and procedure, and the patient’s progress, including documentation of changes whenever they occur. If no changes are occurring, that fact should be documented.

Weekly and monthly progress notes. Brief weekly notes stating changes from the beginning of the treatment week and monthly summaries of changes from the beginning of the treatment month are required. Changes in the patient’s ability to perform activities of daily living from one period to the next are summarized.

In daily, weekly, and monthly notes, the therapist should measure and document changes in key factors previously identified as contributing to the patient’s decreased function. Relevant factors, such as pain, loss of range of motion, loss of functional ability to follow or retain instruction, and attitude, are frequently related to the patient’s performance. The notes should clearly state when the patient reaches a goal. Likewise, if the patient has not reached a goal, an explanation should be provided.

To demonstrate that adequate supervision has been given, the daily notes of all occupational therapy assistants and aides must be consigned as required by state regulation and Medicare’s conditions of participation.

Itemized financial ledger showing daily charges. Itemized services that are billed on the financial ledger must match the daily occupational therapy treatment record. All services billed must be covered by benefits of the Medicare insurance program. Treatments such as biofeedback training for relaxation, driver’s education, and case conferences are not covered by the program.

To avoid technical denials, we recommend that the occupational therapy department be responsible for reviewing the medical records before they are sent to the intermediary to ensure that they are clear and complete, that they include all items requested, and that they reflect the billing period in question. The therapist should include the complete records from the start-of-care date. Determination of the patient’s progress for the billing period under review is difficult without the initial evaluation, treatment notes, and summaries from previous billing periods. The intermediary usually does not keep all of the previous medical records on file.

If a claim is questioned because technical requirements are not met, the areas concerning medical necessity are not reviewed. In the medical review process, the quality of a therapist’s services may not matter if technical requirements have not been properly addressed. The denial of reimbursement because of technical problems is troubling to a clinician.

Medical Necessity Review

Medicare denies coverage for the following basic reasons:

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1. The need for the occupational therapist's unique skills and knowledge is not evident. Covered treatment must be at a certain level of complexity and sophistication, or the condition of the patient must be such that the treatment can be performed safely and effectively only by a certified occupational therapist or under such a therapist's supervision. If the patient or caregiver could provide the care (e.g., activities of daily living routines, endurance activities, exercises, transfers) or if the treatment consists of instructions that another service could provide, then skilled occupational therapy is considered unnecessary.

2. The patient would improve naturally without the help of an occupational therapist. If the general progression of the patient's medical condition would return the patient to a previous level of functioning spontaneously, then skilled occupational therapy intervention is not considered to be medically necessary.

3. The patient shows no significant improvement within a reasonable and predictable amount of time. Reasonable is considered to mean that there is a greater than 50% probability that the patient will make significant improvement as a consequence of occupational therapy. Predictable amount of time is interpreted to mean that the planned frequency and duration of treatments is a knowledgeable estimate of how long it will take the patient to achieve therapy goals in relation to the diagnosis, severity, and prognosis of the condition. If at any point in the course of the treatment it is determined that the expectations will not materialize, occupational therapy services will no longer be considered reasonable. If treatment of underlying causes, such as an increase in endurance, strength, range of motion, or a decrease in pain, does not improve the performance of functional activities, then improvement is not considered to be significant.

4. The patient has not demonstrated sustained gains, is considered to be at a maintenance level, and is not expected to show further improvement. Therapists must document decreased levels of assistance or improved patient responses to assistance provided. Documentation of activity outcomes should be stated in measurable, objective terms.

5. The occupational therapy services duplicate services provided by other therapists. If a single discipline, such as physical therapy, occupational therapy, speech therapy, or nursing, could provide the care, only one discipline can bill the charges. For example, if the occupational therapy program provided upper extremity exercises and the physical therapy program provided lower extremity exercises and gait training, then only physical therapy would be covered because physical therapy could also provide upper extremity exercises. If the occupational therapy program included transfers, dressing, and upper extremity exercises and the physical therapy program provided only upper extremity exercises, then only the occupational therapy would be covered. Services are not considered duplicative in cases where both services involved have unique treatment goals that lead to distinct functional outcomes. For example, in transfer training, the physical therapy goal is for safe and independent transfers and the occupational therapy goal is for the appropriate use of transfer techniques in activities of daily living. In brain injury rehabilitation, the occupational therapy goal is to employ neuromuscular therapies to increase functional use of the upper extremity in dressing or bathing, and the physical therapy goal is to use neuromuscular therapies to assist the patient in the use of the upper extremity during ambulation activities.

