Rancho Los Amigos National Rehabilitation Center
PHYSICAL THERAPY DEPARTMENT
POLICY AND PROCEDURE

DOCUMENTATION: EVALUATION, PROGRESS AND TREATMENT RECORDS	**Policy No.:**	**403**
	Revised:	**June 2021**
	Supersedes:	**June 2018**
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PURPOSE: Documentation is the chronicle of a patient's status while the patient is under the therapist's care. To meet ethical standards, accreditation and reimbursement requirements, clinical documentation must show evidence that the physical therapy services provided are medically necessary, are rendered within the appropriate service setting (e.g., inpatient, outpatient), are directed toward a functional outcome for the patient, and are consistent with professional and accepted community standards of practice.

Documentation for the purpose of communication as to an interaction or patient related occurrence, to provide a patient-related status update or to note an action taken are appropriate and should also be completed.

The burden of proof that these requirements and standards are met lies with the physical therapist responsible for the patient's care. The source for this proof is the therapist's documentation. Therefore, prudence dictates that entries be timely, concise, precise, thorough and legible.

POLICY: Documentation of the status of patients receiving either inpatient or outpatient therapy will be completed on a regular basis according to time frames that appropriately meet the communication needs for safe, effective and relevant clinical care and that are identified by regulatory and reimbursement stakeholders.

I. Documentation serves as:

A. A record of patient status, treatment plan, progress and basis for program change.

B. A legal record of the treatment plan, services given and patient response to treatment.

C. A means to convey information to other health care providers.

D. One's clinical memory as well as providing information for use by self and other staff in the provision of continuity of care.

E. A data source for peer review.

F. A data source for reimbursement.

G. A data source for concurrent review.

H. A data source for research.

II. General Requirements

A. A physician's order or a referral/consult request for physical therapy by appropriate medical personnel, that includes necessary precautions, must be in the medical record before evaluation or direct treatment can be initiated.

B. A physical therapist's evaluation that identifies problems, goals, recommended treatment, and program frequency and duration and is signed by the clinician and then signed by the physician constitutes an order or approval for ongoing treatment.

C. Major changes in the treatment plan require the physician's signature.

D. Re-certification of the treatment program by the physician is required every thirty (30) days for outpatients.

E. When an error occurs with electronic documentation that has been finalized and surpassed the timeframe to retrieve, an addendum must be completed in the electronic medical record.

In the event of an error in a written document, erasures and correcting fluid are not acceptable. An addendum or correction is submitted by drawing one line through the error and initializing the correction. Updated correct text is then entered on that document or if extensive on an additional paper form.

F. Only approved abbreviations included on the medical center's Approved Abbreviation and Symbol List (Attachment A) may be used.

G. All signatures must include the person's title, date and time, i.e., PT, PTA, RTT. Electronic documentation is time stamped. Electronic signatures (eSignature) use will be consistent with Admin Policy # A433

H. Students and graduate physical therapists not licensed in California must have their notes countersigned by a therapist that is licensed in California.

I. Notes written by a PTA or student PTA must be co-signed by the PT to signify review of the patient's progress and program.

J. All Rehabilitation Therapy Technician (RTT) documentation must be reviewed and co-signed by the primary physical therapist the day the note is written.

K. Red flag Medi-tags may be attached to paper versions of notes and treatment orders that require a physician's signature.

The electronic documentation system automatically forwards the electronic evaluations or notes to the referring physician for review and signature. Physicians (and their superiors) are notified by electronic alerts that the documentation is pending review.

Documentation requirements are determined by the setting where assessments and interventions are delivered. At RLANRC, the settings are Inpatient Rehabilitation, Inpatient Medical Surgical/Consults and Outpatient Services. The following table describes the documentation requirements for each setting:

Inpatient Rehabilitation
1. Initial Evaluation: Complete the Physical Therapy Screening and/or Initial Evaluation form in the electronic medical record within 24 hours of admission. (See Attachment B).
2. Quality Indicators for IRF/PAI a. The initial Qualtiy Indicators (QI) scores for mobility items will be entered on the Physical Therapy Initial Evaluation completed within 24 hours of admission. The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) scores will be obtained from the scores entered on the last Physical Therapy evaluation form finalized within 72 hours of admission. The IRF-PAI must be completed for all rehabilitation patients. b. The discharge QI scores for mobility are entered in the Physical Therapy Discharge Evaluation. This evaluation is completed in the electronic medical record system and finalized within 48 hours of the day of discharge from the inpatient rehabilitation program. This evaluation must be completed for all rehabilitation patients.

Inpatient Rehabilitation

3. Daily contact note that relevant information such as pain assessment, the interventions the patient received, how the patient responded, the plan and the time spent with patient will be completed each day services are provided.

4. Comprehensive Evaluation Note: See * below. (comprehensive evaluation) Complete within five (5) calendar days of admission (excluding Sunday hours).

5. Weekly Progress Note:

   A weekly summary note is required for all Rehabilitation patients. This note should include:

   a. Patient name and Rancho number
   b. Status of progress toward functional goals. This documentation populates the interdisciplinary weekly note. This is the discipline-specific portion of Interdiciplinary weekly note.
   c. Status and update of deficiencies identified in the initial note
   d. Education provided to patient/family/significant other (i.e., function, use of equipment, modified diet, home visit instruction) and an assessment of the comprehension of education provided.
   e. New or altered short-term goals for the next week
   f. Barriers to progress
   g. Plans to overcome identified barriers to progress
   h. Statement re: Program discussed with PTA.
   i. Changes in treatment program, frequency and duration. If there are substantive changes, the note must be co-signed by the physician.
   j. Patient/family/significant others participation in treatment decisions and goal setting
   k. Patient/family/significant others education provided, equipment ordered/received, home visit done and determination of comprehension of education provided.
   l. Discharge plan, including evidence of patient/family/significant other participation in discharge plan
   m. Status of long-term goal achievement
   n. Same or adjusted long-term goal
   o. Signature and date

6. Discharge Evaluation: See ** below.

7. Treatment Records: Completed daily, see *** below.

Internal transfers: If a patient is transferred to another unit for more than three days, the patient must be discharged from the initial rehab unit.

