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Therapy Treatments

PT Access	Charting		Chart Review	Reports	Calendars	Schedule	Internal Memo
Main Menu	Screen	Treatment Provided	PTA Charting Cosign	PT Log	PT Calendar (Minutes/Units)	PT Schedule	Write Internal Memo
	Initial Eval	Progress Note	View/Edit Billing	RUG Forecast - Therapy Minutes	PT Calendar (HCPCS)	Resident Schedule	
	Re-Eval	Physician Order	View/Edit Assessments & Notes	Total Pts Seen Per Day	Therapy Calendar - Total Min.		
	Discharge	Continue MDS	View Chart	More Reports	Therapy Tx by Provider		
	Restorative Orders	Care Plans			Progress Notes Due		
	Functional Mobility/ Transfers						

Document Evaluation or Re-Evaluation Provided

1. From the Therapy Access menu, click onto Treatment Provided, select a name, and click OK.
2. Click onto EVAL.
3. Select evaluation type or re-evaluation.
4. Enter the number of minutes.
5. A calendar will pop up. Select the date of the evaluation. Click OK.
6. Click Sign to save the entry and exit back to the Therapy Access menu.

If it has been 10 days or more since the last progress note was last written, the ^ Progress Note button will turn red to indicate that a 10th visit note is required.

Document Service Codes

1. From the Therapy Access menu, click onto Treatment Provided, select a name, and click OK.
2. Choose between SERVICE CODES or NON-BILLABLE Service Codes.
3. A list of service codes and descriptions will display. Click the appropriate code.
4. Select from Individual Minutes, Concurrent Minutes, or Group Minutes. Enter the number of minutes.
5. A calendar will pop up. Select the date of service. Click OK.

6. Select whether the service was provided by the **Therapist** or **Therapy Aide** (if applicable).
7. The user will be brought back to the beginning of the screen where they may document additional codes if needed.
8. When completed, click **Sign** to save the entry and exit back to the Therapy Access menu.

Document Co-treatment Minutes

Co-treatment minutes are a subset of individual minutes and cannot exceed the total individual minutes of therapy administered.

1. From the Therapy Access menu, click onto **Treatment Provided**, select a name, and click **OK**.
2. Click **CO-TREATMENT**.
3. A box will pop up. Enter the number of co-treatment minutes and click **OK**.
4. A calendar will pop up next. Select the date of the co-treatment and click **OK**.
5. Click **Sign** to save the entry and exit back to the Therapy Access menu.

Document X {EPSU} Modifier

X {EPSU} modifiers are used to add additional descriptions in place of a 59 modifier.

1. When you document OT treatment code G0283 and SLP treatment code 92526 with the same effective date and save both entries, you will receive a warning message.
2. When the warning message appears stating the code requires to be tagged with a modifier, click **OK**.
3. A view screen will appear with the effected treatment code, click on the **Edit** button, and select **Append.**
4. Click on **X {ESPU} Modifier and** choose the appropriate modifier code. Then click on **Sign**.

Documenting Additional Data for UB04 Billing Form

All words in each of the below screens that are in red text in the handout and in the Write screen are all required on those residents who have Medicare (B) as a payer source.

From an Initial Evaluation

1. From the Therapy Access menu, click **Initial Eval**, select a name, and click **OK**.
2. Click ONSET DATE**.** A calendar will appear. Select the appropriate date and click **OK**.
3. Click SOC DATE. A calendar will appear. Select the appropriate date and click **OK**.
4. Click MEDICAL DIAGNOSIS. The resident's diagnosis list will appear. A Diagnosis menu will appear. Begin typing the diagnosis name or ICD-10 code in the Search field. A list of matches will appear.
   a. Select a diagnosis from the list and click **OK**. **Red codes are invalid codes.**

    b. A calendar will appear. Select the diagnosis' effective date and click **OK**.
5. Click TREATMENT DX. A Diagnosis menu will appear. Begin typing the diagnosis name or ICD-10 code in the Search field. A list of matches will appear.
    a. Select a diagnosis from the list and click **OK**. **Red codes are invalid codes.**
    b. A calendar will appear. Select the diagnosis' effective date and click **OK**.
6. Click **Sign** to save the entry and exit back to the Therapy Access menu.

From a Re-evaluation

1. From the Therapy Access menu, click **Re-Eval**, select a name, and click **OK**.
2. Click PLAN REVIEWED DATE (29). A calendar will appear. Select the appropriate date and click **OK.**
3. Click **Sign** to save the entry and exit back to the Therapy Access menu.

From a Discharge

1. From the Therapy Access menu, click **Discharge**, select a name, and click **OK**.
2. Click DATE OF LAST TREATMENT (16). A calendar will appear. Select the appropriate date and click **OK.**
3. Click **Sign** to save the entry and exit back to the Therapy Access menu.

Viewing/Editing Billing Entries

4. From the Therapy Access menu, click **View/Edit Billing**, select a name(s), and click **OK**.
5. A **Control** screen will appear. Set a Start Date, End Date or Current Month/Last Month to narrow down the search. Click **OK** and click **Go** to run the search.
6. All entries made within the selected date range will display.
7. Click **Exit** to close the View screen and return to the Therapy Access screen.

