

GUIDELINES FOR PHYSICAL THERAPY DOCUMENTATION BOD 02-02-16-20 (Program 32)
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Preamble

The American Physical Therapy Association (APTA) is committed to meeting the physical therapy needs of society, to meeting the needs and interests of its members, and to developing and improving the art and science of physical therapy, including practice, education and research. To help meet these responsibilities, the APTA Board of Directors has approved the following guidelines for physical therapy documentation. It is recognized that these guidelines do not reflect all of the unique documentation requirements associated with the many specialty areas within the physical therapy profession. Applicable for both hand written and electronic documentation systems, these guidelines are intended to be used as a foundation for the development of more specific documentation guidelines in specialty areas, while at the same time providing guidance for the physical therapy profession across all practice settings.

It is the position of the American Physical Therapy Association (APTA) that physical therapist examination, evaluation, diagnosis, and prognosis shall be documented, dated, and authenticated by the physical therapist who performs the service. Intervention provided by the physical therapist or physical therapist assistant, under the direction and supervision of a physical therapist, is documented, dated, and authenticated by the physical therapist or, when permissible by law, the physical therapist assistant.

Other notations or flow charts are considered a component of the documented record but do not meet the requirements of documentation in, or of, themselves Documentation Authority for Physical Therapy Service (HOD 06-00-20-05).

OPERATIONAL DEFINITIONS

Guidelines:	APTA defines "guidelines" as approved, non-binding statements of advice.
Documentation:	Any entry into the patient/client record, such as: consultation report, initial examination report, progress note, flow sheet/checklist that identifies the care/service provided, re-examination, or summation of care.
Authentication:	The process used to verify that an entry is complete, accurate and final. Indications of authentication can include original written signatures and computer "signatures" on secured electronic record systems only.

I. General Guidelines

- A. All documentation must comply with the applicable jurisdictional/regulatory requirements.
 - 1. All handwritten entries shall be made in ink and will include original signatures. Electronic entries are made with appropriate security and confidentiality provisions.
 - 2. Charting errors should be corrected by drawing a single line through the error and initialing and dating the chart or through the appropriate mechanism for electronic documentation that clearly indicates that a change was made without deletion of the

original record.

3. Identification.

- 3.1 Include patient's/client's full name and identification number, if applicable, on all official documents.
- 3.2 All entries must be dated and authenticated with the provider's full name and appropriate designation, i.e., PT or PTA.
- 3.3 Documentation by graduates or others pending receipt of an unrestricted license shall be authenticated by a licensed physical therapist.
- 3.4 Documentation by students (SPT/SPTA) in physical therapist or physical therapist assistant programs must be additionally authenticated by the physical therapist or, when permissible by law, documentation by physical therapist assistant students may be authenticated by a physical therapist assistant.

4. Documentation should include the referral mechanism by which physical therapy services are initiated:

Examples include:

- Ex 4.1: Self-referral/direct access
- Ex 4.2: Request for consultation from another practitioner

II. Initial Patient/Client Management

- A. Documentation is required at the onset of each episode of physical therapy care and shall include the elements of examination, evaluation, diagnosis, and prognosis.
- B. Documentation of the initial episode of physical therapy care shall include the elements of examination, a comprehensive screening and specific testing process leading to diagnostic classification, or, as appropriate, to a referral to another practitioner. The examination has three components: the patient/client history, the systems review, and tests and measures.

1. Documentation of appropriate history:

- 1.1 General demographics
- 1.2 Social history
- 1.3 Employment/work (Job/School/Play)
- 1.4 Growth and development
- 1.5 Living environment
- 1.6 General health status (self-report, family report, caregiver report)
- 1.7 Social/health habits (past and current)
- 1.8 Family history
- 1.9 Medical/surgical history
- 1.10 Current condition(s)/Chief complaint(s)
- 1.11 Functional status and activity level
- 1.12 Medications
- 1.13 Other clinical tests

2. Documentation of systems review

- 2.1 Documentation of physiologic and anatomical status to include the following systems:
 - 2.1.1 Cardiovascular/pulmonary
 - 2.1.1.1 Blood Pressure

- 2.1.1.2 Edema
- 2.1.1.3 Heart Rate
- 2.1.1.4 Respiratory Rate
- 2.1.2 Integumentary
 - 2.1.2.1 Presence of scar formation
 - 2.1.2.2 Skin color
 - 2.1.2.3 Skin integrity
- 2.1.3 Musculoskeletal
 - 2.1.3.1 Gross range of motion
 - 2.1.3.2 Gross strength
 - 2.1.3.3 Gross symmetry
 - 2.1.3.4 Height
 - 2.1.3.5 Weight
- 2.1.4 Neuromuscular
 - 2.1.4.1 Gross coordinated movement (eg, balance, locomotion, transfers, and transitions)

