

# Helping Students Practice “Defensible Documentation”

With the evolution of Medicare changes, and increasing review of documentation from all payer types, it is crucial that clinicians document well and that students practice and perfect the skills of what APTA refers to as “Defensible Documentation”.

While the guidelines for defensible documentation are broad, review and audit of documentation consistently attempts to answer the following questions: (1) Is this service medically necessary? (2) Did it require skilled intervention? (3) Is there evidence of ongoing assessment and progression of care?

Consider the following suggestions for documentation when providing clinical instruction to PT and PTA students :

## Medical Necessity

Simply put, medical necessity narratives must describe diagnoses and deficits. Documentation must demonstrate:

- 1) Medical history, diagnoses, impairments (i.e., strength, ROM, balance) and functional limitations (i.e., bed mobility, transfers and ambulation).
- 2) Complications and safety issues as a result of the patient's current medical and/or functional status.
- 3) A service provided for any deficit must meet accepted standards of medical practice and be a specific and effective treatment for the patient's condition. Professional guidelines and literature, payer local coverage determinations (LCDs) and Medicare manuals may help in determining accepted, evidence-based practice interventions.
- 4) Service must be provided with an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

The following are examples of medical necessity statements that fit nicely into any progress report:

Patient ambulates 30 feet x 1 requiring moderate assistance for mobility and for safe progression of front-wheeled walker. Patient remains at significant risk for falling at this time due to postural instability from Parkinson's, strength and ROM deficits.

Patient is unable to perform bed mobility without further intervention and training. At present, he demonstrates reduced strength and motor control to roll or weight shift to either side due

to CVA. He remains at risk for complications of skin breakdown and respiratory complications.

Transfer Training example: Patient seen for transfer training from bed to chair. Initial status was maximal assist. Patient trained with tactile and verbal cues to promote trunk flexion and facilitate appropriate lower extremity muscle contraction. Patient able to demonstrate both improved pelvic tilt and more effective hip extensor firing. Will continue to facilitate proper and safe technique as patient continues to require moderate assistance. Prognosis for independent transfers remains good.

Gait training example (without or minimal progress):

Visit #1: Gait training with patient in parallel bars. Patient unable to shift weight to affected side with verbal cueing. Applied manual cues however patient required maximal assistance to shift weight and was unable to maintain weight shift for progression of unaffected lower extremity. Patient complains of vertigo and BP found to be 96/

65. Blood pressure and complaints return to normal after sitting x 5 minutes.

Visit #2 - Vital signs normal at start of visit. Gait training with patient in parallel bars. Patient unable to shift weight to affected side with verbal and manual cues. Requires maximal assistance to shift weight in standing. Modified exercise program to include activities to promote weight shifting in other postures.

Visit #3: Vital signs normal at start of visit. Training with patient to weight shift in sitting. Pt able to shift weight to unaffected side after training in sitting. Requires moderate assistance for trunk control when attempts to weight shift to affected side. Pre-gait training in parallel bars demonstrates increased ability in standing tolerance from 1 minute to 3.6 minutes. Will continue to progress pre-gait activities at this time.

SPTAs can and should be expected to document in a manner that reflects these goals. Encourage your students to describe in their notes the:

- functional rationale for skilled interventions used,
- patient response to those interventions and
- utilize objective assessment tests and measures to reflect patient progress.

For more information members should visit [apta.org](http://apta.org) and select “Practice & Patient Care” then “Documentation”.

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## Therapy Documentation Best Practices

Top 5 best practices for therapy documentation and how to include in the evaluation, plan of care, daily notes, progress reports and discharge reports

BEST PRACTICE	WHERE
1. Test, measure and document functional scores, performance tests and clinical findings	Initial Evaluation
2. Relate clinical findings and short term goals to functional deficits and long term goals	Initial Evaluation & Plan of Care
3. Skilled intervention demonstrated through ongoing patient assessment, exercise, functional progression, and techniques and parameters utilized	Daily Notes
4. Serially track and update important clinical and functional findings related to goals	Progress Report
5. Entire episode of care summarized to include , patient progress, goal achievement, and reason for discharge	Discharge Summary

## How to Communicate Skilled Intervention:

Consider:

1) What was done in the visit which required the skills of a physical therapist or physical therapist assistant? You might want to consider why you had to provide the intervention and another provider or caregiver could not? What knowledge, training and skills were used to provide the intervention?

*Non- skilled:* Gait training – patient ambulated with standard walker

*Skilled:* Moderate assistance provided with gait training to compensate for left sided neglect and assist with weight shifting for proper progression of bilateral lower extremities. Pt able to demonstrate ambulation 30’ x 1 with standard walker

*Non- skilled:* Bike x 15’ followed by treadmill x 10’ at 3.0 followed by therapeutic exercises per flow sheet.

*Skilled:* Prior to activity HR- 83 BP- 128/89 and SaO2 – 98% on room air. Patient monitored during the following activities: bike x 15’ followed by treadmill x 10’ at 3.0 mph. Patient’s vital signs after activity as follows: HR- 123 BP- 146/89 and SaO2 – 89% on room air. Patient also visibly fatigued and short of breath. After 5’ rest, vital signs returned to baseline.

## How to Communicate Progression of Care and Ongoing Assessment in Daily Notes

Consider if the note contains information about:

**Status before interventions? Status after interventions? Assessment of patient’s response to interventions? What is the plan to continue (or change)?**