Defensible Documentation elements

American Physical Therapy Association

TOP 10 TIPS

1. **Limit use of abbreviations.**
2. **Date and sign all entries.**
3. **Document legibly.**
4. **Report functional progress towards goals regularly.**
5. **Document at the time of the visit when possible.**
6. **Clearly identify note types, eg, progress reports, daily notes.**
7. **Include all related communications.**
8. **Include missed/cancelled visits.**
9. **Demonstrate skilled care and medical necessity.**
10. **Demonstrate discharge planning throughout the episode of care.**

Documenting Skilled Care

- Document clinical decision making/ problem-solving process.
- Indicate why you chose the interventions/ why they are necessary.
- Document interventions connected to the impairment and functional limitation.
- Document interventions connected to goals stated in plan of care.
- Identify who is providing care (PT, PTA, or both).
- Document complications of comorbidities, safety issues, etc.

Documenting Medical Necessity

- Services are consistent with nature and severity of illness, injury, medical needs.
- Services are specific, safe, and effective according to accepted medical practice.
- There should be a reasonable expectation that observable and measurable improvement in functional ability will occur.
- Services do not just promote the general welfare of the patient/client.

Tips for Documenting Evidence-Based Care

- Keep up-to-date with current research through journal articles and reviews, Open Door, Hooked on Evidence at www.apta.org.
- Include valid and reliable tests and measures as appropriate.
- Include standardized tests and measures in clinical documentation.

Documentation Format

INITIAL EXAMINATION

History – May include:

◯ Pertinent medical/surgical history	◯ Cultural preferences
◯ Social history	◯ General health status
◯ Growth and development	◯ Previous and current functional status/activity level
◯ Living environment	◯ Medication and other clinical tests
◯ Work status	◯ Current condition(s)/chief complaint(s)

Systems Review – Brief, limited exam to rule out problems in the musculoskeletal, neuromuscular, cardiovascular/pulmonary, and integumentary systems that may/ may not be related to the chief complaint and may require consultation with others. Also may include:

◯ Communication skills	◯ Factors that might influence care
◯ Cognitive abilities	◯ Learning preferences

Tests and Measures – Used to prove/ disprove the hypothesized diagnosis or diagnoses. Includes:

- ◯ Specific tests and measures: increased emphasis placed on standardized tests/measures, eg, OPTIMAL
- ◯ Associated findings/outcomes

Evaluation – A thought process leading to documentation of impairments, functional limitations, disabilities, and needs for prevention. May include:

- ◯ Synthesis of all data/findings gathered from the examination highlighting pertinent factors
- ◯ Should guide the diagnosis and prognosis
- ◯ Can use various formats: problem list, statement of assessment with key factors influencing status

Diagnosis – Should be made at the impairment and functional limitation levels. May include:

- ◯ Impact of condition on function
- ◯ Common terminology, eg ICD-9 CM coding or Preferred Physical Therapist Practice Patterns

Prognosis – Conveys the physical therapist's professional judgment. May include:

- ◯ Predicted functional outcome
- ◯ Estimated duration of services to obtain functional outcome

Plan of Care – May include:

- ◯ Overall goals stated in measurable terms for the entire episode of care
- ◯ Expectations of patient/client and others
- ◯ Interventions/treatments to be provided during the episode of care
- ◯ Proposed duration and frequency of service to reach goals
- ◯ Predicted level of improvement in function
- ◯ Anticipated discharge plans

Tips for Documenting Progress

- Update patient/client goals regularly.
- Highlight progress toward goals.
- Clearly indicate if this is a progress report by demonstrating patient/client improvement.
- Show comparisons from previous date to current date.
- Show a focus on function.
- Re-evaluate when clinically indicated.

Avoid

- "Patient/client tolerated treatment well"
- "Continue per plan"
- "As above"
- Unknown/confusing abbreviations – use abbreviations sparingly

Other Tips

Confidentiality

- Keep patient/client documentation in a secure area.
- Keep charts face down so the name is not displayed.
- Patient/client charts should never be left unattended.
- Do not discuss patient/client cases in open/public areas.
- Follow HIPAA requirements: http://www.cms.hhs.gov/HIPAAGenInfo/

Coding Tips

- Have a current CPT, ICD-9, and HCPCS book.
- Review code narrative language.
- Select codes that accurately describe the impairment or functional limitations that you are treating.
- Use the most specific code that accurately describes the service.
- Know when a modifier is necessary and accepted by a payer.

Additional Resources:

- State Licensing Boards: http://www.fsbpt.org/licensing/index.asp
- Joint Commission: http://www.jointcommission.org/
- CARF: http://www.carf.org/
- CMS: http://www.cms.hhs.gov/
- Physical Fitness: http://www.apta.org/pfsp

APTA
American Physical Therapy Association
The Science of Healing. The Art of Caring.℠

For additional information on Defensible Documentation, please visit **www.apta.org/documentation**

RE-EXAMINATION

Is provided to evaluate progress and to modify or redirect intervention. 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 time factors based on state practice act, or other requirements

◯ Includes findings from repeated or new examination elements

VISIT/ENCOUNTER NOTES

Document implementation of the plan of care established by the physical therapist.

Includes:

◯ Changes in patient/client status

◯ Patient/client/caregiver report

◯ Interventions/equipment provided

◯ Patient/client response to interventions

◯ Variations and progressions of specific interventions used

◯ Frequency, intensity, and duration as appropriate

◯ Communication/collaboration with other providers/patient/client/family/ significant other

◯ Factors that modify frequency/intensity of intervention and progression of goals

◯ Plan for next visit(s): including interventions with objectives, progression parameters, precautions, if indicated

DISCHARGE SUMMARY

Required following conclusion of physical therapy services, whether due to discharge or discontinuation.

May include:

◯ Highlights of a patient/client's progress/lack of progress towards goals/discharge plans

◯ Conveyance of the outcome(s) of physical therapy services

◯ Justification of the medical necessity for the episode of care

Top 10 Payer Complaints about Documentation (Reasons for Denials)

1. **Poor legibility.**
2. **Incomplete documentation.**
3. **No documentation for date of service.**
4. **Abbreviations – too many, cannot understand.**
5. **Documentation does not support the billing (coding).**
6. **Does not demonstrate skilled care.**
7. **Does not support medical necessity.**
8. **Does not demonstrate progress.**
9. **Repetitious daily notes showing no change in patient status.**
10. **Interventions with no clarification of time, frequency, duration.**