

GO TO auth.webpt.com and log in. In the top right corner, click in the white **Search my Patients** box, and type in your patient name (first or last), then click **Search**.



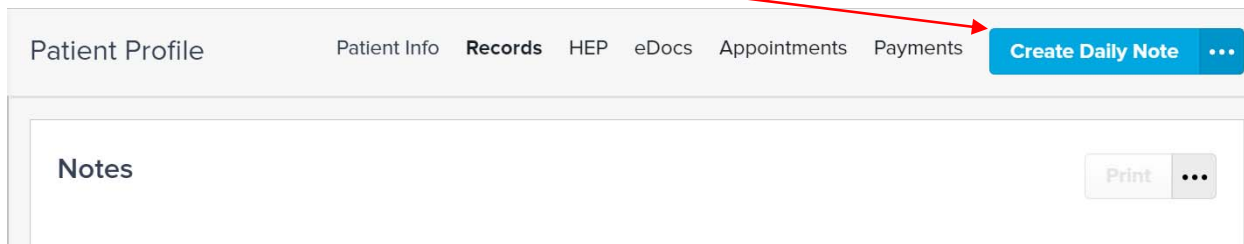
Your patient should come up automatically. If not, double click on their name on the list.

First, make sure you are in the correct case for the patient (ST, OT, or PT).

(if you are not, click on **Case** in blue to see a list of cases that you can choose from.)



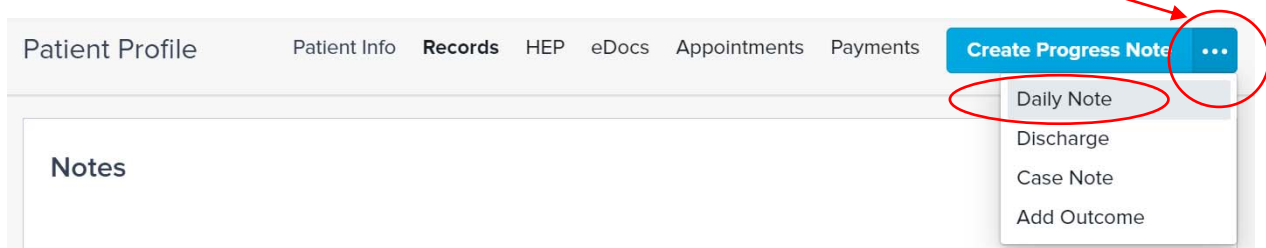
1 – Click **Create Daily Note Note**



IF your client has an alert at the top that says that a Plan of Care is due – please let me know.

This may or may not be true – It might just be a glitch from the transfer. If you do not see

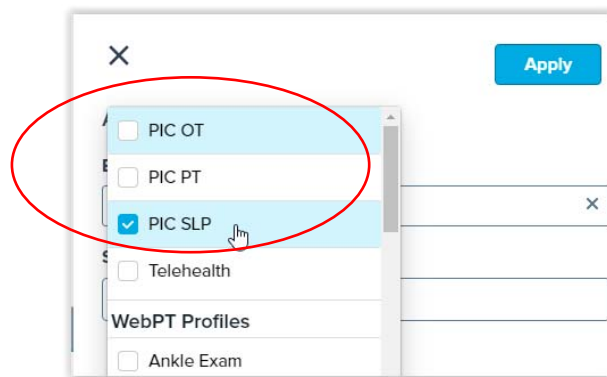
Create Daily Note button, click the button with 3 dots and select **Daily Note**.



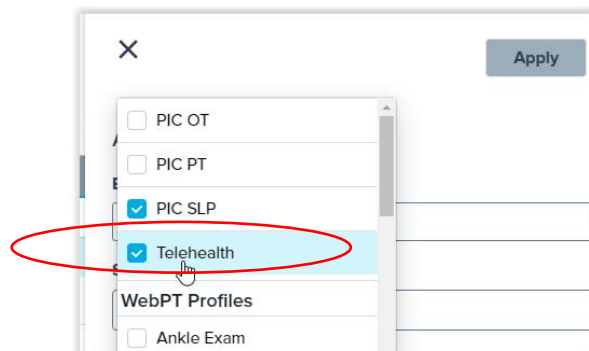
2 – **PROFILES** - Click on the 3 dots beside the word Sign, to access the Menu. Then click **Add Content**.



