

## **DOCUMENTATION IN PHYSICAL THERAPY PRACTICE**

### **LEARNING OBJECTIVES**

- 1. Describe typical challenges therapists have in clinical documentation and identify activities to facilitate efficient and effective documentation skills.**
- 2. Apply the basic components of appropriate clinical documentation accounting for clinical practice, compliance, risk management, regulatory, and reimbursement issues.**
- 3. Describe best practices for documenting patient/client care in physical therapy.**

**Why do we document clinical care?**

### **WHY DO WE DOCUMENT CLINICAL CARE?**

- 1. Practice**
  - a. To serve as a record of patient/client care that coincides with scope of practice.**
  - b. To convey our unique body of knowledge and our practice.**
  - c. To communicate among providers in physical therapy and external to physical therapy (other health providers and teachers).**
  - d. To be used for policy or research purposes including outcomes analysis.**

### **WHY DO WE DOCUMENT CLINICAL CARE?**

- 2. Regulatory**
  - a. To reflect appropriate provision of care in accordance with local, state, and federal regulations.**
- 3. Reimbursement**
  - a. To accurately and efficiently record the episode of care of the patient/client. Documentation should demonstrate medical necessity, progress, and skilled care, etc.**

### **WHY DO WE DOCUMENT CLINICAL CARE?**

- 4. Risk Management**
  - a. To document care and instructions provided to the patient/client and their response to treatment (specifically adverse events) to minimize risk.**

- b. To document any communication (phone, written, electronic) with the patient/client and/or other health professionals involved in the care of the patient/client.

#### **RECENT TRENDS REPORTED IN PHYSICAL THERAPY DOCUMENTATION**

##### **GOVERNMENT ACCOUNTABILITY OFFICE (GAO) REPORT FINDINGS<sup>1</sup>**

1. Found data and research insufficient to identify conditions or diseases that justify waiving caps
2. Data do not capture clinical diagnosis for which therapy received
3. Lengths of treatment for patients with same diagnosis varied widely

##### **CMS COMPLIANCE EFFORTS**

1. CMS established Comprehensive Error Rate Testing (CERT) program and Hospital Payment Monitoring Program (HPMP) to monitor contractor payment of claims.
2. Reports consistently indicate error rate for PT services primarily due to documentation problems.
3. May 2007 CERT report, Ther ex (97110), Manual therapy (97140), & Ther Activities (97530) in the top 20 list of services with insufficient documentation with projected improper payments of \$33M, \$12M, & \$10M. PTs in private practice had a paid claims error rate of 6.1% and projected improper payment of \$58,793,854.

##### **OTHER REIMBURSEMENT/PAYER ISSUES REASONS FOR DENIALS**

1. Poor legibility
2. No documentation for date of service
3. Incomplete documentation
4. Documentation not understood due to abbreviations
5. Does not support the billing (coding)
6. Does not demonstrate progress
7. Does not demonstrate skilled care
8. Does not support medical necessity

##### **Overuse of Abbreviations**

##### **Illegible Documentation**

## **MEDICARE TRANSMITTALS**

### **CLINICAL DOCUMENTATION: BEST PRACTICE**

### **DOCUMENTATION OF PATIENT/CLIENT CARE:**

### ***CHALLENGES FOR THERAPISTS***

### **DOCUMENTATION CHALLENGES FOR THERAPISTS**

**What do you believe are the greatest challenges related to documentation for therapists during clinical practice?**

**Can you give examples of these?**

### **CHALLENGES WITH DOCUMENTATION**

1. **Limited time to document outside of patient care**
2. **Excessive use of abbreviations**
3. **Use of short-cuts when documenting to 'save time' (i.e. A: Tolerated well)**
4. **Keeping pace with various insurance policies / requirements for documentation**

### **CHALLENGES WITH DOCUMENTATION (cont.)**

1. **Goals are not written as functional outcomes**
2. **Medical necessity is not identified clearly**
3. **Documentation is often too sparse**
4. **Handwriting is illegible**
5. **Improper coding**
6. **Others?**

### **ELECTRONIC DOCUMENTATION CHALLENGES**

**Electronic documentation systems may be unfamiliar and require that the therapist orient to the system and change documentation behaviors**

**Templates may not allow for unique or unusual documentation**

**There may be limited decision making due to protocols and drop down lists**

## **WHAT ARE THE ESSENTIAL ELEMENTS REQUIRED IN QUALITY DOCUMENTATION IN ANY PRACTICE SETTING?**

### **THE GUIDE TO PHYSICAL THERAPIST PRACTICE OVERVIEW**

1. Based on Three Key Concepts
  - a. **Disablement model**
  - b. **Continuum of service**
  - c. **Five elements of patient/client management**

