



## **Setting Specific Considerations in Documentation**

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## [Introduction to Setting Specific Considerations in Documentation](#)

Clinical settings influence many aspects of patient/client care documentation. Depending on the setting there may be additional regulations by payer, state, local facility, or accrediting organizations. In addition, various clinical settings have different norms, processes, and influences often outside the control of the physical therapist or physical therapist assistant. For example, in an acute care clinic, patients/clients are often discharged without the knowledge of the treating PT or PTA. In a sub-acute or skilled nursing facility, the Minimum Data Set (MDS) may include specific instructions for therapists related to documentation.

<http://www.cms.hhs.gov/Transmittals/Downloads/R57BP.pdf>

For more information related to Medicare in these settings, you can go to the corresponding chapter of the [Medicare Benefit Manual](#).

For Inpatient Hospital Services, Chapter 1

For Home Health Services, Chapter 7

For Extended Care (SNF) Services, Chapter 8

For CORF Services, Chapter 12

For Outpatient Rehabilitation Services (i.e. any therapy provided under the Part B Medicare benefit), Chapter 15.

To search for the local coverage decisions by your Medicare contractor, go to:

<http://www.cms.hhs.gov/mcd/search.asp?clickon=search>

The following sections are meant to raise awareness of specific regulations by practice setting (additional practice settings will be added in the future). The intent of this section is not to be inclusive, but instead to 1) raise awareness that additional regulations may exist, and 2) provide suggestions to therapists on how to improve documentation given certain unique problems may that occur in a specific setting.

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## **A. Acute Care Hospitals**

Physical therapists and physical therapist assistants in an acute care hospital contend with many factors that may complicate the provision of physical therapy services and emphasize the need for consistent documentation. For instance, varying patient/client care loads and frequent cancellations due to tests can be challenges when a PT or PTA is attempting to establish and carry out a consistent frequency and duration of patient/client care services. The short length of stay and shifting or unknown discharge plans coupled with increased cancellations due to testing or other activities increase the difficulty of predicting the expected outcome within a defined timeframe. Because multidisciplinary communication and collaboration is so important in the care of patients/clients with acute health needs, the physical therapy documentation is the critical vehicle that will ensure that the goals and outcomes of the care that the PT or PTA gives is communicated among all disciplines working with the patient/client. In cases in which the PTA is the last provider to treat and document treatment of the patient/client, the PT will need to write a discharge summary that outlines the status of the patient/client at evaluation and hospital discharge and assess the achievement (or lack of achievement) of the predicted goals and the expected outcomes.

In addition to the standards established under professional guidelines, there are also accreditation standards such as those established by the Joint Commission. This includes documentation of “hand-offs” (i.e., transferring the care of the patient/client to another therapist) to ensure continuity of care, patient/client safety event reporting, multidisciplinary documentation of goals, processes for receiving/transcribing verbal orders, and patient/client education, to name a few. In addition, there are certain abbreviations that may not be used and are included in the Joint Commission "Do Not Use List".

You may use this link to learn more about the Joint Commission standards:

<http://www.jointcommission.org>.

For more information, follow these links:

<http://www.apta.org/DirectAccess/HospitalSettings/>

<http://www.apta.org/Payment/PrivateInsurance/PaymentbySetting/>

For more helpful information related to physical therapy in the acute care setting, visit the Acute Care Section’s Web site at [www.acutept.org](http://www.acutept.org).

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## **B. Health, Wellness, and Fitness**

When providing physical therapy services to address physical fitness for individuals or groups in either traditional or non-traditional settings, it is important from a professional and liability perspective that you document the services you provide. The level of detail in your documentation should be based on the complexity of the patient or client, the intricacy of the plan of care, and the frequency of change. More complex patients/clients or settings may necessitate significantly more detail while some community settings and less complex patients or clients may require shorter and less detailed notes. Regardless, all services provided as physical therapy to patients or clients should address the five components of patient/client management: examination, evaluation, diagnosis, prognosis, and intervention. For more information visit the Physical Fitness for Special Populations web page at: [www.apta.org/pfsp](http://www.apta.org/pfsp)

