SECTION I

Utilizing a Clinical Reasoning Framework for Documentation

CHAPTER 1

Documentation: An Essential Element of Physical Therapist Practice

CHAPTER OBJECTIVES

1. Define "successful" documentation.
2. Define the purpose of documentation.
3. Recognize how clinical reasoning concepts can be applied to the development of successful documentation.
4. Recognize that a thorough clinical picture of a patient or client is generated through many entries into the health record starting with the initial examination and ending with the conclusion of the episode of care.
5. Recognize that proper documentation is imperative for the delivery of a comprehensive physical therapy plan of care regardless of the medium: paper-based or electronic.

KEY TERMS

Clinical decision making
Clinical reasoning
Electronic health record
Feedforward
Feedback
Reflection
Successful documentation

Introduction

Accepting documentation as an integral part of clinical practice is vital to the development of clinical expertise. This chapter is designed to relay the criteria that define **successful documentation**. Equally important is understanding who the users or consumers of your documentation are and the purposes for which your documentation might be used. This chapter also relays the importance of infusing your documentation with your clinical reasoning skills and self-reflecting on the documentation you create so that you consistently produce quality documentation that is meaningful to multiple users. In addition, this chapter introduces the idea that a complete clinical impression of a patient or client is developed through multiple interactions with the patient or client by many healthcare providers. The quality of the account of each of these encounters will further enhance your clinical expertise and your ability to provide quality care to your patient or client. Lastly, this chapter develops the need to apply successful documentation regardless of the documentation medium: an electronic or a paper-based system.

Defining Successful Documentation

What is "good" documentation? If you were reviewing a physical therapist's or a physical therapist assistant's documentation, what characteristics would you look for?

What criteria would you use to judge the documentation as "good"? As a physical therapist or a physical therapist assistant reviewing a colleague's documentation, you might decide that it is "good" if the information you are looking for is included. Now consider that you are in charge of completing internal chart reviews for your company. Or, consider that you are a third-party payer reviewing documentation to determine reimbursement to the physical therapy provider for services rendered. Do your criteria change regarding what constitutes "good" documentation since the individual using the documentation changed? No. In fact, in all three scenarios the criteria are the same: "good" documentation contains the information that the consumer needs to make a sound decision. Consumers of physical therapy documentation are many and can be found listed in **TABLE 1-1**. Often there are multiple consumers of one clinical note, each of whom reviews it to make different decisions.

Critically reviewing documentation for content and actually creating "good" content requires two different skill sets. Conducting a documentation review to establish if documentation is in fact "good" is a feedback type of process, where you read and judge the content against some predetermined set of criteria to make a determination about outcomes. Refer to **APPENDIX 1-A**: American Physical Therapy Association (APTA) *Guidelines: Peer Review Training*.[1] In motor control, **feedback** is used to check the effectiveness of a response and allows for adaptation should the motor pattern generated be different from the actual planned movement.[2] Similarly, when you review a note, you are checking for specific details and making recommendations if you do not find what you are looking for. The criteria you utilize might be part of a formal internal quality assurance process or a more informal set of criteria that you impose as you attempt to extract the desired information. In contrast, creating "good" content is more of a feedforward process that requires you as the author to recognize what detail should be included in that content. A **feedforward** process in motor control allows an anticipatory response, one that is learned from the memory of past successful movements.[2] Hence, knowing the details that constitute "good" documentation will help to facilitate the formation of more "good" content.

If a feedforward framework is used to create documentation, then you will ensure that the content will not be based on the documentation's consumer. For example, a student should not modify his documentation based on the physical presence or absence of his clinical instructor. Likewise, a physical therapist or physical therapist assistant providing care to a Medicare beneficiary, an individual with private health insurance, or an individual who is paying cash should not document differently based on the different payer sources. Rather than tailor your physical therapy documentation to meet the needs of the documentation's consumer, simply include the details required to make well-informed decisions. This is the criterion that defines "successful" documentation. In other words, the term "successful" documentation indicates that which includes all of the information that the consumer wants.

The patient or client health record is a product that has many potential consumers. Therefore, it must possess the utility necessary to meet the needs of each end user. If the end user is a physical therapist assistant, then the documentation must include the interventions that meet the goals outlined in the plan of care as well as any information such as precautions or contraindications that allows

TABLE 1-1 Documentation Consumers

Consumer	Purpose for Documentation Review
Physical therapist, physical therapist assistant, physical therapist aide, or physical therapy student colleague	Gather information needed to provide comprehensive physical therapy care to a patient or client.
Physical therapist supervisor	Internal audit.
Member of the patient or client healthcare team (referring or attending physician, surgeon, nurse, occupational therapy professionals, speech language pathologist, case manager, etc.)	Review patient or client progress or status, make further healthcare decisions.
Patient or client; family members of patient or client	Record keeping.
External consultation service	External audits and clinical reviews.
Third-party payer	Determine reimbursement for services rendered.
Legal system	Verify claims against a physical therapist for services rendered.

the physical therapist assistant to deliver care safely. If the end user of your documentation is the patient or client's referring physician, then details that relay the patient or client's progress with physical therapy should be included. If the end user of your documentation is a third-party payer, then objective data that substantiates the need for skilled physical therapy care is warranted. Third-party payers use daily notes and progress notes for example, to determine continued medical necessity, progress through the plan of care, and remaining deficits including impairments in body functions and structures, activity limitations, and participation restrictions that impact the daily functioning of a patient or client. Consider the following scenario.

> You are working with a teenager who had an anterior cruciate ligament (ACL) reconstruction 8 weeks ago. The frequency of your plan of care is three times per week and the patient or client's goal is to participate in soccer tryouts in 6 months. The patient or client has achieved full flexion and extension active range of motion at the knee and the current focus is re-strengthening the vastus medialis oblique muscle. Towards the end of the session, the patient or client's father asks for a copy of the clinical note you just completed so that his daughter can take it to the appointment with her surgeon, which is in 45 minutes. Your note reads as follows:
>
> > Patient states knee is doing fine. No problems with home exercises.
> >
> > See flow sheet. Added resisted hip abduction in standing.
> >
> > Patient tolerated treatment well.
> >
> > Continue plan of care.

Does this note meet the criteria for successful documentation? Does it contain the information you would want as the patient or client's father or patient or client's surgeon regarding the physical therapy care the patient or client is receiving? You could argue that you would have written your note differently had you known that the patient or client was to follow up with the surgeon that afternoon. However, remember that the content of consistently successful documentation does not depend on the note's consumer. This same note could be reviewed by a team internal to your practice for quality assurance or by a third-party payer to determine reimbursement to your facility for services you provided. Furthermore, this note could be reviewed by a legal team who is working to resolve a billing dispute or to address an inquiry or complaint from a patient or client regarding the physical therapy services he or she received.

Regardless of the note's consumer, every entry into the patient or client's health record should relay the journey through the plan of care from the initial examination to the conclusion of the episode of care summary. In other words, your documentation should tell a story with the end goal of providing the support for why skilled physical therapy services were warranted. In general, high-quality creative writing practice includes knowing your audience and tailoring the content so that the author can connect with the reader to relay a message. Applying this framework however to the documentation in a patient or client's record, a more technical form of writing, may lead you to mistakenly omit content that is vital to the entire clinical picture. With each entry into the patient or client's health record, you are building a case for why your patient or client should receive skilled physical therapy care. Perhaps a more complete note, one you would be proud to copy and give to the patient or client's father for the follow-up visit with the surgeon, might read as follows:

> Patient reports a 3/10 pain at the medial right knee joint line when performing transitional movements like turning or when rolling over in bed.
>
> See flow sheet. 8 weeks status post ACL reconstruction; vastus lateralis oblique exercises dosed for motor control (4 sets of 30). Reviewed lower extremity positioning during transitional movements. Added resisted standing hip abduction bilaterally dosed for increasing strength (3 sets of 10; 1 RM).
>
> Knee Active ROM = 0 to 126 degrees.
>
> No extensor lag noted during straight leg raise performed after session. Decreased stance time on right when ambulating clinic distances after session.
>
> Add treadmill walking with focus at terminal stance, no limp.

