TLC Documentation Orientation

Occupational Therapy

Physical Therapy

Speech Therapy
All Staff will be required to **log in** to access JBS data.

Select the Clinic to proceed.
TLC Home Page

Key Points

(A) **Therapist Name** – Verify your unique ID / Code when logging in

(B) **Messages** – JBS internal messaging system. (number of messages will display in the parenthesis.

(C) Date and clinic abbreviations
### TLC Home Page – Hot List

#### Type: Late Documentation; Items: 9

- late Documentation: WK 3/7/2012
- late Documentation: WK 3/2/2012
- Documentation: Rec 10/13/2011
- late Documentation: WK 3/8/2012
- late Documentation: WK 3/5/2012
- late Documentation: WK 3/5/2012
- late Documentation: WK 2/27/2012
- late Documentation: WK 2/29/2012
- late Documentation: PN 3/8/2012

#### Type: Patient Not Scheduled; Items: 5

- no scheduled visits over the next 7 days.
- has been referred but not scheduled.
- been referred but not scheduled.
- been referred but not scheduled.
- has no scheduled visits over the next 7 days.

#### Type: Patient On Hold; Items: 1

- on hold and has no scheduled visits over the last 14 days.
**TLC Part B Caps**

- Patients are listed in alphabetical order.
- Tracker calculates money utilized from the Super bill charges.
  - PT / ST combined
  - PT visits / ST visits tracked individually
  - OT money / visits tracked (Allows visual tracking for all disciplines)
- Once $1880 is reached visits are tracked.
- Click on the patient name for detailed summary and tracking.

(A) **Part B Charges** – access to the Medicare part B monies utilized by patient / year.

<table>
<thead>
<tr>
<th>Patient</th>
<th>PT/ST $</th>
<th>Remaining $</th>
<th>PT Visits</th>
<th>ST Visits</th>
<th>OT $</th>
<th>Remaining $</th>
<th>OT Visits</th>
<th>DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,652.23</td>
<td>$0.00</td>
<td>2</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>6/3/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,300.29</td>
<td>$0.00</td>
<td>4</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>8/27/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$5,320.77</td>
<td>$0.00</td>
<td>36</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>8/13/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3,093.98</td>
<td>$1,339.62</td>
<td>0</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1,114.60</td>
<td>$755.20</td>
<td>0</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>9/3/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4,916.21</td>
<td>$0.00</td>
<td>4</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$517.74</td>
<td>$1,272.26</td>
<td>0</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>12/8/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$873.25</td>
<td>$996.75</td>
<td>0</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>5/13/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1,470.74</td>
<td>$399.26</td>
<td>0</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>12/2/2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$699.68</td>
<td>$1,250.92</td>
<td>0</td>
<td>0</td>
<td>$1,870.00</td>
<td>0</td>
<td>11/8/2011</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(B) **Patient Payment Select** – allow FOC to receive and post payments for *walk-in* patients.

The FOC can:
- Click to add a new patient or..
- Choose from an existing patient.
  - Use the Drop Down box to sort by the first letter of the last name.
TLC Part B Caps

(C) Therapy Advocacy Center – Advocate for you profession in this section. This is very important to protect our professions and the patients we serve.

(D) Extension Requests – Future growth area.
**TLC Documentation**

(A) **Documentation** – alternate method to access documentation
   - Important - Majority of documentation may be accessed through the super bill however the documentation link is the **ONLY** place to access D/C SUMMARY!! You can not access a DC summary from the super bill.

(B) **Electronic Signatures** – The electronic signature section is where a user can find documentation that is waiting to be validated by a therapist. It can be viewed and then signed.
   - Level of increased security for electronic signatures. If anyone other than the assigned user for an employee code enters a code, the employee will be flagged to validate the signature and use of their code.
     - For example – PT completed evaluation and signed 9999. PTA needs to add an item to the POC that was mistakenly left off and notifies the PT 9999. Once the PTA 1111 goes into the completed evaluation and saves, employee 9999 will be notified to validate the changes. This document will load in the Electronic Signatures “cue” (1).
   - The document will state “electronically signed.

(C) **Electronic Charting** – The FOC utilizes this section to upload orders, signed POCs and other documentation. They can also obtain a list of missing uploaded documents through this link.
## TLC Documentation

(D) **Units / Frequency** – Utilized for weekly planning by the FOC. Patient name, phone number, average visits, units and appointment dates. Used to plan for week ahead.

(E) **Notes Due Report**
- Display every document due on the date the report is pulled
- **Tech needs to run the report daily (all sites)**
- This report is not filtered by therapist however…

(F) **Physician E-Signature** – Future growth area with EMR.

Notations have been added to the **printed weekly schedule** as an additional layer for documentation reminders – (the schedule will allow a visual by therapist)
- (W) – Weekly Note Due
- (P) – Progress Note
- (R) – Recert
(A) All active patients are listed by the current month. To access prior months documents, select the month from the drop down menu.

(B) The discipline will automatically default to the user's discipline that is logged in. To access other disciplines that may be treating the same patient, use the drop down menu.

(C) Patients are arranged by Current Caseload and Discharged charts

(D) Click on the patient's name to view list of documents or you may select from the table to access the current / next document.
Clicking on the **patients name** will display all the documents with the corresponding date and a link for **viewing**.

The most recent document will remain in the **“edit”** phase until the next document is clicked on.
Important!

When the "NEXT Document" doesn’t prompt, this signifies that the Current document is pending or needs electronic signature.
TLC CDS

(A) **View Last Audit** – CDS audits will become visual as the sites transition over and new audits are performed in the system.

(B) **Late Documentation** – List number in parenthesis. Goal is (0) Tool to monitor late documentation. CDS also utilize this for compliance.
   - This displays Progress Reports / Weekly Notes and Recertifications

(C) **Late Daily Notes** – List number in parenthesis of late daily notes for the clinic along with their assigned JBS code.
TLC Personal

(A) **My Reviews** – access to JBS 360 online reviews (clicking this link will require another log in layer). Roll out of this feature will follow full implementation of TLC 2.0.

(B) **Suggestion Box** – Set up to assist with getting your opinions and ideas heard within TMC.

(C) **IT Help** – Accesses the IT Help Section- variance from what previous utilized is that there is no longer need for a secondary log in to access. Also, the JBS messaging system will be utilized to give updates related to the status of Tickets.

(D) **Company Directory** – clicking on this link will open an excel file that contains contact information organized by TMC / TLC Departments and states

(E) **Facility Permissions** – allows quick access for managers / staff to see which employees have permission to the site. This will assist in setting up permission prior to scheduling a therapist. You can check here to see if they have access. The report will list by name / employee code.

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**Personal**

- My Reviews (A)
- Suggestion Box (B)
- IT Help (C)
- Company Directory (D)
- Facility Permissions (E)
- Active PRNs
- Physicians
- Tips & Tools
- Policies
- Reports
- Memo History
- Video Library
- Accessing Operation Manual
- TMC Website: Employee Resource Center

(Please note that you will leave JBS and will need to log in to return.)

Employee Forms
(F) **Physicians** – shows physicians and practice information. A report is also available that list physician information.

(G) **Tips & Tools** – contains frequently used templates and how to guides with step by step directions.

(H) **Policies** – TMC policies and procedures.

(I) **Reports** – link to reporting features in JBS.

(J) **Video Library** – current TMC videos on culture, empowerment, hedgehog, etc.

(K) **Accessing Operation Manual** – contains directions on how to access operation manuals.

(L) **TMC Website: Employee Resource Center** – quick access to the TMC website.

(M) **Employee Forms** – link to upload course certificates, license forms and other forms.
TLC Utility

**A** Employee Search – search for therapist to see scheduled events. This will display the date, clinic scheduled, patients scheduled/assigned for that individual.

