Defensible Documentation

Components of Documentation within the Patient/Client Management Model

I. Initial Examination/Evaluation

A. Examination
(History, Systems Review, Tests and Measures)

B. Evaluation

C. Diagnosis

D. Prognosis/Plan of Care
(Prognosis, Plan of Care, Goals, Goals, Components of well written goals, Interventions for the plan of Care, Discharge Disposition/Planning)

II. Documentation of a Visit/Encounter

A. How to Convey Skilled Interventions in Daily Notes

B. How to Communicate Progression of Care and Ongoing Assessment in Daily Notes

C. Progress Reports

D. Support for Timed Interventions

E. Caution: SOAP Notes and Flow Sheets

III. Reexamination/Reevaluation

IV. Discharge/Discontinuation Summary

What follows is a description of the main documentation elements of patient/client management: 1) initial examination/evaluation, 2) visit/encounter, 3) reexamination, and 4) discharge or discontinuation summary.

I. Initial Examination/Evaluation

Components of an Initial Examination/Evaluation (from APTA's Documentation Guidelines)

Documentation of the initial encounter is typically called the "initial examination," "initial evaluation," or "initial examination/evaluation." Completion of the initial examination/evaluation typically is completed in one visit but may occur over more than one visit. Documentation elements for the initial examination/evaluation include the following: examination, evaluation, diagnosis, prognosis, and a plan of care.

A. Examination

The examination component of the patient/client record documents pertinent findings from the patient's/client's history and the systems review along with findings from various test and measures. It is the findings from these three sections that the physical therapists will use to evaluate the patient/client and determine the diagnosis, prognosis, and plan of care, including goals, selected interventions, and discharge planning. Each section of the examination is described in further detail below:

1. History

The history section of the examination is a collection of information that can be gathered through a patient/client or family/caregiver interview and includes a review of past and current medical and social information. The medical history may include pertinent medical diagnoses, surgical history, previous and/or current interventions, and a list of current equipment, environmental modifications, and medications. It may contain information about previous clinical tests (X-rays, CT scan, etc) and a general review of current health status. For pediatric patients/clients, the medical history may also include history of the mother's pregnancy and complications, birth history, neonatal complications, and age when developmental milestones were achieved. The social history may include information on the patient's/client's premorbid and current living environment, education/work status, and cultural preferences, including preferred language. In addition, information on a patient's/client's previous level of function and comorbidities that could affect the rate of recovery and/or rehabilitation should be included. For pediatric patients/clients, the social history also includes information on the family. This includes information on the child's parents/guardians/caregivers, siblings, and other important people in the child's life. Family history documents the resources, priorities, and needs of the family including information on the child's daily routines, activities, and interests. The social history also includes information on child care, school, and other community activities including play, leisure/recreation, and socialization.

Back to Top

For patients in a skilled nursing facility, a patient's history may be gathered from the hospital discharge summary, current and past facility assessments, previous Minimum Data Sets (MDS) if applicable, and the nursing/consults section of the patient's medical record. Also, the physical therapist should review documentation of the patient's previous functional maintenance program or restorative nursing program if applicable as this will alert the therapist to an understanding of the patient's prior level of function. It is critical for the therapist, through comprehensive record review and patient/caregiver interview, to obtain an accurate social history and anticipated discharge disposition, including current and potential support structure available upon discharge. This information is needed for appropriate goal setting and discharge planning to any setting, including long term placement.

It is important for all providers to provide a complete and thorough history that highlights pertinent information relevant to the patient's/client's or family's/caregiver's reason for seeking physical therapy services. The history should clearly identify the patient/client and family/caregiver concerns. A patient's/client's medical and/or social history provides essential details used in the physical therapist's evaluation and determination of prognosis, goals, and the plan of care. For example, a patient/client with a wound who also has a history of diabetes may require increased intensity, frequency, and duration of services. Likewise, a patient/client with a history of a traumatic brain injury may require increased duration of services due to cognitive deficits or loss of short term memory. Similarly, physical therapy management of a pediatric patient/client with cerebral palsy who is living in the foster care system may require coordination of services across multiple agencies and providers. The impact that these histories have on the current problem should be identified and clearly explained in the evaluation and the plan of care.

2. Systems Review

A systems review is a necessary component of any initial examination. It is a brief or limited examination of the anatomical and physiological status of the cardiovascular/pulmonary, integumentary, musculoskeletal, and neuromuscular systems and the communication ability, affect, cognition, language, and learning style of the patient/client. Information gathered from a systems review is imperative as it assists the physical therapist in determining conditions that may affect the current chief complaint. During this review, the physical therapist collects and records information regarding a patient's/client's ability to initiate, sustain, and modify purposeful movement as well as communication skills, cognitive abilities, and other important personal factors that might influence care or the performance of an activity that is pertinent to function. For the pediatric patient/client, the systems review may also include consideration of the child's safety and well-being, nutrition, behavior/attention, and self determination.

Because patients/clients are able to access the services of a physical therapist without a referral in many states, it is important to include a comprehensive systems review to assist the physical therapist in identifying potential conditions that would require consultation with or referral to another provider. The APTA Guide to Professional Conduct states that if findings are outside of the scope of the physical therapist's knowledge, experience, or expertise, the physical therapist shall refer to an appropriate practitioner.

