### TOP 10 TIPS
1. Limit use of abbreviations.
2. Date and sign all entries.
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:

- Joint Commission: http://www.jointcommission.org/
- CARF: http://www.carf.org/
- CMS: http://www.cms.hhs.gov/
- Physical Fitness: http://www.apta.org/pfsp

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
- Variations and progressions of specific interventions used
- Patient/client/caregiver report
- Frequency, intensity, and duration as appropriate
- Interventions/equipment provided
- Communication/collaboration with other providers/patient/client/family/significant other
- Patient/client response to interventions
- 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.

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