<table>
<thead>
<tr>
<th>Date</th>
<th>Clinic</th>
<th>Patient Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/3/2012 8:00:00 AM</td>
<td>200</td>
<td>Abdul, Azim</td>
</tr>
<tr>
<td>1/5/2012 8:00:00 AM</td>
<td>200</td>
<td>Abdul, Azim</td>
</tr>
<tr>
<td>1/6/2012 8:00:00 AM</td>
<td>200</td>
<td>Abdul, Azim</td>
</tr>
<tr>
<td>12/28/2011 3:50:00 PM</td>
<td>200</td>
<td>Akins, Katherine</td>
</tr>
</tbody>
</table>

**B** Patient Search – wanted to know where a patient is scheduled. You can use this to search for pattern/history.

**C** Patient Payment Select – (multiple locations) In process of hiding one of the links.

**D** Facility Employees – allows FOC to place where therapists rank on the schedule. Adjust which therapist primarily treats at the clinic. Rank corresponds with schedule.

**E** Physician Edit – link to edit physician information.
TLC Daily Activity Reports

(A) **Calendar** – the calendar will default to the log in date

(B) **Enter Super bill** – click this link to access the super bill

(C) **Supervision / Cosignatures** – only available for PT / OT log in access

(D) **Schedule** – scheduling access

(E) **View Schedule** – click on schedule link to view therapist schedule for the calendar date selected

The next slides will review the details of super bill entry and the supervision/ co-signatures.
Super bills only require the therapist to enter CPT codes and the documentation to support the codes billed, timed minutes and total time.

Super bills are not complete without:
- Charges AND associated descriptor notes
- OR selection of Reschedule, Cancel or No Show

Super bills will be STAND ALONE documents- requiring separate completion regardless of if an additional document is required.
Daily Activity Reports
Enter Super bill

1. Click **Enter Superbill**
2. Patient’s scheduled for the individual therapist will display on the left side of the page.
3. Patients names will remain in **blue** until a super bill entry is complete.
Daily Activity Reports
Enter Super bill - Eval

Super bill Visit Count will display at the top of the note along with the next scheduled weekly update. *The 9999 year will occur on the first super bill. The system will display the proper date once charges are entered.

In order for the SOC date to trigger – a unit billed is required. A super bill CAN’T be saved without the Time Minutes / Total time in therapy being completed and saved.

Best Practice – Estimate the common time and mark save to allow you to proceed. This will only occur during the evaluation time. Billing at least one unit will trigger the start of care date. Not doing this will prevent you from printing / saving and finalizing the evaluation.

*Required for all patients*
Daily Activity Reports
Enter Super bill - Treatment

On corresponding super bills that follow the evaluation – the super bill will display:
Next Weekly (Date)
Next Cert (Date)

This will serve as a visual reminder daily of the upcoming documents.
Daily Activity Reports
Enter Super bill

(A) Select Treatment, Reschedule, Cancelled or No Show

(B) Select the CPT codes/units billed from the drop down boxes

(C) Enter timed minutes and total minutes and SAVE and codes will display in blue.
Daily Activity Reports
Enter Super bill

(A) Select EACH CPT code. Formatted sentences will load with a variety of skilled statements that can be utilized. Select from the statements, use your own text or a combination of both to complete the daily documentation for each code.

(B) Select Save once the statements are chosen.

(C) Daily note will display beside the CPT code.

Note – Avoid being repetitive with the daily notes.
Selection of “add” under treatment rendered will access:

Various modalities available for selection if necessary for that particular treatment.

E-stim, general, ice/heat, infrared, lonton, paraffin, traction, ultrasound, whirlpool.
The remainder of the super bill allows for treatment rendered as well as free hand entry of subjective, assessment, plan and any additional notes.
Super bills are typically only 1 page.
TLC Supervisions and Co-signatures

(C) – **Supervisions / Co-signature** – Divided into 2 columns – Co-signatures and supervisions. Each will load in the columns

![Supervisions/Cosignatures Schedule]

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**TLC Rehab Inc**

<table>
<thead>
<tr>
<th>Cosignatures</th>
<th>Supervisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leclair, Brittney</td>
<td>4/20/2011 3:50:00 PM</td>
</tr>
<tr>
<td>Little, Chloe</td>
<td>4/15/2011 8:50:00 AM</td>
</tr>
<tr>
<td>Little, Chloe</td>
<td>4/20/2011 8:50:00 AM</td>
</tr>
<tr>
<td>Bookman, Barbara</td>
<td>4/20/2011 8:50:00 AM</td>
</tr>
<tr>
<td>Duffy, Patrick</td>
<td>4/15/2011 8:50:00 AM</td>
</tr>
<tr>
<td>Duffy, Patrick</td>
<td>4/20/2011 8:50:00 AM</td>
</tr>
<tr>
<td>Haskell, Mary</td>
<td>4/15/2011 9:40:00 AM</td>
</tr>
<tr>
<td>Haskell, Mary</td>
<td>4/20/2011 9:40:00 AM</td>
</tr>
<tr>
<td>Richardson, Evelyn</td>
<td>4/21/2011 2:30:00 PM</td>
</tr>
<tr>
<td>Conley, Larry</td>
<td>4/12/2011 1:20:00 PM</td>
</tr>
</tbody>
</table>

![Save Cosignatures]

![Save Supervisions]

**Only available to Physical and Occupational Therapists**
TLC Schedule
Scheduling Patients

- To change disciplines, select from drop down.
- Then select Treatment.
- Select Evaluation, Treatment, Etc.
- Click on patient’s name you wish to schedule.
- Lastly, click in the slot under the therapist you wish to schedule the patient with and the time.
<table>
<thead>
<tr>
<th>Employee:</th>
<th>Arnette, Tonia</th>
<th>Jacobson, Lee</th>
<th>Scott, Aaron</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:10 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:20 am</td>
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<td></td>
<td></td>
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<tr>
<td>7:30 am</td>
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<td>7:40 am</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7:50 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:00 am</td>
<td></td>
<td>Joseph</td>
<td></td>
</tr>
<tr>
<td>8:10 am</td>
<td></td>
<td>Barbara</td>
<td></td>
</tr>
<tr>
<td>8:20 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:40 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:50 am</td>
<td>Hick(w)</td>
<td>John</td>
<td></td>
</tr>
<tr>
<td>9:00 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:10 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:20 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:40 am</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4/15/2011
**TLC Outpatient Caseload**

(A) **Outpatient Caseload** – can toggle between referrals / PT / OT ST and No Gos

(B) **New Referral**

1. Select the **New Referral** link. From this page, the FOC has 2 options.
   a) Select a patient that has received tx prior by using scroll on left. (This list will be cleaned after the full roll out to remove duplicates)
   b) This will load historical data. Once saved, the referral information can be accessed
   c) This will pull prior insurance. FOC will verify if the insurance is the same.
   d) Second Option is to add patient to the database.

2. Referral page – includes required fields for insurance verification

(C) **Referral List** (pending referrals)
TLC Outpatient Caseload

**PT TOGGLE**

(A) To view the PT caseload, change the toggle to PT. All patients will list according to active/discharge status.

(B) Selecting the individual patient accesses the **patient data page**.

The Patient must be marked “approved” by insurance verification to schedule.
TLC Patient Data

This is to serve as a “dash board” for record payment, view payment history, diagnosis codes, as well as print appointment cards and view insurance information.

ICD-9 Codes are edited and added from this screen.

All documents and authors can be viewed here.