Internal Discharge & Admits
Patient transfers between DRG and DRG-Exempt units are considered internal discharges and admissions within the Medical Center
1. A summary of status at time of discharge from the rehabilitation unit is completed within 24 hours of an internal discharge. Depending upon the extent of the clinical change in the patient since the initial evaluation report, the clinician may write a complete discharge note, or a brief summary note.
2. Upon internal admission and receipt of a physician order, the clinician will review the documentation of the previous physical therapist and conduct an evaluation. If the patient is being admitted to rehabilitation the Physical Therapy Initial Evaluation will be completed. If the patient is not starting rehabilitation program the therapist will determine the extent of clinical change since the previous report. The clinician may write a complete initial evaluation or a brief summary note admitting the patient to the Physical Therapy program.

Inpatient Medical Surgical/Consults
1. Initial Evaluation Note: Completed in the electronic medical record and should include: relevant history, treatment precautions, social history, discharge plan, physical therapy assessment of patient's status, physical therapy/patient goals, proposed program, and estimated length of stay.
2. Daily Treatment Note completed in the electronic medical record should include: a. Patient's status, problem or reason seen b. Pain assessment c. Intervention d. Patient response to intervention e. Plan for follow-up and justification for continued rehabilitation f. Signature and date
3. The amount of time spent in each session for each patient is documented electronically in minutes
5. Discharge Summary: See ** below.

Outpatients	
1.	Initial Evaluation Note: See * below. Complete within 72 hours of evaluation (excluding Sunday hours)
2.	Send Evaluation to referring MD for signature
3.	Outpatient Progress Note: Complete appropriate section of Outpatient Progress Note after each treatment. Complete Functional Status Summary section on a weekly basis.
4.	Obtain Re-certification of PT program (only for patients with Medi-Care) from referring MD every 30 days.
5.	Discharge Summary: See ** below
6.	Treatment Records: Completed daily, see *** below.

*** Initial Evaluation Note**

Complete an initial evaluation note containing:

a. Patient name and Rancho number

b. Diagnosis for which current treatment is provided and onset date

c. Relevant medical history including complications and precautions

d. Functional status

e. Description of impairments using objective measures.

f. Goals: Outside agencies require predictions about both long-term and short-term goals. Goals should be objective and measurable and be congruent with the diagnosis, prognosis, and age of the patient. Long-term goals are patient functional outcomes expected at the time of discharge from the hospital or program, or discontinuation of treatment. Short-term goals are intermediate steps in accomplishing long-term goals.

1) Patient and/or family/significant other goals

2) Therapist short-term treatment goals

3) Therapist long-term treatment goals

g. Expected duration of treatment

h. Treatment plan that:

1) Addresses impairments outlined in the initial note and is directed toward a functional outcome

2) Is congruent with the age, diagnosis, prognosis, and discharge destination of the patient

3) Includes hours of treatment and frequency

4) Shows evidence of patient's and family/significant other's participation in treatment decisions, and consent for treatment.

5) Includes statement addressing if a portion of care will be provided by PTA

i. Discharge plan

j. Physical therapist signature and date

k. Physician signature and date

l. Treatment given, frequency, and amount

**** Discharge Evaluation**

Discharge Evaluation should be completed within 72 hours of discharge.

a. Patient name and Rancho number

b. Unit, service or clinic number

c. Status and update of impairments & functional limitations identified in the initial note

d. Treatment given, frequency and amount

e. Status of long-term goal achievement; if not accomplished, explain why

f. Discharge plan, including follow-up home program or plan for referral given to individual or organization responsible for patient following discharge

g. Signature and date

***** Treatment Records**

Patient treatment records serve as daily documentation for the dates, time, and types of treatment/evaluation delivered. Clinical staff delivering care will enter procedure performed and time in minutes in the electronic medical record.

A Daily Treatment Record with time spent with patient recorded and or cancel codes and a Weekly Treatment Record (Inpatient Services) electronically is completed and must be signed by the primary physical therapist or supervisor and sent to the medical record.

Guidelines for Treatment Records:

a. Document treatment using minutes. Round off treatment to the nearest minute increment.

b. See Attachment D2 for description of "Non-Billable" Procedures. Non-Billable Procedures are defined as direct or indirect patient care services that do not count toward billable hours.

c. Canceled Treatment: When a whole or partial treatment session is canceled or not delivered, locate the appropriate cancellation codes and record in the canceled treatment column. Write in a number of minutes of canceled treatment. When part of a specific treatment is canceled record only the time for that portion of the treatment given and write in the remainder of the scheduled time with a cancellation code.

d. Ensure the following elements are included in treatment record documents and is correct:

1) Provider signature and title. Because this form documents daily patient interventions and in some cases, serves as daily documentation, all treatment records submitted by Rehabilitation Therapy Technicians (RTTs), student interns, and Licensed Applicants must be co-signed by a Physical Therapist. Documentation of supervision of PTA interventions is demonstrated by the co-signature of PTA weekly notes and/or in the

documentation of such supervision in the PT's weekly progress note.

2) Patient information: Name, Rancho number, Service, Inpatient Unit or Outpatient Clinic number.

Director, Physical Therapy Department

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