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## **C. Home Health**

Providing physical therapy services in the home health setting involves creativity, flexibility, and solid documentation skills. Physical therapists need to employ their full scope of assessment skills in order to manage a medically complex individual without the support of a medical facility or quick access to additional staff. Home health services under Medicare Part A are subject to 60-day episodes of care. Due to the relationship between therapy visits and reimbursement under the home health Prospective Payment System (PPS), therapy documentation is under significant scrutiny to determine if services are medically necessary. Attention to detail and use of the various assessment and intervention tools available to physical therapy must be very clear in the documentation. In addition, documentation of impairments, activity limitations, and participation restrictions and strategies to improve functioning is essential. More information on home health PPS can be found at: <http://www.cms.hhs.gov/HomeHealthPPS>. For payers other than Medicare, it is important to determine whether there are payer-specific physical therapy documentation requirements.

The OASIS (Outcome Assessment Information Set) instrument is a documentation tool specific to the home health setting. It is designed to be a discipline-neutral tool that is part of a comprehensive assessment of the patient. It is used at various time points in the 60-day episode of care—the start, the end, when a significant change in condition occurs, and when the patient has ongoing needs into another 60-day episode. The tool measures patient characteristics in clinical, functional, and services domains. OASIS data is used to determine the payment for the episode and to measure outcomes of care by comparing initial answers with final ones. Physical therapists can be called upon to complete the tool at any of the time points. Only physical therapists, speech language pathologists, and nurses can complete the form. More information on the OASIS tool can be found at [http://www.cms.hhs.gov/HomeHealthQualityInits/12\\_HHQIOASISDataSet.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage).

The need for physical therapy alone ensures program eligibility under the Medicare program for home health, thus allowing the physical therapist to assume primary responsibility for care. In these cases, the admission to service is completed by the physical therapist and involves agency-specific consent forms, the OASIS tool, and the comprehensive assessment. This assessment must include therapy-specific items, an overall view of health status and risk factors, and a medication regimen review. All aspects of physical therapy in the home health setting require integration of good documentation practice to support the delivery of clinical care.

In cases that involve the services of a physical therapist and a physical therapist assistant (where allowed by law), routine communication is critical to ensure appropriate direction, supervision, and implementation of the plan of care. Clearly written documentation is an effective tool for communication and evidence of verbal interaction must be reflected in the medical record. Both the physical therapist and the physical therapist assistant share the responsibility in documenting that the supervision requirements are being met.

Home Health physical therapists and physical therapist assistants may have access to electronic health records and documentation systems which include patients' personal health information (PHI). It is important that appropriate safeguards to protect the organization's data are

implemented. This would include physical safeguards which are physical measures, policies, and procedures to protect electronic information systems and equipment from natural and environmental hazards, and unauthorized intrusion. For more information on privacy and security of personal health information, go to the following link:

<http://www.apta.org/Payment/PrivateInsurance/PaymentbySetting/>

For more helpful information related to physical therapy in the home health setting, visit the Home Health Section's website at [www.homehealthsection.org](http://www.homehealthsection.org)

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## **D. Outpatient Services**

Payment sources for outpatient physical therapy services are varied, which offers many challenges. *Third-party payment* is when an entity outside of the physical therapist/patient relationship pays the bill. Examples are private payers, managed care organizations, provider networks, direct contracts with employers, Medicare, Medicaid, public school systems, and workers' compensation programs. First-party payment is when the patient pays the bill for treatment and then may choose to submit the claim to his or her insurance company. For all payment systems, it is important to understand CPT and ICD- 9 CM coding. It is also necessary to understand the difference between billing and payment policy; each payer may implement its payment systems differently, regardless of the coding on the claim. For more information, please follow the following link: <http://www.apta.org/Payment/PrivateInsurance/PaymentbySetting/>

Many payers have specific documentation requirements, such as established frequency of documentation and/or forms to use in order to get authorization for treatment. It is best to check with each patient's/client's insurance company to determine its requirements. To decrease the risk of denials, you may need to use the insurance company's specific forms, include certain demographic or diagnostic coding information, and/or send more information than requested to demonstrate the need for continued care. The most important thing you can do is to give the payer's reviewer a total picture of the patient/client in the documentation. Documenting in functional terms and defining the patient's/client's functional limitations goes a long way toward making the reviewers understand what you are trying to accomplish for the patient/client.