2.2 A review of communication ability, affect, cognition, language, and learning style.

- 2.2.1 Ability to make needs known
- 2.2.2 Consciousness
- 2.2.3 Orientation (person, place, time)
- 2.2.4 Expected emotional/behavioral responses
- 2.2.5 Learning preferences

3. Documentation of selection and administration of appropriate tests and measures to determine patient/client status in a number of areas and documentation of findings. The following is a list of the areas that may be addressed in the documented examination and evaluation, including categories of tests and measures for each area:

3.1 Aerobic Capacity/Endurance

Examples of examination findings include:

- Ex 3.1.1 Aerobic capacity during functional activities
- Ex 3.1.2 Aerobic capacity during standardized exercise test protocols
- Ex 3.1.3 Cardiovascular signs and symptoms in response to increased oxygen demand with exercise or activity
- Ex 3.1.4 Pulmonary signs and symptoms in response to increased oxygen demand with exercise or activity

3.2 Anthropometric Characteristics

Examples of examination findings include:

- Ex 3.2.1 Body composition
- Ex 3.2.2 Body dimensions
- Ex 3.2.3 Edema

3.3 Arousal, attention, and cognition

Examples of examination findings include:

- Ex 3.3.1 Arousal and attention

- Ex 3.3.2 Cognition
- Ex 3.3.3 Communication
- Ex 3.3.4 Consciousness
- Ex 3.3.5 Motivation
- Ex 3.3.6 Orientation to time, person, place, and situation
- Ex 3.3.7 Recall

3.4 Assistive and adaptive devices

Examples of examination findings include:

- Ex 3.4.1 Assistive or adaptive devices and equipment use during functional activities
- Ex 3.4.2 Components, alignment, fit, and ability to care for the assistive or adaptive devices and equipment
- Ex 3.4.3 Remediation of impairments, functional limitations, or disabilities with use of assistive or adaptive devices and equipment
- Ex. 3.4.4 Safety during use of assistive or adaptive devices and equipment

3.5 Circulation (Arterial, Venous, Lymphatic)

Examples of examination findings include:

- Ex 3.5.1 Cardiovascular signs
- Ex 3.5.2 Cardiovascular symptoms
- Ex 3.5.3 Physiological responses to position change

3.6 Cranial and Peripheral Nerve Integrity

Examples of examination findings include:

- Ex 3.6.1 Electrophysiological integrity
- Ex 3.6.2 Motor distribution of the cranial nerves
- Ex 3.6.3 Motor distribution of the peripheral nerves
- Ex 3.6.4 Response to neural provocation
- Ex 3.6.5 Response to stimuli, including auditory, gustatory, olfactory, pharyngeal, vestibular, and visual
- Ex 3.6.6 Sensory distribution of the cranial nerves
- Ex 3.6.7 Sensory distribution of the peripheral nerves

3.7 Environmental, Home, and Work (Job/School/Play) Barriers

Examples of examination findings include:

- Ex 3.7.1 Current and potential barriers
- Ex 3.7.2 Physical space and environment

3.8 Ergonomics and body mechanics

Examples of examination findings for ergonomics include:

- Ex 3.8.1 Dexterity and coordination during work
- Ex 3.8.2 Functional capacity and performance during work actions, tasks, or activities
- Ex 3.8.3 Safety in work environments
- Ex 3.8.4 Specific work conditions or activities

Ex 3.8.5 Tools, devices, equipment, and work-stations related to work actions, tasks, or activities

Examples of examination findings for body mechanics include:

Ex. 3.8.6 Body mechanics during self-care, home management, work, community, or leisure actions, tasks, or activities

3.9 Gait, locomotion, and balance

Examples of examination findings include:

Ex 3.9.1 Balance during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment

Ex 3.9.2 Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment

Ex 3.9.3 Gait and locomotion during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment

Ex 3.9.4 Gait and locomotion with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment

Ex 3.9.5 Safety during gait, locomotion, and balance

3.10 Integumentary Integrity

Examples of examination findings include:

Ex 3.10.1 Associated skin:

Ex 3.10.1.1 Activities, positioning, and postures that produce or relieve trauma to the skin

Ex 3.10.1.2 Assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that may produce or relieve trauma to the skin

Ex 3.10.1.3 Skin characteristics

Ex 3.10.2 Wound:

Ex 3.10.2.1 Activities, positioning, and postures that aggravate the wound or scar or that produce or relieve trauma

