

# Physical, Occupational, and Speech Therapy Services



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# Overview of Therapy Services

## What are the Requirements?

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech and Language Pathology (SP)

# All Therapy Services (PT,OT,SP)

Therapy services may be covered under:

- Therapy services are a covered benefit in §§1861(g), 1861(p), 1861(s)(2)(D), and 1861(ll) of the Social Security Act.
- Therapy services may also be provided “incident to” the services of a physician/NPP under §§1862(a)(20) of the Social Security Act (SSA).



# All Therapy Services (PT,OT,SP)

## Conditions of Coverage and Payment

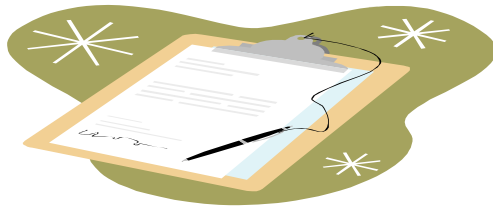
(42 CFR 424.24(c), 424.27 and SSA § 1835(a)(2)(D))

- Services are required based on individual needs
- Services are under a Plan of Care
- Patient must be under the care of a physician or NPP
- These conditions are considered to be met when the physician / NPP certifies the outpatient plan of care
- Furnished on an outpatient basis

Above conditions are met when a physician/ NPP certifies the therapy plan of care.

# Documentation of Therapy Services

- Evaluations and Reevaluations
- Plan of Care
  - Therapy Goals
- Certification /Recertification
- Progress Reports
- Treatment Notes for each treatment day
- Exception justification



# All Therapy Services (PT,OT,SP)

## Plans of Care

- Services must relate directly and specifically to a written treatment plan.
- Must be established by:
  - Therapist who will provide the services (PT,OT, SP)
  - Physician/NPP
- Must be
  - Signed
  - Dated
  - And have the professional's identification (e.g. MD, PT, OT)

# Plan of Care

- The plan of care shall contain, at minimum:
  - Diagnoses,
  - Long term treatment goals,
  - Type, amount, duration and frequency of therapy services.
    - Amount of treatment refers to the number of times in a day the type of treatment will be provided
    - Frequency refers to the number of times in a week the type of treatment is provided
    - Duration is the number of weeks, or the number of treatment sessions

(42CFR424.24, 42CFR424.27, 410.105 and 410.61)



# Referral/ Order

- No order or referral is required for outpatient therapy services.
- An order, where it exists (sometimes called a referral) for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.
- If the signed order includes a plan of care no further certification of the plan is required.
- Payment is dependent on the certification of the plan of care rather than the order.

# All Therapy Services (PT,OT,SP)

Certification / re-certification may be signed by:

- Physicians and NPPs
- Optometrists may certify only low vision services
- Podiatrists consistent with the scope of professional services as authorized by applicable state law

**Note - Chiropractors and Dentists may not refer patient for therapy services nor certify therapy plans of care**



# All Therapy Services (PT,OT,SP)

## Certifications / Recertification

- Certification is a physician's / NPPs approval of a plan of care
  - It indicates the service was provided under the care of a physician for a patient who needs/needed therapy services
- Acceptable documentation of certification may be a:
  - Physicians/NPP progress note
  - Physician/NPP order
  - Plan of Care signed and dated by Physician/NPP
- There is no specific form or format that is required

# All Therapy Services (PT,OT,SP)

## Certifications/ Recertification

- Timing of Certifications
  - Initial Certification by Physician/NPP
    - Should certify the plan as “soon as possible”, or within 30 days of the initial therapy treatment
- Timing of recertification
  - Continued or modified therapy
    - Should be signed whenever the need for a significant modification of the plan becomes evident,
    - Or at least every 90 days after initiation of treatment under that plan, unless they are delayed

# Delayed Certifications / Recertifications

*“Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable without justification for 30 days after they are due. Delayed certification should include one or more certifications or recertification's on a single signed and dated document.”*

# What does a Therapist do?

## Devise a Plan of Care

- Establishes a rehabilitation diagnosis
- Individualized plan for each patient based on the evaluation / examination
- Establish a treatment program
  - Specific interventions to be used to treat the patient's needs
    - (i.e. therapeutic exercise, functional training, manual therapy techniques, adaptive devices / equipment needs, modalities)
- Establish anticipated goals, expected outcomes, any predicted level of improvement
  - Short term goals (optional)
  - Long term goals
  - Determine the intensity, frequency, and duration for care
- The plan of care includes the anticipated discharge plans

# Documentation of Therapy Services

## Progress reports

Provides justification for the medical necessity of treatment

Information required in the progress reports shall be written by a **clinician**.

- The physician/ NPP who provides or supervises the service, or
- The therapist who provides the service and supervises the assistant

The end of the Progress Reporting Period is:

- A date chosen by the clinician
- **The 10th treatment day**
- **or the 30th calendar day of the episode of treatment**

Which ever is shorter

The dates for recertification of plans of care do not affect the dates for required Progress Reports.

# October

The evaluation is performed on Oct. 2<sup>nd</sup>, the progress report is due Oct 24<sup>th</sup> since this is the 10<sup>th</sup> visit.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2 <b>Evaluation Treat</b>	3	4
5	6 <b>Treat</b>	7	8 <b>Treat</b>	9	10 <b>Treat</b>	11
12	13 <b>Treat</b>	14	15 <b>Treat</b>	16	17 <b>Treat</b>	18
19	20 <b>Treat</b>	21	22 <b>Treat</b>	23	24 <b>Progress Report Treat</b>	25
26	27	28	29	30	31	



# October

In this example, the evaluation is performed on Oct 1<sup>st</sup> and the 10<sup>th</sup> visit is on the 31<sup>st</sup> – one day after the 30<sup>th</sup> calendar day. The Progress Report would be due on the 8<sup>th</sup> treatment day or the 29<sup>th</sup> calendar day.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Sunday
			1 <b>Evaluation Treat</b>	2	3	4
5	6	7	8 <b>Treat</b>	9	10 <b>Treat</b>	11
12	13	14	15 <b>Treat</b>	16	17 <b>Treat</b>	18
19	20	21	22 <b>Treat</b>	23	24 <b>Treat</b>	25
26	27	28	29 <b>Treat</b>	30 <b>Progress Report</b>	31 <b>Treat</b>	

# Progress Reports for Services Billed Incident to a Physician's Service

- Incident to services requires for example, the physician's initial service, direct supervision of therapy services, and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment.
- Supervision and reporting requirements for supervising physician/NPPs supervising staff are the same as those for PTs and OTs supervising PTAs and OTAs with certain exceptions noted below.
- **When a therapy service is provided by a qualified therapist, supervised by a physician/NPP and billed incident to the services of the physician/NPP, the Progress Report shall be written and signed by the therapist who provides the services.**
- When the services incident to a physician are **provided by "qualified personnel" who are not licensed therapists (but who are trained as therapists according to 42 CFR 484.4), the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period, and write and sign the Progress Report.**

# Documentation of Therapy Services

Treatment Encounter Note – It is a record of all treatment

- Documentation is required for every treatment day, and every therapy service, it must record the:
  - Date of treatment
  - Treatment, intervention, or activity
  - Total timed code treatment minutes and total treatment time minutes (Includes timed codes and untimed codes)
  - Signature and professional identity of the qualified professional furnishing the treatment
  - Additional information may be included ( response to treatment, changes)