Back to Top

While the systems review is a very important element of the initial examination, this can be completed in a relatively short period of time by experienced clinicians. In many cases, it may be the physical therapist who first recognizes a problem that requires further examination by another clinician. In addition, some patients/clients may not have seen a primary care physician recently. Failure to perform a complete systems review can put your patients/clients and you at risk.
Consider the following three examples:

Case 1: A 38-year-old male with a complaint of knee pain presents to your clinic for an initial evaluation. As part of your initial examination/evaluation you record his blood pressure at 160/ 98. After a discussion with the patient/client, you call his family medicine physician regarding these findings concerned that the patient/client may have undiagnosed high blood pressure. The patient/client returns a week later, on a new medication to lower his blood pressure.

Case 2: A 47-year-old female with a recent left ankle sprain presents for an initial evaluation. In addition to weakness in her left ankle, you note weakness throughout her left side when compared with the right side. This finding along with others from the patient/client history and examination may lead you to contact another provider in consideration of a more systemic cause of her symptoms.

Case 3: A 3-month old infant with past medical history of prematurity is referred to physical therapy with a diagnosis of torticollis. As part of your systems review, you note that the infant is unable to visually fix or track an adult face or a toy. You discuss a referral back to the child's pediatrician or ophthalmologist.

Case 4: An 85 year old male status post left hip replacement with prior level of function listed as independent presents for an initial examination. In performing a systems review, the patient presents with moderately impaired cognition that significantly varies from the patient's current and prior level of function as documented in the nursing portion of the assessment. The therapist alerts the nurse and refers the patient to the patient's primary care physician for reassessment prior to initiating treatment.

Case 5: A 72 year old female with past medical history of hypertension, anemia, GI bleed, wrist fracture, and degenerative joint disease (DJD) is referred for gait training, pain management and strengthening status post thoracic compression fracture. During chart review the therapist notes the patient has been prescribed an anti-hypertensive medication, a SERM (selective estrogen receptor modulator), and a non-steroidal anti-inflammatory (NSAID). After patient interview and initial review of systems, the therapist asks to see the patient's medications. The patient reports the previously known meds, but also states she is taking an antidepressant and aspirin daily. Due to the fact the patient has a history of GI bleed and anemia, you question her regimen of aspirin and NSAID, and call her primary physician to insure he is aware the patient is taking both. He is not aware, and gives you a verbal order to discontinue the aspirin. You advise the patient of the verbal order, document the order, document the consultation with the physician, and communicate the exchange to a nurse manager.

Back to Top

3. Tests and Measures

From the information gathered in the history and systems review, the physical therapist determines a hypothesis for a diagnosis. The physical therapist then determines which tests and measures are required to further prove (or disprove) the hypothesized diagnosis or diagnoses. In the documentation of tests and measures, a physical therapist should clearly identify the specific tests and measures and any associated finding or outcome. There is no specific recommendation for how tests and measures are ordered or displayed; however, the record of findings should be easy to follow. PTs may choose to document certain systems together, they may follow a natural progression of an evaluation by patient position (e.g., from seated to supine to prone to standing), or they may have the patient complete simple tasks before complex activities. In pediatrics, the physical therapist may decide to present the tests and measures related to participation and activity (function) before the tests and measures related to body structure and function.

In addition to more traditional tests and measures (ROM, strength, balance, edema, etc), the physical therapist should rely on standardized tests and measures. These standardized tests can be specific to a diagnosis (knee, low back) or a more general measure relating to disability (OPTIMAL, SF-36) or patient satisfaction. OPTIMAL (Outpatient Physical Therapy Improvement in Movement Assessment Log) is a patient self-report instrument designed to assess a patient's self-reported difficulty and confidence level on 21 actions that describe movements.

Patient/client satisfaction has been shown to influence the outcomes of care. The Physical Therapy Patient Satisfaction Questionnaire has been shown to be reliable and valid. You may access the literature on this tool at the following link: http://www.ptjournal.org/cgi/reprint/80/9/853

Choosing standardized tests and measures requires careful thought and consideration, including patient/client factors such as tolerance of testing, time involved, environment, and the psychometrics of the test. Some will quantify pain or function, while others measure the degree of impairment or disability. In addition, some tests are diagnostic while others are more prognostic in their intent. Physical therapists should use tests and measures that produce data that are accurate and precise enough to allow the therapist to make correct assumptions about the patient/client's condition. Appropriate use of standardized tests and measures are valuable in determining the patient's/client's progress and outcomes through the episode of care and can provide a standard measure of comparison for clinical outcomes. In pediatric practice, outcomes are often documented by achievement of behavioral objectives; thus, documentation of initial test and measures should be precise to record the child's current status on identified priority tasks, including the conditions and criterion under which the behaviors are demonstrated. When documenting the results of standardized tests and measures therapists are encouraged to follow the test's guidelines related to accurate reporting of test scores. In addition, therapists should document any variation of the standard protocol that was needed when administering the test as well as any qualitative findings that are relevant to interpreting the test results.

Back to Top

It is also important to take into account the environment when considering tests and measures. For example, testing related to ergonomics may be best performed in the client's work environment. In a pediatric practice, when appropriate, tests and measures at the participation level should be conducted in the child's natural environments, at home, school, or community. Observations made during key routines and activities such as negotiating from the bus to the classroom or negotiating playground equipment should be documented.