For other helpful information related to physical therapy in the private practice outpatient setting, visit the Private Practice Section's website at [www.ppsapta.org](http://www.ppsapta.org)

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## **E. Skilled Nursing Facility / Long Term Care**

Patients residing in a skilled nursing facility (SNF) can receive physical therapy treatment under the Medicare Part A (inpatient) benefit or the Medicare Part B (outpatient) benefit. Medicare Part A services are paid for using a prospective payment system (PPS) methodology, while Part B services are paid for under the Physician Fee Schedule.

To qualify for Medicare Part A services, a patient must require daily skilled nursing and/or rehabilitation services, and have had a 3-day qualifying stay in a hospital. For more information, follow this link: <http://www.apta.org/Payment/Medicare/CodingBilling/SNF/>

The Minimum Data Set (MDS) is the assessment instrument that determines the Part A per diem payment in the SNF PPS. The information on the MDS classifies residents into resource utilization groups (RUGs) to determine payment to the facility.

The treatment you provide in a SNF must meet the same standard of being “skilled services” as in any other setting; therefore, it is critical that the documentation illustrate this. The information you record on the patient’s chart must support the MDS level being billed. Because SNFs also provide outpatient services, your documentation for Part A services must meet criteria as explained in The Components of Documentation section. The combination of therapy documentation and nursing documentation should support the skilled services provided at the RUG level being billed.

Services provided to patients in the long-term care setting under Medicare Part B follow the same guidelines as other outpatient physical therapy settings.

For treatment under either Part A or Part B, there was a revision in the Medicare Benefit Policy Manual, Chapter 8, Section 30.4.1.1, which clarifies that the initial therapy evaluation of a SNF patient must be performed in the SNF; you cannot use an evaluation that was performed in the acute care or rehabilitation hospital settings. You may find more information about SNF-related therapy evaluations by going to the following link:

<http://www.cms.hhs.gov/Transmittals/downloads/R73BP.pdf>. Finally, the effective delivery of physical therapy services, and the documentation of such, has an impact in the state and federal survey process. It is important to understand the survey process and the role of physical therapy in the facility.

For more helpful information related to physical therapy in the long-term care/skilled nursing facility setting, visit the APTA Section on Geriatrics’ Web site at [www.geriaticspt.org](http://www.geriaticspt.org)



## **F. Inpatient Rehabilitation Facility (IRF)**

Patients admitted to an inpatient rehabilitation facility (IRF) receive physical therapy treatment under Medicare Part A, which is paid for using a prospective payment system (PPS) methodology. To qualify for Medicare Part A services, a patient must require at least 3 hours of rehabilitation services 5 days per week. For more information, follow this link: <http://www.apta.org/Payment/PrivateInsurance/PaymentbySetting/>

The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF\_PAI) is used to determine the per diem payment in the IRF PPS. The information on the IRF-PAI classifies residents into case management groups (CMGs) to determine payment to the facility. Thorough documentation to explain why the patient required 3 hours of therapy is necessary to justify why the patient could not have been treated in a less-expensive setting. The treatment you provide in an IRF must meet the same standard for “skilled services” as in any other setting. The information you record in the patient’s chart must support the CMG level being billed.

The inpatient rehabilitation prospective payment system has a ‘built-in’ outcome component to it. When a patient is discharged from the IRF to a home health agency or to outpatient rehabilitation services, the IRF receives 100 percent of the patient’s CMG payment. However, if a patient is discharged to a skilled nursing facility the IRF receives only 75 percent of his or her CMG payment. Therefore pre-admission screening of patients admitted to IRFs is important to ensure they can tolerate the level of rehabilitation and have an adequate discharge prognosis before they are admitted to the IRF.