The format may vary depending on the therapist and the clinical setting

# Documentation to Meet Requirements

- Services should be appropriate type, frequency, intensity, and duration for the individual needs of the patient
  - The fact that services are billed is not necessarily evidence that they were appropriate
  - Documentation of objective measures
  - Needs of the patient
    - Contributing factors i.e. motivation, cognition, onset, psychological stability, social stability

# All Therapy Services (PT,OT,SP)

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Reasonable and Necessary Services

# Reasonable and Necessary

- Services meet accepted standards of medical practice
- Specific and effective treatment for the condition
- A level of complexity / sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist (or supervised PTA/OTA), and
- Patient's clinical condition requires the skills of a therapist

# Services require the skills of a therapist

- Services must not only be *provided* by the qualified professional (or by qualified personnel for incident to services), *but they must require*, the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently.
- A clinician may not merely supervise, but must apply the skills of a therapist by actively participating in the treatment of the patient during each Progress Report Period.
- In addition, a therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.

# Reasonable and Necessary

- Beneficiary's diagnosis is not the sole factor in determining coverage, the key is that the skills of the therapist were needed to treat the illness or injury.
- Amount, frequency, and duration must be reasonable under accepted standards of practice.



# Reasonable and Necessary

- Acceptable practices for therapy services are found in:
  - Medicare Manuals (Publications 100-2 and 100-4)
  - Contractor's Local Coverage Determinations (LCD and NCD)
  - Guidelines and literature from the professions of
    - American Physical Therapy Association (APTA)  
» <http://www.apta.org/>
    - American Occupational Therapy Association (AOTA)  
» <http://www.aota.org/>
    - American Speech and Hearing Association (ASHA)  
» <http://www.asha.org/default.htm>

# Rehabilitation Therapy-Reasonable and Necessary

**Rehabilitation** services are for the recovery or improvement of function and when possible to restore function to previous level

Skilled services include:

- Evaluations and reevaluations
- Establishing treatment goals
- Designing a plan of care
- Ongoing assessment and analysis
- Instruction leading to development of compensatory skills
- Selection of devices to replace or augment a function
- Patient and caregiver training

**Skilled *rehabilitative* therapy occurs when, “The skills of a therapist are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation.”**

# Rehabilitation Therapy

## Reasonable and Necessary

*“Services that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are **not** rehabilitative therapy services.*

*If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, or does not legitimately require the services of a qualified therapist for management of a maintenance program as described below, the services will no longer be considered reasonable and necessary [as rehabilitation therapy services].*

*Services that are not reasonable or necessary should be excluded from coverage under §1862(a)(1) of the Act.”  
(Benefit Policy Manual-Pub 100-02, Chapter 15, section 220.2, subsection C).*

# Rehabilitation Therapy

## Reasonable and Necessary

- The potential for rehabilitation should be significant in relation to the extent and duration of services
- Expectation for improvement in a reasonable time (and generally predictable) period of time
- Evidence of improvement by successive objective measurements whenever possible
- Therapy is not necessary to improve function where a patient suffers a transient or easily reversible loss of function
  - **‘Spontaneous improvement’**

# Maintenance Services – Reasonable and Necessary



- Maintenance Services Considered to Be Unskilled When They:
  - Do not require the skills of a therapist to carry out the program
  - Could safely and effectively be accomplished by patient independently or by unskilled personnel or family / caregiver
  - These services are excluded under 1862(a)(1) of the SSA
- Maintenance Services Considered to Be Skilled When They:
  - Require the skills of a therapist to carry out the program , which occurs only when:
    - The patient’s special medical complications require the skills of a therapist to perform a therapy service that would otherwise be considered non-skilled, or
    - The needed therapy services are of such complexity that the skills of a therapist are required to perform the procedure

# What is Considered “*NOT* Reasonable and Necessary”

- Services provided by -
  - Professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services
  - Services that are unskilled.
- Services provided for -
  - General exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes.
- Services that are -
  - Not provided under a therapy plan of care, or are provided by staff who are not qualified or appropriately supervised, are not covered or payable therapy services.

# Reasonable and Necessary

## Questions to Ask

- Treatment should be consistent with the nature/ severity of illness / injury
  - Is this a new or acute problem?
    - May need intensive focused care
      - E.g. reduce pain and/or work on a specific impairment or functional loss
  - Is this an old or chronic condition that needs retraining, or has had a change in condition?
    - May need to update or modify program
  - Is this an exacerbation of a condition?
    - May have to modify treatment, change assistive devices as the condition deteriorates
  - Are there other conditions (e.g. medical diagnosis) that are the underlying problem?

# Reasonable and Necessary Questions to Ask

- Cognitive performance can impact care
  - What is the beneficiary's ability to retain newly learned information (cognitive function)?
  - What is the beneficiary's ability to participate and benefit from rehabilitative services?



# Reasonable and Necessary Questions to Ask

## Assessing Objective Measurable Gains for Rehabilitation Therapy

- Look at:
  - Changes in the level of assistance required to perform functional tasks
  - Changes in the types of functional activities/ tasks
  - Changes in the types of assistive devices
  - Improvement in rating of reported pain levels and changes in the ability to perform tasks given the reduction of pain
    - (E.g. - Ability to sit for a duration of time as a result of pain reduction)

# Reasonable and Necessary

## Questions to Ask

- Considerations
  - Did the therapist consider the beneficiary's goals?
  - Were the therapist's and beneficiary's goals realistic based on the beneficiaries condition and,
  - For rehabilitation therapy did the therapist change goals/ treatment plan in response to improvement or lack of improvement in the beneficiary's condition?
  - Were there objective, measurable changes using standard scales and assessment tools?
  - What was the beneficiary's response to treatment?
    - Did this change over time?
    - Was is sustained?

# Services Provided “Incident to”

- To be covered, payable therapy services must require the skills of a therapist
- Provided according to therapy policies
  - Plan of Care
  - Be of a level of complexity that require that they be performed by a therapist or under the direct supervision of the therapist, physician/NPP who is licensed to perform them
  - By or under the ‘direct’ supervision of a physician/NPP authorized to practice therapy
- Direct supervision
  - The physician or NPP must be present in the office suite and immediately available

Reference: Medicare Benefit Policy Manual –Pub. 100-02, Chapter 15, section 230.5 for PT, OT, and SLP services provided incident to the physician/NPP.

# Services Provided “Incident to” con’t

The mandatory assignment provision **does not** apply to therapy services furnished by a physician/NPP or "incident to" a physician's/NPP's service. However, when these services are not furnished on an assignment-related basis; the limiting charge applies.

For emphasis, following are some of the standards that apply to therapy services billed incident-to the services of a physician/NPP in the physician's/NPP's office or the beneficiary's residence.