APTA's *Catalog of Tests and Measures* is an essential tool that describes available tests and measures that physical therapists may use in their patient/client examinations. It contains approximately 500 specific tests and measures used by physical therapists and approximately 2,000 citations on reliability and validity of measurements obtained using those tests and measures. You can access information about the *Catalog of Tests and Measures* at the following link: http://guidetoptpractice.apta.org/
As an additional reference for practice in pediatrics, the Section on Pediatrics has a list of pediatric assessment tools available on their website at: http://www.pediatricapta.org/pdfs/AssessScreenTools2.pdf.
An additional resource is CanChild Centre for Childhood Disability (www.canchild.ca). This site provides a variety of resources on pediatric outcomes and assessment tools.

B. Evaluation

An evaluation is a thought process that may or may not include formal documentation. This evaluation process is a synthesis of all of the data and findings gathered from the examination and collaborative decision making with the patient/client. The evaluation process leads to documentation of such items as impairments, activity limitations, and participation restrictions. It should guide the physical therapist to a diagnosis and prognosis for each patient/client. In pediatrics, consistent with family-centered care, the documentation of the evaluation reflects a strength-based approach. An evaluation would typically include the child's strengths, readiness to learn a new skill, and areas of concern, priority or need. Areas of need would include the child's participation restrictions in the home, school, and community, activity limitations, and body structure and function impairments. The evaluation should also note the child and environmental characteristics hypothesized to be facilitators or barriers to the child's activity and participation.

The documentation of an evaluation can use formats such as a problem list or a statement of assessment with key factors (e.g., cognitive factors, comorbidities, social support) influencing the patient/client status. While the documentation of an evaluation may come in different formats, the record should convey to the reader what examination factors are relevant to the current complaint. The evaluation process should arrive at a physical therapy diagnosis and a prognosis for a functional outcome(s) at the conclusion of physical therapy services.

Back to Top

Narrative example:
Clinical Impression: Pt is a 68-year-old female with significant limitations in right knee AROM, strength, weight bearing tolerance. Pt also limited due to pain and edema in the right leg. Pt requires assistance for transfers, bathing, dressing, grooming, and gait at this time. Pt was independent in all activities prior to admission, is otherwise in good health and has good family support. Pt requires physical therapy intervention to resume normal activity.
Pediatric Narrative Example: John is a three year old boy with significant developmental delays. He is able to communicate to show his likes and dislikes, walks independently, feeds himself finger foods, and manipulates toys with both hands. John can attend to structured learning activities and remembers routines and activities. He has a very supportive family and two playful siblings. John is ready to learn to use his motor abilities during play activities and games with other children. Currently John does not spontaneously initiate play with peers or siblings and has limited verbal communication. He has difficulty with jumping and ball skills. John requires supervision on stairs, assistance for eating with utensils, dressing, and bathing and occasionally falls on outdoor terrain. He requires physical therapy intervention to promote his strength, balance and motor planning, especially considering weakness on his left side. A consistent team approach for communication and positive behavior support is recommended.
Problem list example:
Impairments: Edema, impaired balance, impaired gait, impaired joint mobility, impaired muscle strength, and pain
Activity Limitation: Inability to stand without minimal assistance, inability to ambulate greater than 20' with moderate assistance, requires set-up for bathing and minimal assistance for dressing.
Participation Restrictions: Environmental barriers and home barriers

C. Diagnosis

To best understand the scope of practice of the physical therapist related to diagnosis, one must first understand the concept and use of a disablement model. The concept of *disablement* refers to the "various impact(s) of chronic and acute conditions on the functioning of specific body systems, on basic human performance, and on people's functioning in necessary, usual, expected, and personally desired roles in society." (Jette AM, 1994; Verbrugge L, 1994) Thus, the disablement model is used to delineate the consequences of disease and injury both at the level of the person and at the level of society. The disablement model provides the conceptual basis for all elements of patient/client management that are provided by physical therapists. The International Classification of Functioning, Disability and Health (ICF) was developed by the World Health Organization in 2001 and was endorsed by the APTA in 2008. The ICF, with a focus on *human functioning*, provides a unified, standard language and framework that facilitates the description of the components of functioning that are impacted by a health condition. It enables the collection of data as to how people with a health condition function in their daily lives rather than focusing on their diagnosis or the presence or absence of disease. The ICF describes the situation of the individual within health and health-related domains and within the context of environmental and personal factors.

Back to Top

A diagnosis is determined by the physical therapist after the examination and evaluation process. The objective of the diagnostic process for the physical therapist is to identify discrepancies that exist between the level of functioning that is desired by the patient/client and the capacity of the patient/client to achieve that level. Hence, diagnoses made by the physical therapist are typically made at the impairment, activity, and participation levels.