Clicking on the date will provide the units billed that day.
JBS Documentation

Document Types

- An evaluation will automatically be initiated for the first date of service.
- Weekly status updates/ Progress notes and recertifications will automatically prompt on date due.
  - Weekly status updates: it is mandatory to complete weekly status updates on all patients, regardless of insurance type- this consists of updating patient status on all goal measurements as well as verifying goal validity. Frequency (EVERY 4th visit or 15 days whichever occurs first)
  - Progress Reports: will be completed following the same guidelines. Frequency (EVERY 8th visit or 30 days whichever occurs first)
  - Recertifications: will be completed following the same guidelines. (Medicare required cert every 60 days)
- Discharge Summary: can only be accessed through the documentation link.
  - NO subsequent documents will be accessible until previous document is completed.
  - NO document date will be allowed AFTER the “due” date- the system does allow for EARLY documents in all cases.
Internet Access
The server will log you out if you are inactive for an extended period of time. (this is an uncontrolled event that may occur)
Please note, if you plan to step away, be sure to save.
If time outs become frequent, IT may need to assess the internet access and signals.

**JBS will also time out if more than one window is open**
There are **TWO methods** to accessing documents

From the **home page** to access cumulative documentation list/all patients documents

1. Documentation
   - Denial Management
   - Electronic Signatures (1)

2. CDC
   - View Last Audit
   - Late Documentation (1062)
   - Late Daily Notes (0)

From the **super bill** page on date document is required
TLC Evaluation

- Once super bill is completed, Select “super bill” to view completed super bill document. This will load in a new window (PDF)
- The clinician will have the option to access directly any required documents for that date
Evaluation – Set up Page

This allows **key information** to be entered **prior** to the evaluation template being loaded. Therapist can **pre document** on a patient.

This allows access to certain portions of the patient prior to the measurement / assessment component.

Charges **must** be entered on the super bill prior to entering any information into the evaluation. If you are not sure what CPT codes you are going to bill prior at least put in the charge for the evaluation in the super bill and save. You can return to the super bill after the evaluation to add your other CPT codes and other necessary information.
## Diagnosis / Onset Date

- The red alerts will not prevent the therapist from moving forward with the evaluation.
- Enter applicable ICD-9 codes into the ICD box and click **save**. The prompts will continue to alert until one is deemed as Medical and all Exception Rules are met for Medicare B’s.
- The Medicare B Exception rules are accounted for here. The system may flag for more than 1 exception code if the ICD-9 is a complexity. (Reminder – to be considered an exception, the patient must have 2 complexities or one condition code on the claim)
- Onset Date – Enter valid date when symptoms began (**It is important that the onset date is no more than 30 days prior to the SOC date**).
- **Med Dx Box** – allows therapist to type in what is on the prescription. This does not tie into the Exception list.

### Diagnosis – the red

(Will resolve once codes are entered)

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Save**

*No valid exception codes have been selected*

*No medical diagnoses have been selected*

**Evaluation Info**

<table>
<thead>
<tr>
<th>Onset Date</th>
<th>Med Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Once codes are entered and saved, they will load in this table.**

<table>
<thead>
<tr>
<th>ICD9 MD? Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

| Remove | 723.4Tx | 4-15-2011 |
| Remove | 728.2Tx | 4-15-2011 |
| Remove | 719.7MD | 4-15-2011 |

**Save**
**Occupation** – Enter the occupation into the text box

**Work Status** – choose from the drop down.

**Subjective / Reason for Referral** - free hand text box. Enter the reason the patient was referred to therapy services. Recommend relating impacted functional loss as well.

**PLOF** – (Prior Level of Function) Drop downs are provided to assist therapist in supporting medical necessity of therapy claim or therapist can free hand their statement. Choices are discipline specific.
First select any check box statements in the precautions, medical history & family goals sections that are applicable, and then make desired additions/edits. If you **do not** select the applicable check boxes prior to typed additions the check box statements will disappear.
**Evaluation – Set up Page**

- **Frequency** – choose from the drop down – (1-7 days per week)

- **Duration** – Enter the Number of weeks / Days in the text box and choose weeks / days from the drop down.

- **Certification** – choose 30 / 60 / 90 / 180. **Medicare Patients Must be recertified every 60 days.**

- **STG Duration / LTG Duration** - Enter the Number of weeks / Days in the text box and choose weeks / days from the drop down.

Select **Save**
Evaluation – Templates

1. Select the evaluation template.
2. Each template will load the most common measures / modules for that particular template.
3. For example – if the **General Evaluation** is selected, the following modules will load (see screen shot below) The boxes checked off indicate they will load on the evaluation.
4. Please note that you may remove modules by unchecking the box.

The ALF based templates are more functional task driven versus the physiological dysfunction driven model for most of the outpatient templates.
Evaluation
Adding Modules & Templates

If the clinician wishes to add an additional module to the evaluation, this can be completed by utilizing the additional module section. Select desired module from the list then select enter.

If the clinician wishes to add a template to the evaluation, this can be completed by selecting the template from the drop down then select enter.

Any Module / Template added will load onto the evaluation for completion.

** Be cautious of the 20 module limit when adding templates **

To clear unused modules – the link is at the bottom of the page. Please note! If you have taken measures, be sure to SAVE them prior to clearing unused modules.
Key Points:

1. For the module to display on the evaluation, the module **MUST** have a measurement taken. A common mistakes includes the therapist documenting in the descriptors only. *The descriptors will not show without a measure.*

2. Common measures for the module will pre-load onto the page as evidenced by the example for Balance.

3. **Each Module is comprised of:**
   1. **Standard measures**
   2. **Additional measures** – list of additional measure available.
   3. **Skilled deficit descriptors**
Evaluation – Module Basics

All modules are “open” with all related measurements open and ready to address upon initially accessing measurement section of a document-

Address **only those areas that are deemed relevant** - any measurement left blank will “suppress” on the printed documents and future documents

The therapist has the option to save measures after each module OR save the data as a whole by utilizing “Next” “Save” or “Save and Exit” at bottom of page- this saves all page info.

Once Saved, measures will appear in this table (screen shot below)
Located at the bottom of the evaluation data entry screen on page one.

Select relevant statements for assessment impression utilizing check boxes, make additions/edits as desired, then select desired save option.

**NEXT (SAVES PAGE):** Accesses second page of data ENTRY
• Plan of care items are discipline specific, and, limited due to future denial management growth with restriction of billing to POC items- to add items that are NOT listed (non billable/ and/ or alternate terminology) please utilize “additional POC items”
• If you intend to utilize group therapy with this patient you must ✓ group and provide detailed information as specified on the page in red.
• When all POC items are checked and additional POC items are provided select SAVE POC.

POC items are limited to CPT codes.
Example ~ MHP – we do not bill for this code, so it must be entered in additional POC items.

Example: 3x week x 15 minutes (not to exceed 15 minutes per patient)
Utilize **other notes** section for documentation of additional information as needed. Save item via utilization of “Save Other Notes”.

### Other Notes

Type in Additional notes here - click SAVE OTHER NOTES when complete.

### Measurement

<table>
<thead>
<tr>
<th>Notes</th>
<th>STG</th>
<th>LTG</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance: Dyn Stand (fair)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamic Standing Balance fair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance: s/stand: fair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static standing balance: fair</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Save Goals**

You may not sign a document without a saved plan of care.
Goal Basics

1. The **measurements** will list on the left hand side and will individually list from the modules addressed on page 1.

2. The **measurements taken** will load in the middle box. Always double check for accuracy to ensure you have correct measures and that they are objective if you plan to set a goal for them.

3. The box to the far right gives you the option to set a **STG, LTG** only or to set **both**.
   - You may select them individually or run through all the measures and select applicable areas to address all of the goals at one time.