Edit Treatment Entries

Example #1: Removing incorrect entries (e.g., an entry was put on the incorrect resident or with the incorrect effective date)

1. Follow instructions above for *Viewing/Editing Billing Entries*.
2. Click on the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if all are incorrect.
3. Click **Edit**.
4. Select **Archive Selected**. A box will pop up: "Are you sure you want to archive all selected entries?" Click **Yes**.
5. The entry or entries will appear grey to show the edit is complete.
6. Click **Go** to refresh the screen and see your changes.

Example #2: Removing incorrect entries and charting correct ones (e.g., an entry was put on the incorrect resident or with the incorrect effective date)

1. Follow instructions above for *Viewing/Editing Billing Entries*.

2. Click on the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if all are incorrect.
3. Click **Edit**.
4. Select **Archive Selected**. A box will pop up: "Are you sure you want to archive all selected entries?" Click **Yes**.
5. The entry or entries will appear grey to show the edit is complete.
6. Click onto an archived (grayed out) entry, click onto **Edit** again.
7. Select **New**.
8. A Write screen will appear allowing you to enter in the correct entry.
9. Click **Next** once the entry is complete to save the updated entry.
10. Click **Go** to refresh the screen and see your changes.

Print Therapy Logs

1. From the Therapy Access screen, click **[OT/PT/SLP] Log,** select resident(s) names, click **OK**.
2. A Select Dates box will appear. Select the appropriate date range and click **OK**. The report preview will appear.
3. Click **Exit** to return to the Therapy Access menu.

View Therapy Calendar Logs

1. From the Therapy Access screen, click **[OT/PT/SLP] Calendar (Minutes/Units), [OT/PT/SLP] Calendar (HCPCS), Therapy Calendar – Total Min,** or **Therapy Tx by Provider**, select resident(s) names, click **OK**.
2. The Calendar will load and will default for the current month.
3. If another date range is desired, click **Control**, edit the Start Date and End Date, and click **OK**.
4. Click **Exit** to return to the Therapy Access menu.

Co-Sign Therapy Notes

1. From the Therapy Access screen, click **[COTA, PTA] Charting Cosign,** select the resident name(s), and click **OK**.
2. The Electronic CoSign screen will appear.
3. Click on the cell to the right under today's date to cosign the note.
4. (Optional) All notes may be signed at once by clicking on the **Sign All** button at the top of the screen, then clicking on the first empty cell under today's date.
5. Click **Exit** to return to the Therapy Access menu.

Document Therapy Assessments and Progress Notes (Initial Eval, Re-Eval, Discharge)

1. From the Therapy Access menu, click onto the appropriate button **(Progress Notes, Initial Eval, Re-Eval, or Discharge).**
2. A Write screen will appear with the selected topic loaded. Document by moving left to right and selecting all appropriate words. Add free text where necessary and skip past any words that are not relevant to your note/assessment.
3. When finished documenting on this screen, select **Sign** to save the entry and exit back to the Therapy Access menu.

Edit Assessments and Notes

1. From the Therapy Access menu, click **View/Edit Assessments & Notes**, select name(s), and click **OK.**
2. (Optional) Set a Start Date, End Date or User to narrow down the search. Click **OK** and click **Go** to run the search.
3. Click on the incorrect entry to turn it red. This is called 'tagging' the entry. You may tag multiple entries if all are incorrect.
4. Click **Edit**.
5. Select the appropriate editing option based on the table below. A box will pop up to confirm the chosen editing option. Click **Yes**.
6. The entry or entries will appear gray to show the edit is complete.
7. (Optional) Click **Go** to refresh the screen and see your changes.
8. Click **Exit** to return to the Therapy Access screen.

Editing Feature	Function	Example
Append / Append All	Information is permanently attached to the entry; further editing will not be able to be done to the entry except to discontinue	Cosigning a student's documentation
New	A new, separate entry made in the same topic area	Not typically used when editing department notes. Can be used to see where an entry was charted
Copy	An exact copy of the entry is made	An entry was accidentally discontinued and needs to be made active again
Copy One (All) to Other Client[s]	An exact copy of the entry is made and placed in another resident's chart	An entry was accidentally made in the wrong resident's chart. Use ALL if more than one entry was selected
Discontinue and Append	Entry is discontinued and user is taken to a Write screen to document additional notes	An error was made in documenting the entry and the user would like to

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		explain why the entry is being discontinued
Discontinue and New	Entry is discontinued, a new entry is made in its place	Not typically used when editing department notes
Discontinue and Copy	Entry is discontinued, copy of entry is displayed allowing user to make changes to the original entry	User forgot to use a button word when documenting and would like to 'insert' the word into the entry
Discontinue	Entry is discontinued	Not typically used when editing department notes
Discontinue All	All highlighted entries are discontinued for one client	Not typically used when editing department notes
Discontinue Multiple Client Entries	All highlighted entries are discontinued for multiple clients	Not typically used when editing department notes
Skip	Allows user to skip a highlighted entry	Highlighted an entry that does not need editing