This note includes specific information regarding the patient or client's status, what was done during the treatment session including education to address the patient or client's pain complaint, an outcome measure (range of motion), the patient or client's response to the intervention provided that session, and the plan for the following session. While not a formal reassessment of all of the outcomes

measured for this patient or client, a clear, succinct, and informative update is relayed. Furthermore, it is apparent from this note why physical therapy services are still warranted for this patient or client and that the care provided met or exceeded the standard of physical therapy care.

Defining the Purpose of Documentation

If successful documentation includes all the details necessary to make informed decisions, what then is the *purpose* of successful documentation? Take a moment to reflect on this question. Would you say that the purpose of successful documentation is to serve as the log of services you provide to a patient or client at a given time? Would you say that the purpose of successful documentation is to serve as a mechanism for you to communicate with the other healthcare providers involved in the health care of your patient or client? Would you say that the purpose of successful documentation is to serve as a legal representation of the care you delivered to a patient or client for optimal reimbursement from a third-party payer? What if the patient or client pays out of his or her pocket for the physical therapy services that you provide? Does the purpose of successful documentation now change? In fact, the purpose of successful documentation is multifaceted; however you need not be concerned with the exact purpose if you are consistently precise about the content. Knowing which details signify the content of successful documentation regardless of the consumer involves recognizing how to transfer your thoughts, and therefore your clinical reasoning processes, from your brain to the patient or client's health record. If your reasoning is clear then communication between you, the patient or client, and the rest of the patient or client's healthcare team will also be clear. Likewise, anyone who accesses your note would be able to extract the content they seek to make a sound decision.

Clinical Reasoning and Self-Reflection in Documentation

Clinical decision making is a deliberate and dynamic process used by clinicians to synthesize data collected from an encounter with the patient or client.[3] It requires an ability to integrate knowledge and technical skill when making decisions about a patient or client's care.[4] **Clinical reasoning** is the framework that supports why you have made these decisions and ultimately, why you do what you do with each patient or client. It includes knowledge of evidence in practice, but also the cognitive process of reflection to achieve successful outcomes in patient or client care.[4] It stands to reason that as long as you have a firm, evidence-based rationale for why you chose a certain clinical test and measure, outcome measure, or intervention for a patient or client, then your actions based on this reasoning are justified. Furthermore, your execution of the patient or client's plan of care is guided by this rationale and exemplary care is offered. If your reasoning is reflected in your documentation, you or your employer will likely be reimbursed for the physical therapy services you provide, and potential inquiries by the legal system will not evolve into threats to your professional license.

Expert clinicians continuously challenge their knowledge base by constantly reflecting on the clinical decisions made in patient or client care. Characteristics shared by expert clinicians include clinical reasoning that is centered on the individual patient or client and that is further enhanced by a strong knowledge base, skills in differential diagnosis, and the ability to engage in self-reflection.[5] **Reflection** involves allowing future behavior to be guided by a systematic and critical analysis of past actions and their consequences.[6] Self–reflection is being able to self-direct this developmental process for proficiency in clinical practice. Wainwright and colleagues report that a specific skill set is required for effective self-reflection **(TABLE 1-2)**. These skills include self-awareness, description, critical analysis, synthesis, and evaluation. Consider the following scenario.

> Your patient or client is a 71-year-old female who was referred to outpatient physical therapy for knee pain. You start the initial examination 15 minutes late because the patient or client got lost on the way to the clinic. She also required some assistance completing the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC), a self-report questionnaire. You decide to begin your examination using the items from the WOMAC as a guide. You ask her to stand and she does not. When you repeat your request, she stands and starts to walk across the room. You decide to allow her to continue so that you can

TABLE 1-2 Skills Needed for Reflection

Skill	Description
Self-Awareness	The ability to assess how the situation has affected the person and how the person has affected the situation
Description	The ability to recognize and recall salient events
Critical Analysis	The ability to examine, identify, and challenge assumptions, and imagine and explore alternatives
Synthesis	The ability to integrate new knowledge with existing knowledge to solve problems and make predictions
Evaluation	The ability to make judgments about the value of something

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observe her gait pattern. You proceed with other tests and measures and end the session prescribing a home exercise program to improve her knee extension range of motion. She has a difficult time understanding your instructions for the exercise so you decide to try schedule her next appointment the following day so that you can get started on intervention right away.

After an interaction such as this, what is your impression of the patient or client's behavior? Completely answering this question requires reflection on the interaction. For example, you could assume that your patient or client has cognitive impairments based on the fact that she arrived 15 minutes late to the appointment, required assistance to fill out a self-report outcome measure, misunderstood your directions during the examination, and had difficulty executing an exercise you prescribed. However, making a judgment regarding cognitive status based on her behavior is an inappropriate assessment strategy. Since you did not assess her cognition, you cannot make this assertion. An alternative approach to formulating your impression based on your observations alone includes utilizing self-reflection to determine if alternative solutions exist that explain the behaviors you observed **(TABLE 1-3)**.

Creating successful documentation is as important a skill as perfecting your hand placement for a manual technique or appropriately prescribing exercise. Therefore, reflecting on your documentation to extract content and examine the context can serve to improve your ability to successfully document. One does not become an Olympian without taking the time to train and practice. Likewise, you will not become a proficient documenter if you do not take time to review your work. Therefore, the concept of reflection can be applied to documentation to improve the content of the patient or client's health record so that you can rely on it as an adjunctive tool to your clinical practice. In other words, the well-constructed health record serves not only as a tool you can use to accurately and precisely keep track of the plan of care you created for your patient or client, but also as a tool used by other consumers of your note. The APTA *Guidelines for Peer Review Training* (**APPENDIX 1-A**) indicate that

"… a physical therapist performing a peer review must have an understanding that documentation is a:

- Chronological record of the physical therapy provided.
- Legal medical document.

TABLE 1-3 Results of Clinical Reflection

Consider that events may have occurred prior to the patient or client's arrival at the clinic that may have affected her behavior.

- Never had physical therapy before and is nervous about the encounter.
- Had a poor previous experience in physical therapy.
- First time in an unfamiliar location.
- Disturbing phone call with family member prior to entering the clinic.
- Presence of comorbid conditions not obvious from the external documentation you received.
- There was an error in the map and directions to the clinic that she received from the front office staff.

Consider that impairments exist in body structures and functions that you did not assess.

- Visual impairment kept patient or client from independently completing the self-report assessment tool.
- Hearing impairment kept patient or client from being able to follow verbal instructions.
- Cognitive impairments affected the patient or client's executive functions.

Consider that your communication style did not meet the patient or client's needs.

- You do not make eye contact or directly face your patient or client when speaking to her.
- Your voice volume was not adequate.
- Your verbal instructions were unclear.

- Means of communication with other healthcare providers.
- Reflection of medical necessity.
- Rationale for care.
- Method to demonstrate outcomes.
- Record of the effectiveness of intervention.
- Means to support reimbursement."[1]

Consider inserting the word "self-review" for "peer review." It is important to apply the above definition of what documentation is to your documentation every time you create an entry into your patient or client's health record so that you are consistently precise about any given note's content. Recognizing what your documentation represents will help you to consistently identify relevant content.