MAKE SURE that you see the Profile listed for your discipline in grey. If you do not, please see the next page for how to add it. (This Profile houses all of our required boxes/statements that Medicaid requires. If you accidentally delete any of those statements, or they disappear, please delete the Profile, Apply, and re-add the PIC ST, OT, or PT Profiles to get the statements to come back in.)

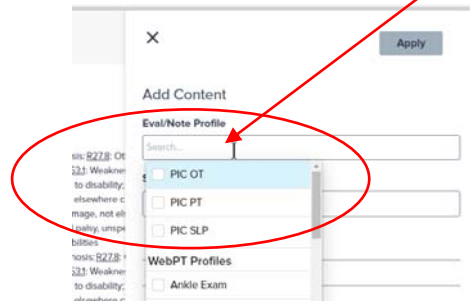


TELEHEALTH – if you see the client on telehealth, click in the checkbox beside **Telehealth** to add the **Telehealth** profile. This will bring in your Place of Service, Telehealth consent, and Doxy statements, which need to be on there if you are seeing through telehealth.

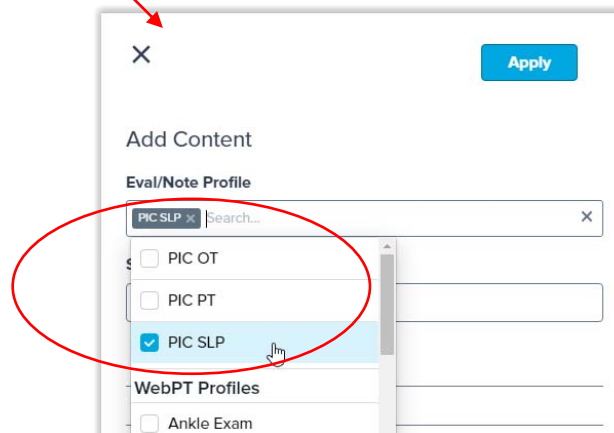


HOW TO ADD PROFILES:

IF YOU DO NOT SEE YOUR PROFILE IN GREY - Once you click in to the line below Eval/Note Profile, you will see the PIC OT, PIC PT, & PIC SLP Profiles. **Click the profile (OT, PT, or SLP) for your discipline.**



After you select your discipline, you should see it in grey and checked. **After you see your profile listed in grey and checked, click [Apply](#).**



3 – Confirm your **Date of Visit**, then Enter in the **Start and End Time**

Records ▾ > Daily Note ▾

Date of Visit (required) Start Time End Time

07/09/2021 12 : 00 PM ▾ 1 : 00 PM ▾

4 – **Place of Service** – should ALWAYS be **Home**, unless you are seeing the client through Telehealth. If you are seeing them through **Telehealth**, choose Telehealth.

Records ▾ > Daily Note ▾

Date of Visit (required) Start Time End Time

07/09/2021 12 : 00 PM ▾ 1 : 00 PM ▾

Place of Service

12 – Home ✕

5 – **SUBJECTIVE** - Scroll down to **Subjective, Patient Presentation** section. Click on **Patient Presentation** to enable editing. Type your **Subjective comments** in the Patient/Caregiver Report box.

Subjective

> Patient Report ← (You can always ignore and skip this first Patient Report, IF you see it – go down to Patient Presentation to document your Subjective Comments.)

✓ Patient Presentation

Patient/Caregiver Report Primary Concern

enter Subjective Comments here

Date of Injury/Onset Patient/Caregiver Goals

MM/DD/YYYY

Other Services Received

6 – Enter your **COVID-19 temperature**, and change the **PLACE OF SERVICE** line **IF needed**

(e.g, if you switch back and forth with telehealth/in-person, or change the physical location of where you provide therapy)