Only select the areas you wish to establish goals for!!
1. Once goals are selected, complete the goal components utilizing the drop down boxes.
2. The baseline is listed at the end of each goal for easy reference.
3. Save Goals – the * will denote the area has saved.
How to Remove Goals:

1. To remove a goal, you must first go ahead and set and save the goal to access the remove option.
2. Choose from the drop down **REMOVE** and then **Save Goals**.
3. This will remove the goal from the list.

<table>
<thead>
<tr>
<th>Measurement</th>
<th>STG</th>
<th>LTG</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance: Dyn Stand (fair)</td>
<td>Dynamic Standing Balance fair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance: s/stand: fair</td>
<td>Static standing balance: fair</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LTG 1. Balance: s/stand: fair</strong></td>
<td>Patient's static standing balance will be improved to, to impact, (Static standing balance: fair)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. The STG / LTG link will appear in the table allowing you to access the goal again for completion.

Additional Note!!!
Some measures do not have a template goal set up in JBS. This is a focus area. If any errors are noted with the flow of the goal, please contact the programming office for immediate correction.
1. Double check the frequency for accuracy
2. Enter your employee code and sign – this will allow the view document link to load.
3. Previous (saves page) – allows access to the first page of the document
4. View Document – once electronically signed, you may click here to view the document (will load in PDF in a new window)
5. Save Page – functions as master save
6. Save and Exit – saves and exits the document. You are directed back to the documentation list.
7. Exit – exits the page and directs you back to the documentation list.
8. Screen – this feature is applicable for ALF facilities
Sample Evaluation

Page 1
This particular evaluation is only 2 pages, however they can be more depending on the amount of content.
Electronic Validation of Signatures

A message has been sent to the author of this document requesting that they validate these changes.

If the individual logged in is **NOT** the individual whose e code is entered for signature, a message that will be sent to the signee.

The document must be validated before subsequent documents can be accessed and/or **“electronic signature”** will display on the document.
1. To access the early link – click on the documentation link from the home page. The screen above will load and the Early link is visible beside the document.

2. Following the evaluation, the clinician has the option to do any document type early- this allows for completion with the date to reflect with a date OTHER than the due date. To complete a document early, first, select the “early” link next to the document due date.
The clinician will have the option to complete documents including progress notes and recerts for any date AFTER the date of the last completed document.

Discharge summaries usually prompt for the day after the last treatment, however you can complete them on the last day of treatment if you wish with this feature.

Select document type and date for completion, then create.

Your document will then load with the selected date.
1. As previously noted, **weekly status updates** will be required every 4th visit or 15 days whichever occurs first. This will **minimally require** documentation reflecting the measurements for goal areas. These are due for all payer types.

2. **Progress Reports** are required every 8th visits or 30 days whichever occurs first. This is required for ONLY Medicare Patients.

Other key points-

- Only measurements completed on the evaluation will be displayed in the weekly update / PN if you wish to add additional measure area, add module or utilize additional measures as required.
- It is **required** that all measurements for goal areas be completed
- Any measurement area that is not completed will not be carried over to subsequent documents
1. The Weekly Update / Progress Report can be accessed through the documentation link or on the super bill that corresponds with a day of treatment.

2. On the Weekly update & PN required (goal) measures are shaded yellow for visual reminders. Complete ALL measures by completing the measurement template that is pre-loaded. Measures not required will suppress once saved.

3. Once the measure is saved, it will load in the table beneath current measurement.

To the right of the measurement, the previous recorded status will display in parenthesis.
Weekly Updates/Progress Reports

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Current Measurement</th>
<th>Current Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Gait: Assist/distance</td>
<td>Remove Ambulates 100 feet requiring minimal assist.</td>
<td></td>
</tr>
</tbody>
</table>

***NOTE***

Goal info and yellow highlighting suppress once the measurement is completed & saved.
Weekly Updates/Progress Reports

Deficit descriptors and treatment strategies are **NOT Required for the Weekly UPDATES.**

Completion is **required** for the progress report. Complete Deficits and Treatment Strategies for GOAL AREAS to support the medical necessity of services provided.
Weekly Updates/Progress Reports

Subjective Data

- Increased pain
- Decreased pain
- Constant pain
- No new c/o
- C/o of dizziness
- Sore

Assessment Data

- Progressing
- Increased function
- Decreased function

Plan

- Continue POC
- Upgrade
- Change in plan
- Potential to improve
- D/c planning

Note:
All areas can be completed by utilizing check boxes, free hand, or a combination. Please make all check box selections prior to editing information.

Select desired save option to complete first page of documentation.
### Weekly Updates/Progress Reports

#### Plan of Care

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ PT Eval</td>
<td>Ther Ex</td>
</tr>
<tr>
<td>☐ Orthotic Training</td>
<td>WC Management</td>
</tr>
<tr>
<td>☐ Paraffin Bath</td>
<td>Whirlpool/Hydrotherapy</td>
</tr>
<tr>
<td>☐ Rmvl Devtal Tis (&gt;20CM²)</td>
<td>Estim, wound care III / IV</td>
</tr>
<tr>
<td>☐ Iontophoresis</td>
<td>TENS</td>
</tr>
<tr>
<td>☐ Aquatic Therapy</td>
<td>Pneumatic Compression</td>
</tr>
<tr>
<td>☐ Rmvl Devtal Tis (≤20CM²)</td>
<td>Estim, wound care</td>
</tr>
<tr>
<td>☐ Group (Frequency and Duration)</td>
<td>Gait Training</td>
</tr>
<tr>
<td>☐ Manual Therapy</td>
<td>Self Care / ADL</td>
</tr>
<tr>
<td>☐ Prosthetic</td>
<td>Mechanical Traction</td>
</tr>
<tr>
<td>☐ E-Stim (unattended)</td>
<td>Biofeedback</td>
</tr>
<tr>
<td>☐ Anodyne</td>
<td>Community/Work Reint</td>
</tr>
<tr>
<td>☐ Physical Performance Testing</td>
<td>Biofeedback training</td>
</tr>
</tbody>
</table>

*Example: 3x week x 15 minutes (not to exceed 15 minutes per patient)*

**Group Plan of Care to Impact:** Document how the group will improve individualized skills & function.

**Additional POC Items**

![Save POC](star)

Functions identical to that in evaluation— with the exception that no POC items can be removed from previous documents.
Weekly Updates/Progress Reports

All completed measurements will display within grid view. If a goal is not associated with the measure, the user will have the option to add STG/ LTG/ Both as on the Evaluation.

- Status documented for the goal areas will be visible in parenthesis next to goal.

Document additional areas needed in this section.
Weekly Updates/Progress Reports

Select appropriate goal status- Continue, Met, or Discharge

Please be sure you are playing close attention the current measurement in parenthesis and if the patient has met the stated goal that you select met. It is important that we do not continue goals that are actually met.