Limited physical therapy research is available regarding the use of reflection to develop clinical expertise.[3,4,5,7–10] Furthermore, an area of study that has not been explored is the use of reflection to develop expertise in physical therapy documentation and linking this development to improved patient or client outcomes, higher reimbursement, decreased claims denials, and decreased litigation due to poor documentation. In the example above, engaging in a systematic reflective process regarding your interaction with your patient or client may reveal content that should be reflected in your documentation to support a longer episode of care, to support a referral to a different healthcare provider, or to support your rationale for the assessment and intervention choices you make. **TABLE 1-4** provides a list of questions to use when self-reflecting on the documentation you create.

TABLE 1-4 Questions for Self-Reflection on Documentation

○ What did you record regarding your patient or client's status? ○ Why did you choose to capture this information? ○ What gains did the patient or client make since the last session? ○ What are the patient or client's remaining deficits?
○ What did you do during your physical therapy session? ○ Why did you choose to perform these interventions?
○ What was the result of what you did with your patient or client during the session? ○ What did you accomplish with your patient or client? ○ What was the outcome of your session? ○ How did the patient or client respond to your interventions? ○ Why do you think these outcomes occurred? ○ What information did you use to formulate your clinical impression of the patient or client?
○ What is your plan for the next session? ○ Why did you choose this content for the next session?

Capturing the Whole Clinical Picture through Documentation

Consider that every aspect of your interaction with a patient or client generates a data point that you ultimately use when formulating your patient or client's plan of care. As you and your patient or client exchange initial greetings with each other, you immediately begin formulating what is likely the most appropriate communication level and style for that individual. The breadth and depth of data that you collect during your history and systems review support the development of a preliminary clinical impression of your patient or client's chief complaint. As you further examine your patient or client, you select tests and measures and outcome tools based on additional results from your examination. This process assists you in refining your clinical impression allowing you to develop an appropriate physical therapy diagnosis and prognosis, including the frequency and duration of the episode of care as well as an intervention plan. It is important to recognize that you develop judgments or opinions based on every interaction you have with your patient or client.

You have likely been taught to "document what you do." However, using this axiom as a guide for your documentation will fall short of helping you produce successful documentation. If you simply document what you do, you are omitting the patient or client's perception of their progress, the patient or client's response to your interventions, your clinical impression of your findings, and your plan for the next visit. In fact, documenting what you do is analogous to completing only the examination element of patient or client management, or only the objective portion of a daily physical therapy note. The APTA *Guide to Physical Therapist Practice* indicates that an examination occurs when a physical therapist "conducts a history, performs a systems review, and uses tests and measures to describe and/or quantify an individual's need for services."[11] During the examination, the physical therapist must also "determine if the individual would benefit from physical therapy, develop a plan of care, progress the plan of care based on the individual's response to intervention, and determine if a referral to or consultation with another provider is indicated." [11] The Guide also confirms that there are other essential components to patient or client management in addition to collecting data. Remember, the examination is but one of the five elements of patient or client

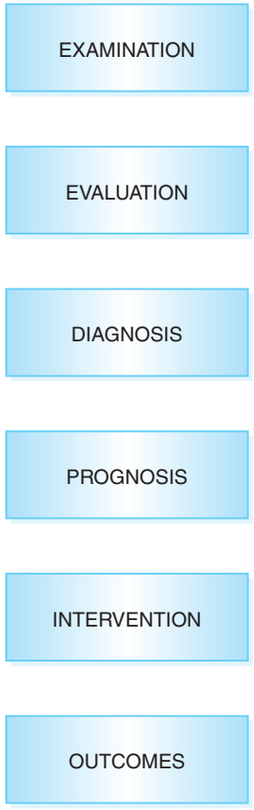

FIGURE 1-1 Elements of the Patient/Client Management Model.
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management leading to optimal outcomes to physical therapy care **(FIGURE 1-1)**.[11]

The online version of the APTA *Guide to Physical Therapist Practice* was developed to serve as an electronic resource to physical therapists and physical therapist assistants to help influence knowledge as research develops and examination and intervention strategies evolve.[11] The Guide was also developed as a resource to educate other healthcare professionals as well as the community about the physical therapy profession. Furthermore, the Guide lays a valuable foundation for successful documentation because it can be used to standardize terminology across practice settings to optimize communication within and about the profession.

The APTA's *Defensible Documentation for Patient/Client Management* also serves to promote consistently successful documentation. These guidelines exist to raise awareness among physical therapists and physical therapist assistants of documentation issues regarding legal, regulatory, and payer requirements as well as providing tools including templates and tips for documenting medical necessity and evidence-based care.[12]

Along with documenting what you do, you may have also been taught that "if you didn't document it, you didn't do it." This axiom demonstrates the weight given to a patient or client's health record in that it serves as the legal representation of the services you actually provided. APTA's *Defensible Documentation* guidelines emphasize that appropriate documentation is crucial because it represents a physical therapist's and physical therapist assistant's responsibility to a patient or client and helps to ensure safety and quality in the delivery of services.[12] Ultimately when creating your documentation, it is important to become proficient at identifying the balance between too much documentation and not enough. Consider the following daily note.

> Mrs. A reports that she is noticing more and more mobility in her arm and is trying to use it more during her daily activities although she notes that she is still unable to reach the back of her head when washing her hair and is not able to reach across her body with her right arm to put on her seatbelt when in the driver's seat of the car. She reports a 6/10 pain by the end of the day in the lateral aspect of the right upper extremity to the elbow that is also interfering with her ability to get to sleep.
>
> See flow sheet for completed exercises. Added functional reaching tasks with emphasis on postural positioning of the cervical spine, glenohumeral joint, scapulothoracic joint and thoracic spine in standing, as well as an emphasis on motor control. When reaching overhead Mrs. A displayed limited right shoulder elevation to 110 degrees with approximately 5 cm of scapular elevation and 40 degrees of scapular upward rotation. Mrs. A demonstrated 30 degrees of a lateral trunk lean to the left with increased weight bearing through the left lower extremity and decreased weight bearing along with increased plantarflexion with the heel lifting off the ground on the right.
>
> Continue to improve motor control of the shoulder girdle and progress to a strengthening dose of the lower trapezius, middle trapezius, and rhomboid musculature as able.

What do you think about the level of detail in this note? Is there enough information to determine how to proceed with the next session? Is there enough detail to relay medical necessity and to show why physical therapy services are

warranted? While the note appears to include the content necessary to appropriately and accurately support the services you provided, it also relays many other details that do not add value to the note. Now consider this note.

> Mrs. A reports improved mobility at the right shoulder; she continues to experience limitations reaching to don her seatbelt in her car and washing her hair. She reports a 6/10 pain in the lateral shoulder to elbow by the end of the day that limits her ability to fall asleep.
>
> See flow sheet. Added lateral functional reaching tasks with an emphasis on motor control.
>
> Mrs. A demonstrates poor scapular stability during lateral functional reaching tasks requiring moderate tactile cues for positioning.
>
> Isolate scapular depressors and adductors next session for improved static positioning and add functional reaching tasks as stability with straight plane movements improve.

What do you think about the level of detail in this note? This note appears to include relevant information in terms of relaying medical necessity and supporting the services you provided in a succinct and efficient way. Clinical circumstances regarding the safety of your patient or client may also warrant a certain level of detail in a daily note. Consider the following example of a daily note for your patient or client in the inpatient rehabilitation setting who is recovering from a fall that resulted in a concussion and a humeral fracture who also experiences tachycardia and shortness of breath during your session.