Determining Medical Necessity

To determine medical necessity, the intermediary reviews the patient's medical records from the start-of-care date. In this review, the intermediary asks, Why does this patient need an occupational therapist now? The therapist's knowledge of disability and activity analysis must be combined with a reasonable expectation for improving functional performance.

The medical reviewer's role is to determine medical necessity on the basis of documentation in the medical records that indicates that the patient's condition and level of function required the special knowledge and skill of an occupational therapist. As practicing therapists, we focus on the patient's disability, but as medical reviewers, we focus on whether the nature of that disability requires a therapist's knowledge to successfully help the patient.

Establishing Reasonability and Necessity of Services

To be covered by the fiscal intermediary, occupational therapy services must be reasonable and necessary. Services are reasonable if the patient has a fair or good rehabilitation potential for the established goals. A good rehabilitation potential exists when the patient's function is expected to improve significantly within a limited and predictable amount of time on the basis of the occupational therapist's initial assess-
ment. Services are necessary if skilled occupational therapy is required to produce the expected improvement. If the expected improvement is not achieved, the intervening variables that invalidated the therapist's prediction of rehabilitation potential should be identified.

Documentation of the presence of a disability alone, however, is not enough. Therapists must identify the specific diagnosis (ICD-9 code) that substantiates the need for a skilled occupational therapist's assessment and must prove that the patient could only improve through the application of the therapist's special knowledge of activity analysis and treatment methods.

**Documenting Treatment**

To document treatment so that the medical reviewer does not need to search for treatment goals and for the patient's progress toward these goals, the therapist can use the following four steps as guidelines.

**Step 1: The initial evaluation.** In this step, the therapist asks, Where are we? and determines the patient's current levels through an initial evaluation. The initial evaluation begins with an interview of the patient, which is a crucial component of the evaluation and a prerequisite to the establishment of a practical treatment plan. The interview follows a complete review of the medical record and focuses on the perspective of the patient, the caregiver, or both. The interview establishes what activities the patient can perform, how often these activities are performed, and if the patient or caregiver is satisfied or dissatisfied with his or her performance. A successful interview uncovers the patient's perceived problems, physical or cognitive disabilities, relevant medical history, and available family and community support. The interview establishes a request for services by identifying areas in which the patient is doing well or poorly, and by screening out activities that are not relevant.

After the initial evaluation, a list of activities requested by the patient or caregiver is developed and improved upon with the special knowledge and skills of an occupational therapist. The therapist should document the patient's current levels for each of the requested activities. This is the starting point for the rest of the documentation.

**Step 2: Rehabilitation potential.** In this step, the therapist asks, Where are we going? and What are the specific expected levels of activity for the patient? The therapist then establishes measurable, realistic goals for the patient. Once the specific activities that can be improved through the intervention of an occupational therapist have been developed and the patient's current activity levels have been documented, the occupational therapist can determine the patient's expected levels. The therapist should write these expected levels as goals for each activity. Such goals must be measurable and must realistically reflect the patient's rehabilitation potential. Each of these goals must be specifically relevant to the performance of functional activities. Ascertaining the patient's potential for improving functional status is a critical assessment decision for the therapist. It not only determines the type of therapy intervention that may be used but also enables the therapist to predict the outcome of the intervention on the patient's task performance.

**Step 3: The treatment plan.** In this step, the therapist asks, How do we get there? and What specific treatments will bring the patient to the expected levels? The therapist determines a specific treatment plan for each expected level identified in Step 2 and states the specific treatment plan and any changes in either the plan or its implementation. Documentation should include a record of treatment activities, modalities, and procedures; the patient's and family's education; the equipment ordered; the need for further evaluation; conferences with others; and discharge plans. The specifics of the discharge plan should be stated, that is, the amount of supervision required, the education of the patient and family that has been accomplished and that is still required, and a tentative discharge date.

**Step 4: Assessment of the patient's progress.** In this step, the therapist asks, How are we doing? The patient's progress is measured. This is the proof that the plan is working, the facts that prove that an occupational therapist is essential to the patient's progress. Each treatment diagnosis has a probable set of outcome alternatives. Once the treatment goal has been established, each progress note must reestablish the appropriateness of these goals and monitor the specific change the patient has made toward the goal.