- A. Therapy services provided to the beneficiary must be covered and payable outpatient rehabilitation services as described, for example, in this section as well as Pub. 100-08, chapter 13, §13.5.1.
- B. Therapy services must be provided by, or under the direct supervision of a physician (a doctor of medicine or osteopathy) or NPP who is legally authorized to practice therapy services by the state in which he or she performs such function or action. Direct supervision requirements are the same as in 42CFR410.32(b)(3). The supervisor must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician/NPP must be present in the same room in the office where the service is performed.
- C. The services must be of a level of complexity that require that they be performed by a therapist or under the direct supervision of the therapist, physician/NPP who is licensed to perform them. Services that do not require the performance or supervision of the therapist, physician/NPP, are not considered reasonable or necessary therapy services even if they are performed or supervised by a physician/NPP or other qualified professional.
- D. Services must be furnished under a plan of treatment as in §220.1.2 of this chapter. The services provided must relate directly to the physician/NPP service to which it is incident. 36

# Problematic Areas

- Excessive amount of time therapy is provided (extreme duration of each treatment each day)
- Excessive duration of care (extensive number of visits)
- Services not reasonable and necessary
  - Unskilled services
- Excessive use of the –KX modifier to override the therapy cap
- Excessive and improper use of -59 modifier to override the CWF edits.  
Note: using the -59 modifier indiscriminately, i.e. on every line, would be improper use of the -59 modifier
- Utilization of unqualified individuals to furnish therapy services
  - “incident to”
  - No evidence of skilled management or intervention

# Documentation Examples

- SNF Part B
- Outpatient Therapist
- Physician/ NPP

# SNF Documentation Example

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Types of Documentation

# SNF Part B services

**Start of treatment 1/17/08, discharged 4/15/08 but look at the next slide**

This is an example of therapy services provided in a nursing facility to a patient who is not in a Part A stay; services are billed under Part B.

This is the discharge note for a patient that was evaluated in January and discharged in April. It appears that the patient makes gains with the care provided. However, in the review of the documentation, most of these gains occurred within the first month of care. (see next page)

4-15-08	D/C Summary:	
	<u>Initial Eval 1/17/08</u>	<u>D/C 4/15/08</u>
	Bed Mobility	CGA (1)
	Supine to Sit	CGA (1)
	Sit to Stand	SBA ± 4WW, mod (1)
	Gait	60' x 2, VC's for posture, 4WW Mod (2) 4WW for 400' = good safety <sup>bed mat</sup>
	↑ 10-20 Steps	↑ 20 steps ± use of
	All goals met, great progress. Gait ± (1).	



# By 2/19/08 patient was able to go up and down 10 steps

## And ambulated 100 ft x 2 with 4ww

The treat notes demonstrate that patient was able to go up and down 10 stairs with contact guard assistance using the rail and, was able to ambulate 200 feet with a four wheel walker by Feb 19. Treatment continued for two more months; the subsequent treatment notes did not justify the need for continued skilled care. There was no description of gait deviations, balance problems, impairments, or reassessments to support continued treatment. Note there is no documentation of treatment time; the following slide is the record of treatment time.

INTERVENTIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Evaluation/Re-Evaluation	2/13/08	2/14/08	2/15/08	2/16/08	2/17/08	2/18/08	2/19/08
Modalities			OK		W		
Specific Modality Used (Required)			HP x 15' to hand walk		HP x 15' low back		
Ther-ex	OK	OK	OK	W		OK	OK
	20' GLE SLR, SAQ 1/2s, Glut Iso, Numbness	Numbness 5', walk	sitting on 3 steps, Numb step walk, 15'	seated hand DUE 15' MATH 15'	seated AK w/ 24 DUE 15' MATH 20'	Numbness walk, 15'	Numbness walk, 15' last 3 min E LE only
Gait Training	OK	OK	OK	W	W	OK	OK
	300' EFW ESBA	150' EFW ESBA	50' ESBA 54WN-1 200'	100' x 2 4WN 1/2 A	300' x 1 4WN SPK	E back support 200', 50' x 2 + 1/2 steps E CB	10' x 10 steps E CB, 2 min of Board, 100' x 2 EFW
Therapeutic Activity	OK		OK	W	W	OK	OK
	transfer with 2 WIC E7, and 2 WIC's to hand, SBA		transfer ESBA to WIC's for safety at 1/2 gait	transfer ch, standing balance	transfer ch, standing balance	WIC's for safety 2 FWJ & WIC use CB out 1/2 sid	transfer WIC's to lock WIC & FWW brakes
Other							

# Time Log

Example of record of the minutes of therapy provided for the services in the previous slides.

						--
2/13/08	1/23/08	PT	Therapeutic Exercises	97110	GP	33
			Neuromuscular Re-education	97112	GP	14
			Gait Training Therapy	97116	GP	16
						<b>63</b>
2/14/08	1/23/08	PT	Therapeutic Exercises	97110	GP	5
			Neuromuscular Re-education	97112	GP	25
						<b>30</b>
2/15/08	1/23/08	PT	Therapeutic Exercises	97110	GP	36
			Neuromuscular Re-education	97112	GP	11
			Gait Training Therapy	97116	GP	25
						<b>72</b>
2/16/08	1/23/08	PT	Therapeutic Exercises	97110	GP	24
			Neuromuscular Re-education	97112	GP	17
			Gait Training Therapy	97116	GP	22
						<b>63</b>
2/17/08	1/23/08	PT	Therapeutic Exercises	97110	GP	26
			Neuromuscular Re-education	97112	GP	16
			Gait Training Therapy	97116	GP	20
						<b>62</b>
2/18/08	1/23/08	PT	Therapeutic Exercises	97110	GP	16
			Neuromuscular Re-education	97112	GP	11
			Gait Training Therapy	97116	GP	32
						<b>59</b>
2/19/08	1/23/08	PT	Therapeutic Exercises	97110	GP	24
			Neuromuscular Re-education	97112	GP	14
			Gait Training Therapy	97116	GP	18
						<b>56</b>

# Example of services provided in the nursing facility

The weekly progress note lacks objective measurements; there are only "increase" and "decrease" arrows. This patient is on the restorator for 20 minutes and is given very repetitive exercise. The only change documented is the distance that the patient ambulated. There is little documentation of clinical judgment or complexity of care to support the need for, or receipt of skilled care.

JNTH/YEAR	2/07	DATE	2/27	28	1	2	3
EVALUATION (E) or DISCHARGE (D)							
P.T. EVAL. (97001) UNITS/MINUTES							
THERAPEUTIC EXERCISES (97110) UNITS/MINUTES		2/33	2/32	2/34	2/35	2/30	
Restorator		20'	20'	20'	20'	20'	
ⓐ LAG		3/30	3/30	3/35	3/35	3/30	
ⓑ Hip flexion		3/30	3/30	3/35	3/35	3/30	
ⓒ Ankle Pump		3/30	3/30	3/35	3/35	3/30	
ⓓ Hip abduction/add		3/30	3/30	3/35	3/35	3/30	
NEUROMUSCULAR RE-ED (97112) UNITS/MINUTES							
Sitting (static/dynamic)							
Standing (static/dynamic)							
GAIT: (97116) UNITS/MINUTES		1/5	1/5	1/5	1/5		
Weight Bearing		FWB	FWB	FWB	FWB		
Assistive Device		KW	RW	KW	KW		
Distance		300'	305'	310'	325'		
Level of Assistance		CGA	CGA	CGA	CGA		
THERAPEUTIC ACTIVITIES (97530) UNITS/MINUTES		1/0	1/0	1/0	1/0		
Transfers		CGA	CGA	CGA	CGA		
Supine ↔ Sit		CGA	CGA	CGA	CGA		
Sit ↔ Stand		CGA	CGA	CGA	CGA		
Bed ↔ W/C		CGA	CGA	CGA	CGA		