> Mr. B reports extreme fatigue.
>
> Appears to be short of breath; pulse rate fast but regular. Skin clammy.
>
> Unable to complete any exercise or functional training today due to fatigue.
>
> Continue plan of care as able.

Are there any details missing from the above note that would help to complete the clinical problem that this patient or client has experienced? You may have ultimately communicated with the rest of your patient or client's healthcare team and suspected that this individual was experiencing symptoms related to congestive heart failure; however if you did not record your patient or client's vital signs or communications you had on his behalf, then it is assumed that these actions were not taken. Now consider this daily note.

> Mr. B reports increased fatigue and that when he woke this morning he did not feel rested. He reports that he felt unable to propel his wheelchair with his legs like you taught him yesterday.
>
> Baseline vital signs: BP rest = 145/89 mmHg; HR rest = 122 bpm; RR rest = 20 breaths per minute on room air; oxygen saturation = 98% on room air; skin appears clammy; no swelling noted in the lower extremities bilaterally.
>
> Exercise program was not completed today due to tachycardia and shortness of breath at rest. Consulted nursing staff to relay findings during session.
>
> Mr. B's therapies are on hold until results of further medical assessment are known.

This note relays that you were responsible for determining your patient or client's medical stability and that you practiced quality care. This note also includes the details that other members of this patient or client's healthcare team can use to make further clinical decisions regarding your patient or client's status and need for further assessment.

If your documentation were to come under review, from either a colleague following the care of your patient or client, a patient or client inquiring about his or her own plan of care, an internal audit conducted by your employer, or an external audit conducted by a third-party payer, you should be assured by the fact that your documentation is successful, meaning it relays to the consumer exactly the information needed. Consider that your documentation should be so succinctly complete that there is little need for clarification. Your colleague should not have to ask for a quick synopsis of the patient or client you initially examined prior to initiating care. Rather, a colleague should know that he or she can go to your initial examination documentation, as well as any follow-up notes or progress notes and identify exactly *why* that patient or client has sought physical therapy services, *what* he or she has been doing in physical therapy, *how* he or she has responded to date, *what* the plan is for that visit, and *where* he or she is in the journey through the current plan of care. Indeed it is beneficial to verbally confer or to conduct rounds with your colleagues regarding patient or client management. In fact, the purpose of conferencing on a patient or client's

care is to relay the clinical reasoning and rationale used to support the organization of your plan of care. Opportunities may then exist for your colleagues to provide you with constructive feedback regarding this rationale to help you grow as a clinician. Unfortunately, however, what should be documented in writing regarding a patient or client's plan of care is often only shared verbally among colleagues. One shortcoming of this practice is that the treating physical therapist or physical therapist assistant is influenced by the verbal information being shared by other providers involved in the patient or client's care. The treating therapist or assistant then organizes thoughts and makes clinical decisions based on information that is not clearly represented in the health record. These clinical decisions are the product of the clinical reasoning process and should be captured in the health record. Consider the following scenario.

> You practice in a busy inpatient rehabilitation environment. You work with individuals who have suffered a neurological event such as a cerebrovascular accident or a cerebral aneurysm. You have already discussed and planned your schedule for the day with your occupational therapist, speech therapist, and therapy aide team members. A physical therapist from another team approaches you with a request to include one of her patients or clients on your schedule due to a conflict that she has to ensure that the patient or client receives her full amount of therapy allotted for the day. As you look at your schedule you see that you have a 30-minute window of time when you can provide care for this patient or client.

As the treating therapist or assistant you are now responsible for the safe delivery of care to the patient or client, which requires you to be aware of the plan of care including the patient or client's functional status, cognitive status, precautions or contraindications, comorbid conditions, and goals for therapy. In addition, you may want to know how the patient or client responded to the last physical therapy session. To gather this information you decide to review the patient or client's health record and find the following information from the initial examination:

> FIM transfers: moderate assistance × 1 via sliding board transfer
>
> FIM locomotion: 2 – maximum assistance (patient can perform 25% to 49% of task)
>
> Fugl-Meyer Assessment UE Motor Function Score: 10/66
>
> Fugl-Meyer Assessment LE Motor Function Score: 12/34
>
> Trunk Impairment Scale: 13/23
>
> Left neglect, left upper and lower extremity hemiparesis, aphasia; the patient is receiving IV fluids and has a PEG tube

The physical therapy daily note from the previous session reads:

> Required maximum assistance × 1 to stand in parallel bars for weight-bearing and pre-gait activities such as weight shifting.

After reviewing the health record you might decide that it would be beneficial to transfer the patient or client to the edge of the mat to work on sitting balance and to help her orient more to midline using visual and verbal cues. Based on the reported outcome measures and the goals established in the initial examination this appears to be an acceptable and beneficial way to spend 30 minutes of intervention with this patient or client. When you relay your ability to work with the patient or client, your colleague shares that the patient or client is very confused and became agitated when the team attempted to use the body weight support system for overground walking. During a session yesterday the patient or client was unable to consistently follow simple one-step commands and became agitated during a dependent transfer from her wheelchair to the bed. Your colleague adds that the patient or client has been difficult to work with since her admission 2 days ago and is not willing to participate in therapy.

Does your intervention plan for this patient or client change now that you are aware of additional information about her? If you were to listen only to a verbal account of the team's perception of the patient or client, you may formulate inaccurate opinions regarding the patient or client and make clinical decisions based on this information without fully assessing why the she became agitated. A more complete daily note from this patient or client's previous physical therapy session might include the following to reveal a more accurate clinical picture:

> Required maximum assistance × 1 to stand in parallel bars for weight-bearing and pre-gait activities such as weight shifting. Patient became agitated at attempt

> to use body weight support system for pre-gait activities. Variable ability to follow one-step commands. Required a dependent transfer × 2 from wheelchair to bed at end of session.

Having access to this additional information during your review of the patient or client's health record might lead you to further investigate the change in the patient or client's transfer status from moderate assistance × 1 to dependent × 2. You might also decide to communicate with the patient or client's nurse regarding the patient or client's behavior at various points in the day. Perhaps further discussion would identify a need for a toileting schedule or a medication change, for example. You might also decide to conduct a brief cognitive screen to assess the patient or client's current ability to respond to your cues. Furthermore, you might decide to conduct her session in a more closed, private, and calm environment or take time to educate her further on the use of a body weight support system and how it can prepare her for walking. Essentially, the verbal information that was shared with you by your colleague may have generated further productive discussion regarding the care of the patient or client. Remember, that verbally conferencing about a patient or client should occur to complement your documentation and further develop your clinical reasoning that drives the choices you make in the delivery of physical therapy care to a patient or client.

Being responsible for a patient or client's care requires that you are an advocate for his or her health by documenting why the care he or she received was medically necessary. The APTA *Standards of Practice for Physical Therapy* state that

"The physical therapist of record is the therapist who assumes responsibility for patient/client management and is accountable for the coordination, continuation, and progression of the plan of care."[13]

Consider the following scenario.

> You practice in an outpatient clinic and are filling in for a therapist who is out sick. There is a new patient or client on the schedule so you are to provide the initial examination for this individual to determine the physical therapy plan of care.