### **DISABLEMENT MODEL**

### **THE GUIDE TO PHYSICAL THERAPIST PRACTICE OVERVIEW**

**Provides a framework for practice**

**Provides a common language and framework for clinical instruction**

**Implements a common approach to measuring outcomes for documenting effectiveness**

**Develops research hypotheses**

**Educates external community and payers**

### **DOCUMENTATION:**

#### **PROVISION OF PATIENT/CLIENT CARE**

1. **Initial Examination/Evaluation**
2. Re-examinations
3. Visit/Encounter Notes
4. Discharge or Discontinuation Summary

#### **INITIAL EXAMINATION/EVALUATION**

1. **History**
  - a. **Review of past and current medical and social information**
  - b. **May include:**
    - i. **Medications**
    - ii. **Previous clinical tests**

- iii. **Living environment**
- iv. **Previous level of function**
- v. **Cultural preferences**
- c. **Highlight pertinent information**

#### **INITIAL EXAMINATION/EVALUATION**

##### **2. Systems Review**

- a. **Helps determine conditions that may impact the chief complaint**
- b. **Can identify conditions that require consultation with other providers**
- c. **Can be completed in a relatively short time by experienced clinicians**

#### **INITIAL EXAMINATION/EVALUATION**

##### **3. Tests and Measures**

- a. **Identify the specific tests and measures used**
- b. **Document the associated finding or outcome**
- c. **Use standardized test and measures**

#### **INITIAL EXAMINATION/EVALUATION**

##### **Documenting Evidence-Based Practice**

- a. **Document tests and measures that are valid and reliable for diagnostic and/or prognostic information**
- b. **Use standardized outcome measures to communicate changes in impairments/function**

#### **INITIAL EXAMINATION/EVALUATION**

##### **4. Evaluation**

- a. **A synthesis of all of the data and findings gathered from the examination**
- b. **Collaborative decision making with the patient/client**
- c. **Process leads to documentation of impairments, functional limitations, and disabilities**
- d. **Guides the physical therapist to a diagnosis and prognosis for each patient/client**

## **INITIAL EXAMINATION/EVALUATION**

### **5. Diagnosis**

- a. **Determined by the physical therapist after the examination and evaluation process**
- b. **Typically made at the impairment and functional limitation levels**

## **INITIAL EXAMINATION/EVALUATION**

### **6. Prognosis**

- a. **Conveys the physical therapist's professional judgment for the patient's/ client's predicted functional outcome and the required duration of services to obtain this functional outcome.**

## **INITIAL EXAMINATION/EVALUATION**

### **7. Plan of Care**

- a. **Include goals stated in functional, measurable terms that indicate the predicted level of improvement in function.**
- b. **Collaboration with the patient/client and other appropriate stakeholders.**
- c. **A statement of interventions/treatments to be provided during the episode of care.**
- d. **Duration and frequency of service required to reach the goals.**
- e. **Anticipated discharge plans (may also be part of the prognosis or written separately).**

## **INITIAL EXAMINATION/EVALUATION**

### **Documenting Evidence-Based Practice**

- a. **Select and implement a plan of care and interventions based on available research or clinical guidelines**
- b. **Keep up to date with current research**
- c. **Hooked on Evidence, Open Door**

## **PLAN OF CARE**

### **Documenting Goals**

- a. **Write goals in conjunction with the plan of care to provide a roadmap for progression and communication.**

- b. **Write goals related to impairments and function.**
- c. **Write goals that are measurable with specific parameters.**
- d. **Update the goals regularly and document the achievement/progress or lack of progress toward the goals.**

**DOCUMENTATION:**

**PROVISION OF PATIENT/CLIENT CARE**

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3. Visit/Encounter Notes
4. Discharge or Discontinuation Summary

**RE-EXAMINATIONS**

1. **Re-examinations**
  - a. **Include data from repeated or new examination elements**
  - b. **Evaluate the patient's/client's status and modify or redirect intervention**
  - c. **Indications for a re-examination include new clinical findings or failure to respond to interventions**

**DOCUMENTATION:**

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**VISIT/ENCOUNTER NOTE**

**Documents sequential implementation of the plan of care established by the physical therapist, including:**

**changes in patient/client status**

variations and progressions of specific interventions used.

May include specific plans for the next visit or visits

Documentation is required for every visit/encounter

#### **VISIT/ENCOUNTER NOTE (CON'T)**

May include as applicable:

Patient/client self-report (as appropriate).

Identification of specific interventions provided, including frequency, intensity, and duration as appropriate. Examples include:

Knee extension, three sets, ten repetitions, 10# weight

Transfer training bed to chair with sliding board, verbal cueing and minimal assistance

Equipment provided.