Ex 3.10.2.2 Burn

Ex 3.10.2.3 Signs of infection

Ex 3.10.2.4 Wound characteristics

Ex 3.10.2.5 Wound scar tissue characteristics

3.11 Joint Integrity and Mobility

Examples of examination findings include:

Ex 3.11.1 Joint integrity and mobility

Ex 3.11.2 Joint play movements

Ex 3.11.3 Specific body parts

3.12 Motor Function

Examples of examination findings include:

- Ex 3.12.1 Dexterity, coordination, and agility
- Ex 3.12.2 Electrophysiological integrity
- Ex 3.12.3 Hand function
- Ex 3.12.4 Initiation, modification, and control of movement patterns and voluntary postures

3.13 Muscle Performance

Examples of examination findings include:

- Ex 3.13.1 Electrophysiological integrity
- Ex 3.13.2 Muscle strength, power, and endurance
- Ex 3.13.3 Muscle strength, power, and endurance during functional activities
- Ex 3.13.4 Muscle tension

3.14 Neuromotor development and sensory integration

Examples of examination findings include:

- Ex 3.14.1 Acquisition and evolution of motor skills
- Ex 3.14.2 Oral motor function, phonation, and speech production
- Ex 3.14.3 Sensorimotor integration

3.15 Orthotic, protective, and supportive devices

Examples of examination findings include:

- Ex 3.15.1 Components, alignment, fit, and ability to care for the orthotic, protective, and supportive devices and equipment
- Ex 3.15.2 Orthotic, protective, and supportive devices and equipment use during functional activities
- Ex 3.15.3 Remediation of impairments, functional limitations, or disabilities with use of orthotic, protective, and supportive devices and equipment
- Ex 3.15.4 Safety during use of orthotic, protective, and supportive devices and equipment

3.16 Pain

Examples of examination findings include:

- Ex 3.16.1 Pain, soreness, and nociception
- Ex 3.16.2 Pain in specific body parts

3.17 Posture

Examples of examination findings include:

- Ex 3.17.1 Postural alignment and position (dynamic)
- Ex 3.17.2 Postural alignment and position (static)
- Ex 3.17.3 Specific body parts

3.18 Prosthetic requirements

Examples of examination findings include:

- Ex 3.18.1 Components, alignment, fit, and ability to care for prosthetic device
- Ex 3.18.2 Prosthetic device use during functional activities
- Ex 3.18.3 Remediation of impairments, functional limitations, or disabilities with use of the prosthetic device
- Ex 3.18.4 Residual limb or adjacent segment
- Ex 3.18.5 Safety during use of the prosthetic device

3.19 Range of motion (including muscle length)

Examples of examination findings include:

- Ex 3.19.1 Functional ROM
- Ex 3.19.2 Joint active and passive movement
- Ex 3.19.3 Muscle length, soft tissue extensibility, and flexibility

3.20 Reflex integrity

Examples of examination findings include:

- Ex 3.20.1 Deep reflexes
- Ex 3.20.2 Electrophysiological integrity
- Ex 3.20.3 Postural reflexes and reactions, including righting, equilibrium, and protective reactions
- Ex 3.20.4 Primitive reflexes and reactions
- Ex 3.20.5 Resistance to passive stretch
- Ex 3.20.6 Superficial reflexes and reactions

3.21 Self-care and home management

Examples of examination findings include:

- Ex 3.21.1 Ability to gain access to home environments
- Ex 3.21.2 Ability to perform self-care and home management activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment
- Ex 3.21.3 Safety in self-care and home management activities and environments

3.22 Sensory integrity

Examples of examination findings include:

- Ex 3.22.1 Combined/cortical sensations
- Ex 3.22.2 Deep sensations
- Ex 3.22.3 Electrophysiological integrity

3.23 Ventilation and respiration

Examples of examination findings include:

- Ex 3.23.1 Pulmonary signs of respiration/gas exchange

- Ex 3.23.2 Pulmonary signs of ventilatory function
- Ex 3.23.3 Pulmonary symptoms

3.24 Work (job/school/play), community, and leisure integration or reintegration

Examples of examination findings include:

- Ex 3.24.1 Ability to assume or resume work (job/school/play), community, and leisure activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment
- Ex 3.24.2 Ability to gain access to work (job/school/play), community, and leisure environments
- Ex 3.24.3 Safety in work (job/school/play), community, and leisure activities and environments