No change in exercises.  
Patient is ambulating 300+ ft with CGA, no objective measurements

## SIGNIFICANT EVENTS:

∅

## WEEKLY SUMMARY

### Problems/Issues:

- ↓ LE Strength
- ↓ gait
- ↓ endurance

### Education:

Gait & endurance training

### Positive Func. Status Changes (describe):

- ↑ LE Strength
- ↑ gait
- ↑ endurance

### Justification For Continued Skilled Therapy Intervention:

PT appears not met. Pt. making progress towards  
↑ LE strength, ↑ gait  
↑ ↑ endurance

### New/Revised Goals:

Continue to doc

# Discharge Note for SNF Part B Care –

These discharge notes indicate that the only reason for ending treatment was that the patient reached the Cap limitation.

2-8-06	Pt is D/C'd from OT services on 2-8-06 due to reaching limit on Medicare part B payer cap.
2-9-06	P.T. Classification - Pt to be D/C'd from PT services 2 <sup>nd</sup> meeting Medicare Part "B" Cap for PT services

# Out Patient Therapist Documentation Example

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Types of Good Documentation

# Examples of Good Documentation Needed for Therapy Services

## Documentation indicates:

- Previous medical history including diagnosis, premorbid conditions, and recent hospitalizations impacting functional abilities
- Patient's prior level of functional abilities, i.e. able to ambulate functional distance in recent past
- Timely physician certification/involvement with clear frequency/duration and certification date range parameters on plan of care
- Medical necessity supported - patient would benefit from the development of an effective home strengthening program to:
  - Regain ability to safely ambulate to/from bathroom to ensure appropriate pericare, etc.
  - Facilitate the patient's ability to maintain strength and prevent further functional decline with other functional skills, i.e. transfers/bed mobility.

# Good Documentation- Evaluation for Outpatient PT

## Benign Paroxysmal Positional Vertigo- BPPV

This is an example of the clinical judgment and reasoning skills in the assessment and examination of a patient.

20. INITIAL ASSESSMENT (History, medical complications, level of function at start of care, Reason for referral)

19. PRIOR HOSPITALIZATION FROM TC X N / A

S: hx: Pt is 74 yo WF who reports onset of dizziness began about 2-3 months ago. Pt reports 1 time sitting still and not moving and sudden onset dizziness lasting about 5 min and a second onset a few days later when she turned head to the left. Pt reports that the last one lasted about 10 min. Pt denies any numbness, tingling, or wkness with the episodes. Pt reports that she went to MD last wk and he did an EKG and took vital signs to r/o MI. Pt reports that he then told her about BPPV and sent her to therapy. Pt reports that she has not had any dizziness since last episode. PMH: neg significant, hypercholesteremia. O: Mental status: A&O x3. Bed mobility and transfers: Independent. Strength: 5/5 B UE's and LE's except hip flexors 4/5 B. Neuro: lt touch/ sharp dull intacted. Proprioception intacted. ROM: WNL except cervial rotation R decreased ~50%. Dizziness: 0/10 baseline at rest. Oculomotor: Corrective saccadics WNL, Smooth prusuits: L beating horizontal nystagmus noted with L gaze. Without visual fixation: L beating nystagmus again noted. Hallpike dix: negative B. Motion sensitivity: 0/10 with all head movements and trunk flexion, SB and rotation. A: Pt presents with L beating nystagnus with smooth pursuits and episodic dizziness lasting 5-10 min and no motion sensitivities. These s/s are not consistent with BPPV or other peripheral vestibular problems. Concerned that these s/s are from central neuro problems. Recommend pt return to MD for further medical work up and evaluation. No skilled physical therapy is indicated at this time.

# Examples of Good Documentation Needed for Therapy Services

<p><b>Physical Therapy</b></p> <p><input checked="" type="checkbox"/> Evaluate and Treat</p> <p><input type="checkbox"/> Therapeutic Exercise</p> <p><input type="checkbox"/> Manual Therapy</p> <p><input type="checkbox"/> Ultrasound</p> <p><input type="checkbox"/> Low-level Laser</p> <p><input type="checkbox"/> Neuromuscular Re-education</p> <p><input type="checkbox"/> Gait Training</p> <p><input type="checkbox"/> Functional Mobility Training</p> <p><input checked="" type="checkbox"/> Fall Prevention/Balance Evaluation/Training</p> <p><input type="checkbox"/> Vestibular Rehab</p> <p><input type="checkbox"/> Wheelchair/Seating Evaluation</p> <p><input type="checkbox"/> Iontophoresis (with dexamethasone)</p> <p><input type="checkbox"/> Electrical Stimulation</p> <p><input type="checkbox"/> Pool Therapy</p> <p><input type="checkbox"/> WCE (work capacity eval) = 6 hour/2 day test</p> <p><input type="checkbox"/> PCE (physical capacity eval) = 3 hour/1 day test</p> <p><input type="checkbox"/> Work Conditioning Evaluation</p> <p><input checked="" type="checkbox"/> Other <u>Walker Training + Ambulation Therapy</u></p> <p>Frequency <u>2-3x/week</u> Duration <u>4 weeks</u></p> <p><b>Women's Health</b></p> <p><input type="checkbox"/> Evaluate and Treat</p> <p><input type="checkbox"/> Osteoporosis Rehab</p> <p><input type="checkbox"/> Urinary Continence Rehab</p> <p><input type="checkbox"/> Pelvic Pain</p> <p><input type="checkbox"/> Prenatal/Post-Partum conditions</p> <p><input type="checkbox"/> Ultrasound for Mastitis/Engorgement</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency _____ Duration _____</p> <p><b>Speech-Language Pathology</b></p> <p><input type="checkbox"/> Evaluate and Treat</p> <p><input type="checkbox"/> Speech/Language/Memory Disorder</p> <p><input type="checkbox"/> Swallowing Disorder</p> <p><input type="checkbox"/> Voice Disorder</p> <p><input type="checkbox"/> Video Swallowing Studies</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency _____ Duration _____</p>	<p><b>Occupational Therapy</b></p> <p><input type="checkbox"/> Evaluate and Treat</p> <p><input type="checkbox"/> Therapeutic Exercise</p> <p><input type="checkbox"/> Neuromuscular Re-education</p> <p><input type="checkbox"/> Fine Motor Skill Development</p> <p><input type="checkbox"/> ADL Training</p> <p><input type="checkbox"/> Splinting</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency _____ Duration _____</p> <p><b>Hand Therapy</b></p> <p><input type="checkbox"/> Evaluate and Treat</p> <p><input type="checkbox"/> Therapeutic Exercise</p> <p><input type="checkbox"/> Manual Therapy</p> <p><input type="checkbox"/> Desensitization</p> <p><input type="checkbox"/> Fine Motor Skill Development</p> <p><input type="checkbox"/> Splinting</p> <p><input type="checkbox"/> Low-level Laser</p> <p><input type="checkbox"/> Ultrasound</p> <p><input type="checkbox"/> Iontophoresis (with dexamethasone)</p> <p><input type="checkbox"/> Fluidotherapy</p> <p><input type="checkbox"/> Paraffin</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency _____ Duration _____</p> <p><b>Cancer Rehab</b></p> <p><input type="checkbox"/> Evaluate and Treat-Physical Therapy</p> <p><input type="checkbox"/> Evaluate and Treat-Occupational Therapy</p> <p><input type="checkbox"/> Evaluate and Treat-Speech-Language Pathology</p> <p><b>Lymphedema (Physical Therapy or Occupational Therapy)</b></p> <p><input type="checkbox"/> Manual Lymphatic Drainage and Bandaging</p> <p><input type="checkbox"/> Compression Pumping</p> <p><input type="checkbox"/> Measure and Fit for Compression Garments</p> <p><input type="checkbox"/> Edema Follow-up Visit</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency _____ Duration _____</p>
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# Examples of Good Documentation Needed for Therapy Services con't