Even though another physical therapist will be working to carry out the plan of care you created for this patient or client, you are considered the physical therapist of record unless your documentation explicitly indicates that you are transferring the care to another physical therapist. The *Standards of Practice for Physical Therapy* also state that

"The physical therapist of record is responsible for 'handoff' communication."[13]

Your documented plan of care might reflect this information as follows:

> John Doe will benefit from daily skilled physical therapy intervention to improve his ability to manage his wheelchair and to perform independently all of the activities required of him throughout a 6-hour school day including mobility, pressure relief, toileting, and lower extremity range of motion from a wheelchair level. The treating physical therapist will be different than the evaluating therapist, and therefore John Doe's physical therapy plan of care is being transferred to the treating therapist for any subsequent physical therapy management of this plan of care.

The detail in this note ensures that you are not only meeting the requirements of successful documentation by alerting the note's consumer of the actual circumstances surrounding this plan of care, but that you are also following the *Standards of Practice for Physical Therapy*.

Documentation in an Electronic Health Record

Documentation skills develop over time as experience mounts and self-reflection occurs regardless of the medium used to record it, written or electronic. You likely do not have the option of choosing your preferred documentation format, and therefore you must be comfortable successfully documenting in both formats. **Electronic health records** (EHRs) are not standardized and vary greatly across and within practice settings. However, what should not vary are the key elements utilized to create successful documentation **(TABLE 1-5)**. Your clinical reasoning processes should not change when creating your documentation, but could however be influenced by some of the features of EHRs. For example, drop-down menus and pre-populated fields could halt your clinical reasoning process. Your ability to use a feedforward framework could also be compromised.

TABLE 1-5 Key Elements for Creating Successful Documentation

Transfer clinical reasoning processes from thoughts to medical record.
Use a feedforward framework.
Include details required to make well-informed decisions.
Provide support for why physical therapy services are needed.

For example, premade templates could guide your decisions and determine the flow of your encounter with a patient or client rather than be used as a means to quickly record collected data carefully selected for that individual. In addition, your ability to include all of the details you prefer to make well-informed decisions regarding the components of your plan of care may be constrained by the features of an electronic system such as character limits or areas that require selecting items from a list rather than an area available for free text. Alternatively, these elements of an EHR, such as drop-down menus, pre-populated fields, templates, and lists can serve to improve your documentation time, accuracy, and efficiency as long as you preserve your professional obligation to create meaningful and usable information. Overall, the ability to be a proactive documenter in an EHR rather than reactively entering data will afford you the ability to provide evidence that the physical therapy care you provided was medically necessary and of value to your patient or client.

Additional benefits of EHRs include facilitating communication within and among healthcare providers to ensure that a patient or client's health record is accessed and updated in real time for the most accurate information possible for sound clinical decision making. EHRs may also reduce medical errors and improve operational efficiency[14] thereby saving money. Recognize however, that the data input into an electronic system is only as good as its creator. For the contents of electronically written documentation to be usable by multiple consumers, the key elements of successful documentation must be at the foundation.

Summary

Creating successful documentation is a complex process that evolves over time and likely requires practice to ensure that all the necessary elements are included. For example, successful documentation involves the ability to accurately capture quality content including any elements that may be required from a regulatory standpoint in a time efficient manner. This text is designed to help you include the content that you need within every note to meet these objectives. As mentioned above, creating sound documentation is a skill that is just as important to your success as a physical therapist or physical therapist assistant as your manual skills or your ability to prescribe effective exercise for a given clinical scenario. To become refined, skills must be sharpened. Just as you create goals and collect outcome measures from which to gauge the success of your plan of care, so too should you have goals when striving to create successful documentation. These goals might include creating a process for critically reviewing your own documentation or the documentation of your peers with the intention of providing constructive feedback.

Capturing your clinical reasoning within the context of your documentation will ensure that the interaction you had with your patient or client was accurately represented. In other words, anyone who reads your note would know the details of the session and be able to make decisions based on this information. As you review a note that you created, remember to ask yourself why you included certain details of your note and determine if you omitted any details that you think may have been useful to include. Reflect on how you will change your documentation the next time you create a daily note or document the results of an initial encounter with your patient or client. Using a feedforward framework such as this to practice refining your documentation skills will help you identify gaps in your plan of care and ultimately help you to improve your expertise as a clinician. Another key element important for the creation of successful documentation is ensuring that the details required to make informed decisions are included. For example, you should be able to review your documentation and make decisions about various aspects of the plan of care including determining the prognosis, setting goals, and developing intervention strategies from the information you collated from each part of the examination. Furthermore, you should look at your documentation and be able to defend why your skilled services are necessary. If you are able to do this, then you have likely created successful documentation!

Discussion Questions

1. What is meant by the term *successful documentation*?
2. If you were to judge one's documentation as "good," what information would be included?
3. What is the purpose of documentation?
4. For whom should you document and why?
5. What is the difference between the concepts of feedforward and feedback? How can you use these concepts as frameworks for structuring clinical documentation?
6. Describe the skills helpful for engaging in critical reflection of documentation.
7. Take a few minutes to recall a clinical scenario where your patient or client had a successful outcome with physical therapy. Now retrieve your documentation for this patient or client. Based on what you reviewed in your documentation, reflect on the following:
   a. Why did your patient or client have a successful outcome with physical therapy?
   b. Does the history and systems review follow a logical sequence and structure?
   c. Can you determine why certain tests and measures and outcome measures were collected based on the information documented in the history and systems review?
   d. Is there a clear rationale obvious from the history, systems review, and physical examination that leads to the development of the clinical impression or diagnosis?
   e. Is there a clear rationale that leads to the prognosis?
   f. Is there a clear rationale that leads to the frequency and duration of the episode of care?
   g. Can you determine the rationale behind why each goal was written?
   h. Can you determine the rationale behind the inclusion of each intervention?
8. Take a few minutes to recall a clinical scenario where your patient or client had an unsuccessful or negative outcome with physical therapy. Now retrieve your documentation for this patient or client. Based on what you reviewed in your documentation, reflect on the following:
   a. Why did your patient or client have an unsuccessful or negative outcome with physical therapy?
   b. Does the history and systems review follow a logical sequence and structure?
   c. Can you determine why certain tests and measures and outcome measures were collected based on the information documented in the history and systems review?
   d. Is there a clear rationale obvious from the history, systems review, and physical examination that leads to the development of the clinical impression or diagnosis?
   e. Is there a clear rationale that leads to the prognosis?
   f. Is there a clear rationale that leads to the frequency and duration of the episode of care?
   g. Can you determine the rationale behind why each goal was written?
   h. Can you determine the rationale behind the inclusion of each intervention?
9. Choose a patient or client with whom you have recently had a follow-up physical therapy session. Reflect on the following questions:
   a. What did you record regarding your patient or client's status?
   b. Why did you choose to capture this information?
   c. What did you do during your physical therapy session?
   d. Why did you choose to perform these interventions?
   e. What was the result of what you did with your patient or client during the session?
   f. What did you accomplish with your patient or client?
   g. What was the outcome of your session?
   h. Why do you think these outcomes occurred?
   i. What information did you use to formulate your clinical impression of the patient or client?
   j. What is your plan for the next session?
   k. Why did you choose this content for the next session?
10. Gather your documentation from two of your patients or clients. Include all elements of patient or client management. Exchange documentation with two of your colleagues. Critically review the documentation and provide constructive feedback using the following guidelines:
    a. Does the history and systems review follow a logical sequence and structure?
    b. Can you determine why certain tests and measures and outcome measures were collected based on the information documented in the history and systems review?
    c. Is there a clear rationale obvious from the history, systems review, and physical examination that leads to the development of the clinical impression or diagnosis?
    d. Is there a clear rationale that leads to the prognosis?
    e. Is there a clear rationale that leads to the frequency and duration of the episode of care?
    f. Can you determine the rationale behind why each goal was written?
    g. Can you determine the rationale behind the inclusion of each intervention?
11. Ask your clinical instructor or one of your colleagues to access the health record for one of your patients

or clients and to develop an intervention plan after a 5-minute review of your documentation. Was he or she able to formulate a plan that was similar to your own? What information did he or she look for when creating this plan? Was there any information that he or she sought in developing this plan that could not be found? How can you use the information to improve your documentation?