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## **G. Long Term Care Hospitals (LTCH)**

A long-term care hospital (LTCH) has greater than 25 days as an average length of stay. A facility also may be considered a LTCH if the length of stay averages 20 or more days, and 80 percent or more of its annual Medicare discharges have diagnoses that reflect a finding of neoplastic disease in the 12-month cost-reporting period ending in 1997. LTCHs usually provide extended medical and rehabilitative care for clinically complex patients who frequently suffer from multiple chronic and acute conditions. Services typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. The LTCH system uses the same Diagnosis Related Groups (DRGs) for payment as are used under the inpatient hospital PPS. However, they are weighted to reflect the greater complexity of the cases.

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## **H. Pediatrics**

### **1. Early Intervention**

Physical therapist practice in early intervention (EI) incorporates unique features that may alter the typical physical therapy documentation process. Physical therapy services provided to children from birth to age 3 years are part of a child's and family's Individualized Family Service Plan (IFSP) under Part C of the Individuals with Disability Education Act (IDEA) (2004). Early intervention services are family centered and typically provided in the child's natural environment. Documentation is family friendly, written in lay language with minimal medical or technical terminology so that it is meaningful to all team members, including the family and nonmedical professionals. In early intervention documentation, the physical therapist (PT) refers to the child as a "child" rather than as a "patient" or "client," as reflected in the *Guide to Physical Therapist Practice*. In addition to state physical therapy practice acts, compliance with the delivery of physical therapy as part of EI services is regulated by IDEA federal legislation and its corresponding state legislation on early intervention. Also, in some states payment for a portion of early intervention physical therapy services may be through the state's Medicaid plan or other payer sources. Documentation, therefore, needs to meet the standards established by each of these specific payers. All physical therapists documenting services to children need to be aware of both federal and state requirements for how long medical records are to be maintained.

#### **Initial Examination**

In early intervention, a multidisciplinary team conducts and documents the initial examination, referred to as an evaluation and assessment. The physical therapist contributes to the process but also may need to maintain supplementary documentation not required for the early intervention team report. Such information may include detailed information related to the child's musculoskeletal or neuromuscular status. The team report is to represent the child's functioning in 5 developmental areas: 1) physical, 2) cognitive, 3) communication, 4) social or emotional, and 5) adaptive. The report also serves to document the child's unique strengths and needs in these 5 areas. In some cases, the physical therapist may be requested to conduct a separate evaluation and assessment for a child in early intervention who was not previously receiving physical therapy services.

In early intervention, physical therapists collaborate with other team members, including the family, in the development of the IFSP. This plan documents the child's current levels of development; information voluntarily provided by the family on their resources, priorities, and concerns related to enhancing the development of their child; measureable results or outcomes (child and family); early intervention services to be provided (including length, frequency, intensity, duration, and method of delivering services); natural environment in which services will be provided; identification of service coordinator; and plan for transition (components listed in IDEA 2004, Sec. 636). A physical therapist may elect to provide additional documentation in the form of a supplemental intervention plan that delineates more specifically the physical therapy intervention strategies to be used in providing early intervention services for the child.

## **Visits**

In early intervention, physical therapists typically document their visits (also known as daily encounters) on a standard form developed at the county or state level for early intervention services. In many cases, the family receives a copy of the form, and so it is structured to be family friendly. This form also is shared with other early intervention providers who serve the child. The documentation usually is structured to capture what interventions were performed during the visit to address the outcomes on the IFSP, progress towards achievement of the outcomes, family input, suggestions for the family, and follow-up plans of the provider. In addition, in some counties or states, a more detailed progress note may be required periodically, such as bimonthly.

## **Reexamination**

In early intervention, formal documentation related to reexamination occurs at a minimum of every 6 months and takes the form of a team review of the IFSP. During this review, the team documents the child's and family's progress toward achieving their outcomes and any required revisions to the outcomes or services. At least annually the review is more comprehensive, based on a reevaluation in order to document the child's continued eligibility for early intervention services and to update the service plan.