## INITIAL EVALUATION - PHYSICAL THERAPY

DX: Peripheral Neuropathy and Gait Abnormality ICD9m: 354.9, 781.2  
 Tx Dx: Gait Abnormality ICD9m: 781.2  
 Treatment/Service Dates: 9-7-10

Name: [REDACTED]  
 DOB: [REDACTED]  
 SSN/ICD#: [REDACTED]  
 Initial Rx: [REDACTED]

PRECAUTIONS: VRE, Fall risk Initial Visit: 9-7-10 DO / Onset: 07/10

**MEDICAL HISTORY / Treatment History:** Pt is a 60 year old female with multiple co-morbidities that have greatly decreased the pt's ability to safely ambulate. She has had multiple recent hospital admissions for LE cellulites and per patient has had a recent abdominal surgery. Safe ambulation is complicated by morbid obesity, but patient reports since she is unable to safely walk and she has fluid draining from her legs her exercise options are limited.

**SUBJECTIVE / Patient Goals:** Pt states that within the last year she was able to walk into the bathroom at her adult foster home. Her power chair does not fit into the bathroom so she would use a walker and walk into the bathroom. She states after a fall the facility has now asked that she no longer walk into the bathroom and pt agrees stating she is afraid of falling. Pt states she now just uses a diaper and goes to the bathroom in that and then changes herself. Pt states she does transfer on her own and does take a few steps around the edge of her bed at home, but she does this by leaning on furniture or using her FWW. She states it is very hard for her to take the first steps and that her knees have buckled in the past.

### OBJECTIVE / Areas of Focus:

Issue	Progress	Goals
Basic mobility skills/Transfers	<p>Performed egress test to assess pt safety for gait away from edge of bed. Pt was able to perform the 3 sit to and from stand w/ FWW and CGA. She was able to weight shift to perform the advance/retract portion of the test, but this took a lot of effort and pt required CGA, verbal cues for wt shifting, and CGA. This test fatigued the patient and she required a seated rest. Based on this test it was felt it was not safe to continue with gait assessment away from the edge of the mat table. Pt will need to increase BLE strength prior to beginning gait training for safety.</p> <p>Pt is currently able to perform transfers in and out of her wheel chair w/ a FWW and close SBA for safety (at the facility she does this on her own): For transfers wheel chair is placed as close as possible to transfer surface.</p>	<p>Pass Egress test without difficulty and without requiring a seated rest following. This will indicated sufficient strength to proceed to gait training.</p>
Gait	<p>Pt currently depends on her power wheelchair for all functional ambulation. At this eval she was unsafe to further assess gait. Will need to pass above goal to begin working on gait training.</p>	<p>Mod Independent with ambulation w/ FWW at least 15 feet to allow pt to safely ambulate in and out of the bathroom at her APC facility.</p>

### ASSESSMENT

Rehab Potential:  Good  Fair  Poor  
 Patient presents with functional mobility deficits as described above. This places pt at a high risk for falls. Pt would benefit from skilled therapy to increase her strength, balance, and gait to allow her to walk into the bathroom at her APC and to decrease her risk of falls.

### PLAN

<input checked="" type="checkbox"/> Therapeutic Ex/HEP (97110)	<input checked="" type="checkbox"/> Therapeutic Activities/Mob Training	<input type="checkbox"/> Seating/Pressure Eval
<input checked="" type="checkbox"/> Neuromuscular Re-ed (97112)	<input checked="" type="checkbox"/> Balance Eval/Training	<input type="checkbox"/> Equipment/Orthotics
<input checked="" type="checkbox"/> Gait (97114)	<input type="checkbox"/> Pool Therapy	<input type="checkbox"/> Other

3 Tx per week x 4 weeks for the order period 9-7-10 to 10-3-10

# Examples of Good Documentation Needed for Therapy Services con't

Diagnosis: Peripheral Neuropathy, Gait Abnormality  
 MD order: Date: 9/7/19 Time: 1306-1345 ICD9 Code: 356.9, 781.1  
 Total # of Visits to Date: 1 # of Txes from last Prog Note: 1 Visit #: 1 / Date of Order: 9/7/19 (Print)

History: Insulin dependent diabetes, neuropathy, CVA x 2, morbid obesity, chronic venous stasis with recurrent cellulitis, history of pulmonary embolism, breast cancer, s/p mastectomy, CHF, chronic low back pain with degenerative disk disease

Pain Scale: 10 or N/A

**Assessment:**

- Pt and/or caregiver are actively participating in appointment for assessment for wheelchair modifications.
- Pt and/or caregiver are independent and safe with functional operation of the recommended equipment.
- Pt and/or caregiver need additional training for safe and functional operation of the recommended equipment.
- Pt is progressing toward established goals. Specific goals:
- Pt is not progressing toward goals. Reason:  compliance /  slow response to Rx /  PT ill /  Other:
- Seating system is contributing to improved pressure relief and wound healing.
- Changes needed to Plan of Care. Specify:
- Changes needed to goals. Specify new goals:

Please  See assessment below  Therapeutic Activities/ Mobility Training (9753)  Patient/Caregiver Training (97530)  Wheelchair Management and Training (97452)

**Goals:**

- Pt will be independent with mobility and motor-related ADLs (MRADLs) in the home and community.
- Pt will be independent with MRADLs in the community.
- Pt will be independent with relieving pressure while in the wheelchair to decrease risk for skin and wound issues.
- Pt will be independent with using tilt feature to adequately relieve pressure and for postural control.
- Pt and/or caregiver will be independent with using recline feature to adequately relieve pressure and for postural control.
- Pt and/or caregiver will be independent with obtaining optimal position in seating systems to facilitate improved function and safety.
- Pt will demonstrate improved physiological functions, such as breathing, swallowing and digestion.
- Pt will report decrease in pain to /10.