12. Ask your colleague to review your documentation for one of your patients or clients, preferably a patient or client with whom he or she is not very familiar. Ask him or her to describe this patient or client to you based on what he or she read in your documentation. Is the description accurate? Does it match your description of this patient or client? Ask your colleague what information he or she used in the documentation to develop the clinical picture of your patient or client in his or her mind. How can you use this information to improve your documentation?

Case Study Questions

1. Assume that you work for a home health agency and are filling in for a therapist who is sick. You are to make a follow-up visit to an older adult who was discharged from the hospital 3 days ago after an open reduction internal fixation of an intertrochanteric fracture of the femur. You are reviewing the clinical note from the last visit and see that the patient or client's vital signs are within normal limits and that the patient or client reported a 6/10 pain at the lateral aspect of the right hip that is relieved with pain medication. You also see the following information:

> Patient has no new complaints to report.
>
> Performed ankle pumps, resisted knee flexion and extension exercise, hip adduction squeezes. Gait not performed. Independent with transfers. Reviewed safe positioning for sleeping.
>
> Patient tolerated treatment well.
>
> Continue POC.

   a. Does this note meet the criteria for successful documentation? Why or why not?
   b. Does it contain the information you would want as the treating therapist?
   c. What would make this note more complete? Rewrite the note to reflect successful documentation.

2. You are working in a busy outpatient clinic. As you review your schedule for the day, you see that your 8:00AM patient or client is the new patient or client that you examined yesterday afternoon at the end of the day. Your plan was to finish documenting the plan of care for this new patient or client first thing in the morning; however when you arrived at work, you had to return a few e-mails and help organize a shipment of new equipment that arrived the evening before. You did not have time to complete your documentation prior to the patient or client's arrival for their first follow-up appointment.
   a. Should you initiate the first follow-up session without having completed the documentation from your initial encounter with the patient or client?
   b. What are the consequences, if any, of initiating this session? Of postponing the session?
   c. If you choose to treat your patient or client for the first follow-up session, how should you start this session? What information did you use to make this decision?
   d. What will you do to avoid this situation in the future? How will you implement this strategy?

3. Your patient or client is an 81-year-old male who suffered a myocardial infarction 8 days ago. He was admitted to the inpatient rehabilitation facility in which you work 3 days ago. You are the physical therapist who will be responsible for his physical therapy plan of care over the weekend. He has a 10-year history of diabetes and moderate-to-severe osteoarthritis at the left knee. His heart rate and blood pressure have been regulated with medication; however, he is having difficulty maintaining a steady blood oxygen saturation level on room air. You review the primary physical therapist's note from yesterday's session and find the following:

> Patient reports that he gets short of breath when rolling in bed.
>
> Bed mobility activities performed (rolling and supine to sit) at bedside.
>
> Pt required minimum assistance × 1 with bed mobility activities.
>
> Continue to improve tolerance to functional activities.

   a. Does the information above meet the criteria for successful documentation? Why or why not?
   b. Develop one short-term and one long-term goal based on the information given in the above scenario. Provide a rationale for why you chose to

write your goals in this way. Are they functional, measurable, and objective?

c. Develop a 15-minute intervention session based on the information given in the above scenario. Provide a rationale for why you included this information in your intervention plan.

d. Was there any information that could have been included in the note above that may have helped you to better plan your intervention without having met the patient or client? Rewrite the note to reflect this detail.

4. Your patient or client is a 76-year-old female with severe osteoporosis. She was recently admitted to the skilled nursing facility where you work after a 3-week stay in an inpatient rehabilitation setting. She experienced spontaneous fractures of three ribs one of which punctured her lung 4 weeks ago. She has intermittent pain at her low back and hips that limits her ability to participate in tasks such as transfer and gait training. At the end of your session, you recommend the use of an assistive device such as arm troughs on a walker to determine if this assistance improves her ability to transfer and ambulate short distances for increased independence with tasks such as getting to the bathroom. She responds to your suggestion that she does not want to use a walker and will not participate in physical therapy if you suggest she use one.

a. Imagine yourself in this situation. What is your immediate response to your patient or client's comment?

b. What is your impression of this patient or client's behavior? Use the skills required for self-reflection to generate an interpretation of the situation above.

c. Does your interpretation after critical self-reflection of this situation differ from your immediate response above?

d. How might you approach this patient at your next session?

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Appendix 1-A

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

GUIDELINES: PEER REVIEW TRAINING BOD G03-05-15-40 [Amended BOD 03-04-17-41; BOD 03-01-14-50; BOD 03-99-15-48; Initial BOD 06-97-03-06] [Guideline]

I. Purpose

Guidelines: Peer Review Training provide direction to APTA chapters and sections, to physical therapy services, and to individual physical therapists who want to develop or pursue training in the peer review of the provision of physical therapy. These Guidelines are APTA-approved, nonbinding statements of advice intended to promote standardization both in the content of peer review training and in the performance of peer review. They also may be helpful as a tool for self-review. It is important to note, however, that these Guidelines do not provide the training itself.

Specifically, these Guidelines:

- Describe peer review.
- Delineate the underlying principles of peer review.
- Describe the content areas required for peer review training.
- Provide a framework for the training process.
- Provide a list of tools required both for peer review training and for the performance of peer review.

In addition to having the knowledge described in these Guidelines, a physical therapist providing external peer review services:

- Should be a licensed physical therapist, with no history of license suspension or revocation.
- Should be a member of APTA.
- Should have current clinical expertise in the area of the review.
- Is recommended to have a minimum of 5 years of clinical experience.

II. Description of Peer Review

The purposes of peer review are to educate physical therapists to: (1) uphold professional standards, (2) be accountable to the public, and (3) be consistent in interactions with payers and managed care organizations. Peer review provides a framework to evaluate the quality, the medical necessity, and the appropriateness of the physical therapy provided. It can lead to identification of the need for corrective actions and can provide instructive feedback to practitioners.

Definitions

Claims review: Review of the billing record that may result in identification of issues that may require medical review.

Guidelines: APTA defines "guidelines" as a statement of advice.

Medical Review: Review of the medical record based on standards of practice in regard to medical necessity and appropriateness of care.

Peer: A person of the same profession who is like-licensed.

Peer review: A system by which peers with similar areas of expertise assess the quality of physical therapy provided, using accepted practice standards and guidelines.

> **Internal:** The process in which a physical therapist reviews the services provided by peers within a physical therapy service
>
> **External:** The process in which a physical therapists reviews physical therapy provided by a peer outside of the reviews physical therapy service a the request of a payer, a medical review organization, a professional organization, or a regulatory agency.

Utilization review: Utilization review is a system for reviewing the medial necessity, appropriateness, and reasonableness of services proposed or provided services to a patient or group of patients. This review is conducted on a prospective, concurrent, and/or retrospective basis to reduce the incidence of unnecessary and/or inappropriate provision of services. Utilization review is a process that has two primary purposes: to improve the quality of services (and patient outcomes) and to ensure the efficient expenditure of money.