- C Documentation of evaluation (a dynamic process in which the physical therapist makes clinical judgements based on data gathered during the examination).
- D Documentation of diagnosis, a label that identifies the impact of a condition on function at the level of the system, especially the movement system, and at the level of the whole person in terms that can guide the prognosis, the plan of care, and intervention strategies.
- E Documentation of prognosis (determination of the level of optimal improvement that might be attained through intervention and the amount of time required to reach that level. Documentation shall include goals, outcomes, and plan of care).
 - 1. Patient/client (and family members and significant others, if appropriate) is involved in establishing goals and outcomes.
 - 2. All goals and outcomes are stated in measurable terms.
 - 3. Goals and outcomes are related to impairments, functional limitations, and disabilities and the changes in health, wellness, and fitness needs identified in the examination.
 - 4. The plan of care:
 - 4.1 Is based on the examination, evaluation, diagnosis, and prognosis
 - 4.2. Identifies goals and outcomes of all proposed interventions
 - 4.3 Describes the proposed interventions taking into consideration the expectations of the patient/client and others as appropriate
 - 4.4. Includes frequency and duration of all proposed interventions to achieve the goals and outcomes
 - 4.5 Involves appropriate coordination and communication of care with other professionals/services.
 - 4.6 Includes plan for discharge
- F Authentication by and appropriate designation of the physical therapist.

III. Documentation of the Continuation of Care

- A. Documentation of intervention or services provided and current patient/client status.

- 1. Documentation is required for every visit/encounter.

- 1.1 Authentication and appropriate designation of the physical therapist, or the

physical therapist assistant providing the service under the direction and supervision of a physical therapist.

2. Documentation of each visit/encounter shall include the following elements:

2.1 Patient/client self-report (as appropriate).

2.2 Identification of specific interventions provided, including frequency, intensity, and duration as appropriate.

Examples include:

2.2.1 Knee extension, three sets, ten repetitions, 10# weight

2.2.2 Transfer training bed to chair with sliding board

2.3 Equipment provided

2.4 Changes in patient/client status as they relate to the plan of care.

2.5 Adverse reaction to interventions, if any.

2.6 Factors that modify frequency or intensity of intervention and progression toward goals and outcomes, including patient/client adherence to patient/client-related instructions.

2.7 Communication/consultation with providers/patient/client/family/significant other.

B. Documentation of Reexamination

1. Documentation of reexamination provided as appropriate, to evaluate progress and to modify or redirect intervention.

2. Documentation of reexamination shall include the following elements:

2.1 Documentation of selected components of examination to update patient's/client's status.

2.2 Interpretation of findings and, when indicated, revision of goals and outcomes.

2.3 When indicated, revision of plan of care, as directly correlated with goals and outcomes as documented.

2.4 Authentication by and appropriate designation of the physical therapist.

IV. Documentation of Summation of Episode of Care

A. Documentation is required following conclusion of the current episode in the physical therapy intervention sequence.

B. Documentation of the summation of the episode of care shall include the following elements:

1. Criteria for termination of services:

Examples of discharge include:

Ex 1.1 Goals and outcomes have been achieved.

Examples of discontinuation include:

Ex 1.2 Patient/client, caregiver, or legal guardian declines to continue intervention.

- Ex 1.3 Patient/client is unable to continue to progress toward goals due to medical or psychosocial complications or because financial/insurance resources have been expended.
- Ex 1.4 Physical therapist determines that the patient/client will no longer benefit from physical therapy.

2. Current physical/functional status.
3. Degree of goals and outcomes achieved and reasons for goals and outcomes not being achieved.
4. Discharge or discontinuation plan that includes written and verbal communication related to the patient's/client's continuing care.

Examples include:

- Ex 4.1 Home program.
- Ex 4.2 Referrals for additional services.
- Ex 4.3 Recommendations for follow-up physical therapy care.
- Ex 4.4 Family and caregiver training.
- Ex 4.5 Equipment provided.

5. Authentication by and appropriate designation of the physical therapist.

Additional References:

1. Direction and Supervision of the Physical Therapist Assistant (HOD 06-00-16-27).
2. Comprehensive Accreditation Manual for Hospitals, Oakbrook Terrace, Ill: Joint Commission on the Accreditation of Healthcare Organizations.
3. Glossary of Terms Related to Information Security, Schamburg, Ill: Computer-based Patient Record Institute.
4. Guidelines for Establishing Information Security Policies at Organizations Using Computer-based Patient Records, Schamburg, Ill: Computer-based Patient Record Institute.
5. Current Procedural Terminology, American Medical Association (AMA)
6. Coding and Payment Guide for the Physical Therapist 2000, St. Anthony's Publishing and the American Physical Therapy Association
7. Healthcare Finance Administration (HCFA) (www.hcfa.gov):
Minimal Data Set (MDS) Regulations
CMS (formerly HCFA)/AMA Documentation Guidelines
Home Health Regulations
8. State Practice Acts (www.fsbpt.org)

(Program 32 – Practice, ext 3176)