Skilled Nursing Facility
Narrative for Self-Audit Checklist

1. Certification – Signed and dated by the physician, clinical nurse specialist or nurse practitioner on admission, or as soon as is reasonable and practical. (Facility policy to dictate timing.)

2. Recertifications - The first recertification should be obtained by the 14th day and subsequent recertifications should be obtained no later than at 30 day intervals. Recertifications should be signed and dated by the physician, clinical nurse specialist or nurse practitioner. A reason for the recertification and any plans for discharge should be included (i.e. home care, long term care placement).

   Delayed Certification or Recertifications – Must be obtained if there has been an oversight or lapse. An explanation for the delay must be included and any medical or other evidence that is relevant for the explanation of the delay. A delayed certification and recertification may appear in one statement. The facility may determine the format and method it is obtained (CMS Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Ch. 4, “Delayed Certifications and Recertifications for Extended Care Services”, §40.5).

3. Therapy plans of treatment for all therapies involved including occupational therapy (OT), physical therapy (PT), and speech-language pathology (SLP). Include all plans of treatment to support each Minimum Data Set (MDS) Resource Utilization Group (RUG-III) code billed AND for all of the dates of service on the claim.

4. Include a log of all therapy minutes that were provided during the dates of service of the claim. In addition, include therapy minutes to support each MDS therapy RUG-III code billed for the dates of service of the claim, and to support the timeliness of any Other Medicare Required Assessments (OMRAs) completed. The 5 day MDS requires the first 15 days of therapy minutes on a log for verification of a therapy RUG level. Subsequent MDS must have minutes to support each look back period, which is 7-days from the Assessment Reference Date (ARD) of each MDS.

5. Therapy progress notes to support the look back period of each MDS RUG-III code billed, and to support the entire payment period for the dates of service. This documentation may fall outside the dates of service under review.
6. Therapy documentation should also include the diagnosis for which the treatment is provided, the patient’s prior level of function, and the date of onset for the diagnosis for which treatment is provided. Always include the initial evaluation and any updated functional assessments. Therapy documentation should include the functional level at admission, prior level of function, restorative potential, short and long term goals including time frames, types of services/modalities provided, documentation of expectation for significant progress, change in condition, and ongoing progress including gains in independence.

7. Nurse’s notes 30 days prior to the ARD of each MDS RUG-III code billed and for the dates of service (DOS). This documentation may fall outside the dates of service under review.

8. Hospital information – Discharge Summary – History and Physical – Transfer sheet

9. Each MDS for every RUG-III code billed for the dates of service.

10. Physician orders and progress notes to support each MDS RUG-III code billed and services provided during DOS.

11. Dietary documentation to support each MDS RUG-III code billed and care provided during DOS.

12. Complete medication, treatment and wound care records.

13. If the timeliness of a physician signature is being confirmed, a visible and readable fax date documenting the return from the physician’s office is acceptable.

14. If the physician, clinical nurse specialist or nurse practitioners do not date their signature, the facility should not enter a signature date. Instead, stamp or hand-write the date when you received the signature. This applies to certification and recertifications for skilled care, and physician signing of therapy orders.