



Improving Your Clinical Documentation: Reflecting Best Practice

- A. [Evidenced-Based Practice](#)
- B. [Demonstrating Progress](#)
- C. [How to Convey Medical Necessity and Skilled Care](#)
- D. [Documentation as a Risk Management and Compliance Tool](#)

A. Evidenced-Based Practice

APTA's position on Evidence-Based Practice (HOD P06-99-17-21) states: "To promote improved quality of care and patient/client outcomes, the American Physical Therapy Association supports and promotes the development and utilization of evidence-based practice that includes the integration of best available research, clinical expertise, and patient/client values and circumstances related to patient/client management, practice management, and health policy decision making."

Of course, before you can document evidence-based practice, therapists must first know how to integrate evidence into clinic practice.

Therapists can demonstrate evidence-based practice in their clinical documentation in various ways:

1. By documenting tests and measures that are valid and reliable for diagnostic and/or prognostic information.
2. Through the use of standardized outcome measures, which are an effective means of evaluating and communicating changes in a patient's/client's impairments and/or functioning.
3. By selecting and implementing an appropriate plan of care and interventions/treatments based on available research or clinical guidelines and that reflect patient perspectives and preferences and their influence on the plan of care.

Keeping up-to-date with current research and expert opinion may be difficult, but there are many tools available to make the process easier. While it is not the intent of this Defensible Documentation for Patient/Client Management Resource to teach evidence-based practice, the following are some tools that can get you started.

A) [*Guide to Physical Therapist Practice*](#). A resource that defines scope of practice; guides patterns of practice; improves quality of care; promotes appropriate use of health care services; and explains physical therapist practice to insurers, policymakers, and other health care professionals.

B) *Catalog of Tests and Measures*. Describes tests and measures and links to available research on their validity and reliability that physical therapists may use in their patient/client examinations. The catalog is combined with the [*Guide to Physical Therapist Practice*](#).

C) [*Hooked on Evidence*](#). A resource on the APTA Web site that represents a "grassroots" effort to develop a database containing current research evidence on the effectiveness of physical therapy interventions.

D) [PubMed](#). The National Library of Medicine's electronic bibliographic database of health care research. Find articles published recently or as far back as the early 1950s.

E) [*Open Door*](#). Provides members with free access to full-text journal articles and other resources relevant to clinical practice whenever and wherever they need it.

[Back to Top](#)

B. Demonstrating Progress

As stated previously, the therapist should carefully consider how the goals, in conjunction with the treatment plan, provide a roadmap for communication and patient/client progression. The initial goals are written after the physical therapist evaluates the findings from the initial examination and determines the patient's/client's prognosis in specific terms.

Consider the following:

What will the patient's/client's mobility be like when he or she completes the episode of care? Is it likely the patient/client will be able to return to his/her prior level of functioning? Will he or she require an assistive device or other equipment to promote safety and independence? Will he or she require assistance from a caregiver or community service? What is the potential for improvement in the patient's/client's strength, balance, and endurance? What is the impact of a child's home/family situation on his/her developmental progress?

After determining the anticipated outcomes the next step is to establish specific criteria for each outcome. These should be written in terms of function whenever possible and include specific parameters. Parameters are the objective statements of a goal that make it "measurable" and ensure that anyone who reads the goals will have a clear picture of what outcome is expected. Physical therapists can specify the anticipated patient/client goals by a variety of methods including timeframes, expected outcomes (distance, level of assistance, etc). "Measurable goals" are further clarified by the examples below:

Example of a short-term goal:

Patient/client will perform stand-pivot transfers from bed to chair with full weight bearing on both lower extremities and contact guard assistance within 1 week in order to decrease risk of falls with transfers.

Example of a long-term goal:

Patient/client will walk 200 feet independently on level surfaces with a straight cane so he can attend the dining room for 3 meals/day within 1 month.

Example of a pediatric long term goal:

Child will sit independently on the floor with both hands free to play with a toy within 6 months.

After the initial evaluation, updating the goals shows others how the patient/client is achieving (or not achieving) the predicted outcome. If a patient/client achieves a goal, this should be documented so others may also know what the patient/client has achieved. This is important in all settings so other health care providers (i.e., nurses, physicians, case managers, etc) will know that the patient/client has achieved the goal. These changes will then drive the subsequent care of the patient/client. Clearly documenting updates of a patient's/client's physical therapy goals communicates to third-party payers any functional changes in a patient's/client's status and the benefits of the service along with the need for continued services, if indicated. Consider the following: *To what extent was the evidence considered prior to developing and implementing the intervention plan that has resulted in less than optimal progress?*

The goals should be updated regularly depending on the length of the episode of care. The goals should be updated whenever there is a change in the patient's/client's progress or medical status. When goals are initially set by the physical therapist in conjunction with the patient/client and/or family/caregiver, the achievement of the goals is dependent on many factors that may affect the patient's/client's progress toward the goals. The physical therapist makes the best prediction of when a patient/client will accomplish the goals, but this can change for a variety of reasons. For example, if the goal is to transfer from bed to chair with minimal verbal cues within 3 days, but the patient/client has more difficulty with bed mobility than expected (an essential component of the goal achievement), then the goal would need to be revised in terms of timeframe or level of assistance.

Note: State laws and certain third-party payers may have specific expectations on how often goals are updated.

What if a patient/client does not demonstrate the expected progress toward his or her goals? In this case, the physical therapist must analyze/consider any factors that may have prevented progression. For example: Was there a medical issue that prevented progression? Was the patient/client unable to participate in physical therapy as expected? Whenever there is little or no progress toward the anticipated goals, the reasons for the delay should be clearly documented and discussed. The physical therapist should also indicate what measures are being taken to overcome the problems over the next treatment period. Documentation of these clinical decision-making processes indicates the physical therapist's involvement in the overall care management of the patient/client.