Progress notes must contain a series of established causes and must measure progress and monitor functional outcome. Each note must reflect progress toward the determined goal. For example, if full range of motion of the shoulder is the goal, then the therapist should (a) establish that the causative factor (pain) is being controlled; (b) measure the shoulder's passive, active, and functional range of motion; and (c) monitor changes in specific tasks, for example, upper extremity dressing. Alternatively, the therapist could (a) establish that muscle weakness is the underlying cause of shoulder immobility; (b) measure quantitative changes in strength; and (c) monitor changes in specific tasks (e.g., independence in meal preparation at home). By establishing causes and measuring progress, the therapist clearly outlines each step toward predetermined goals. This method will help substantiate that the services of an occupa-
Table 1: Use of the Four Documentation Steps for a Patient With Left Hemiparesis From a Cerebrovascular Accident

<table>
<thead>
<tr>
<th>Documentation Steps</th>
<th>Commonly Used Information (Insufficient)</th>
<th>Specific Information (Sufficient)</th>
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<tbody>
<tr>
<td>Step 1: Initial evaluation</td>
<td>Patient requires assistance with self-care.</td>
<td>The patient requires moderate physical assistance and step-by-step verbal cuing to dress (secondary to left-side neglect, decreased left upper extremity function, and diminished motor planning). The caregiver is knowledgeable of compensatory dressing techniques and typically performs these tasks for the patient.</td>
</tr>
<tr>
<td>Step 2: Rehabilitation potential</td>
<td>Instruct the patient in self-care.</td>
<td>The patient will achieve at least a minimum assistance level for dressing with the use of compensatory techniques. The caregiver will learn the proper methods and cues for assisting the patient.</td>
</tr>
<tr>
<td>Step 3: Treatment plan</td>
<td>Provide functional activities.</td>
<td>The therapist will provide dressing training and practice with the use of various compensatory techniques to determine the most suitable technique for the patient, combined with instruction of the caregiver to follow through.</td>
</tr>
<tr>
<td>Step 4: Assessment of the patient's progress</td>
<td>Patient improved in self-care.</td>
<td>The patient performs dressing with minimum assistance, requiring cuing for left arm placement into sleeve. The caregiver is able to demonstrate appropriate methods of assisting the patient.</td>
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</table>

Conclusion

When reimbursement is denied or delayed, it is often due to insufficient documentation—either the documentation lacks technical accuracy or lacks details supporting medical necessity. We recommend that the therapist pay attention to the areas that are screened for accuracy and take the time to review claims before they are sent to the fiscal intermediary. Regardless of the fiscal intermediary or medical reviewer, however, the suggestions on this paper were made to assist occupational therapists in submitting complete documentation for outpatient Medicare reimbursement.

Because clerical errors cause the majority of technical errors, we suggest that billing clerks as well as therapists and administrators become familiar with claims coding. PT Medicode+, a software program designed specifically to decrease billing errors, may be useful in this endeavor.

The guidelines presented in this paper to help therapists keep medical records can be used to provide the information necessary for a fair review. By following these guidelines from the beginning of treatment, therapists will have proper documentation when records are requested. Additionally, the four steps of documentation that we provided should help therapists develop a clear image of a patient's progress and should substantiate the need for the specific skills of an occupational therapist, thus helping to establish medical necessity.

Appendix A

A Provider's Guide to Health Care Financing Administration Rules and Medicare Interpretations

There is a difference between Health Care Financing Administration (HCFA) regulations, which are issued by HCFA in Baltimore, and interpretations of regulations, which are done by HCFA regional offices, the fiscal intermediaries, and their medical reviewers.

Regulations and guidelines are sent directly to providers by HCFA headquarters in Baltimore. An example is Health Insurance Manuals, which are general guidelines, distinguished by type of facility. Each Health Insurance Manual giving Part A and Part B information has three sections: one on general information, one on coverage of services, and one on billing procedures.

HCFA clarifies the Health Insurance Manual with transmittals. Four recent transmittals (1989), written to deal with a perceived lack of standards in Part B occupational therapy medical reviews, are (a) No. 281, for skilled nursing facilities; (b) No. 565, for acute-care hospitals; (c) No. 223, for home health care; and (d) No. 87, for rehabilitation agencies and comprehensive outpatient rehabilitation facilities. These four transmittals contain similar information.

In addition to the Health Insurance Manual, HCFA publishes and updates Coverage Issues Manual with details on selected topics across all disciplines. For example, the Cardiac Rehabilitation section of the Coverage Issues Manual (Reference No. 35-25) is updated every few years. Although the content changes, the reference number of the updates remains the same. The Coverage Issues Manual includes valuable information on the available benefits and exclusions of the Medicare program.