Changes in patient/client impairment, functional limitation, and disability status as they relate to the plan of care.

Response to interventions, including adverse reactions, if any.

#### **VISIT/ENCOUNTER NOTE (CON'T)**

Factors that modify frequency or intensity of intervention and progression goals, including patient/client adherence to patient/client-related instructions.

Communication/consultation with providers/patient/client/family/ significant other.

Documentation to plan for ongoing provision of services for the next visit(s), which may include, but not be limited to:

The interventions with objectives

Progression parameters

Precautions, if indicated

#### **DOCUMENTATION:**

##### **PROVISION OF PATIENT/CLIENT CARE**

1. Initial Examination/Evaluation
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3. Visit/Encounter Notes
4. **Discharge or Discontinuation Summary**

#### **DISCHARGE OR DISCONTINUATION SUMMARY**

1. **Discharge/Discontinuation Summary**
  - a. **Required at the conclusion of services, whether due to discharge or discontinuation of physical therapy services.**
  - b. **Should summarize a patient's/client's progress towards goals, status at discharge and future plans for self-management.**
  - c. **Completed by Physical Therapist**

#### **EXAMPLE:**

**"Patient tolerated treatment well"**

- a. **Does this show Medical Necessity?**
- b. **Does this demonstrate skilled care?**
- c. **Does this show progression of the patient/client?**

#### **MEDICAL NECESSITY**

1. **Therapy services are considered reasonable and necessary when the following conditions are met:**
  - a. **The services provided are consistent with the nature and severity of the illness, injury, and medical needs.**
  - b. **The services provided are specific, safe, and effective treatment for the condition according to accepted medical practice.**
  - c. **There should be a reasonable expectation that observable improvement in functional ability will occur.**
  - d. **The services do not just promote the general welfare of the beneficiary.**

#### **MEDICAL NECESSITY**

2. **Document complications and safety issues as a result of the patient/clients current status. As examples:**

- a. **Fall risk**
- b. **Reduced mobility – increase risk for further complications**
- c. **Inability to complete tasks (ie, activities of daily living)**

#### **SKILLED LEVEL OF CARE**

1. **Services must be at such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his/her supervision/direction.**
2. **The services must require the expertise, knowledge, clinical decision making or problem solving, and abilities of a therapist that other staff, caretakers, or the patient/client cannot provide independently.**
3. **A therapist's skill may also be required for safety reasons.**

#### **SKILLED LEVEL OF CARE**

1. **Patient educated in the use of progressive exercises to facilitate trunk stabilization for improved balance during gait.**
2. **Training provided in donning/doffing lower extremity prosthesis with verbal and manual cues for technique and safety.**
3. **Ambulation training with standard walker. Patient requires frequent monitoring of vital signs due to cardiac risk factors.**
4. **Patient demonstrates consistently good balance on level surface, therefore progressed patient to performing standing balance activities on unstable surface to decrease fall risk and increase community ambulation safety.**

#### **DEMONSTRATING PROGRESSION**

**Document previous as compared to current function.**

**Use percentages, levels of assistance or function but make sure they can be easily understood**

**Use standardized outcome measures**

#### **DEMONSTRATING PROGRESSION**

**Examples:**

**Patient increased quadriceps strength from 2/5 to 3+/5 enabling him to increase independence in household ADLS and reduce need for set up for grooming and feeding.**

**Patient increased ambulation from minimal assistance to contact guard for safety, so spouse can now provide appropriate level of assistance for discharge to home**

#### **DEMONSTRATING PROGRESSION**

**Consider a patient three weeks into a physical therapy episode of care:**

**What impairments have been improved?**

**What functions can now be performed?**

**What barriers have been reduced or eliminated through therapy or education?**

#### **DEMONSTRATING PROGRESSION**

**What impairments still exist?**

**What functional activities cannot be performed?**

**What barriers exist to reach function (safety, co-morbidities, environmental, etc)?**

**What goals do patient / family still wish to achieve?**

#### **DEMONSTRATING PROGRESSION**

- **Cite valid and specific reasons why progress might not have occurred:**

**Patient had medical complications**

**Patient was not able to attend / participate in therapy as expected**

- **Document consideration of change in Plan of Care or why you chose not to change Plan.**

**Review documentation examples and determine elements that reflect appropriate and inappropriate documentation.**

#### **DOCUMENTATION EXAMPLES**

##### **EXAMPLE**

**“Therapeutic exercise and right shoulder mobilization including AP glides of the glenohumeral joint resulted in increased flexion from 90° to 110° allowing the patient/client to reach overhead and independently complete ADLs.”**

- a. Does this show Medical Necessity?
- b. Does this demonstrate skilled care?
- c. Does this show progression of the patient/client?

