

DOCUMENTATION FOR PHYSICAL THERAPIST PRACTICE

A Clinical Decision Making Approach

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Preface

I am a physical therapist with a passion for the physical therapy care of older adults. I am an educator in a post-professional residency program facilitating clinical expertise in my residents. I am a mentor who provides feedback to clinicians regarding clinical reasoning and decision-making at all levels of clinical care including documentation. I am also a clinician who documents. I have a great respect for what my documentation represents primarily because early in my career I was subpoenaed to be an expert witness in a court of law for an individual whose motives regarding her physical therapy care were questioned. As her physical therapist, my documentation was also questioned in an effort to gain insight into her claims of continued dysfunction and pain. When I learned that my presence was requested in a court of law and that I would be engaging in a conversation about my job, I could not think. Who was this patient again? Who was the third-party payer? Did I follow all the rules and regulations? Did I perform a thorough enough initial examination? Did I complete the re-examination on time? Were my interventions clearly described? Did I show that the care I delivered was necessary? Did I write what I was supposed to write?

It turns out, I did write what I was supposed to write. There were no issues identified that could implicate the care that I delivered to my patient or my license in anyway. But how was I to make sure that I write what I am supposed to write every single time I document? It seemed so daunting to try to create the content of my notes based on who I thought might read them. How was I to know that I would be defending my documentation to a lawyer in front of a judge more than a year after I wrote it? Thankfully, I didn't have to remember the patient or the clinical situation because as I reviewed the health record in preparation for my day in court, I realized I had documented my clinical reasoning. In other words,

my thought processes and justification for every decision I made were clarified by my documentation from my chosen tests and measures to the interventions included in my plan of care. It was my clinical reasoning that added value to my documentation. It was my clinical reasoning that validated my actions as a physical therapist. It was my clinical reasoning that preserved my license. I realized then what an asset my documentation was to me in my clinical practice and I have treated it as such ever since.

Documentation is the vehicle that validates your delivery of physical therapy services. You document to relay what happens with your patient or client during a clinical encounter. You document to communicate with other health care providers regarding the care of your patient or client. You document for the patient or client and for the patient or client's family members. You document to get paid and you document to keep your license. However, successful documentation is more than simply keeping a record of the patient or client's comings and goings in the form of a physical therapy plan of care. It is the justification of your clinical reasoning to others. The American Physical Therapy Association supports infusing clinical reasoning into your documentation and has adopted the position that documentation with focus primarily on clinical reasoning and decision-making should occur in the provision of physical therapy services.¹

It is a goal of this text to help you deem documentation as essential an element of your daily practice as manual techniques and exercise prescription and to help you recognize that documentation is not an ancillary responsibility but is in fact an integral component of your practice that permeates the care you provide as a clinician. The efficiency, consistency and utility of your documentation will reflect its purpose as a tool that will support rather than hinder

your clinical practice. It is important to realize that the content of successful documentation does not depend on the consumer of the note, the purpose of the documentation, or the payer source. In other words, successful documentation includes any information that the consumer needs to make a well informed decision, whether that consumer is you, a colleague, an internal auditor, an external auditor or a third-party payer.

Many barriers exist that derail intentions of producing successful documentation. Time constraints in the clinical setting usually mean shortcuts in documentation so that more time can be spent in direct patient or client care. Documenting within an electronic health record may present even further challenges to timely, meaningful and successful documentation. Individual clinic policies further confuse the issue of what should actually be included in the health record. Nonetheless, your professional responsibility as a provider of physical therapy services is to persevere under the influence of these barriers and recognize that the consequences of poor documentation can be severe.

An additional goal of this text is to provide practical guidance in using the terminology and framework developed by the American Physical Therapy Association and the World Health Organization to create successful documentation across all practice settings in patients and clients with any health condition regardless of the payer source. The intention is to illustrate how the common and standard language of The Guide to Physical Therapist Practice and the International Classification of Functioning, Disability, and Health (ICF) model can be integrated with a physical therapist's clinical reasoning process and a physical therapist assistant's skill set to produce successful documentation.

This text has 12 chapters divided into three sections.

- **Section I: Utilizing a Clinical Reasoning Framework for Documentation** includes Chapters 1 and 2. These chapters present the framework used to facilitate a common documentation language among physical therapists and physical therapist assistants using terminology from The Guide, the APTA's documents on Defensible Documentation, and the WHO's ICF model.
- **Section II: Physical Therapy Documentation** Content includes Chapters 3 – 7. These chapters investigate the explicit details of the content that belongs in initial examination notes, daily notes including intervention flow sheets, home exercise programs, re-examination notes, and conclusion of the episode of care summaries.
- **Section III: Critical Issues in Physical Therapy Documentation** includes Chapters 8 – 12. Chapter 8 describes the relevance of the principles of measurement such as reliability, validity, and responsiveness to documentation. Chapter 9 illustrates how to document alternative forms of communications to other health care providers in the health record such a phone conversations, interactions that occur outside the context of a patient or client visit, and creating letters of medical necessity. Chapter 10 compares and contrasts paper-based documentation systems and electronic systems. Additionally, the relevant features of using electronic health records in documentation as well as recognizing the advantages and disadvantages of using electronic health records for documentation are introduced. Chapter 11 relays information about the current state of health care reform and its impact on physical therapy documentation. Finally, Chapter 12 demonstrates why sound documentation is vital should any interaction between a clinician and a patient or client come into question by the legal system.