## **Discharge/Discontinuation**

IDEA, in early intervention, does not require formal physical therapy "discharge summaries" because the entire team, of which the PT is part, makes the decisions on discontinuing services. However, it is important that the physical therapist check his or her state practice act and physical therapy board regulations to determine if there are requirements for the completion of a discharge summary. Review the [State Advocacy](#) Web page for information about your state practice act. The physical therapist may document what is referred to either as 1) a discontinuation summary, if the child is "graduating from" or leaving early intervention service, or 2) a transition summary if the child is transitioning to preschool services under Part B of IDEA (if applicable in the state).

Physical therapists working in early intervention also may be required to contribute to documentation related to the IDEA Part C state monitoring program (State Performance Plan) of global child and family outcomes for accountability to the federal government (Office of Special Education Programs). Typically the status of the child and family on set outcomes is documented at entry and exit from the early intervention system (Early Childhood Outcomes Center).

## **Resources**

McEwen I. [\*Providing Physical Therapy Services Under Parts B & C of the Individuals with Disabilities Education Act \(IDEA\)\*](#). Alexandria, VA: Section on Pediatrics of APTA; 2009.

Public Law 108-446, Individuals with Disabilities Education Improvement Act of 2004, 118 Stat. 2647-2808.

Building the Legacy: IDEA 2004. U.S. Department of Education. <http://idea.ed.gov>. Part B of this Web site, services for children 3-21, is currently available and provides general information on the legislation that is also relevant to early intervention. Part C of this Web site is under development and will provide resources on implementation of Part C IDEA regulations.

The Early Childhood Outcomes Center. <http://www.fpg.unc.edu/~ECO>.

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## **1. School-Based**

Physical therapy is provided in the school system as a related service for a student qualifying for special education under IDEA (Individuals with Disabilities Education Act, 2004). Physical therapy services also may be provided to individuals under Section 504 of the Rehabilitation Act of 1973 if the student does not meet the eligibility criteria for inclusion in special education but has a disability as defined under federal law. Under Section 504 physical therapy may provide specific accommodations, modifications, and adaptations enabling students to access and participate in the educational environment (see Section 504 below). In addition, there are school-based services that are covered under the Medicaid program.

### **IDEA, Part B and the Individualized Education Program**

Physical therapy is a related service under Part B of IDEA; a supportive service to assist a child with a disability to benefit from special education services. Special education provides specially designed instruction to meet the individual needs of a student with a federally recognized disability. An Individualized Education Program (IEP) team develops an educational program for each identified student based on his or her unique needs. Members of the IEP team include the student's parents/guardians, a regular education teacher, a special education teacher, a representative of the public agency, someone who can interpret the instructional consequences of the evaluation results, other individuals who have knowledge and/or expertise relevant to the child (such as the physical therapist), and the child, if appropriate. The IEP team collaborates to develop the IEP document. The IEP document outlines current levels of educational performance (this includes physical functioning), measurable annual goals (in most states, objectives), specific special education, related services and supplementary aids/services to be provided, how the child will participate with their non-disabled peers, modifications necessary for state or district assessments, projected dates for services, modifications, frequency, duration, a description of how the goals will be monitored and progress reported, as well as appropriate transition plans.<sup>1</sup> Physical therapists are a part of the IEP team; however, educational goals are discipline free, meaning the goals are developed by the team to meet the needs and priorities of the student. The IEP team decides if physical therapy services are necessary as part of the student's educational goals or their access and participation in the educational environment. The IEP team determines the frequency and duration of relevant physical therapy services, based on the recommendations of the PT.

As a related service, a physical therapy examination for a student receiving special education services is required initially and again at least once every 3 years as part of the integrated educational assessment, when a physical/motor concern has been identified for that student (check your state practice act because it may differ). The evaluation and assessment of the student reflects how the student is functioning in the educational environment. Observations may be necessary in the classroom(s), cafeteria, school bus, playground, and other locations throughout the school. Input from the educators as well as other school personnel is essential. Unlike more traditional medical model assessments, the IEP assessment must be presented in a format all members of the IEP team can understand.