[Back to Top](#)

C. How to Convey Medical Necessity and Skilled Care

Unsubstantiated evidence of medical necessity and skilled care are two of the most common reasons for payment denial in physical therapy. According to most third-party payers, every patient/client visit must be both medically necessary and require skilled intervention. To effectively establish medical necessity, the documentation must clearly indicate WHY intervention is indicated at the current time. Evidence of skilled service must reflect why the skills of a therapist are required to deliver the necessary intervention versus another provider. Evidence of these two elements is expected in the patient/client records. Documentation of skilled services is also discussed in the section on “Visit/ Encounter Notes.”

Suggestions for how a physical therapist might support these two elements in clinical documentation include:

- 1) Provide a brief assessment of the patient’s/client’s response to the intervention(s) at every visit or event.
- 2) Document your clinical decision making process. For instance, explain why you changed the patient’s/client’s exercise program, added or discontinued a modality, or progressed a functional activity.
- 3) Make sure documentation is not repetitive, re-stating the same thing day after day.
- 4) Make sure that when you re-read your own documentation, there is no doubt that only a skilled physical therapist could have provided the treatment.

Suggestions for how a physical therapist assistant might support these two elements in clinical documentation include:

- 1) Document how the patient/client tolerated the intervention(s) at every visit or event.
- 2) Document how specific exercises or activities will help the patient/client achieve a goal.
- 3) Make sure documentation is not repetitive, re-stating the same thing day after day.
- 4) Make sure that when you re-read your own documentation, there is no doubt that only a skilled physical therapist assistant could have provided the treatment.

Lastly, when a payer requests documentation for a particular date of service, review the note(s). It may be necessary to send supporting documentation for additional dates of service, such as the most recent summary of progress or reevaluation, so the payer can fully appreciate the context in which that date of service was provided.

For more detailed information on skilled care and medical necessity, go to Appendix E.

[Back to Top](#)

D. Documentation as a Risk Management and Compliance Tool

Thorough documentation is both a benefit and protection for the patients/clients and the therapist. It serves the patient/client well because it gives all providers involved with the patient's/client's care the information they need to make informed decisions and render the best possible care. High-quality documentation serves you well because it is the one thing that provides a real-time, historical account of your encounters with patients/clients and can be an important source of evidence in the event your care is called into question.

Documentation is often used as evidence during litigation. If your documentation is non-existent or incomplete, there is no evidence to support your recall of events, and an attorney can call it into question. If your documentation is solid, it can help support your oral account of events and demonstrate that you met or exceeded the standard of care. With this in mind, when considering documentation from a risk management perspective, it is important that you:

- Follow facility/practice policy regarding documentation. Ensure that documentation meets minimal payer/regulatory requirements.
- Record information only on proper forms, and write legibly. If your handwriting is illegible, the note may be considered as not having been written at all.
- Date, time, and sign every note. Often, there will be questions regarding the timing of events within the course of a day. If you include the time, there will be no question as to the chronology of events.
- Record information as close as possible to the time that you deliver care. Don't document in advance, and don't leave important notations for the end of the day or the end of the week.
- Use only common abbreviations that are approved by your facility/practice.
- Do not change the documentation after the fact. Make identified revisions in documentation according to your facility/practice policy to eliminate any questions about authenticity.
- Describe the patient's/client's symptoms as they are elicited and offered. Use quotations properly. If a patient/client reports an adverse situation, make sure you respond accordingly and document your response or assessment of the situation.
- Be objective and factual—never allow opinions or emotions to become a part of the medical record.
- Report the facts in an organized and systematic manner with adequate detail and in chronological order.
- Document all telephone calls involving pertinent patient/client information. This includes cancellations, conversations with other care providers or referral sources, etc. Also document any handouts, instructions, or follow-up information that you give the

patient/client and/or caregivers with parameters and date. Include the patient's/client's name/identifier on each page.

- If interpretive services are required in order to communicate with a patient/client who speaks a different language or has a hearing loss or other disability that makes communication difficult, document the method of interpretation that was provided (e.g., face-to-face or telephone interpretation), the name of the interpreter and his/her credentials, what instruction was given, and the result of the instruction (e.g., “patient/client and/or family verbalizes their understanding or can demonstrate...”). Be certain that a [HIPAA Business Associate](#) agreement is in place if the interpreter is not part of the workforce or provided by the patient/client.
- Follow both internal protocol and external regulations (including HIPAA privacy and security regulations) and policies relative to patient/client confidentiality. These regulations and policies may come from the federal, state, or local government and/or reimbursement sources or other entities. It is important to be mindful of this issue when handling incoming calls related to a patient's/client's condition and/or when using electronic documentation.
- When using electronic documentation, take steps to protect the confidentiality of the record and alert authorized users to their responsibility to maintain the confidentiality of the record at all times.
- Document all attempts to contact the referral source and/or payment source (e.g., the insurer). In addition, document any communication with anyone.
- Release records only upon consultation with your risk manager and in accordance with organizational/practice policies and laws.
- Provide documentation for each physical therapy visit.
- Report any information regarding a patient/client incident separately from the medical record, using the proper incident report form.

Information in bulleted list is adapted and excerpted from APTA's *Risk Management in Physical Therapy: A Quick Reference, 2nd edition* (Alexandria, VA: APTA; 2005) and *Spanish for Physical Therapists: Tools for Effective Communication* (Alexandria, VA: APTA; 2006).

[Back to Top](#)

[Last updated: 03/10/11 | Contact: practice-dept@apta.org]