Patient/Caregiver Report		Primary Concern
enter Subjective Comments here		
Date of Injury/Onset	Patient/Caregiver Goals	
MM/DD/YYYY		
Other Services Received		
COVID-19 PRECAUTIONS: Client Temperature: Therapist & Client wore masks during the session. Client responded "no" to all COVID-19 screening questions. Materials and surfaces were sanitized before and after client use. 6-foot distance was maintained.		COVID Temperature
Additional Comments		
PLACE OF SERVICE: Therapy services were provided at LIST FULL ADDRESS		PLACE OF SERVICE line for NON-TELEHEALTH
Patient initiated therapy through Doxy.me, a HIPAA compliant telehealth platform. Patient consented to receiving services through telehealth/e-visit. This is part of a Coronavirus/COVID-19 prevention plan. Client/caregivers have requested no-contact or less-contact treatment at this time.		
PLACE OF SERVICE: Therapy services were provided via telehealth while client was in their home at: LIST FULL ADDRESS		Doxy / PLACE OF SERVICE lines for TELEHEALTH (these will show if you have added the Telehealth Profile)



*Please use this specific PLACE OF SERVICE line if you are seeing the client on Telehealth.

IMPORTANT – TEXT IN BLUE WILL ONLY SHOW ON THE CURRENT NOTE AND CARRY OVER TO THE NEXT NOTE IF YOU EDIT IT, OR IF YOU CLICK ADD TO NOTE.

Patient Presentation Last updated 06/07/2021

Date of Injury/Onset: 08/25/1994

Other Services Received:COVID-19 PRECAUTIONS: Client Temperature: Therapist & Client wore masks during the session. Client responded "no" to all COVID-19 screening questions. Materials and surfaces were sanitized before and after client use. 6-feet distance was maintained.

Additional Comments:PLACE OF SERVICE: Therapy services were provided at patient's home at 2040 Fox Trail Drive, Lagrange, KY 40031

[Add to Note](#)

IF YOU DO NOT EDIT THE TEXT , OR HIT ADD TO NOTE, INFORMATION IN BLUE WILL NOT SHOW IN YOUR CURRENT NOTE OR CARRY FORWARD TO YOUR NEXT NOTE. If you do not edit text in a section PLEASE hit [Add to Note](#), so that the info will show in the current note and carry over to the next note.

ALSO – ANYWHERE you see a “Last updated Date” – PLEASE CLICK IN TO THAT SECTION AND HIT ADD TO NOTE. If you do not do this, these fields will not carry over, and you will not have them when you need them on your next recert.

After you do your first recert in this system, you will really only need to do this “Adding to Note” on all fields on subsequent recerts (not every daily note). (data flows from recert-to-recert, and daily note – to – daily note.)

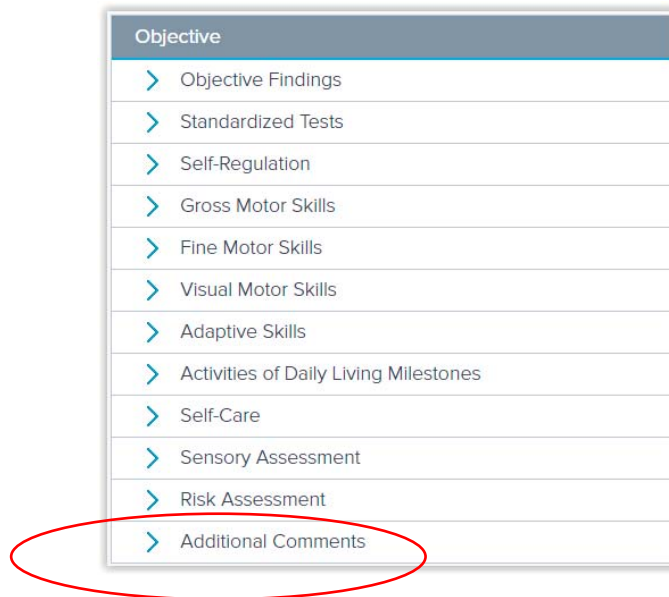
> Patient Presentation	Last updated 07/06/2021
> Current Functional Limitations Impacting Prior Level of Function ⓘ	Last updated 06/07/2021
> Past Medical History	
> Current Medications	Last updated 06/22/2021
> Plan of Care Dates	Last updated 07/05/2021
> Discharge Summary	Last updated 06/22/2021

Current Medications Last updated 06/22/2021

Additional Comments:See MAP 351, Participant Summary, or HRST

[Add to Note](#)

7 – **OBJECTIVE/INTERVENTIONS** - Scroll down to the **Objective, Additional Comments** section. THIS is where WebPT is advising to put/update your **Interventions**, if you used the Notes > Interventions tab in Revflow. If you did not use the Notes > Interventions tab in Revflow, you can skip this step.



