

## Medicare Progress Report Requirement By Ann Shafer, PT

Many clinicians are not aware of a Medicare requirement that has been in place for over one year. Originally, Progress Report requirements applied to out-patient practice, but now that requirement has been expanded to inpatient facilities.

As of January 1, 2006, Medicare requires that a Progress Report be created every tenth visit or once during a certification period, whichever is less. Progress Reports may be written as often as daily, however, attention should be given to clearly demonstrate progress in your documentation.

### Requirements of the Progress Report:

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's Progress Report; and
- Changes to long or short term goals, discharge or an updated Plan of Care this is sent to the physician/NPP for certification of the next interval of treatment.

Justification of necessity of the services provided during the reporting period must include objective evidence or clinically supportable statement of explanation that:

- The patient's condition has the potential to improve or is improving in response to therapy;
- Maximum improvement is yet to be attained; and
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

In ReDoc, you have the option to generate a Plan of Care Report or a Progress Report once the ReExam/ReEvaluation is completed. A Progress Report does not require the referring physician's signature. However a Plan of Care/Certification does. When the required elements of the Progress Report are written into the Treatment Notes or Plan of Care/Certification, requirements for Progress Report are fulfilled. Therefore you may prefer to use a Plan of Care report to meet the Progress Report requirements, especially for a patient that is seen 3 or fewer times per week. For a 5 visit/week patient, you could easily insert a Progress Report between each Certification. There may also be situations when you use the Plan of Care/Certification prior to 30 days and just reset your calendar for when the next Certification is due.

Using the ReExam/ReEvaluation form in ReDoc does not necessarily indicate that you should bill for a ReEvaluation (97002). You should only bill 97002 if there has been a significant change in status. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable. A significant change could mean that the patient is making better or worse progress than anticipated or they have a complicating factor.

The first visit is counted toward those 10 visits, even if there was only evaluation performed without treatment. Unexpected absences may not necessarily delay the generation of a Progress Report. If a clinician has not seen the patient during the reporting period due to an unexpected absence, a delayed report may be provided within seven calendar days of the reporting period end, with explanation provided. A clinician is required to provide at least one billable unit of care during the certification period.

The Discharge Report will also serve as the last Progress Report. No referring physician's signature is required for either document's requirements.

According to CMS Publication 100-02, contractors may require that treatment notes and progress reports be entered in to the record within one week of the last date to which the note refers.

Refer to [cms.gov](http://cms.gov) for complete details and further explanation of Progress Reports.