The diagnosis by a physical therapist should be clearly documented and can take different formats. In most cases, physical therapists select the corresponding ICD code that reflects the results of the examination and evaluation process. In addition, the selection of the appropriate Preferred Physical Therapist Practice Patterns as outlined in the *Guide to Physical Therapist Practice* will provide additional insight. A thorough description of the Preferred Physical Therapist Practice Patterns is available in the *Guide to Physical Therapist Practice*, but some examples include:

- Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated With Localized Inflammation (4E)
- Impaired Motor Function and Sensory Integrity Associated With Progressive Disorders of the Central Nervous System (5E)
- Impaired Aerobic Capacity/Endurance Associated With Cardiovascular Pump Dysfunction or Failure (6D)
- Impaired Integumentary Integrity Associated With Partial-Thickness Skin Involvement and Scar Formation (7C)

For billing purposes, diagnoses are coded according to ICD coding. While the practice patterns are also numbered (i.e., 4E—see example above), this numbering is not the same as ICD coding. When coding diagnoses by ICD for reporting purposes, you may be required to use codes that relate to the impairment for which you are treating the patient/client. In fact, some payers have specific policies for reporting medical and treatment diagnoses, e.g., Medicare's Local Coverage Determinations (LCDs), so it is important to be familiar with the specific payer policies. For example, if you have a patient/client with a cerebral vascular accident, the medical diagnosis code may be 434.9 (artery occlusion, unspecified). But the reason that you are seeing the patient/client may be best coded as Gait, spastic (781.2). It is best to include more information and incorporate codes specific to function so the reviewer knows why the patient/client is receiving therapy. It is recommended that the primary diagnosis on the claim form be the impairment-based diagnosis. The secondary ICD code could be the medical diagnosis. Some payers prefer as much specificity in ICD coding as possible. There are opportunities to include two numbers after the decimal point for some diagnoses. Therefore, it is recommended that you have a current ICD book.

To meet requirements of various pediatric practice settings, medical diagnoses may also be noted, i.e. in Early Intervention, medical diagnosis is included secondary to medical diagnosis being one criterion for eligibility of services under the Individuals with Disabilities Education Improvement Act (IDEA, 2004). In school-based practice, one of the disability categories under IDEA is similarly reported to document eligibility of services. In both early intervention and school-based practice, physical therapy diagnosis may not be noted on multidisciplinary Individualized Family Service Plans (IFSPs) or Individualized Education Programs (IEPs); however, the selection of the Preferred Physical Therapist Practice Pattern can be noted in supplemental physical therapy documentation. Traditionally, IFSPs and IEPs are team documents to guide early intervention and school services under IDEA; however they may not include a physical therapy diagnosis but only a medical diagnosis.

Back to Top

Note 1: Certain state practice acts contain specific regulations regarding physical therapy diagnosis. Review the State Advocacy Web page for information about your state practice act.

Note 2: Third-party payers also may specifically identify ICD-9 codes paired with CPT codes that it considers to be medically necessary.

D. Prognosis / Plan of Care

1. Prognosis

Documentation of the prognosis 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. It is important to differentiate between the patient's/client's medical prognosis and his/her rehabilitation prognosis. It is also recommended to consider the prognosis for the entire episode of care and not just one specific timeframe (i.e., during the acute care stay) as this may significantly affect options for continued physical therapy and/or skilled care.
In pediatrics it is recommended that therapists document the clinical reasoning that supports the stated prognosis. As an example: "The child's prognosis for independent walking is positive secondary to the child presenting with a Gross Motor Functional Classification System level of I and a supportive family who provide appropriate movement opportunities."

2. Plan of Care

Documentation of the plan of care includes the following components, all of which are further described below:

1) Overall goals stated in functional, measurable terms that indicate the predicted level of improvement in function. These goals are made in collaboration with the patient/client and other appropriate stakeholders.
2) A statement of interventions/treatments to be provided during the episode of care.
3) Duration and frequency of service required to reach the goals.
4) Anticipated discharge plans (May be part of the prognosis or written separately).
5) The physical therapy plan of care for a child from birth to three can be embedded in the IFSP. The plan of care for a child of school age (3-21) can be embedded in their IEP, or documented in a 504 plan as a supplemental service to support modifications and adaptations within the school environment. Both in early intervention and school based services, the IFSP/IEP plan of care is developed through team collaboration inclusive of the family and when appropriate, the child. In early intervention the plan of care includes plans to prepare the child for transition out of early intervention. In school based services, when the child reaches the age of 16 the plan of care includes plans to transition the child to adulthood.

Back to Top

*Note: Medicare includes diagnoses within their documentation requirements for the plan of care. See http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf, Section 220.1.2.B.

Goals

Physical therapists develop goals with the patient/client and/or family/caregiver at the onset of care for a variety of reasons. Goals provide an opportunity for the patient/client and/or family/caregiver to describe what functional changes they hope to accomplish through physical therapy services. The goals established during an initial evaluation, while dynamic, should provide the foundation on which the plan of care is directed. Furthermore, the physical therapist can demonstrate progression (or lack of progression) and ongoing communication of expected outcomes and discharge planning, through updates, changes, deletions, and additions to these initial goals in subsequent documentation (daily notes, summaries and re-examinations).