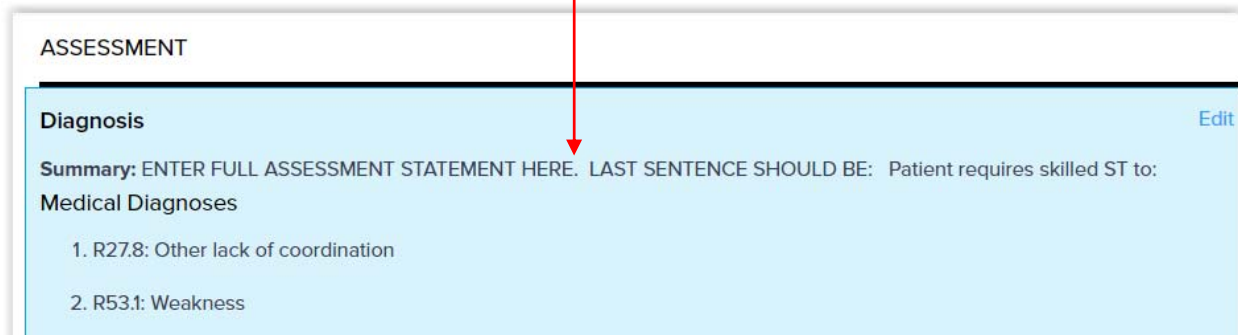
8 – **FLWSHEETS** – this is an optional section. You may use this section if you choose to add Activities (kind of similar to the Notes > Interventions tab in Revflow).



9 – **ASSESSMENT** - Scroll down to the **Assessment** section. Click on the **Assessment, Diagnosis** Section to enable editing.

Under Diagnosis Summary – enter your **Assessment Statement**. for today’s treatment visit.

Please don’t forget to always **leave/add** the last “**Skilled ST is required to what & why**” **sentence**.



ASSESSMENT

Diagnosis [Edit](#)

Summary: ENTER FULL ASSESSMENT STATEMENT HERE. LAST SENTENCE SHOULD BE: Patient requires skilled ST to:

Medical Diagnoses

1. R27.8: Other lack of coordination
2. R53.1: Weakness

10 – document Progress on Goals – Scroll down to the **Problems & Goals** section. Click on the **Problems & Goals** section to enable editing.

****If you only documented daily treatment progress in your Goals section in Revflow, you will want to use the Goals section in WebPT.** Use the Progress section to enter progress like you would have in Revflow.

EXAMPLE

Problems & Goals

Problem: No formal communication system | Status: Active

Goals

Type	Description	Target Timeframe	Progress	Status
Short term	enter full STG here	Three months	enter goal data/comments here (e.g., with min verbal cues required)	56-60%
Long term	enter full LTG here	Three months	enter goal data/comments here (e.g., with min verbal cues required)	36-40%

Problem: Mild oropharyngeal dysphagia | Status: Active

11 – Scroll down to Patient/Caregiver Education. Click on it to edit. Document any patient/caregiver education here (like you would have in the Notes > Interventions tab in Revflow)

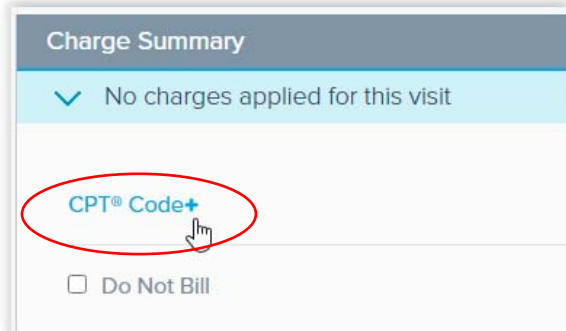
✓ Patient/Caregiver Education

Education Provided: [Text Input Field]