A fiscal intermediary is an insurance company that has a contract with the government to process Medicare Part A claims for payment. Each fiscal intermediary is assigned to one of nine HCFA regional offices. The HCFA central office provides direction and coordination responsibilities within the Social Security Administration for the Medicare program.

HCFA regulations establish the framework from which interpretations may be made. Each HCFA region provides additional structure to HCFA guidelines. Both the regional
office and the fiscal intermediary use professional community standards to assist in the interpretation of regulations to meet the needs of the Medicare beneficiary. The medical reviewers are instrumental in monitoring both community standards and current interpretations of Medicare guidelines.

To keep the providers informed, each fiscal intermediary publishes Medicare bulletins and periodically holds workshops on billing and medical coverage issues. Blue Cross of California, for example, has published updates on a variety of issues, including certification, billing, and therapy guidelines. To obtain information on workshops and other services, the therapists should contact the fiscal intermediary that processes their Medicare claims.

### Appendix B

Concurrent Review of Outpatient Occupational Therapy Services

1. Primary diagnosis: ___________________________ Onset date: ____________
2. Treatment diagnosis: __________________________ Onset date: ____________
3. a. Specific type, frequency and duration of treatment: __________________________

   b. Was certification timely? Yes No
      From: ____________ To: ____________ Date: ____________
4. Prior functional level: __________________________
5. How long has the patient been treated since the initial evaluation? Date of evaluation: __________________________ Length: __________________________
6. Is therapy going to continue after this billing period? Why? Yes No
   Comments: __________________________
7. Initial patient evaluation
   a. Initial interview regarding activity performance and services? Yes No
   b. Observation of patient's activity performance? Yes No
   c. Identification of adaptations or compensations needed? Yes No
   d. Identification of underlying factors interfering with task performance that are therapeutic indications for occupational therapy? Yes No
   Lack of awareness of
   Sensory cues: __________________________
   Effects of actions: __________________________
   Safety hazards: __________________________
   Disability: __________________________
   Prior knowledge: __________________________
   Attention span: __________________________
   Impaired strength: __________________________
   Incoordination: __________________________
   Abnormal muscle tone: __________________________
   Range of motion limitations: __________________________
   Impaired body scheme: __________________________
   Perceptual deficits: __________________________
   Impaired balance/head control: __________________________
   Environmental barriers: __________________________
   e. Objective functional limitations identified in therapist's documentation? Functional activities Yes No
      Assistance levels
      Physical Yes No
      Cognitive Yes No
      Response to assistance Yes No
      Assistive device Yes No
   f. Short-term goals identified? Yes No
   g. Long-term goals identified? Yes No
8. Are there weekly objective measures of patient's progress or problems in achieving treatment goals? Yes No
   Comments: __________________________

<table>
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<tr>
<th>Functional Skills</th>
<th>Date</th>
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<tr>
<td>Eating</td>
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<td>Feeding</td>
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<tr>
<td>Grooming/hygiene</td>
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<tr>
<td>Bathing</td>
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<td>Dressing</td>
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<tr>
<td>Writing skills</td>
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<td>Homemaking skills</td>
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<tr>
<td>Avocational skills</td>
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<tr>
<td>Transfers (toilet, tub)</td>
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</table>
Mobility—wheelchair skills
Activity tolerance
Equipment assistance/adaptive devices
Joint protection
Energy conservation/work simplification
Object manipulation

9. Does treatment plan address stated problems?

10. Is Medicare being billed for noncovered services?
   a. No skilled occupational therapy
      (1) General supervision of exercises already taught to patient/caregiver.
      (2) Routine assistance with self-care activities.
      (3) Endurance training.
      (4) Billing for reevaluations that are not medically necessary.
   b. Maintenance care
      (1) Slow or no progress.
      (2) Loss—gain: Unable to sustain gain, no overall improvement.
   c. Duplication of service with physical therapy, speech therapy, neuropsychology, or nursing
   d. Evaluation as a screening device
   e. Deleted services
      (1) Case conferences
      (2) Billing separate documentation time

11. Was the patient discontinued from occupational therapy when one of the following criteria was met?
   a. Achieved goals:
   b. No expectation of significant progress:
   c. Unable to participate in the treatment program because of medical, psychological, or social complications:
   d. Treatment no longer requires skilled occupational therapy (i.e., can be continued by patient or caregivers). Maintenance established:

Comments:

References