Goals can be written to address impairments, activity limitations, participation restrictions, and prevention. To utilize goals effectively to direct the progression of physical therapy services, physical therapy goals should be objective, measurable by re-evaluation, related to the impairment, activity limitation, and participation restriction and include anticipated timeframes. In addition, most physical therapy goals should be stated in functional terms related to the patient/client rather than the physical therapist. Writing goals in functional terms is important because they support both the medical necessity of the physical therapy services and the need for the skilled intervention of the physical therapists or physical therapist assistants. The functional goals are a PT's means of conveying to external stakeholders why this patient/client requires physical therapy services, rather than simply a checklist of what needs to be accomplished. Consider the following examples of goals:

1. Increase shoulder flexion to 150 degrees
2. Decrease pain
3. Improve safety

The above goals do not identify the specific needs of a patient/client. It is important to go one step further and express why the patient/client needs to increase their ROM or level of assistance. For example, the therapist could document the above goals more functionally:

1. Increase shoulder flexion to 150 degrees to enable overhead activities.
2. Decrease pain to 2/5 on VAS with reaching activities.
3. Patient/client will walk with a standard walker independently within the home to complete activities of daily living.

Medicare and third-party payers determine the physical therapy benefit or continuation of physical therapy services based on evidence of a significant functional change in a reasonable amount of time. In other words, payers want to see progress. In certain circumstances, therapists may need to communicate very clearly what this means for the patient/client. For example, for some patients/clients, progressing from a maximum level of assistance to a moderate level of assistance may not appear to be a significant change in their status. However, if that degree of change represents a patient's/client's ability to go home with caregiver support, this must be conveyed in the documentation.

Back to Top

Time frames for the achievement of anticipated goals and expected outcomes are determined by the physical therapist to maximize the effectiveness of care but must be realistic. They may be written in terms of time (i.e., days, weeks, months) or in terms of visits in which the goal will be achieved. PTs also can clarify if the goal is *short term* or *long term*. A short-term goal implies that the patient/client will achieve the activity in the near future (e.g., in a day, within a week, etc.) or may indicate a change that needs to occur before long-term or outcome goals can be met or exceeded by the patient/client.

Finally, goals should be designed based on collaboration with the patient/client and/or family/caregiver. The documentation should reflect both collaboration and agreement on the goals. Updating goals during a physical therapy episode of care is important to clinical practice and should be documented clearly and frequently. Documentation of goals after the initial evaluation will be discussed in later sections.

Components of well written goals include:

1. Identification of the person who is receiving therapy and will carry out the program. This is generally the patient/client, but may also be the caregiver or family members.
2. Description of the movement or activity that the patient/client will perform such as stand-pivot transfer from bed to chair.
3. A connection of the movement/activity to a specific function such as to eat breakfast or to perform dressing.
4. Specific conditions in which the activity will be performed such as with full weight bearing on both lower extremities or with the use of a walker.
5. Factors for measuring performance such as with contact guard assistance or with 2/5 pain on VAS.
6. The time frame for achieving the goal.[1]

[1]*Physical Therapy Reimbursement News*, Volume 13, Number 3

Examples:

1) Short-term goal: Patient/client will walk from his bedroom to the bathroom with a walker in 2 minutes within 1 week to prevent accidents which may lead to falls.

2) Short-term goal: Patient/client will report a decrease in pain in the right shoulder after exercise to 2/10 within 5 visits to enable her to move walker in home.

3) Short-term goal: Patient/client will demonstrate ambulation with a standard walker x 100' with contact guard and stable vital signs in one week.
4) Long-term goal: Patient/client will ambulate independently with a straight cane greater than 500' for community activities in 4 weeks.

1) Pediatric long term goal: In 6 months, the child will walk with one hand held from the family room to the kitchen, a distance of 25 feet, at dinner time.

Back to Top

Interventions for the Plan of Care

The physical therapy plan of care should include an intervention plan or a description of the planned treatment. It is important that physical therapists consider a number of factors when they write the plan of care for each patient/client. Factors to consider include, but are not limited to, the following:

1) The patient's/client's status, including physical, cognitive, and emotional factors (i.e., acuity, prognosis, learning barriers, language barriers, etc.);
2) The patient's/client's expected progression;
3) Discharge disposition/plan (see below); and
4) Whether or not additional staff, either another PT or a PTA, will provide some of the interventions during the episode of care.
5) The physical therapy plan of care in early intervention and school-based practice is often incorporated into the child's general team intervention plan provided in the IFSP or IEP, respectively. The general plan may also include general methods or strategies that will be used by the team to assist the child and family in early intervention or child in school-based practice in meeting their goals. More specific details regarding the intervention strategies are contained in the therapist's supplemental intervention plan or daily visit documentation notes.
6) The physical therapy plan of care in a skilled nursing facility is incorporated into the patient's individualized, interdisciplinary comprehensive care plan which reflects problem areas documented through data obtained on the MDS. The therapist should initiate and document patient and caregiver training in addition to providing the results of the initial evaluation to the interdisciplinary team.

When a physical therapist is providing care in conjunction with a physical therapist assistant, the documented plan of care should be a clear communication tool for coordination of care. It is this documented plan of care, (along with verbal communications as indicated) that guides the PTA in following the therapist's plan during the episode of care. Consider the following two examples:

Plan of Care Example A:
Gait training, therapeutic exercises, modalities prn

Plan of Care Example B:

1) Gait training with standard walker—progress distance up to 100' with stable vital signs.
2) Therapeutic exercises for both lower extremities—avoid flexion past 90 degrees; add up to 5 pounds of weight once AROM is within 15 degrees of normal limits.
3) Pulsed ultrasound to bilateral knees 1.5 W/cm2 X 5 min per knee after therapeutic exercise.