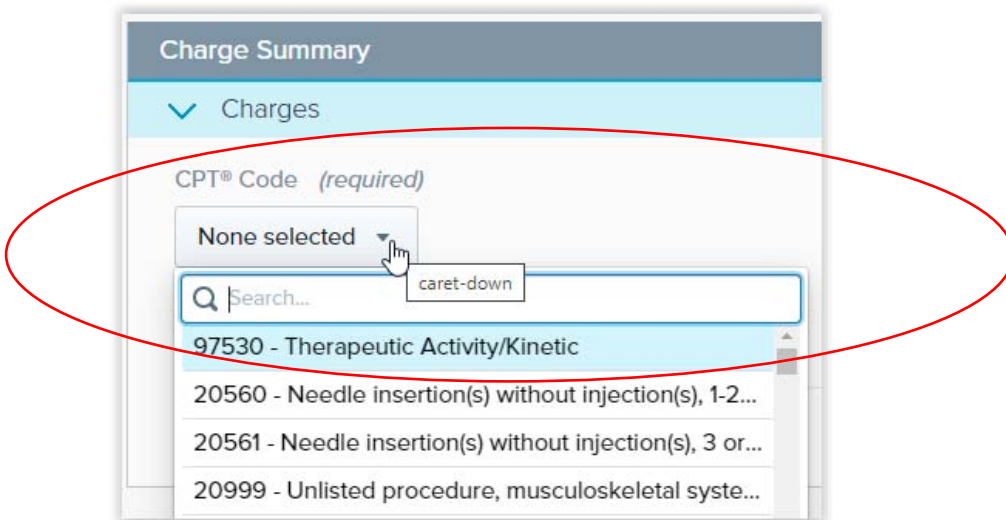
Comments: [Text Input Field]

Additional Comments: The caregiver is and will continue to be educated on the stated goals and has committed to consistent follow through to show improvements in the home exercise program.

12 – **ENTER CHARGES** - Scroll down to Charge Summary. Hit CPT Code+ to add charges for this visit. If you have entered charges from a previous visit, they will carry over, and you won't need to add them again.



Click **None selected**, and it will pop up codes for you to search and choose from.



EXAMPLE OF CHARGE SUMMARY SCREEN. **DO NOT TRY TO DELETE OR ADD ANY MODIFIERS!**

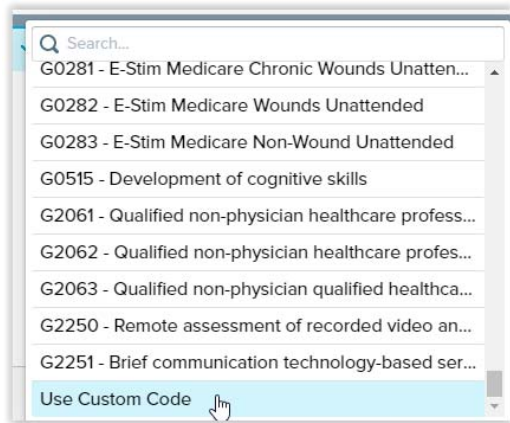


EPSDT, MPW, AND SELF PAY CODES - INSTRUCTIONS

**EPSDT, MPW, and Self Pay (use CASHVIS) codes should have automatically popped up from your last visit. If they did not, please enter them as a Custom Code, EXACTLY as listed below.

EPSDTST
EPSDTOT
DWMPWOT
CASHVIS

To do this, scroll ALL the way to the bottom of the code list (or you can start typing “Custom”), where it says “**Use Custom Code.**”



Click “**Use Custom Code.**”

EPSDTST or **EPSDTOT** – type **EPSDTST** or **EPSDTOT** in the Code field, and leave the button for **Untimed Code** selected.

A screenshot of a "Custom Code" dialog box. The "Code" field contains "EPSDTOT". Below the field, there are two radio buttons: "Untimed Code" (which is selected) and "Direct Timed Code". A red circle highlights the "Untimed Code" radio button and the "Code" field. At the bottom of the dialog, there are "Cancel" and "Apply" buttons.