As part of the IEP team, after each interaction, physical therapists document all:

- Strategies,
- Interventions,
- Staff/student training and education, and
- Communication with the student's parents/guardians or community based services.

IDEA requires that progress be reported to parents at the same frequency that is provided to children who do not have a disability, concurrent with the issuance of report cards.

### **Discontinuation of Physical Therapy Services**

Physical therapy services may be discontinued in the school system if the IEP team decides the services are not necessary to the student's educational goals or their access/participation in the educational environment. Based upon the recommendations of the IEP team, physical therapy services are available at any time during the student's participation in the educational system, usually through the age of 21. It may be appropriate to discontinue physical therapy services one year but later resume the services as the student's needs and priorities change. The IEP team can determine from one year to the next whether physical therapy services will be necessary during the upcoming school year based upon the planned educational objectives and the student's ability to access/participate in the current educational environment. Although the discontinuation of physical therapy services would be noted in the IEP document, the physical therapist needs to summarize the student's current status as part of a final summary to close the current episode of care.

### **Transition Planning**

Appropriate transition planning is a necessary component of the IEP document. For students aged 16 and older transition means there is a coordination of services to prepare for opportunities when the student leaves school. Physical therapy can ensure the student is functioning at an optimal level in a variety of environments to enable the student's full potential. The physical therapist may assist in identification of appropriate assistive technology or training necessary for a student's successful integration in new environments.

Documentation for school-based physical therapy services that follow IDEA regulation and philosophies are similar to procedures described in the *Guide to Physical Therapist Practice*. There are a few differences in terminology and procedures. School-based PTs use the terms "child" or "student" instead of "client" or "patient." These PTs collaborate with IEP team members for instructional objectives, compared with the typical approach for the establishment of discipline-specific goals.

Physical therapists need to be familiar with their individual state's practice act and regulations related to school services to ensure that documentation required by the local school district for the IEP is sufficient to meet all aspects of professional documentation in their state.

Supplemental documentation of daily visits, specific procedures and assessment time frames may be indicated to ensure compliance with professional documentation standards. All therapists documenting services to children need to be aware of their state requirements for how long

documents are to be maintained. If services are billed through Medicaid additional documentation may be necessary.

### **Section 504 of the Rehabilitation Act of 1973**

If the student does not meet the eligibility criteria for inclusion in special education, Section 504 of the Rehabilitation Act of 1973 entitles people with disabilities protection under civil rights law. Children or students with a permanent or temporary disability, a physical or mental impairment that limits one or more major life activities, might need physical therapy at school to accommodate for the disability. The local school district may have a written 504 plan with the type of accommodation along with the frequency and duration of physical therapy services; however, individual physical therapists must also ensure that their own documentation follows the requirements and criteria of their individual state practice acts.

For more helpful information related to physical therapy in the pediatric setting, visit the Pediatric Section's website at [www.pediatricapta.org](http://www.pediatricapta.org)

### **Reference**

<sup>1</sup> Building the Legacy: IDEA 2004. Washington, DC: US Department of Education, 2004.  
Available at:

<http://idea.ed.gov/explore/view/p/%2Croot%2Cdynamic%2CTopicalBrief%2C10%2C>. Accessed on March 11, 2011.

### **Resources**

McEwen, I. [\*Providing Physical Therapy Services Under Parts B & C of the Individuals with Disabilities Education Act \(IDEA\)\*](#). Alexandria, VA. Section on Pediatrics, APTA 2009.

Public Law 108-446, Individuals with Disabilities Education Improvement Act of 2004, 118 Stat. 2647-2808.

<http://www.ed.gov/policy/speced/reg/narrative.html> Special Education & Rehabilitative Services, The Rehabilitation Act.