Key Features

- **Electronic Health Records** content are featured in each chapter to relay which concepts developed in that chapter may have special considerations in an electronic documentation system. This content is also intended to facilitate the notion that successful documentation is not determined by the system in which this information is stored or by the source from which physical therapy services are reimbursed.
- **Learning Objectives** at the start of each chapter help focus learners on key concepts.
- **Keywords** listed at the beginning of each chapter and defined in an end-of-book glossary provide learners with the vocabulary for successful documentation.

- **Case Study Questions** and **Discussion Questions** are intended as opportunities for both students and practicing clinicians to apply the information from the text. These questions are designed to get readers to think about the decision-making that goes into creating successful documentation and to facilitate the identification of errors and shortcomings in documentation.

Instructor Resources

- Answers to End of Chapter Questions provide instructors with tips and tricks in assessing students' responses to the **Discussion Questions** and **Case Study Questions**.
- Robust **Test Bank** with Chapter Quizzes, Mid-term, and Final.
- Lecture Slides in PPT Format to aid instructors in teaching the content in their course's **Image Bank** of key elements in the text.

Audience

This text is intended for an audience with a range of experience levels and includes complex scenarios that clinicians may face at any level of clinical training or practice. Suggestions for introducing these scenarios to students who may not yet have access to patients or clients include creating opportunities for a student to shadow or interview a practicing clinician. Students on clinical affiliations could engage in discussions with clinical instructors. Additionally, the content of this text could be delivered directly before or concurrent with clinical experiences so that learning can be maximized with application.

Medicare

Specific billing scenarios related to Medicare beneficiaries are not relayed in this text because interpretation of billing rules and regulations by Medicare Administrative Contractors, entities who process Medicare claims, are extremely varied. Billing practices vary by practice setting and by which individuals (physical therapists, physical therapist assistants, students) are involved in the clinical scenario. It is paramount that a clinician be aware of the billing codes that can and cannot be reported together in order to avoid fraudulent billing practices. However, because of the complex nature of the law, this is

one area of documentation that students and entry level clinicians will need to glean support from their colleagues in the settings in which they practice, resources available from the APTA, or the payer's themselves.

Abbreviations

It is recommended that abbreviations are used judiciously in physical therapy documentation.² Therefore, a specific list of recommended abbreviations are not provided in this text. Chapter 12 however includes details regarding error prone abbreviations as well as abbreviations that have dual meanings that may lead to medical errors. Additionally, the need to establish specific policies and procedures for the use of abbreviations in any one clinical practice is also reinforced.

Summary

My sincere hope is that the content presented in this book will serve as a valuable resource to guide you in creating consistently successful documentation. Remember, successful documentation includes common details that are present in *every* note, regardless of the note's consumer. When writing the content of a health record the author need not write for an intended audience. Rather, the author should write so that any one note could be used by multiple consumers for multiple reasons.

Acknowledgments

This work would not have been possible without the initial ideas and prompting from my friend and colleague Marilyn Moffett, PT, DPT, GCS, PhD(c) who contributed to Chapter 10 on electronic health records, or the invaluable contributions of Raine Osborne, PT, DPT, OCS, FAAOMPT who authored Chapter 8 on the Principles of Measurement in Documentation and, Sheila K. Nicolson, Esquire, PT, DPT, MBA, MA who authored Chapter 12 on Legal Considerations in Documentation. Most importantly I could not have attempted or completed this project without the companionship and support of my husband, Raine Osborne, who loves me enough to engage in ridiculous, philosophical arguments.

Jacqueline A. Osborne

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1. American Physical Therapy Association (APTA). *Physical Therapy Documentation Reform*. Alexandria, VA: American Physical Therapy Association; June, 2013.
2. APTA. *Defensible Documentation General Documentation Guidelines*. Alexandria, VA: American Physical Therapy Association; 2012.

About the Author

Jacqueline A. Osborne, PT, DPT, GCS, CEEAA is the Director of the Geriatric Residency Program at Brooks Rehabilitation, a non-profit rehabilitation system in Jacksonville, Florida. In addition to this role, she maintains a clinical practice at Brooks Rehabilitation and serves the American Physical Therapy Association (APTA), the American Board of Physical Therapy Specialties (ABPTS), the American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE), the Florida Physical Therapy Association (FPTA), and the Florida Injury Prevention Advisory Council (FIPAC) as a member of a variety of workgroups and taskforces.

Dr. Osborne received a Bachelor of Science degree in Business Administration with a concentration in Operations Management from the University of Delaware in 2000 and a Doctor of Physical Therapy Degree from Beaver College (now Arcadia University) in Glenside, Pennsylvania in 2003. She obtained Board

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Dr. Osborne has a passion for the care of older adults. She is an advocate for this group in many ways. One way that she works on behalf of older adults on routine basis, however, is through her clinical documentation. There is little more valuable than obtaining needed resources known to benefit patients or clients because of successful documentation! With this text, she hopes to share an approach to documentation rooted in clinical decision-making that will continuously serve as an adjunct to clinicians to advocate for patients and clients in clinical practice.

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