EPSDTST
EPSDTOT

CASHVIS or DWMPWOT – type CASHVIS or DWMPWOT in the Code field, and select the button for **Direct Timed Code**.

Custom Code

Code
CASHVIS

Untimed Code Direct Timed Code

Description

Cancel Apply

DWMPWOT
CASHVIS

These custom codes should carry over to your next note, so you should not have to put them in again, unless you delete them out.

(In the future - if you are just doing a recert with no billed charges for treatment that day - select **Do Not Bill** instead of deleting charges.)

13 – don't forget – ANYWHERE you see a "Last updated Date" – PLEASE CLICK IN TO THAT SECTION AND HIT ADD TO NOTE. If you do not do this, these fields will not carry over, and you will not have them when you need them on your next recert.

> Plan of Care Dates Last updated 07/05/2021

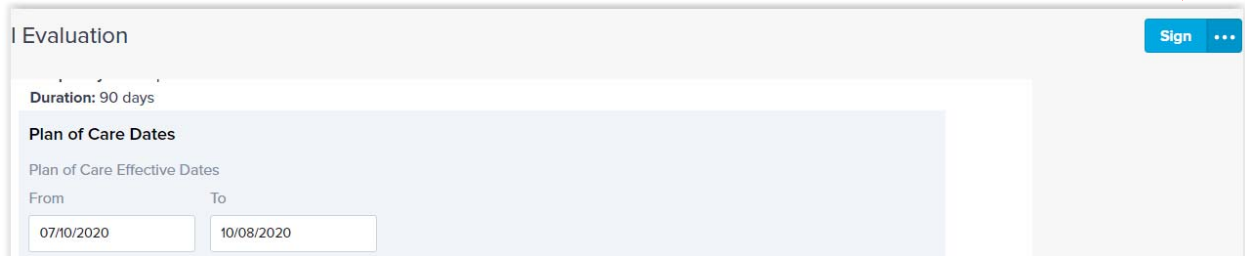
> Discharge Summary Last updated 06/22/2021

✓ Discharge Summary Last updated 06/22/2021

Additional Comments:1. Testing discharge comments here – xxxxxxxx
2. Discharge when ----
DISCHARGE PLAN : Discharge to caregivers when short-term and long-term goals are met or maximum rehabilitation potential has been achieved.
ORDER: ST TREATMENT X 6 MO

Add to Note

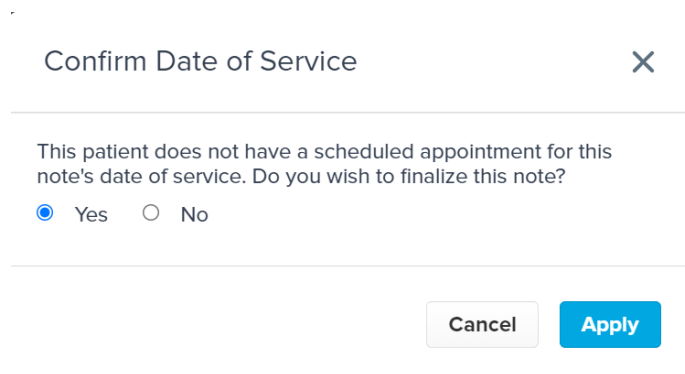
14 – **SIGN** - After double checking that you have completed all of the above steps, click **Sign** in blue.



The screenshot shows a form titled "Evaluation". In the top right corner, there is a blue button labeled "Sign" with a three-dot menu icon to its right. A red arrow points down to this button. Below the title, the form contains the following fields:

- Duration: 90 days
- Plan of Care Dates
- Plan of Care Effective Dates
- From: 07/10/2020
- To: 10/08/2020

Click **Yes** on the below scheduling error to Confirm the Date of Service. We are still working to get clients on to your schedules.



The dialog box is titled "Confirm Date of Service" and has a close button (X) in the top right corner. The text inside reads: "This patient does not have a scheduled appointment for this note's date of service. Do you wish to finalize this note?". Below the text are two radio buttons: "Yes" (which is selected) and "No". At the bottom of the dialog are two buttons: "Cancel" and "Apply".

YOU ARE NOW DONE WITH YOUR DAILY NOTE!! 😊