PART B HELP LETTER CHECK LIST

Resident Name:_____
Period Skilled Nursing Chart Review: From: _____ To: _____
Discipline: PT OT ST Reason for Referral:_____

UB-04 Diagnosis:_____

Billed Services:

HCPCS	Total Units	$	Dates Billed

CAP date: PT/ST_____ OT_____

Physician Certification

- ❑ Plan of Treatment Signed.

Physician Orders for Review Period

- ❑ Monthly orders signed by physician
- ❑ Interim orders signed by physician
- ❑ Telephone orders signed by physician
- ❑ Therapy evaluation order
- ❑ Therapy order for entire treatment period

Therapy - For Review Period

- ❑ Evaluation (700) signed timely by physician (always include initial evaluation with all review periods)
- ❑ PLOF stated reflects decline
- ❑ Updated monthly plan (701), every 30 days, signed by physician for reviewed period
- ❑ Progress filled in at bottom of 700s and 701s to support skill
- ❑ Progress note for entire billing period that supports skilled level of care (every 10th treatment).
- ❑ Documentation reflects progress towards goals

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Part B Help Letter Check List (continued)

Therapy logs

- ❑ All completed billing logs for treatments that were billed during the period
- ❑ Minutes and days on therapy logs match treatment record
- ❑ Daily documentation of minutes on log or in record
- ❑ HCPCS codes billed supported by daily note
- ❑ 59 modifier used for mutually exclusive codes
- ❑ KX modifier used for treatment above the cap

Physician Progress Notes

- ❑ Related to therapy

Nurses Notes

- ❑ Related to referral for therapy
- ❑ Related to deficits being treated for in therapy
- ❑ Related to improvement for deficits being treated
- ❑ Skin documentation for positioning

Diagnostic Reports (labs, x-ray)

- ❑ Include for review period

The following items must be added to this record prior to submitting:

1. 5.
2. 6.
3. 7.
4. 8.

Comments:

_____
_____
_____
_____
_____

DON: _____ MDSC:_____ Rehab:_____ Regional/Consultant : _____

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Part B Help Letter Check List (continued)

Therapy Services Summary:

Attached please find the requested records to support Part B therapy services provided by _____(facility):

Patient Name: _____ HIC#:_____
Physical Therapy Occupational Therapy Speech Therapy
Dates of Service:_____

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