Back to Top

Plan of Care Example B, by providing more information, is a much better tool for communicating with other staff in directing the care of the patient/client than Plan of Care Example A. Writing a more detailed plan of care can improve patient/client safety and quality of care. Consider a scenario in which a PT and a PTA are not often in the same vicinity (home health, skilled nursing facility, or acute care). A plan of care that contains the level of detail shown in Plan of Care Example B, in conjunction with the patient's/client's anticipated goals, can ensure much better coordination of care. Written communication should provide the details of when the patient/client should be reevaluated by the PT before the plan of care is progressed.

In summary, providing increased detail in the initial goals and the treatment plan identifies the expected progression of the patient/client. The PT/PTA team can follow the patient's/client's progression more closely and identify any unanticipated problems or red flags more readily. A detailed plan of care allows patient/client progression (or lack of progression) to be easily identified.

Discharge Disposition/Planning

It is considered good practice to anticipate discharge planning from the start of every episode of care. This is particularly important in settings in which a physical therapist's evaluation assists in determining discharge disposition or when discharge planning takes time and coordinated effort with other health care professionals. In other circumstances, a discharge disposition/plan may be included in a prognosis statement.

In certain pediatric settings, discharge and discontinuation may include additional factors. In early intervention and school based practice disposition planning is referred to as transition planning and will be documented in the child's IFSP and IEP respectively. The transition plan to discontinue physical therapy services should be collaborative and are based on the child's needs. Individual students may not require skilled physical therapy every year they attend school. They may be discontinued from skilled PT service one year, but referred again, the next year as their individual needs and the physical environment changes.

Back to Top

II. Documentation of a Visit/Encounter

Documentation of a visit or encounter, often called a *daily note* or *treatment encounter note*, documents sequential implementation of the plan of care established by the physical therapist. It includes changes in patient/client status, a description and progressions of specific interventions used that may be documented in a flowsheet format, and communication among providers. It also may include specific plans for the next visit or visits.

Documentation of a visit or encounter may include:

1) Patient/client or caregiver report
2) Interventions provided including frequency, intensity, time, duration, and level of physical &/or cognitive assistance provided as appropriate (see discussion of support for timed interventions below). Examples include:
    - Right knee extension, three sets, 10 repetitions, 10# weight, full range with 100% manual cues to facilitate use of medial quad and 50% verbal cues for timing
    - Transfer training bed to chair with sliding board; required moderate physical assist of 1 and 100% verbal cues for placement of board
    - Description of equipment provided (sliding board, long handles sponge) for home use
    - Description of education/training provided (Pt educated in proper lifting technique from floor to chest height and able to demonstrate technique with up to 25 pounds)
    - Ultrasound at 1.5 W/cm2 for 5' to the L medial knee joint
3) Patient/client response to treatments/interventions.
4) Communication/collaboration with other providers/patient/client/family/ significant other as applicable/indicated.
5) Factors that modify frequency or intensity of intervention and progression within the plan of care.
6) Plan for next visit(s) including interventions with objectives, progression parameters and precautions, if indicated within the plan of care.

Back to Top

A. How to Convey Skilled Interventions in Daily Notes

It is important to convey in the documentation of a visit or encounter (i.e., daily note) that the interventions provided require the skills of a physical therapist or physical therapist assistant under the direction and supervision of a physical therapist. Many therapists consider the daily note to be just a 'listing' of what treatments took place. While it is important to include the interventions provided, this does not demonstrate skilled care. Demonstration of skilled care requires documentation of the type and level of skilled assistance given to the patient/client, clinical decision making (PT) or problem solving (PTA), and continued analysis of patient progress. This can be expressed by recording both the type and amount of manual, visual, and/or verbal cues used by the therapist to assist the patient/client in completing the exercise/activity completely and correctly. It can also be illustrated by documenting why the therapist chose the interventions and/or why the interventions are still necessary. Some ways of documenting skilled care include documenting what the therapist observes before, during, and after an intervention, the patient's/client's specific response to the intervention, determining functional progress, etc. The interventions provided by the physical therapist/physical therapist assistant should correlate to the impairment, activity limitation, participation restriction, and the goals stated in the plan of care. For example: "Patient required verbal and manual cues to complete shoulder flexion and abduction exercises without substitution. Therapeutic exercise and right shoulder mobilization resulted in increased flexion from 90° to 110° allowing the patient/client to reach overhead and complete activities of daily living. Patient still unable to perform overhead activities needed in performance of job duties." Another example is "Patient required moderate verbal and manual cues to control movement of right leg in swing phase of gait. Therapeutic exercise to hip flexors/extensors and knee flexors/extensors at 50% of one repetition max has resulted in increased strength. Patient still demonstrates inability to clear right foot 100% of the time during gait increasing her risk for falls".

When a clinician documents an assessment as "patient/client tolerated treatment well," it does not provide evidence of skilled services. In addition, it does not give enough information regarding your clinical decision making or problem solving to demonstrate what actually happened if this visit were to be called into question in a legal case.