PLEASE NOTE-
Any goal indicated as met or discharged will no longer be visible nor listed on future documents.
1. Double check the frequency for accuracy
2. Check weekly Update box if you are completing a weekly update (keep in mind this is the only way to signify a weekly update).
3. Enter your employee code and sign – this will allow the view document link to load.
4. Previous (saves page) – allows access to the first page of the document
5. View Document – once electronically signed, you may click here to view the document (will load in PDF in a new window)
6. Save Page – functions as master save
7. Save and Exit – saves and exits the document. You are directed back to the documentation list.
8. Exit – exits the page and directs you back to the documentation list.
<table>
<thead>
<tr>
<th>Goal</th>
<th>Term</th>
<th>Initial</th>
<th>Previous</th>
<th>Current</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patte will present with an increase in left AROM knee flexion to 100° to impact task</td>
<td>STG</td>
<td>Right 104 degrees left 90 degrees</td>
<td>Right 112 degrees left 90 degrees</td>
<td>Right 112 degrees left 90 degrees</td>
<td>Cost</td>
</tr>
<tr>
<td>1. Patte will present with an increase in bilateral AROM knee flexion to 120° to impact task</td>
<td>LTG</td>
<td>Right 104 degrees left 90 degrees</td>
<td>Right 112 degrees left 90 degrees</td>
<td>Right 112 degrees left 90 degrees</td>
<td>Cost</td>
</tr>
<tr>
<td>2. Patte will complete timed up and go in 15 seconds indicating improved quality of ability to impact risk of fall</td>
<td>STG</td>
<td>Timed up and Go: 19 sec</td>
<td>Timed up and Go: 17</td>
<td>Timed up and Go: 17</td>
<td>Cost</td>
</tr>
<tr>
<td>2. Patte will complete timed up and go in 10 seconds indicating improved quality of ability to impact risk of fall</td>
<td>LTG</td>
<td>Timed up and Go: 19 sec</td>
<td>Timed up and Go: 17</td>
<td>Timed up and Go: 17</td>
<td>Cost</td>
</tr>
<tr>
<td>3. Patte will increase gait quality to take to increase gait mobility</td>
<td>STG</td>
<td>Gait quality: Tall Amb with SPC, Excessive knee extension during (9) and (8) stance phase, Decreased cadence, Abnormal offload and heel strike, Decreased (8) stride length</td>
<td>Gait quality: Tall Amb with SPC, Excessive knee extension during (9) and (8) stance phase, Decreased cadence, Abnormal offload and heel strike, Decreased (8) stride length</td>
<td>Gait quality: Tall Amb with SPC, Excessive knee extension during (9) and (8) stance phase, Decreased cadence, Abnormal offload and heel strike, Decreased (8) stride length</td>
<td>Cost</td>
</tr>
<tr>
<td>3. Patte will increase gait quality to go to increase gait mobility</td>
<td>LTG</td>
<td>Gait quality: Tall Amb with SPC, Excessive knee extension during (9) and (8) stance phase, Decreased cadence, Abnormal offload and heel strike, Decreased (8) stride length</td>
<td>Gait quality: Tall Amb with SPC, Excessive knee extension during (9) and (8) stance phase, Decreased cadence, Abnormal offload and heel strike, Decreased (8) stride length</td>
<td>Gait quality: Tall Amb with SPC, Excessive knee extension during (9) and (8) stance phase, Decreased cadence, Abnormal offload and heel strike, Decreased (8) stride length</td>
<td>Cost</td>
</tr>
<tr>
<td>4. Patte will demonstrate an increase in bilateral knee flexion to 90° to impact knee control</td>
<td>STG</td>
<td>Right 3+5 Left 3+5</td>
<td>Right 3+5 Left 3+5</td>
<td>Right 3+5 Left 3+5</td>
<td>Cost</td>
</tr>
<tr>
<td>4. Patte will demonstrate an increase in bilateral knee flexion to 90° to impact knee control</td>
<td>LTG</td>
<td>Right 3+5 Left 3+5</td>
<td>Right 3+5 Left 3+5</td>
<td>Right 3+5 Left 3+5</td>
<td>Cost</td>
</tr>
</tbody>
</table>
Sample Progress Report

Page 2
Nature Coast Orthopaedic

PT Weekly Update

05/03/2012

Insurance Number

Insurance Name

Referred By

DOB

SIC Date

Onset Date

Report Period

T51.2- Abnormality of gait, left ankle weakness

ICD10: D57.0-Joint involucrosis, knee, T851.2-

Medical Dr

(T) TKA

Visit Number

Goal Status

Goal

Terminus

Initial

Previous

Current

Goal Status

1. Pat will present with an increase in bilateral ROM knee flexion to 120 degrees.

Goal Status

2. Pat will complete timed up and go in 10 seconds indicating improved quality of ability to impact the task.

Goal Status

3. Pat will tolerate gait quality to good gait tolerance.

Goal Status

4. Pat will demonstrate an increase in bilateral knee extension to 45 degrees to impact the task.

Goal

Goal

Goal

Goal

Goal

Goal

Goal

Goal

Goal

Goal

Goal

LE ROM by Joint

LE Strength Joint

Special Tests

New Goals

Subjective

Pat states that the knee hurts on the outside of the back when he tries to bend it forward. He would rate the pain at 4/10 when it occurs.

Attachment

Progress demonstrating progress with increased strength and flexibility.
**PT Weekly Update**

**Nature Coast Orthopedic**

2155 W Mustang Rd
Belleview, Hills, Florida 34465

02/03/2012

**Insurance Information**

- **Insurance Number**: [Redacted]
- **Insurance Name**: Medicare
- **Referral By**: [Redacted]

**Medical Diagnosis**

- (B) TKA

**Report Period**

2/1/2012 - 2/7/2012

**ICD Code**

- J43.65 - Joint Rep Boemert Knee 791.2 - Abnormality of gait 725.87 - Muscle weakness

**Plan of Care**

- Goal: To continue with ICR and progress to partial weight-bearing.
- Potential for Improvement: The patient's condition shows potential for improvement.

**Plan of Care**

- **PT Goal**
  - Ultrasound
  - Ther Ed
  - Nerve Reflex Ed
  - Gait Training
  - Manual Therapy
  - Group Therapy
  - Exercisb Activities
  - Home Ed, Patient Education

**Signed**

[Redacted]  

Electronically Signed
To add ICD-9 codes to claim, enter data into field. If diagnosis should be indicated as Medical code, select check box, then select save.

The code will be verified for validity.

Once added, the code along with if is a medical diagnosis and effective date will display. Repeat process to add additional codes to claim.
Recertifications

This section assists in establishing medical necessity for continuation of services.

Creates a template statement Patient would benefit from continued therapy services including SELECTED THERAPY AREAS to impact potential for SELECTED TREATMENT AREAS
Recertifications

- Complete Goal durations / Work status and Precautions (as with the evaluation)
- Frequency / Duration complete (I.E. 3x wk x ____weeks / Days)
- Enter Recertifying employee code and Save Recert

Please note: completion of a recert will generate a recertification and a progress note- it is possible to have 2 distinct authors- be sure the recertifying therapist employee code is entered. If the same therapist is completing the entire form, complete the code in both places. (as above and at the bottom, page 2)
Recertifications

All remaining RECERTIFICATION areas are identical to that of the PROGRESS NOTE- please refer to progress note section if information is needed.

Assessments and Impressions section will be mandatory on both the evaluation & recertification!!
Nature Coast Orthopaedic

PT Recertification: Nature Coast Orthopaedic - Physical, Occupational & Speech Therapy

Nature Coast Orthopaedic
2155 W. Mustang Rd
Bay Hill, FL 34460

DOB: 12/22/2011

Onset Date: 12/15/11

COD: 840.0 - Sprain or Strain Localized to Left Shoulder Joint - Painful - Bilateral - Shoulder Weakness

Work Status: Retired

Occupation: LTG

STG(0)

1. Patient will present with an increase in Right shoulder tension strength to 4/5, impact ability to perform ADLs and IADLs
2. Patient will report a decrease in maximal pain localized (RU) shoulder and upper arm to 1/10, to impact daily task performance
3. Patient will present with an increase in Right shoulder abduction strength to 3+5/6, impact functional reach
4. Patient will present with an increase in Right AROM shoulder abduction to 115° impact lateral reach.
5. Patient will present with an increase in Bilateral AROM cervical ROM rotation (in degrees) to 65°, impact ability to scan the environment.
6. Patient will present with an increase in Right AROM shoulder ER to 80°, impact biomechanics of shoulder motion.
7. Patient will present with an increase in Right AROM knee ROM (in degrees) 110° to 120° impact gait and transfers
8. Patient will increase gait quality to able to increase gait safety