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## **I. State Physical Therapy Practice Acts**

References to state laws governing physical therapy services are found throughout this document. Every state has different language in their state practice acts, and many include specific language related to documentation of patient/client services. They may include issues of specific types of documentation required, minimum timeframes for documentation, and even scope of practice issues. In determining what is required by your state, review the [State Advocacy](#) Web page for information about your state practice act.

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## **J. Workers' Compensation Defensible Documentation**

Physical therapists and physical therapist assistants who provide care for workers' compensation patients/clients need to be aware of additional documentation necessary to support the provision of services.

Insurance carriers consistently point out that physical therapy notes lack a focus on functional performance in goal-setting and the plan of care. A primary goal for workers' compensation patients/clients should be return to work.

In addition to standard APTA documentation guidelines, these additional areas of documentation should be considered and addressed as indicated for each patient/client. Consideration of these areas of documentation will help to objectively document your patient's/client's progression toward return to work and/or functional status.

Inclusion of these elements should be based on the specifics of the case and your clinical judgment. The elements are neither designed nor intended to be required for every case and should not be used by insurance carriers as the sole basis for payment denial.

Physical therapists and physical therapist assistants should also be familiar with specific documentation requirements for the workers' compensation jurisdiction in their state. The [Workers' Compensation State Resource Guide](#) is available (members only) on the [Workers' Compensation](#) page of the APTA Web site.

For more information about workers' compensation, visit the Occupational Health Special-Interest Group page on the Orthopaedic Section Web site at: [http://www.orthopt.org/sig\\_oh.php](http://www.orthopt.org/sig_oh.php).

### **I. Initial Visit: Elements for Documentation Specific to Workers' Compensation**

#### **a. Examination**

##### **i. History**

1. General information regarding the worker's employer and work history: How many years in this job and in other occupations with similar physical requirements?
2. Work release status (by attending physician): eg, no work restriction, temporary restriction, permanent restriction, disabled totally, unspecified; date of most recent work release status
3. Employment impact (current work status)
  - Working full duty or modified duty
  - Working full-time or part-time
  - Not working, on disability leave or personal leave
  - Not working, conducting job search
  - Date of most current work status
  - Is modified work available?
4. What is job goal? (same as pre-injury or alternate job?)

5. Worker's description of critical physical job demands, and which demands he or she cannot perform/has difficulty performing currently
  6. Mechanism of injury: Describe how injury occurred; include specific work tasks and work risks that may have attributed to or caused the work-related injury.
- ii. Worker's rating of health status, current complaints
1. Explore worker's confidence in his or her ability to return to work. Consider potential barriers or facilitators to recovery, including:
    - Medical
      - Comorbidities
      - Other injuries or illnesses
      - Pre-injury health status
    - Behavioral
      - Fear avoidance
      - Kinesiophobia
    - Workplace
      - Employer return-to-work requirements
      - Employer-employee relationships
    - Environmental
      - Disability benefits
      - Regional unemployment rates
- iii. Test and measures
1. Disability questionnaires that may provide valid and reliable correlation to work disability
  2. Functional tests related to job demands, if medically appropriate to perform
  3. Functional outcome tools with demonstrated validity and reliability

b. Evaluation

- i. Consider impact of factors identified that may be potential barriers or facilitators to return to work
- ii. Provide assessment of correlation of mechanism of injury and work risk factors along with clinical findings. Note consistency of subjective reports, mechanism of injury, and objective measurements. Click [here](#) to learn more about medical and legal causation in workers' compensation.
  1. Identify specific work-related tasks the worker cannot perform or should avoid, based on the musculoskeletal and functional exam and the therapist's professional opinion.
  2. What factors/impairments are limiting performance of these activities?
  3. Do these limitations relate to any impairment noted during physical exam?
  4. Identify the (impairment) source of the work-related activity limitations. When appropriate, provide opinion regarding whether

impairments that limit work ability are consistent with the mechanism of injury or work risks.