Internal peer review and external peer review are based on the same principles and guiding documents (e.g., APTA's Standards of Practice for Physical Therapy and the Criteria, and the *Guide to Physical Therapist Practice*.) They differ, however, in the source of the request for the review, the party to whom the report is sent, and the final actions. Internal peer review may result in self-correction (by an individual physical therapist or physical therapy service), whereas external peer review may result in a reimbursement, provider status, licensure, accreditation, or credentialing decision. Internal peer review processes may include additional requirements that reflect the type of practice setting or the individual service's policies and procedures.
An internal peer review process may assist a physical therapy service with the following:

- Performing quality improvement review.
- Providing for continuing professional competence and growth.
- Assessing medical necessity, effectiveness of intervention, and patient/client outcomes.
- Identifying problems and possible corrective actions.
- Meeting the requirements of regulatory agencies.
- Preparing for credentialing (e.g., by managed care organizations) of an individual physical therapist or a physical therapy service.

An external peer review process may assist with the following:

- Determining (concurrently or retroactively) medical necessity and appropriateness of care for payers, managed care organizations, provider networks, and governmental agencies (e.g., agencies governing Medicaid and Medicare, state physical therapy licensing boards) that request a review of a physical therapist's performance or a physical therapy service's performance.
- Providing a quality assurance review.
- Determining fair and equitable levels of reimbursement.

III. Training Content

A. Principles of Peer Review

A physical therapist performing peer review must have a working knowledge of the following principles:

- A peer review process performed by a physical therapist assesses the physical therapy provided based on APTA's Standards of Practice for Physical Therapy and the Criteria; the *Guide to Physical Therapist Practice*; other core documents; and, when applicable, state laws and chapter documents.

Peer review of physical therapy services is provided only by physical therapists who possess an active license without current sanctions to practice physical therapy. This peer review shall be based on American Physical Therapy Association (APTA) Standards of Practice for Physical Therapy and other pertinent documents including state practice acts. APTA is opposed to any activities related to peer review that may adversely impact a physical therapist's plan of care or intervention without the involvement of a physical therapist peer reviewer. Adverse physical therapy patient/client management decisions made without the involvement of a physical therapist reviewer may constitute the unlawful practice of physical therapy. (Peer Review of Physical Therapy Services, House of Delegates Position).

- The peer review process is a quality improvement mechanism that applies to all physical therapists and to all patient management provided by physical therapists.
- The peer review process, both internal and external, is appropriate for use in a variety of physical therapy settings.
- APTA core documents, including the Standards of Practice for Physical Therapy and the Criteria and the Guidelines: Physical Therapy Documentation of Patient/Client Management, and the *Guide to Physical Therapist Practice* put forth minimal requirements for documentation and practice and apply to all physical therapy settings. The physical therapy service is encouraged to set optimal requirements to promote quality improvement in practice.

- The clinical expertise of the physical therapist providing the peer review should be commensurate with that of the physical therapist(s) whose services are being reviewed and have a minimum of 5 years of clinical experience.
- A physical therapist should apply the Guidelines and standards for peer review of the provision of physical therapy.
- Peer review must be performed with impartiality and objectivity.
- In the performance of peer review, as in other areas of practice, physical therapists are legally and ethically accountable for the services provided.

B. Documentation

A physical therapist performing peer review must have a working knowledge of physical therapy documentation as described by APTA's Guidelines: Physical Therapy Documentation of Patient/Client Management. Training should be based on the understanding that documentation is a:

- Chronological record of the physical therapy provided.
- Legal medical document.
- Means of communication with other health care providers.
- Reflection of medical necessity.
- Rationale for care.
- Method to demonstrate outcomes.
- Record of the effectiveness of intervention.
- Means to support reimbursement.

Documentation should reflect the critical thinking and sound professional judgment that are required for patient/client management. Documentation should show that the physical therapist integrates the five elements of patient/client care--examination, evaluation, diagnosis, prognosis, and intervention--in a manner designed to maximize a patient's/client's outcome. Training therefore should provide a working knowledge of the following:

- APTA's Core Documents including: Standards of Practice for Physical Therapy and the Criteria, Guidelines: Physical Therapy Documentation of Patient/Client Management, Code of Ethics, Guide for Professional Conduct, Standards of Ethical Conduct for the Physical Therapist Assistant, Guide for Conduct of the Physical Therapist Assistant, and Professionalism in Physical Therapy: Core Values.
- *Guide to Physical Therapist Practice*.
- Chapter guidelines, when applicable.
- Functional assessment tools and various types of outcomes and their relationship (or lack of relationship) to functioning.
- Literature-based (including evidence-based) practice and functional outcomes, including APTA's Hooked on Evidence database and preferred practice patterns in the *Guide to Physical Therapist Practice*.

C. Billing and Coding

A physical therapist performing peer review must have an understanding of billing, coding and confidentiality, including but not limited to diagnostic classification systems, current or applicable Current Procedural Terminology (CPT) and Relative Value Resource Based System (RVRBS) guidelines, current Medicare and Medicaid regulatory guidelines, The Health Insurance Portability and Accountability Act (HIPAA) or other accepted codes or guidelines used for billing.

Training should be based on the following principles:

- Documentation must substantiate the number and description of CPT or other accepted codes used for billing.
- Contracts may include specific exclusions or limitation of the services to be provided. Application and interpretation of contracts is the responsibility of the payer. Physical therapist

peer review addresses medical necessity and appropriateness of care, not contractual agreements.

- The party requesting peer review may ask the reviewer to comment on the fees associated with the services or codes billed. The peer reviewer may choose to make recommendations concerning appropriate payment based on his or her knowledge of (a) the value of the services and (b) standardized and accepted payment methodologies (e.g., RVRBS). It is not the peer reviewer's role, however, to determine actual payment for services.

D. Record Review

A physical therapist performing peer review must have a working knowledge of record review. Training should address each step of record review. These steps include:

1. Organize and record the documents that are provided.
2. Determine whether the documents are adequate for the purpose of peer review, and request additional information when necessary.
3. Review the claims made.
4. Match the record to the billings.
5. Review the medical record and assess it relative to identified standards, guidelines, state laws, and regulations, including Standards of Practice for Physical Therapy and the Criteria, and the *Guide to Physical Therapist Practice*. (A checklist may be useful in organizing the review process.)
6. Evaluate findings, answering such key questions as:
   a) Were services provided by appropriate personnel?
   b) Is there evidence of coordination and communication with other health care professionals as appropriate?
   c) Does the record reflect timely patient/client-related instruction, including a home program and education of patient/client, family, significant other, and caregiver?
   d) Is there measurable, sustainable, and functional progress toward defined goals and outcomes, with reference to ongoing discharge planning?
   e) Does the record reflect appropriate changes in patient/client management strategy? Is there evidence of critical thinking, professional judgment, and skilled interventions?
   f) Does the documentation link impairment, activity limitation, and participation restriction to predicted functional outcomes and the physical therapy plan of care?
   g) Is the billing supported by the documentation?
7. Develop conclusions and recommendations based on evaluation of the record using the established standards, guidelines, state laws, and regulations.
8. Answer any specific or additional questions that have been posed by the party requesting the review.

E. Report Writing

A physical therapist performing peer review must have a working knowledge of report writing. Training should address each item of a peer review report, including, but not limited to:

- Basic identification information for each file (e.g., patient/client ID #, claim #).
- The list of records and claims received by the peer reviewer.
- Documents on which the review is based (e.g., Standards of Practice for Physical Therapy and the Criteria, Guidelines: Physical Therapy Documentation of Patient/Client Management, the *Guide to Physical Therapist Practice*, and state practice act).
- The results of the claims review and the medical review.
- Conclusions.
- Recommendations.
- Answers to specific questions and concerns.