Subjective: I need to get a chair with power tilt and elevating legs so I can get my legs above my heart

Treatment Provided: Verbal consult provided

Rx Time: 1306-1345  Initial evaluation  Therapeutic Activity/  Mobility Training/  Transfer Training/  Posture

Wheelchair Management and Training  Re-assess / Other:

**Teaching needed:**

Content	Learner (circle)	Teaching Method	Barriers (circle)
1. Insurance guidelines for wheelchair	<input checked="" type="checkbox"/> Pt <input type="checkbox"/> Spouse <input type="checkbox"/> Partner	<input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Explanation	<input type="checkbox"/> Hearing / Vision
2.	<input type="checkbox"/> Friend <input type="checkbox"/> Caregiver	<input type="checkbox"/> Handout <input type="checkbox"/> Reinforcement	<input type="checkbox"/> Language
3.	<input type="checkbox"/> Family Member	<input type="checkbox"/> Demonstrate <input checked="" type="checkbox"/> Verbalize skill	<input type="checkbox"/> Integritty present: Y / N
	Ready to Learn: <input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> With <input type="checkbox"/> without verbal assistance	<input type="checkbox"/> Memory / Insight
		<input type="checkbox"/> With <input type="checkbox"/> without physical assistance	<input type="checkbox"/> Attention Span
		<input checked="" type="checkbox"/> Verbal reinforcement	<input checked="" type="checkbox"/> None identified

Response to The Client: the the doctor wants her to have tilt on her chair with elevating legs. I could not find this in Eschert documentation but I did note that Dr. X does want her to try walking and balance training in physical therapy. She will have her evaluation today. She therapy first to see what her potential would be. If this is not successful then a referral back to the seating clinic may be indicated to look at wheelchair needs. Her wheelchair will not accept a power tilt.

Therapist: \_\_\_\_\_ Date: 9/7/19

I approve of above Rx plan.  
 I approve of above Rx plan w/ the following modifications:

Physician Signature: \_\_\_\_\_ Date: 9/8/19  
 Physician's Name Print: \_\_\_\_\_

# Examples of Good Documentation Needed for Therapy Services con't

**OUTPATIENT THERAPY RECORD (with Acromy Clinic)**

Date: 9/7/10 Time: 1:30 Visit #: 1/1 Eval: See Initial

Subjective: Having issues E. Ankle  
Having issues E. Edema  
Revisit skin issues on bottom on leg

Height: 5'4"  
 Weight: 305

Treatment Provided:

Rx Time: \_\_\_\_\_ US @ \_\_\_\_\_ w/cm<sup>2</sup>, \_\_\_\_\_ MHz, \_\_\_\_\_ % to \_\_\_\_\_ Pulsed / Continuous  
 Paraffin / Fluidotherapy: temp \_\_\_\_\_ °, speed \_\_\_\_\_ N, location \_\_\_\_\_ Pulsed / Continuous  
 Estim @ \_\_\_\_\_ to \_\_\_\_\_ TENS to \_\_\_\_\_ # pads \_\_\_\_\_, setting: \_\_\_\_\_ (Un / Attended)  
 Ionto: design: \_\_\_\_\_ rec: \_\_\_\_\_ pad size: \_\_\_\_\_ site: \_\_\_\_\_ Action Patch  
 Ice Massage OR Ice / Heat Pack to \_\_\_\_\_ PT in Sitting / Supine / Prone / Sidelying  
 Manual Therapy / Joint Mob (Grade I / II / III / IV) / Graston: (covers needed @ #\* use - correct given Y / N)

Mechanical Traction - C / T / L spine Setting: \_\_\_\_\_ Sitting/Supine/Prone Angle: \_\_\_\_\_  
 Neuromuscular Re-education: Vestibular / Sensory Integration / Balance / Limits of Stability / Proprioception: \_\_\_\_\_

Gait Training [Device Used: \_\_\_\_\_ Assistance Needed: \_\_\_\_\_] Modified Clinical Test of Sensory Integration & Balance: \_\_\_\_\_

Splinting: \_\_\_\_\_  
 Therapeutic Activity / Ther Ex / Transfer Training / Ergonomics / Body Mechanics / Lifting / Posture: \_\_\_\_\_

LL Laser used with: Manual Rx / NM Re-educ / Ex to facilitate: & Pain / & Inflammation / T ROM / other: \_\_\_\_\_ [ ] See Ex Flow Sheet

Teaching record:  
 Re-assess / Other: with consent

Concept	Learner (circle)	Teaching Method	Barriers (circle)
1.	PT / Spouse / Partner	Demonstration / Explanation	Hearing / Vision
2.	Friend / Caregiver	Handout / Reinforcement	Language
3.	Family Member	Demonstrates / Verbalizes skill: Y / N	Motor/verbal present: Y / N
	Ready to Learn: Y / N	With / without verbal assistance	Memory / Insight
		With / without physical assistance	Attention Span
		Needs reinforcement	

Pre Rx: Pain (NA) / 0 ROM: \_\_\_\_\_ Strength: \_\_\_\_\_ Post Rx: (NA) / 0 ROM: \_\_\_\_\_ Strength: \_\_\_\_\_

Other: Client reports condition has changed (declined)  
Nx of neuropathy affecting hands and feet, etc

Assessment: Current with gait assist 148 (Swanson of America), L & Edema  
has worsened

• PT is: Improving / Flared / Ready to Progress  
 • Progressing towards goals: Yes: Specify goal: \_\_\_\_\_  
 No: Why: & HEP compliance / Slow response to Rx / PT is / Other: \_\_\_\_\_

• Changes to Plan of Care: No / Yes  
 • Changes to STGs: No / Yes - New STG: \_\_\_\_\_

Plan / Next treatment to include:  
 Progress Note Due on: \_\_\_\_\_  
 See Progress / Discharge Note

Therapist: \_\_\_\_\_

# Examples of Good Documentation Needed for Therapy Services con't

Date: 9-7-10 Time: 15<sup>00</sup>-16<sup>00</sup> Visit #: 1/1 Eval: See Initial

Subjective: See initial eval

Treatment Provided:

Rx Time: \_\_\_\_\_ w/cm2 \_\_\_\_\_ MHz \_\_\_\_\_ % to \_\_\_\_\_  
 Paraffin / Fluidotherapy: temp \_\_\_\_\_ °, speed \_\_\_\_\_ N, location \_\_\_\_\_ Pulsed / Continuous  
 Estim @ \_\_\_\_\_ to \_\_\_\_\_ TENS to \_\_\_\_\_ Pulsed / Continuous (Un / Attended)  
 Ice Massage DR Ice / Heat Pack to \_\_\_\_\_ # pads \_\_\_\_\_ setting: \_\_\_\_\_ Action Patch  
 Manual Therapy / Joint Mob (Grade I / II / III / IV) / Graston: (cotton needed @ 1" size - cotton given Y / N)

Mechanical Traction - C / T / L spine Setting: \_\_\_\_\_ Sitting/Supine/Prone Angle: \_\_\_\_\_  
 Neuromuscular Re-education: Vestibular / Sensory Integration / Balance / Limits of Stability / Proprioception: \_\_\_\_\_

Gait Training (Device Used: \_\_\_\_\_ Modified Clinical Test of Sensory Integration & Balance: \_\_\_\_\_  
 Assistance Needed: \_\_\_\_\_)