In pediatrics, especially school based practice there may be some misconception that daily notes are not required. However, skilled physical therapy intervention should be documented for each visit. In skilled nursing facility settings, there may not be payer specific requirements for daily notes. However, it is best practice for clinicians to have a system in place to track what skilled interventions were provided in daily treatments and why those treatments required the skills of a physical therapist or physical therapist assistant so that when the weekly note/progress report is written, there is enough factual evidence to complete the documentation efficiently and completely.

Back to Top

B. How to Communicate Progression of Care and Ongoing Assessment in Daily Notes

At its most basic level, a daily note serves as a record of all treatments and skilled interventions provided along with the time of the services so there is justification for what services are billed on the claim form. For each daily note, there could also be a notation as to whether there were changes in the impairments, activity limitations and participation restrictions as a result of the interventions and if there is progress toward the goals and ultimately toward discharge. (As noted earlier some payer guidelines restrict a physical therapist assistant from documenting this information) If any measurements are taken, they should be recorded and relate back to the achievement or lack of achievement toward the functional goals. When a physical therapist is completing the daily notes, and the ongoing assessment is demonstrated, frequently with this level of detail, a progress summary or progress report may not be required.

C. Progress Reports

A *progress note or progress report/summary* is often referred to in third-party payer, state, and facility regulations. The progress report/summary is similar to a daily note but includes more detailed information on the patient's/client's current status as compared with a previous date(s) (i.e., date of initial evaluation, last reexamination, or last progress report). In most cases, important changes in examination findings are described. Note that the daily notes and progress reports/summaries work together. If progress is described in daily notes then a progress report/summary may not be necessary. This is particularly true for shorter or less intense episodes of care.

Physical therapists may choose to title certain daily notes as progress reports/summaries and include this level of detail at one time. Progress reports/summaries should be performed regularly on all patients to substantiate the ongoing need for physical therapy services. The report should provide an update on the patient's/client's status as it relates to the physical therapy goals and plan of care. Keep in mind that any note that requires assessment of the patient/client and his/her progression or lack of progression can only be written by a physical therapist. Physical therapist assistants cannot write this type of assessment as noted in APTA policy, Medicare regulations, other third-party payer rules, and state law. While the physical therapist is responsible for progress reports/summaries, the physical therapist may use data gathered by PTAs.

In early intervention, a team progress report is provided on a six month basis when the team reviews the IFSP. In this review, the family and child's progress toward their outcomes and objectives are noted and the plan of care is revised as indicated. In school based practice progress reports to parents are required on the same frequency that parent's receive reports on academic progress.

In the Home Health setting, a progress report is required as part of the recertification process if services are going to continue beyond the current 60 day episode of care. Recertification is required to be completed in the last 5 days of the current certification period. There is also a requirement of individual notes for every patient encounter.

Back to Top

In the Skilled Nursing Facility setting, a weekly progress note may be the only required documentation. The physical therapist and physical therapist assistant should collaborate on the information presented in the weekly note to insure the information supports the skilled nature of the services provided during the week and provides objective evidence of progress towards goals. Any further assessment of what changes to the plan of care might need to be made should be completed by the physical therapist.

D. Support for Timed Interventions

Physical therapists and physical therapists assistants are required to support the reporting of timed procedure and modality codes in their clinical documentation in many settings. This requirement derives from the Common Procedural Terminology (CPT) code definitions for procedures and modalities reported by physical therapists. The time reported should reflect direct one-on-one contact time with the patient (e.g., Medicare requires documentation of total treatment time spent on timed codes). If the setting does not use CPT coding, such as Home Health and Part A Medicare skilled nursing facilities, then the documentation must substantiate the total visit time.

For Medicare regulations on timed codes and documentation of time, please refer to http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf

For more information about the Skilled Nursing Facility setting: http://www.apta.org/Payment/Medicare/CodingBilling/SNF/

Medicaid regulations may have specific language on documentation for each state.

Back to Top

E. Caution: SOAP Notes and Flow Sheets

Many therapists choose to document in a standard SOAP note format for their daily notes and progress notes. While commonly used in clinical practice, SOAP notes are often incomplete. If a physical therapist utilizes the SOAP format, the following guidelines are recommended:

S: Subjective: This should reflect the patient's (and at times caregiver's) self report of status and response to previous treatment(s). Some tests and measures that are subjective may be included in the subjective portion of the SOAP note (e.g., self report such as the SF-36).

O: Objective: This should reflect the physical therapist's objective findings made through observation of the patient, as well as measurements and tests, such as circumferential measurements for edema, range of motion measurements, or heart rate before and after exercise. The treatment provided to the patient and the response to treatment on that specific date also should be included in this category, but it should not be in place of objective data.

A: Assessment: This should reflect the physical therapist's clinical decision making or the physical therapist assistant's clinical problem solving, including their professional assessment of the patient's progress, response to therapy, remaining functional limitations and possible precautions. It should never say "treatment tolerated well."

P: Plan: The physical therapist should provide specific information related to the plan for future services including patient/caregiver education and any possible changes in the treatment program. Do not simply say "continue."

Flow sheets are another common form of documentation for daily notes. While they may be a useful format to note specific interventions such as exercises, and parameters such as repetitions and weights, flow sheets often lack space for the physical therapist to include the elements that made those interventions skilled treatment as well as the assessment of the patient's status and plans for ongoing care. Evidence of skilled decision making and other critical factors should be included in the daily documentation. APTA's Guidelines: Physical Therapy Documentation of Patient/Client Management (BOD G03-05-16-41), state that "… other notations or flow charts are considered a component of the documented record but do not meet the requirements of documentation in and of themselves."