- A disclaimer indicating that the payer is ultimately responsible for the payment or the denial of the claim.
- Invoice, if appropriate.

Training also should encourage the physical therapist reviewer to:

- Substantiate the findings of peer review by quoting from the preamble of APTA's Standards of Practice for Physical Therapy and the Criteria: "These Standards are the profession's statement of conditions and performance that are essential for provision of high-quality physical therapy. The Standards provide a foundation for assessment of physical therapy practice."
- Be as specific as possible, quoting the medical record, APTA's Standards of Practice for Physical Therapy and the Criteria, the *Guide to Physical Therapist Practice*, and state statutes to support conclusions.
- Assess overall quality of the physical therapy provided, but be very specific in the report itself regarding whether the physical therapy provided meets APTA's Standards of Practice for Physical Therapy and the Criteria and therefore, criteria for medical necessity and appropriateness of care.
- Use language that reflects that recommendations are based only on medical necessity and appropriateness of care. (Recommendations should not indicate whether a claim should be paid.)

F. Claims Appeals

A physical therapist performing peer review must have a working knowledge of the claims appeals process of each payer and should encourage payers to develop an appeals process if one does not exist. Training should emphasize the following:

- When an appeals process is initiated, the peer reviewer may review additional information and write an addendum to the original report.
- The appeals process should include the option for the provider to receive a review by another peer reviewer if the provider and the original reviewer are unable to reach agreement.

G. Communication With Payers

Physical therapists performing peer review should use communication with payers as an opportunity to educate them about the appropriate utilization of physical therapy. Training should emphasize that, at a minimum, communication must convey the following principles:

- Professional guidelines and standards used in peer review can be appropriately applied only by a physical therapist.
- It is critical for the payer requesting the review to supply the entire record, including referral, when applicable; initial examination and evaluation; daily notes; progress reports; billings; and background information from other providers.
- The terms physical therapy and physiotherapy should be used only in reference to services that are provided by or under the direction and supervision of a licensed physical therapist/physiotherapist and, when so used, these terms are synonymous.

Training should also instruct physical therapists in how to do the following as part of the peer review process:

- In all communications regarding the role of the physical therapist and the scope of physical therapist practice, emphasize that physical therapy can be provided or directed only by physical therapists.
- Provide pertinent documents to educate payers about the scope of physical therapist practice and about appropriate utilization of physical therapy (e.g., APTA's *Guide to Physical Therapist Practice*, and APTA's Guidelines: Physical Therapy Claims Review).
- Encourage or support an appropriate appeals process.
- Promote positive communication among payers, reviewers, and providers.

- Encourage payers to inform physical therapy providers of the peer review process.

H. Communication with Providers

Communication with providers should have an educational focus. Training should address the following:

- Different types of review (retrospective, concurrent, prospective) require different means of communication.
- Communication should be based on established guidelines and should direct providers to pertinent resources.
- All conclusions and recommendations should be based on available physical therapy documentation and established standards, guidelines, state laws, and regulations.

I. Marketing the Value of Peer Review

A physical therapist performing peer review must have a working knowledge of how to market the value of peer review to payers and providers. Training should instruct the physical therapist to base marketing efforts on the following:

- The value of peer review, including the value of established guidelines and nationally accepted professional standards as applied by a trained peer reviewer.
- The value of peer review in (a) ensuring adherence to professional standards, (b) promoting appropriate utilization outcomes through the education of physical therapists, and (c) ensuring accountability to the community for the quality of physical therapy provided.

Training also should emphasize:

- The importance of networking to develop relationships, using various marketing vehicles (e.g., telephone, visits, letters, brochures).
- The legal ramifications involved in marketing peer review services.

J. Ethical and Legal Issues

A physical therapist performing peer review must have a working knowledge of ethical and legal issues, including:

- State practice acts both for physical therapists and for non-physical therapists.
- Other state, jurisdiction, and federal rules, regulations, and statutes regarding (a) data privacy, (b) patient/client bill of rights, and (c) confidentiality.
- Facility policies and procedures regarding release of information.
- Reviewer's responsibility for obtaining liability protection coverage for performance of external reviews.
- Confidentiality in all matters related to the review process, with the understanding that the physical therapist reviewer should access information only when there is a need to know. Adherence to The Health Insurance Portability and Accountability Act (HIPAA).
- Potential conflicts of interest, which might skew the reviewer's judgment.
- APTA's Code of Ethics, Guide for Professional Conduct, Standards of Ethical Conduct for the Physical Therapist Assistant, and Guide for Conduct of the Physical Therapist Assistant.
- Antitrust laws.
- Peer review contract negotiation with insurers, including clarification of (a) whether the reviewer is masked to the provider, (b) insurer expectations, and, (c) reviewer payment guidelines (i.e., paid per review or per hour).

Additional considerations:

- The reviewer should request that the review be referred to another reviewer when that review is beyond his or her own clinical expertise and body of knowledge.
- The reviewer should understand the ethical and legal dimensions of the claims appeals process.

IV. Training Methods

Suggested methods of peer review training (which does not have to be limited to a workshop) may include any of the following:

- Lecture and audiovisual presentations.
- Use of a training manual.
- Presentation of case studies during instruction or as part of post-course assessment.
- Use of self-assessment tools.
- Assignment of pre-program readings.
- Testing on course content.
- Small group discussions.
- "Test" reviews conducted with mentors and as a member of a review team.
- Use of interreviewer reliability determination as part of ongoing training.

When instructors are utilized, the following is suggested:

- The instructor, or at least one instructor of a training team, should be an experienced physical therapist peer reviewer.
- Instructors must ensure confidentiality throughout all sensitive material, regardless of whether that material is presented verbally or in writing.

The effectiveness of training efforts can be assessed through determination of interreviewer reliability.

V. Recommended Resources

Training should incorporate resources that include, but are not limited to:

- APTA's Guide to Physical Therapist Practice.
- APTA's Hooked on Evidence database
- APTA's Core Documents:
    - Code of Ethics and Guide for Professional Conduct.
    - Standards of Ethical Conduct for the Physical Therapist Assistant and Guide for Conduct of the Physical Therapist Assistant.
    - Standards of Practice for Physical Therapy and the Criteria.
    - Guidelines: Physical Therapy Documentation of Patient/Client Management.
- APTA's Resource Guide: Peer Review/Utilization Review (includes core documents).
- APTA's Guidelines: Physical Therapy Claims Review.
- Pertinent state practice acts.
- Pertinent state laws and regulations.
- Other related state and federal statutes (e.g., data privacy; liability protection, if available; patient bill of rights).
- Examples of release forms used and signed by patients/clients.
- Standards of utilization review accrediting bodies (e.g., American Accreditation HealthCare Commission/URAC).
- Confidentiality statements signed by reviewers.
- Bibliography of related topics in *Physical Therapy, PT--Magazine of Physical Therapy*, and other professional publications.
- Common Procedural Terminology (CPT Codes) (year specific) and CPT definitions.
- Diagnostic classifications systems (e.g., International Classification of Disease-9, Clinical Modification [ICD-9-CM]), [ICD-10-CM].
- Health Care Financing Administration Common Procedure Coding System (HCPCS).
- Various claim form samples.

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Explanation of Reference Numbers:
BOD P00-00-00-00 stands for Board of Directors/month/year/page/vote in the Board of Directors Minutes; the "P" indicates that it is a position (see below). For example, BOD P11-97-06-18 means that this position can be found in the November 1997 Board of Directors minutes on Page 6 and that it was Vote 18.
P: Position | S: Standard | G: Guideline | Y: Policy | R: Procedure