Problem List:

- Functional deficit related to dysfunction
- Cervical ROM rotation (in degrees)
- Cervical rotation (in degrees)
- Upper extremity
- Knee ROM (in degrees)
- Max Flex
- Max Ext
- Shoulder Abduction
- Shoulder ER
- STRENGTH: Shoulder Flexion
- STRENGTH: Shoulder Abduction

Plan of Care:

- PT Bahn
- THERAPY
- NEURO REHAB
- RT
- Education

Certification Period: 2/2/2012 - 4/1/2012

Therapist: Electronically signed

FREQ/ Durm: 3x/wk x 6 weeks

Page 1 of 4
**Sample Recertification**

<table>
<thead>
<tr>
<th>Goal Status</th>
<th>Term</th>
<th>Initial</th>
<th>Current</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Patient will present with an increase in Right shoulder flexion strength to 4+5 to impact ability to perform ADLs and IADLs</td>
<td>STG (6D)</td>
<td>Right 35 Left 4+5</td>
<td>Right 35 Left</td>
<td>Cосте</td>
</tr>
<tr>
<td>Assessment / Impression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Patient is unable to perform activities of daily living due to pain and limited function.
- Patient has difficulty with transfers and reaching.
- Patient has difficulty with balance and gait.
- Patient has difficulty with ADLs (activities of daily living).
- Patient has difficulty with ROM (range of motion).

**Recommendations for Improvement:**

- Patient should continue with physical therapy to improve strength and range of motion.
- Patient should continue with pain management strategies.
- Patient should continue with ADLs and ROM exercises.

**Potential for Improvement:**

The patient's condition has potential for improvement with continued therapy and management of pain.
Sample

Recertification

[Text that appears to be a table or some form of data is partially visible, but the content is not clear due to the image quality.]

Page 4
TLC Documentation
Discharge Summary

How to set the DC date

1. From the Home page – Under the Caseload section – use the toggle to choose PT / OT or ST Caseload
2. Click on the patient's name in which you want to set the DC date for.
3. Click Set DC Date – the date will change for the day after the last treatment. This will trigger the DC document.
Discharge Summary

How to access the DC summary once the DC date is set –

1. Select the Documentation link
2. Select the appropriate month and discipline.
3. The discharged patient will fall under Discharged Patients and the DC date will prompt.

Please note! If a progress note is Loading and the DC summary will Not load, please contact your CDS for instructions.
**Discharge Summary**

<table>
<thead>
<tr>
<th>Reason (A)</th>
<th>Precautions (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Document relevant data related to the reason for discharge/discharge situation.</td>
<td>- Document relevant data related to precautions that are still in force at time of discharge.</td>
</tr>
</tbody>
</table>

(A) **DISCHARGE REASON** - Document relevant data related to the reason for discharge/discharge situation.

(B) **DISCHARGE PRECAUTIONS** - Document relevant data related to precautions that are still in force at time of discharge.

*Save Discharge Information*
**Discharge Summary**

### Subjective Data

- Complete subjective data applicable - **Save**
- Increased pain
- Decreased pain
- Pain constant
- Pain unchanged
- Act. exacerb/c pain
- < bal and safety
- No new c/o
- c/o of dizziness
- Sore

### Assessment Data

- Provide assessment data, use check boxes, text or combo - **Save**
- progressing
- Increased function
- Decreased pain
- Tx/s effects
- Good potential
- Upgrade
- Dec. pain

### Assessments/Impressions

- Include the status – DC goals met, no residual problems - **Save**
- DC goals met
- DC - no residual problems

**Next (Saves Page)  Save  Save & Exit  Exit  Clear Unused Modules**
Discharge Summary

The primary components of the discharge summary follow the same process as the progress reports and weekly updates.

**Please note** – if a patient has received treatment from the previous progress report date to the d/c date, then the deficits / treatment strategies are required to support the skilled therapy.

*The goals section is the only area that differs from other forms (regarding data entry)*

Goals must be marked as 0% / 50% / 75% / 90% - MET
Once all goals are addressed – select **Save** goals and sign the note

![STG 10a. STRENGTH: Hip Adduction](image)
Sample Discharge Summary

<table>
<thead>
<tr>
<th>Goal</th>
<th>Term</th>
<th>Initial Status</th>
<th>Current Status</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient will report a decrease in maximal pain localized across the low back to 0 or 10 to impact tolerance of daily task performance.</td>
<td>LTG</td>
<td>Level 7 of 10 Location: across the low back</td>
<td>Level 1 of 10 Location:</td>
<td>Met</td>
</tr>
<tr>
<td>2. Patient will report a decrease in maximal pain localized across the low back to 0 or 10 to impact tolerance of daily task performance.</td>
<td>STG</td>
<td>Level 7 of 10 Location: across the low back</td>
<td>Level 1 of 10 Location:</td>
<td>Met</td>
</tr>
<tr>
<td>3. Patient will present with an increase in bilateral hip extension strength to 5/6 to impact stability and decreased stress patters to the spine with ADLs.</td>
<td>LTG</td>
<td>Pain localized to the sacrum</td>
<td>Pain localized to the sacrum</td>
<td>Met</td>
</tr>
<tr>
<td>4. Patient will report an increase in hours slept. Patient will no longer be awakened by pain &amp; will wake more related to joint pain.</td>
<td>LTG</td>
<td>Pain affecting sleep: yes</td>
<td>Pain affecting sleep:</td>
<td>Met</td>
</tr>
<tr>
<td>5. Patient will present with an increase in bilateral hip flexion strength to 5/6 to impact stability and decreased stress patters to the spine with ADLs.</td>
<td>LTG</td>
<td>Right 4/5 Left 4/5</td>
<td>Right 4/5 Left 5/5</td>
<td>Met</td>
</tr>
</tbody>
</table>
### PT Discharge Summary

**Date:** 03/08/2012

**Medical Dr:** [Redacted]

**Referral By:** [Redacted]

**Insurance Name:** Medicare

**Insurance Number:** [Redacted]

**DOB:** [Redacted]

**SOC Date:** 12/20/11

<table>
<thead>
<tr>
<th>Goal</th>
<th>STG</th>
<th>Observation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gait to present with equal sacral alignment and symmetrical gait patterns with ADL’s.</td>
<td>STG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taft to present with equal balance and to maintain S1 stress pain patterns with ADL’s.</td>
<td>STG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STG</th>
<th>Objective Measurements</th>
</tr>
</thead>
</table>

**Objective Measurements**

- **STRENGTH:** Hip Abduction
  - Right: 50 Left: 50
  - Low: 10 of 10 Location:

- **ASIS:**
  - Left: 10 of 10
  - Hind: 10 of 10

  **Pain:**
  - Left: 10 of 10

- **Pain Level:**
  - Hip: 10 of 10
  - Lower Extremity: 10 of 10

- **STRENGTH:** Hip Extension
  - Right: 50 Left: 50

- **STRENGTH:** Hip Flexion
  - Right: 50

- **STRENGTH:** Hip Adduction
  - Right: 50 Left: 50

- **Functional Assessment/Interventions**

  **STRENGTH:** Hip Extension

  - Pt. gains functional LLE strength and functional stability.

  **Pain:**

  - Knee: 0/10

  - Hip: 0/10

  - Lower Extremity: 0/10

  **Objective:**

  - Hip abduction: 50/50

  - Knee extension: 50/50

  - Ankle plantarflexion: 50/50

  **Functional Assessment/Interventions**

  **Objective:**

  - Hip abduction: 50/50

  - Knee extension: 50/50

  - Ankle plantarflexion: 50/50

**Patient Discharged with all goals met, with a HEP with a handout.**

**Subjective**

Pt. has return to an active lifestyle withptoms and mild pain, but less shortness when occurs.