#### **DOCUMENTATION GOALS IN CLINICAL PRACTICE**

1. Convey clinical practice (actions and judgments) into effective and efficient report/documentation.
2. Document goals appropriately, ensure they relate to function and update / refer to them routinely.
3. Consider the format of a note and does it facilitate best practice documentation?

#### **DOCUMENTATION GOALS IN CLINICAL PRACTICE (cont)**

4. Periodic education/updates about specific documentation needs determined by setting/payers.
5. Perform quarterly documentation review with staff/self assessment (or more often for new hires) to provide feedback and assess compliance to standards.
6. Utilize the *Guide* when documenting (ie, identify pathology, impairments, functional limitation, and disability)

#### **RECOMMENDATIONS TO**

##### **IMPROVE DOCUMENTATION IN CLINICAL PRACTICE**

1. Review all documentation forms/procedures with new hires including facility specific abbreviations.
2. Provide documentation samples of staff documentation (ie, initial examinations/evaluations, progress notes, discharge notes as examples) and provide feedback individually.
3. Periodically review how to document for insurance requirements (i.e. total timed code treatment minutes, total treatment time in minutes, etc).

#### **RECOMMENDATIONS:**

##### **IMPROVE DOCUMENTATION IN CLINICAL PRACTICE (cont.)**

1. Provide periodic inservices to ensure documentation compliance.
2. Establish goal writing exercises for a variety of patient/client situations.
3. Others?

Review the 2 examples of typical physical therapy notes and discuss the following:

- a. What can be done to improve the documentation examples?
- b. Discuss problems typically shown in PT and PTA documentation
- c. Reflect on your own notes – what will you do differently?

#### APTA RESOURCES

1. Defensible Documentation Resource
2. Guidelines for Documentation
3. Peer Review/Utilization Review Guidelines
4. *Guide to Physical Therapist Practice*
5. Code of Ethics
6. Guide for Professional Conduct
7. Criteria for Standards of Practice for Physical Therapy
8. Medicare Guidelines
9. Documentation online course (future)

#### DOCUMENTATION RESOURCES

1. Provision of Therapy Services by Students under Medicare Part B  
[http://www.apta.org/AM/Template.cfm?Section=Assistants\\_Aids\\_Students&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31946](http://www.apta.org/AM/Template.cfm?Section=Assistants_Aids_Students&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31946)
2. CMS Transmittal 60

<http://www.cms.hhs.gov/transmittals/downloads/R60BP.pdf>

3. Guidelines: Physical Therapy Documentation Of Patient/Client Management  
[http://www.apta.org/AM/Template.cfm?Section=Policies\\_and\\_Bylaws&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31688](http://www.apta.org/AM/Template.cfm?Section=Policies_and_Bylaws&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31688)

4. HIPAA General Information

<http://www.cms.hhs.gov/HIPAAGenInfo/>

#### DOCUMENTATION RESOURCES

5. **OPTIMAL**

<http://www.apta.org/AM/Template.cfm?Section=Home&CONTENTID=30366&TEMPLATE=/CM/ContentDisplay.cfm>

6. **CERT Reports**

[https://www.cms.hhs.gov/apps/er\\_report/index.asp](https://www.cms.hhs.gov/apps/er_report/index.asp)

7. **Medicare Regulations On Timed Codes And Documentation Of Time**

<http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf>

**DOCUMENTATION RESOURCES**

8. **Direction And Supervision Of The Physical Therapist Assistant**

[http://www.apta.org/AM/Template.cfm?Section=Policies\\_and\\_Bylaws&CONTENTID=25672&TEMPLATE=/CM/ContentDisplay.cfm](http://www.apta.org/AM/Template.cfm?Section=Policies_and_Bylaws&CONTENTID=25672&TEMPLATE=/CM/ContentDisplay.cfm)

9. **Provision Of Physical Therapy Interventions And Related Tasks**

[http://www.apta.org/AM/Template.cfm?Section=Policies\\_and\\_Bylaws&CONTENTID=25472&TEMPLATE=/CM/ContentDisplay.cfm](http://www.apta.org/AM/Template.cfm?Section=Policies_and_Bylaws&CONTENTID=25472&TEMPLATE=/CM/ContentDisplay.cfm)

10. **Peer Review**

[http://www.apta.org/AM/Template.cfm?Section=Policies\\_and\\_Bylaws&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=29994](http://www.apta.org/AM/Template.cfm?Section=Policies_and_Bylaws&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=29994)

11. **Defensible Documentation Resource: Available on the APTA web site**

<http://www.apta.org/documentation>

**QUESTIONS?**