Splinting: \_\_\_\_\_  
 Therapeutic Activity / Ther Ex / Transfer Training / Ergonomics / Body Mechanics / Lifting / Posture: \_\_\_\_\_

LL Laser used with: Manual Rx / NM Re-ed / Ex to facilitate: ↓ Pain / ↓ Inflammation / ↑ ROM (other) [  See Ex Flow Sheet ]  
 Aquatic Therapy: \_\_\_\_\_  
 Re-assess / Other: \_\_\_\_\_

Teaching record:

Content	Learner (circle)	Teaching Method	Barriers (circle)
1. Benefit of ther ex	PT / Spouse / Partner Friend / Caregiver Family Member	Demonstration / Reinforcement Handout / R / Reinforcement	Hearing / Vision Language - Interpreter present: Y / N Memory / Attention Admission Span
2.	Ready to Learn: <input checked="" type="checkbox"/> Y / N	Demonstrates / Verbalizes / N With / without verbal assistance With / without physical assistance Needs reinforcement	
3. <input type="checkbox"/> Reviewed HEP / education			

Pre Rx: Pain (NA) / IO: No (new)  
 ROM: \_\_\_\_\_  
 Strength: \_\_\_\_\_

Post Rx: Pain (NA) / IO: No (new)  
 ROM: \_\_\_\_\_  
 Strength: \_\_\_\_\_

Other: braces, trachs, (per patient)  
 Fall Risk  
 work on ther ex + ther act prior to walking

Assessment: See initial eval.

• PT is improving / Flared / Ready to Progress  
 • Progressing towards goals: Yes: Specify goal \_\_\_\_\_  
 No: Why: ↓ HEP compliance / Slow response to Rx / PT ill / Other: \_\_\_\_\_

• Changes to Plan of Care: No / Yes: \_\_\_\_\_  
 Targets to STGs: No / Yes - New STG: \_\_\_\_\_

Plan: Next treatment to include: ther ex + ther act  
 Progress Note Due on: 10/5/10  
 See Progress / Discharge Note

Therapist: \_\_\_\_\_

# Orders / Referral

This was the referral to initiate care. Notice the date for the referral is in April of 2009 for three times a week for eight weeks.

Patient's Name: [REDACTED]

Diagnosis: LBP, limb pain, osteoarthritis

---

**Physical Therapy** *multisites*  
**Evaluation**

Please evaluate and treat

Duration & Frequency: 3x/week f (8 weeks)

---

Doctor: [REDACTED], MD

Signature: [REDACTED]

Date: 4/13/09

Note frequency is for 8 weeks

# Evaluation Plan of Care

This is the initial evaluation.

## Physical Therapy Assessment

Patient's Name: [REDACTED] Evaluation Date: 4/3/09

Chief Complaint / Diagnosis: LBP, (R) leg pain onset: 2008

S: 79yo female c/o (R) knee, (R) hip & LBP since last great injury

PMHX: HTN, breast lumpectomy (R), Aug 2008 pt started she had cardiac ablation

Current Pain Rating: 6/10 Constant or Intermittent Sharp, aches Numbness or Tingling (R) leg & fingers

Description of Pain: walking, stand, lift

Aggravated by: Medicine

Relieved by: Retired house worker

Occupation: walking, stand, lift

Functional Limitations/ADLS: Retired house worker

O: Observation / Posture: Forward head

### Lumbar Spinal Range of Motion:

Motion	ROM	Pain Level
Flex	<u>MAX LIM</u>	<u>8/10 H/R</u>
Extension	<u>0°</u>	<u>-</u>
Rt. Rotation	<u>0°</u>	<u>++ (R) knee</u>
Lt. Rotation	<u>0°</u>	<u>+</u>
Rt. SB	<u>10°</u>	<u>-</u>
Lt. SB	<u>10°</u>	<u>-</u>

### Strength:

Motion	Left Strength	Rt Strength
Hip Flex	<u>5</u>	<u>5</u>
Knee Ext	<u>5</u>	<u>5</u>
Knee Flex	<u>5</u>	<u>5</u>
DF	<u>5</u>	<u>5</u>

Special Tests: (R) SLR (+) (L) SLR (-)  
flex leg toes (R) LG radiating pain

Palpation: \_\_\_\_\_

Gait Analysis: \_\_\_\_\_

Treatment: pt recd qms & medics to leg

Notes: \_\_\_\_\_

# Evaluation Plan of Care continued

A: Impression / Problems:  Pain  Decreased Flexibility  Decreased Strength  
 Impaired Posture  Decreased ROM  
 Unable to perform functional activities without pain  
 Other: \_\_\_\_\_

Short Term Goals (2 weeks):  
 Decreased Pain to 4/10  Improvement in flexibility  Improve posture  
 Increased strength by 1/2 grade  Full ROM with minimal pain  
 Able to perform functional activities with minimal pain  
 Other: \_\_\_\_\_

Long Term Goals (4-6 weeks):  
 Decreased Pain to 0/10  Improvement in flexibility  Improve posture  
 Increased strength to WNL  Full pain free ROM  
 Able to perform functional activities without pain  
 Other: \_\_\_\_\_

Rehab potential:  Excellent  Good  Fair  Poor  
P: Frequency / Duration: 3 X's weekly for 8 weeks  
Education: \_\_\_\_\_

Interventions:  
 Therapeutic Exercise  Therapeutic Activities  Modalities: \_\_\_\_\_  
 Neuro Re-ed / Balance  Manual Therapy  Other: \_\_\_\_\_

Comments / Treatment Provided: \_\_\_\_\_

Findings and plan of care have been reviewed with patient /caregiver with opportunities for questions/answers.  
Therapist: \_\_\_\_\_ Date: 4/3/09

Referring Physician Please Complete & Fax to 901-751-0332:

My signature below acknowledges receipt of the patient's initial evaluation and agreement with the treatment plan and goals. I certify the need for these services furnished under this treatment plan.  
MD Signature: \_\_\_\_\_ Date: 4/3/09

The short term and long term goals are generic (check boxes), with little to show the expected measurable outcomes. Check boxes simply say improve flexibility, posture and perform functional activities (not specified). The treatment plan is for three times a week for eight weeks.

# Treatment Note

This is the treatment note for the services established from the evaluation on the previous slide. The patient is still receiving services in June 2010 for the same problem. There was not a break in services, and there were no changes in goals or treatment provided.

This is the discharge note for a patient that was evaluated in January and discharged in April. It appears that the patient makes gains with the care provided. However, in the review of the documentation, most of these gains occurred within the first month of care.

## PT DAILY NOTE

Date: 6/1/10

Pt's Name: [REDACTED]

**SUBJECTIVE:** Pt seen for OPPT on this day with c/c of: pain about the same

Pt reports stiffness/tenderness/ pain to problem area(s) to be a 5 out of 10 to (B) knees.