**Assessment**

Pt. has return to an active lifestyle, and is seen with a HEP with a handout.

### Thank you for referring the patient to TLC Rehab and Aquatics.

*If you have any questions regarding the treatment plan, please contact me.*

**Signature**

**Electronically Signed**
If you have any problems printing or view documents. Your computer may not have the updated PDF version.

Submit an IT ticket to resolve the issue.
Some Paper Documentation Still Being Used by TLC Clinics

1. Script
2. Health History Questionnaire
3. Insurance Verification
4. Exercise Flow Sheet
5. Berg Balance Test
6. Tinetti Assessment Tool
7. Foot Evaluation Form (used with the Semmes-Weinstein Monofilament)
8. Hand Evaluation Form (used with the Semmes-Weinstein Monofilament)

***Please see following slides for sample documents***
PRESCRIPTION AND PLAN OF CARE

PT / OT / ST EVALUATE & TREAT

Date of Onset: __________

Patient’s Name: ____________________________
Physician’s Name: ____________________________
Certification Period From: __________
To: __________

Diagnosis: ____________________________

Frequency: ____________________________

☐ Anodyne Infrared Therapy
☐ Biostimulation
☐ Electrical Stimulation
☐ Iontophoresis
☐ Splinting
☐ TENS
☐ Therapeutic Exercise
☐ Ultrasound

☐ Neck/Back
☐ Pre/Post Orthopaedic Surgery
☐ Sport Injury
☐ Hand Therapy

☐ Balance / Falls
☐ Cardiac Program
☐ Pediatrics
☐ RSD/Pain Mgmt
☐ TMJ
☐ Vestibular
☐ Wound Care
☐ Incontinence

COMMENTS:

I certify that I have examined the patient and therapy is necessary and that service will be furnished under my care, and that the plan is established and will be reviewed every 60 days, or more often if the patient’s condition requires.

Physician’s Signature: ____________________________

Date: ____________________________
Clinicians can access important information needed to structure plan for treatment.
Insurance Verification

Any important information will be listed in the open space under the “Estimated Co-pay” section such as Pre-Cert after Eval, only bill the following codes, PT must co-sign, etc.

<table>
<thead>
<tr>
<th>TLC Rehab Inc. Medicare and Private Insurance Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C16</strong></td>
</tr>
<tr>
<td><strong>Patient Name</strong></td>
</tr>
<tr>
<td><strong>Discipline</strong></td>
</tr>
<tr>
<td><strong>Insurance Name</strong></td>
</tr>
<tr>
<td><strong>Date</strong></td>
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<tr>
<td><strong>Provider Number</strong></td>
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<td><strong>Phone</strong></td>
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<tr>
<td><strong>Group #</strong></td>
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<tr>
<td><strong>Max Coverage</strong></td>
</tr>
<tr>
<td><strong>$0.00</strong></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
</tr>
<tr>
<td><strong>Out of Pocket</strong></td>
</tr>
<tr>
<td><strong>Present/Required</strong></td>
</tr>
<tr>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Present Phone</strong></td>
</tr>
<tr>
<td><strong>Present Certified</strong></td>
</tr>
<tr>
<td><strong>Co-Pay Certified</strong></td>
</tr>
<tr>
<td><strong>Auth Required</strong></td>
</tr>
<tr>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Continued Auth Req</strong></td>
</tr>
<tr>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Auth #</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>Preexisting Waived</strong></td>
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<tr>
<td><strong>Max Visits</strong></td>
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<tr>
<td><strong>4</strong></td>
</tr>
<tr>
<td><strong>Previous PT/OT/ST?</strong></td>
</tr>
<tr>
<td><strong>False</strong></td>
</tr>
<tr>
<td><strong>Insurance Person</strong></td>
</tr>
<tr>
<td><strong>Health Plan</strong></td>
</tr>
<tr>
<td><strong>Decision Left</strong></td>
</tr>
<tr>
<td><strong>MC# HMO</strong></td>
</tr>
<tr>
<td><strong>MC#</strong></td>
</tr>
<tr>
<td><strong>Previous MC#</strong></td>
</tr>
<tr>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Estimated Co-pay</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please sign below indicating to the best of your knowledge, the above information concerning your insurance benefits are correct, and you agree to compensate TLC Rehab, Inc. for any services they provided based on this information that are not reimbursed by your insurance company. If a refund is due to you, once we have seen that your last claim has been paid by your insurance carrier, we will process your refund. This process typically takes four weeks.

<table>
<thead>
<tr>
<th>Patient’s Signature</th>
<th>FOM Signature</th>
<th>Evaluating/Treating Therapist Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
<td><strong>Date</strong></td>
<td><strong>Date</strong></td>
</tr>
</tbody>
</table>
Exercise Flow Sheet

Used to record daily exercises to promote communication between therapy staff.
## BERG BALANCE TEST

<table>
<thead>
<tr>
<th>Name:</th>
<th>Initial Test Date:</th>
<th>Interim Test Date:</th>
<th>Discharge Test Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Initial</th>
<th>Interim</th>
<th>Discharge</th>
</tr>
</thead>
</table>

### 1. Sitting to Standing

Instructions: Please stand up. Try not to use your hands for support.

- 4. Able to stand without using hands and stabilize independently
- 3. Able to stand independently using hands.
- 2. Able to stand using hands after several tries.
- 1. Needs minimal aid to stand or stabilize.
- 0. Needs moderate or maximal assistance to stand.

### 2. Standing Unsupported

Instructions: Please stand for two minutes without holding...

- 4. Able to stand safely 2 minutes.
- 3. Able to stand 2 minutes with supervision.
- 2. Able to stand 30 seconds unsupported.
- 1. Needs several tries to stand 30 seconds unsupported.
- 0. Unable to stand 30 seconds unassisted

### 3. Sitting with Back Unsupported but Feet Supported

on Floor or on a Stool.

Instructions: Please sit with arms folded for 2 minutes.

- 4. Able to sit safely and securely for 2 minutes.
- 3. Able to sit 2 minutes under supervision.
- 2. Able to sit 30 Seconds.
- 1. Able to sit 10 seconds.
- 0. Unable to sit without support for 10 seconds.

### 4. Standing to Sitting

Instructions: Please sit down.

- 4. Sits safely with minimal use of hands.
- 3. Controls descent by using hands.
- 2. Uses back of legs against chair to control descent.
- 1. Sits independently but has uncontrolled descent.
- 0. Needs assistance to sit.

### 5. Transfer

Instructions: Arrange Chair(s) for a pivot transfer. Ask subject to transfer one way toward a seat with armrests and one way toward a seat without armrests. You may use two chairs (one with and one without armrests) or a bed and a chair.

- 4. Able to transfer safely with minor use of hands.
- 3. Able to transfer with definite use of hands.
- 2. Able to transfer safely with verbal cueing and/or supervision.
- 1. Needs one person to assist.
- 0. Needs two people to assist of supervise to be safe.
Berg Balance Test

6. Standing Unsupported with Eyes Closed
   Instructions: Please close your eyes and stand still for 10 seconds
   4. Able to stand 10 seconds safely.
   3. Able to stand 10 seconds with supervision.
   2. Able to stand 9 Seconds.
   1. Unable to keep eyes closed 3 seconds but stays steady.
   0. Needs help to keep from falling.

