

## 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](http://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:

<input type="radio"/> Pertinent medical/surgical history	<input type="radio"/> Cultural preferences
<input type="radio"/> Social history	<input type="radio"/> General health status
<input type="radio"/> Growth and development	<input type="radio"/> Previous and current functional status/activity level
<input type="radio"/> Living environment	<input type="radio"/> Medication and other clinical tests
<input type="radio"/> Work status	<input type="radio"/> 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:

<input type="radio"/> Communication skills	<input type="radio"/> Factors that might influence care
<input type="radio"/> Cognitive abilities	<input type="radio"/> Learning preferences

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

<input type="radio"/> Specific tests and measures: increased emphasis placed on standardized tests/measures, eg, OPTIMAL
<input type="radio"/> Associated findings/outcomes

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

<input type="radio"/> Synthesis of all data/findings gathered from the examination highlighting pertinent factors
<input type="radio"/> Should guide the diagnosis and prognosis
<input type="radio"/> 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:

<input type="radio"/> Impact of condition on function
<input type="radio"/> Common terminology, eg ICD-9 CM coding or Preferred Physical Therapist Practice Patterns

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

<input type="radio"/> Predicted functional outcome
<input type="radio"/> Estimated duration of services to obtain functional outcome

**Plan of Care** – May include:

<input type="radio"/> Overall goals stated in measurable terms for the entire episode of care
<input type="radio"/> Expectations of patient/client and others
<input type="radio"/> Interventions/treatments to be provided during the episode of care
<input type="radio"/> Proposed duration and frequency of service to reach goals
<input type="radio"/> Predicted level of improvement in function
<input type="radio"/> 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>



American Physical Therapy Association  
*The Science of Healing. The Art of Caring.™*

For additional information on Defensible Documentation, please visit [www.apta.org/documentation](http://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:

- |  |  |
|--|--|
| <input type="radio"/> Changes in patient/client status   | <input type="radio"/> Variations and progressions of specific interventions used |
| <input type="radio"/> Patient/client/caregiver report  |  |
| <input type="radio"/> Interventions/equipment provided   | <input type="radio"/> Frequency, intensity, and duration as appropriate          |
| <input type="radio"/> Patient/client response to interventions   |  |
| <input type="radio"/> Communication/collaboration with other providers/patient/client/family/significant other                           |  |
| <input type="radio"/> Factors that modify frequency/intensity of intervention and progression of goals                                   |  |
| <input type="radio"/> 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.