Back to Top

SOAP Notes: Pros and Cons

PROS	CONS
Simple format that is well understood and frequently used by physical therapists.	Does not easily offer a category for treatment on a specific date of service.
Prompts (S, O, A, P) remind physical therapists to include specific information.	Physical therapists might not know what information to place in a specific category or fail to include useful information because a category does not exist. For instance, the SOAP format does not clearly indicate where they should document a conversation with a physician or case manager.[1]

[1] *A Payer's Guide to Physical Therapy Documentation for Patient/Client Management*, Alexandria, VA: Department of Reimbursement, APTA; 2006.

Back to Top

III. Reexamination/Reevaluation

Reexamination is the process of performing selected tests and measures after the initial examination to evaluate progress and to modify or redirect interventions. The tests and measures may be repeated from the initial examination and/or include new elements of tests and measures in order to evaluate the patient/client's status. Reexamination may be indicated more than once during a single episode of care and for a number of reasons. A reexamination might be indicated for a number of reasons. However, due to certain payer regulations, many therapists confuse a clinical reexamination with a billable reevaluation code. In general, a billable reexamination of a patient/client should occur whenever there is an unanticipated change in the patient's/client's status, a failure to respond to physical therapy intervention as expected, the need for a new plan of care, and/or requirements based on state practice acts or other requirements (https://www.fsbpt.org/LicensingAuthorities/index.asp)

In clinical practice, a reexamination and reevaluation can serve many purposes. One of the most important objectives of the reexamination is to determine the patient's/client's progress or lack of progress toward the established goals and prognosis. The reevaluation compares similar data at two points in time and determines whether or not the plan of care needs to be updated or changed and how this will affect the expected outcomes and timeframe of care.
Physical therapy goals should be addressed noting where progress has (or has not) been demonstrated. If appropriate, new timeframes and new goals should be established, as well as confirmation of the clinical evaluation or impression, prognosis, and discharge recommendations. If progress has not occurred as expected, reasons for the lack of progress should be included (i.e., illness, comorbidity, etc). In addition, any changes to the interventions should be documented. Reexaminations can be performed and recorded only by the physical therapist.

In the case of the geriatric patient/client, it is recommended to document vital signs (e.g. blood pressure, heart rate, respiratory rate and pulse oximetry), as well as to record any medication changes with implications for functional recovery. This information may contribute to the information gathering for the Minimum Data Set (MDS).

In most cases in pediatric early intervention practice, the comprehensive team re-examination report is required annually as part of the annual formal team review of eligibility for services and review of the IFSP. In school based practice, comprehensive team reexamination, reevaluation and reassessment for the integrated educational assessment are performed every three years or as mandated by state and federal regulations (Individuals with Disability Education Improvement Act, 2004). This is a minimal requirement and may be done more frequently as indicated either by child's change of status, parent request and team decision or any requirements of individual state practice acts.

Back to Top

IV. Discharge/Discontinuation Summary

Documentation is required at the conclusion of physical therapy services. The purpose of the discharge summary is to summarize a patient's/client's progress toward goals, status at discharge, and future plans for self-management. Essentially, this is the last opportunity a therapist has to convey the outcome of physical therapy services. It is also a time to justify the medical necessity for the episode of care. Medicare requires that discharge summaries include all progress report elements.

It is the position of APTA and many state policies and payer regulations that only physical therapists can complete the discharge summary. Discharge occurs based on the physical therapist's analysis of the patient's/client's achievement of the predicted goals and expected outcomes. Important concepts to include in the discharge summary include current patient/client status; attainment of goals; goals that have not been attained; and recommendations and instructions that were provided to the patient/client, such as home program, equipment provided, and any patient/client or caregiver training/education. When a patient/client is discharged to another level of service (i.e., from an acute setting to home health or another inpatient setting), evidence of coordination of care should also be included. Issues related to patient/client compliance also may be noted as well as the number of completed visits. A discharge summary should comment if the patient/client stops coming to therapy against recommendation of the physical therapist. If the patient/client is discharged prior to achievement of goals and outcomes, there should be documentation as to the status of the patient/client and the rationale for discontinuation.

In pediatric early intervention, a discontinuation summary is typically written in the format of a Transition Report which provides information on the child's status and progress during birth to three services as they transition to preschool services under Part B of the Individuals with Disabilities Education Improvement Act, 2004. In school based practice, the closure of physical therapy intervention is termed *discontinuation* of services. This terminology is consistent with IDEA legislation. The decision is reflected in the IEP. Written documentation of the discontinuation should include a summary of the student's progress, the current status, and the rationale for discontinuing services. Discontinuation summaries in both early intervention and school based programs typically also provide recommendations for community resources to support the child's continued health, fitness, development, and well-being. In both early intervention and school based practice settings, a decision to discharge/discontinue physical therapy services is decided between the physical therapist and the team. The decision is related to whether physical therapy services are needed to support the child's and family's outcomes on the Individualized Family Service Plan in early intervention or on the child's goals on the Individualized Education Program in school.

Back to Top

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