7. Standing Unsupported with Feet Together
   Instructions: Place your feet close together and stand without holding.
   4. Able to place feet together independently and stand 1 minute safely.
   3. Able to place feet together independently and stand 1 minute with supervision.
   2. Able to place feet together independently but unable to hold for 30 seconds.
   1. Needs help to attain position but able to stand 15 seconds feet together
   0. Needs help to attain position and unable to hold for 15 seconds.

8. Reaching Forward with Outstretched Arm While Standing.
   Instructions: Lift arm to 90 degrees. Stretch out your fingers and reach forward as far as
   you can. (Examiner places a ruler at end of finger tips when arm is at 90 degrees. Fingers
   should not touch the ruler while reaching forward. The recorded measure is the distance
   forward that the fingers reach while the subject is in the most forward lean position. When
   possible, ask the subject to used both arms when reaching to avoid rotation of the trunk.)
   4. Can reach forward confidently > 25cm. (10 inches.)
   3. Can reach forward > 13 cm. (5 inches.)
   2. Can reach forward = 5cm. (2 inches)
   1. Reaches forward but needs supervision.
   0. Loses balance while trying/requires external support.

9. Pick Up Object from the Floor from a Standing Position
   Instructions: Pick up the shoe/slipper while it is in front of your feet.
   4. Able to pick up slipper safely and easily.
   3. Able to pick up slipper but needs supervision.
   2. Unable to pick up but reaches 2-5 cm. (1-2 inches) from the slipper and keeps balance
      independently.
   1. Unable to pick up and needs supervision while trying.
   0. Unable to try/needs assistance to keep from losing balance of falling.

10. Turning to Look Behind Over Left and Right Shoulders While Standing.
    Instructions: Turn to look directly behind you over/forward left shoulder. Repeat to the right.
    Examiner may pick up an object to look at directly behind the subject to encourage a better
    twist turn.
    4. Look behind from both sides and weight shifts well.
    3. Looks behind one side only, other side shows less weight shift.
    2. Turns sideways only, but maintains balance.
    1. Needs supervision when turning.
    0. Needs assistance to keep from losing balance or falling.

11. Turn 360 Degrees
    Instructions: Turn completely around in a full circle. Pause. Then turn a full circle in the
    other direction.
    4. Able to turn 360 Degrees safely in 4 seconds or less.
    3. Able to turn 360 degrees safely one side only in 4 seconds or less.
    2. Able to turn 360 degrees safely but slowly.
    1. Needs close supervision or verbal cuing.
    0. Needs assistance while turning.
Berg Balance Test

12. Placing Alternate Foot on a Step or Stool While Standing Unsupported
   Instructions: Place each foot alternately on the step/stool. Continue until each foot has
   touched the step/stool 4 times.
   4. Able to stand independently and safely complete 8 steps in 20 seconds.
   3. Able to stand independently and complete 8 steps >20 seconds.
   2. Able to complete 4 steps without aid, with supervision.
   1. Able to complete >2 steps, needs minimal assistance.
   0. Needs Assistance to keep from falling/unable to try.

13. Standing Unsupported one Foot in Front
   Instructions: Place one foot directly in front of the other. If you feel that you cannot place
   your foot directly in front, try to step far enough ahead that the heel of your forward foot is
   ahead of the toes of the other foot. (To score 3 points, the length of the step should exceed
   the length of the other foot and the width of the stance should approximate the subject's
   normal stride width.)
   4. Able to place foot tandem independently and hold 30 seconds.
   3. Able to place foot ahead of other independently and hold 30 seconds.
   2. Able to take small step independently and hold 30 seconds.
   1. Needs help to step but can hold 15 seconds.
   0. Loses balance when stepping or standing.

14. Standing on One Leg
   Instructions: Stand on one leg as long as you can without holding.
   4. Able to lift leg independently and hold > 10 seconds.
   3. Able to lift leg independently and hold 5-10 seconds.
   2. Able to lift leg independently and hold = or > 3 seconds.
   1. Tried to lift leg, unable to hold 3 seconds but remains standing independently.
   0. Unable to try or needs assistance to prevent fall.

BERG BALANCE TEST SCORE

<table>
<thead>
<tr>
<th>Initial</th>
<th>Interim</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Score:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 37</td>
<td>High Risk for fall</td>
<td></td>
</tr>
<tr>
<td>37-41</td>
<td>Moderate risk for fall</td>
<td></td>
</tr>
<tr>
<td>41-50</td>
<td>Minimum risk for fall</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Maximum Score</td>
<td></td>
</tr>
</tbody>
</table>

Therapist Signature: ____________________
### Tinetti Assessment Tool

**Physical, Occupational & Speech Therapy**

**Balance Tests Initial Instructions:** Subject is seated in chair, arms in place. The following maneuvers are tested.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Score</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting Balance</td>
<td>0 = Leans or slides in chair</td>
<td>1 =idy, stable</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Arises</td>
<td>0 = Unable without help</td>
<td>1 = able, uses arms to help</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Attempts to Rise</td>
<td>0 = Unable without help</td>
<td>1 = Able, requires 1 attempt</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Immediate Standing Balance (first five seconds)</td>
<td>0 = Unsteady (swatgers, moves feet, trunk sway)</td>
<td>1 = Steady but uses walker or other support</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Standing Balance</td>
<td>0 = Unsteady</td>
<td>1 = Steady but wide stance (medial heels &gt; 4 in. apart) and uses cane or other support</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Nudge (subject at max. position with feet as close together as possible, examiner pushes lightly on subject with palm of hand 3 ft)</td>
<td>0 = Begin to fall</td>
<td>1 = Stagger, grasps, catches self</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Eyes Closed (at maximum position No. 6)</td>
<td>0 = Unsteady</td>
<td>1 = Steady</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Turning 360 degrees</td>
<td>0 = Discontinuous steps</td>
<td>1 = Continuous steps</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Sitting Down</td>
<td>0 = Unsteady (grabs, stagers)</td>
<td>1 = Stagers</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Balance Score:** /16

| Gait Tests Initial instructions: Subject stands with examiner, walks down hallway or across room, first at "usual" pace, then back at "fast" or "slow" pace using usual walking aids (Note: rate slower whichever subject does worse on.) |
|---|---|
| 10 | Initiation of Gait (immediately after told to "go") | 0 = Any hesitation or multiple attempts to start |
| 11 | 2 | 3 |
| 11 | Step Length and Height | 0 = Does not pass right stance foot |
| 13 | 2 | 3 |
| 12 | Step Symmetry | 0 = Right and left step lengths not equal (estimate) |
| 13 | 2 | 3 |
| 13 | Step Continuity | 0 = Stepping or discontinuity between steps |
| 14 | 2 | 3 |
| 14 | Path (estimated in relation to floor tiles, 12-inch diameter, observe excursion of 1 foot over about 10 ft of the course) | 0 = Marked deviation |
| 15 | 2 | 3 |
| 15 | Thunk | 0 = Marked sway or uses walking aid |
| 16 | 2 | 3 |
| 16 | Walking stance | 0 = Heels apart |
| 17 | 2 | 3 |

**Risk For Falling:**

- **< 19 High, Risk of Falling**
- **19 to 23, Increased Risk of Falling**
- **> 24, Low Risk of Falling**

**Gait Score:** /12

**Balance + Gait Score:** /28

**Therapist:**
Foot Evaluation Form

Used with the Semmes-Weinstein Monofilament
Hand Evaluation Form

- Used with the Semmes-Weinstein Monofilament.
- This version of the Hand Evaluation Form is often used by the PT clinics.
Hand Evaluation Form

- Used with the Semmes-Weinstein Monofilament.

- This version of the Hand Evaluation Form is mostly used by the OTR at our hand clinic.
Contact your Clinical Documentation Specialist with any questions!!