c. Plan of Care

i. Goals

1. Return to work goals are typically considered in the following sequence:
  - Pre-injury job/same employer (with or without accommodation)
  - New job/same employer (with or without accommodation)
  - Pre-injury job/new employer (with or without accommodation)
  - New job/new employer (with or without accommodation)
  - Vocational retraining
  - Not expected to return to work
2. Treatment goals need to be functional and related to the physical requirements of the job.
  - SAMPLE WORK RELATED Short-term Goal: Patient/client will be able to lift 20# from floor to waist 10 times with good body mechanics within 2 weeks, preparing patient/client for modified duty work tasks
  - SAMPLE WORK RELATED Long-term Goal: Patient/client will be able to lift 40# from floor to waist 20 times with good body mechanics within 4 weeks, preparing patient/client for full duty status.

ii. Statement of Interventions

1. Include relevant work-related tasks such as a plan to assess material handling/movement/postural tolerances. These tasks can be actual or simulated tasks.
2. Interventions should focus on preparing the patient/client for prompt, safe, and appropriate return to work and minimizing noted impairments, limitations, and restrictions in ADLs and work ability.

d. Communication

- i. Be sure to refer to the HIPAA laws and regulations regarding whether consent is required before communicating with others. Click [here](#) to learn more about HIPAA and releasing Personal Health Information (PHI) to employers for workers' compensation cases.

## **II. PT Daily Visit Note (Treatment Intervention): Elements for Documentation Specific to Workers' Compensation**

- a. Identification of Specific Interventions
  - i. Include any job-related functional testing; functional activities related to job demands (eg, work circuit, education regarding workstation set-up, etc).
- b. Response to Interventions
  - i. Include worker's progress with job-related activities or explanation for lack of progress.
- c. Factors that modify frequency or intensity of intervention/progression
  - i. Consider any noted barriers to recovery, such as transportation or scheduling issues, poor attendance or compliance/participation with program, language barrier, personal/family issues, or fear-avoidance behavior.
- d. Identify progress to date, rationale for need for continued treatment and action plan to address any potential barriers or facilitators as they are encountered.
  - i. These findings do not need to be documented each and every intervention if findings don't change.

## **III. PT Progress Report Elements**

- a. Documentation of extent of progress
  - i. Include specific work abilities and limitations (material handling, movement abilities and positional tolerances) with relevant accommodations.
- b. Factors that modify frequency of intensity of intervention/progression
  - i. Discuss any noted barriers to recovery, such as transportation or scheduling issues, poor attendance or compliance/participation with program, language barrier, personal/family issues, fear-avoidance behavior, pain catastrophizing behavior, workplace barriers, or environmental factors,
- c. Communication/Consultation
  - i. Include any communication with case manager, employer, or physician relevant to progress towards work demands/return to work/accommodations.
  - ii. Assist in the development of action plans with other stakeholders (case manager, employer, referring physician) to address identified barriers or facilitators with established deadlines for action items to be completed and by whom.

**IV. Reexamination Elements for Documentation**

- a. Include physical abilities relevant to job demands to evaluate and compare to prior performance.
  - i. Reexamination of physical abilities can include components of an FCE. Notation of observed and tested functional activities and apparent limitations.
- b. The revised plan of care should include interventions to address any remaining functional limitations for work.

**V. PT Discharge/Discontinuation/Final Visit Elements**

- a. Criteria for termination
  - i. May include return to work considerations, such as returning to job of injury or to a modified job or other options
- b. Current physical/functional status
  - i. Include discussion regarding worker's performance relative to work requirements and education provided (eg, back safety, proper body mechanics, workstation set-up, ergonomic equipment, etc).
- c. Discharge/discontinuation plan
  - i. Summarize any discussions with physician, case manager, adjuster, or employer.
- d. Identification of appropriate candidates for advanced return-to-work program or FCE, including rationale.
  - i. Document the necessity for any further clinical intervention.

**VI. PTA Visit Note Elements**

- a. Identification of specific interventions
  - i. Include work activities, indicating weights and repetitions or time duration as appropriate.
- b. Changes in worker impairment, activity limitations, or participation restrictions
  - i. Include performance-related changes. For example, improvement in transitioning in and out of different postures, sustained posture with less postural adjustments, etc.