Defensible Documentation Quick Reference

Following the Patient/Client Management module, patient care should be documented through the episode of care:

Initial Examination

History- The history of the examination is a collection of information which can be gathered through a patient/client or caregiver interview and includes a review of past and current medical and social information. The medical history may include pertinent medical diagnosis, surgical history, a list of current medications, information about previous clinical tests (X-rays, CT scan, etc) and a general review of current health status. The social history may include information on the patient / client's living environment, work status, and cultural preferences. In addition, it is recommended to include information on a patient / client's previous level of function.

Systems Review - A systems review is a necessary component of any initial examination. Information gathered from a systems review is imperative as it assists the physical therapist in determining conditions related and perhaps unrelated to the current chief complaint. In addition to a review of the various systems, this is a where information regarding a patient's / client's communication skills, cognitive abilities, and other important factors that might influence care or that is pertinent to function should be documented.

Tests and Measures - From the information gathered in the history and systems review, the physical therapist determines a hypothesis for a diagnosis. The physical therapist then determines which tests and measures are required to further prove (or disprove) the hypothesized diagnosis or diagnoses. In the documentation of tests and measures, a physical therapist should clearly identify the specific tests and measures, and any associated finding or outcome. In addition to traditional tests and measures (ROM, strength, balance, etc), more and more emphasis is placed on the importance of standardized tests and measures.

Evaluation – An evaluation is a thought process which leads to documentation of such items as impairments, functional limitations, and disabilities. This evaluation process is a synthesis of all of the data and findings gathered from the examination and should guide the physical therapist to a diagnosis and prognosis for each patient / client. The documentation of an evaluation can use formats such as a problem list or a statement of assessment with key factors (e.g., cognitive factors, co- morbidities, social support) influencing the patient/client status.

Diagnosis – The diagnosis determined by the physical therapist after the evaluation process should be made at the impairment and functional limitation levels. It should identify the impact of a condition on function at the level of the system and the level of the whole person. The diagnosis by a physical therapist should be clearly documented and can take many formats. Some therapists choose to use common terminology to describe a diagnosis such as ICD coding or similar medical terminology. Another option is the Practice Patterns in the Guide to Physical Therapist Practice.

Prognosis - Documentation of the prognosis conveys the physical therapist's professional judgment for the patient / client's predicted functional outcome and the required duration of services to obtain this functional outcome.

Plan of Care - Documentation of the plan of care includes: 1) Overall goals stated in measurable terms that indicate the predicted level of improvement in function. Consider the expectation of the patient/client and others as appropriate; 2) A statement of interventions / treatments to be provided during the episode of care; 3) Proposed duration and frequency of service required to reach the goals; 4) Anticipated discharge plans

Re-examination- Includes data from repeated or new examination elements and is provided to evaluate progress and to modify or redirect intervention. In general, a re-examination of a patient/client 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.

Visit / Encounter Notes – Can be referred to as daily notes. Document sequential implementation of the plan of care established by the physical therapist, including changes in patient/client status and variations and progressions of specific interventions used and may include specific plans for the next visit or visits. Components include: Patient / client or caregiver report; Interventions provided including frequency, intensity, and duration as appropriate; Patient/client response to treatments / interventions; Communication / collaboration with other providers/patient/client/family/ significant other; Factors that modify frequency or intensity of intervention and progression of goals; Plan for next visit(s) including interventions with objectives, progression parameters and precautions, if indicated.

Discharge Summary – Documentation is required following conclusion, whether due to discharge or discontinuation of physical therapy services. The purpose of the discharge summary is to highlight a patient / client's progression towards goals and discharge plans. Essentially, this is the last time a therapist has to convey the outcome of physical therapy services. It is also the last opportunity to justify the medical necessity for the episode of care.

Tips for Documenting Evidence-Based Care

1) Keep up to date with current research through journal articles and reviews, Open Door, Hooked on Evidence at www.apta.org.
2) Continue to incorporate valid and reliable tests and measures as appropriate.
3) Include standardized tests and measures in your clinical documentation.
4) Review literature for evidence based interventions with APTA's Hooked on Evidence.

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State Laws and Other Regulations
Physical therapists and physical therapist assistants must consider all requirements imposed by regulations when practicing and documenting.
State Law - Some state practice acts regulating physical therapy services may contain specific documentation requirements within their regulations. It is important that you review your state's licensure regulations with respect to documentation requirements. If state law is stricter than third party requirements, state law supersedes. The following link will direct you to information about your state practice act: http://www.apta.org/AM/Template.cfm?Section=Practice_Management1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=201&ContentID=21791
Insurance Regulations – Different insurance companies can require unique requirements for payment. Examples may include authorization, certification, progress reports, etc.
Other – Additional requirements may be imposed based on practice setting, accreditation status, etc.
JCAHO – www.jcaho.org (accredits Hospitals, Home Care, Long Term Care, Ambulatory Care, Behavioral Health)
CARF – www.carf.org

Terms/ Phrases to Avoid
• "Patient/client tolerated treatment well"
• "Continue per plan"
• "As above"

How to Use Abbreviations
Abbreviations can be a quick and efficient way of documenting information. However, use of unknown or confusing abbreviations can be the source of communication breakdown. APTA does not endorse any particular set of abbreviations and recommends that physical therapists use abbreviations sparingly and that facilities clearly define what abbreviations are allowed in clinical documentation. A facility accepted abbreviations list should be in the Policy and Procedure Manual.
Improper use of abbreviations can also cause frequent denials in payment. A clinic may wish to develop a key of frequently used abbreviations on most documentation forms or request therapists to completely spell any word the first time it is written with the shortened form in parentheses (e.g. American Physical Therapy Association (APTA)).
There are some abbreviations considered as Do Not Use (DNU) according to JCAHO National Patient Safety Goals (www.jcaho.org). These abbreviations should be avoided (i.e., QD, TID, etc).

Top 10 Tips for Defensible Documentation
1. Limit use of abbreviations.
2. Date & sign all entries.
3. Document legibly.
4. Report progress towards goals regularly.
5. Document at the time of the visit when possible.
6. Clearly identify note types, e.g. progress reports, daily notes, etc.
7. Include all related communications.
8. Include missed/cancelled visits.
9. Demonstrate skilled care.
10. Demonstrate discharge palnning throughout the episode of care.

Useful Links
www.cms.org – Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/transmittals/downloads/R140PI.pdf - Therapy Cap Transmittal
http://www.cms.hhs.gov/TherapyServices/ - CMS Therapy Service link
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf - CMS manual - includes therapy requirements
http://www.apta.org – APTA's Home Page – links to Reimbursement, Practice, and Medicare information

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.

Ways to Improve Documentation

- Establish a Peer Review program
- Take advantage of CEU courses related to documentation

How to Handle Denials

- Review the Explanation of Benefits (EOB) voucher. That voucher should have a code with a descriptor that states why a denial was made.
- Review your claim form & documentation to see if you have grounds for an appeal.
- Appeals should be submitted in writing and not initiated over the phone. It is recommended that you mail the appeal with a "return receipt requested". Submit in a timely fashion as specified on the EOB.
- Forward your documentation along with the letter of appeal but make sure that the documentation supports your case.
- You may also need a copy of your state practice act, APTA's *Guide to Physical Therapist Practice*, APTA's Standards of Practice, a copy of the patient/client's benefit language, and the records of any conversations that the office staff has had with the payer's professional services personnel.

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
- HIPAA web site: http://www.cms.hhs.gov/HIPAAGenInfo/

Coding Tips

1. Have a current CPT, ICD9, and HCPCS Book.
2. Review code narrative language.
3. Select codes that accurately describe the impairment or functional limitations that you are treating.
4. Utilize the most specific code that accurately describes the service.
5. Know when a modifier is necessary and accepted by a payer.