**OBJECTIVE:** Pt. performed therapeutic ex per hip and knee strengthening  
Pt required min. assistance with exercise program

Modalities performed included:  
 IFC  INTERSEGMENTAL TRACTION  DRX  KINESIOTAPE  
 IONTOPHORESIS  INFRARED LIGHT  ANODYNE  ULTRASOUND  
 MANUAL THERAPY

**ASSESSMENT:** Pt tolerated treatment: POOR  FAIR   WELL  VERY GOOD  
 PAIN ASSESSMENT: DECREASED  INCREASED   NO CHANGE  
 ROM/ STRENGTH/ FUNCTION IMPROVEMENTS:  MILD  MODERATE  NO CHANGE  
 Comments:

**PLAN OF CARE:** Continue current POC per initial PT eval and/ or as needed to achieve goals and progress with hip and knee strengthening  
 Comments/Recommendations: Pt. does 10 reps x 2 sets of the exercises.

Treatment began April of 2009, original referral 8 weeks. Assistant provided all of the care. No change over time.

[Signature]  
Signature



# Out Patient Documentation

- One side is the billing
- The other is the treatment note
- Note the time reported
- Note the services billed

# Billing and Documentation Examples

Procedure	CPT	DIAG	QTY
Application / Education TENS	64550		
Muscle Testing (manual) w/ rpt (excl hand)	95831		
ROM Measurement w/ rpt (excl hand)	95851		
PT Initial Evaluation	97001		
PT Re-evaluation	97002		
ST Evaluation / Re-evaluation	92506		
E-Stim (Manual) (15 min)	97032		
Iontophoresis (15 min)	97033		
Contrast Bath (15 min)	97034		
Ultrasound (15 min)	97035		
Therapeutic Ex. (15 min)	97110		3
Neuromuscular Re-Education (15 min)	97112		
WP with Ther-Ex (15 min)	97113		
Gait Training (15 min)	97116		
Manual Therapy (Jt. Mob. Traction (Manual, Myofascial) (15 min)	97140		
Group Procedures	97150		
Ortho Training, Fitting, Fabricating (15 min)	97504		
Prosthetic Training (15 min)	97520		
Therapeutic/ Kinetic Activities (15min)	97530		1
ADL's (15 min)	97535		
Community /Work Reintegration (15min)	97537		
Wheel Chair Management (15 min)	97542		
Work Condition (initial 2 hrs)	97545		
Additional 1 hr.	97546		
Wound Care (selective/ equal or less 20 sq cm)	97597		
Wound Care (selective/greater than 20 sq cm)	97598		
Ext. Testing (with a written report) (15 min)	97750		
Impairment Rating Evaluation	99456		
ST Treatment of Speech Individual	92507		
ST Group, two or more individuals	92508		
ST Complex dynamic pharyngela	70371		
ST Assess of Aphasia w/interp. (PH)	96105		
ST Develop testing Limited w/interp. (PH)	96110		
ST Neurobehavioral status exam w/ interp.	96115		
<b>Modalities (indirect supervision)</b>			
Traction (Mech)	97012		
Electrical Stimulation	97014		
Paraffin Bath	97018		
Diathermy	97024		
Whirlpool TX /Fluidotherapy (dry WP)	97022		
Compression Pump	97016		
Diathermy	97024		
Resale (indicate item & price) Exercise Equip	A9300		
Other:			
Total units	Non-timed Units	Timed Units	Total Units
			40
Total time with Medicare patient			Mins. 60

**Subjective:** *Back a little better during Exercises*

**Objective:**  
5 Pain rating at rest      5 Pain rating with activity  
 A/PROM *R/SB 8090*      *L/SB 7340*

Strength \_\_\_\_\_

Functional Status Change/Other \_\_\_\_\_

**Treatment:**  
 Iontophoresis dosage \_\_\_\_\_ Fluidotherapy \_\_\_\_\_  
 Paraffin bath \_\_\_\_\_ MHP/CP \_\_\_\_\_ (location) \_\_\_\_\_  
 Ultrasound \_\_\_\_\_ w/cm2 \_\_\_\_\_ MHz (location) \_\_\_\_\_ Time \_\_\_\_\_  
 Electrical E-Stim (IEC/Rus/HV/VMS/PREMOD): \_\_\_\_\_  
 (location) \_\_\_\_\_ Time \_\_\_\_\_ with MHP/CP \_\_\_\_\_  
 Traction: \_\_\_\_\_ Cervical \_\_\_\_\_ Lumbar \_\_\_\_\_ pounds \_\_\_\_\_ on/off \_\_\_\_\_  
 Manual Therapy (Jt. Mob / Myofascial / SoftTissue) \_\_\_\_\_

*1 in. x 1.5 in. w/straps 11, 60 x 15 min*  
 Therapeutic Exercise \_\_\_\_\_ Kinetic Activities *15 min w*  
 Aquatic Therapy *45 min* See Exercise Flow Sheet   
 Other *SKTC, RSB, L/SB, RPT, LPT 1155, Mini-squat, single leg minisq plus, etc*

**Assessment:**  
 Progress Toward Goals: *tolerated to well*

Problems Remaining: \_\_\_\_\_

Other: \_\_\_\_\_

**Plan:**  
 Continue current POC as indicated  
 Modify treatment program/POC

(D/C treatment reason)  
 Re-evaluation /Progress note next visit  
 Return to M.D - Awaiting new order \_\_\_\_\_ Next M.D visit \_\_\_\_\_

Medicare	Non-Medicare
Units	Minutes
1	8 to 22
2	23 to 37
3	38 to 52
4	53 to 67

Medicare       Non Medicare

# **“Incident to” Physician/ NPP Services Documentation**

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# Treatment Note

This is an example of services provided incident to a physician / NPP. These services were provided by a PTA. PTAs do not meet the education and training requirement and therefore cannot provide services "incident to".

Date: 7/13/09

SUBJECTIVE: "about the same."

Objective: Data collected on this visit?  NO YES(see Re-eval)

Exercises:  See exercise flow sheet

Manual Therapy: \_\_\_\_\_

Modalities:  IFC  Intersegmental traction  Infrared Light

Ultrasound: \_\_\_\_\_

Anodyne: \_\_\_\_\_


Iontophoresis: \_\_\_\_\_

ASSESSMENT:  Slowly improving  Mild Improvements  Moderate improvements  No Change

Comments/New Goal: \_\_\_\_\_

PLAN OF CARE:  Con't PT  \_\_\_ more visits  Re-eval next visit  D/C to HEP

Comments: \_\_\_\_\_

 PTA  
Therapist's Signature

# Exercise Flow Sheet

## EXERCISE FLOW SHEET

NO PAIN

Patient's Name: [REDACTED]  
 Diagnosis: UHP B12 Def

Exercises	4/6	4/8	4/13	4/15	4/17	4/22	4/27	4/29/5/1	5/4	5/8	5/11	
Bike	8:2	8:2	10:2	10:3	10:3	10:3	10:3	10:3	10:3	10:3	10:3	
reach ext												
SB												
HL LTR	10	10	10	10	10	10	10	10	10	10	10	
HL crunches	10	10	10	10	10	10	10	10	10	10	10	
bridging	10	10	10	10	10	10	10	10	10	10	10	
pelvic tilts												
off UE												
head bugs												
ATLE												
Wall squats												
HS stretch	10	3x20	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	
prof. stretch												
Bike	5/15	5/18	5/22	5/27	5/29	6/1	6/4	6/5	6/8	6/10	6/17	6/19
HL LTR	10	10	10	10	10	10	10	10	10	10	10	10
HL Crunches	10	10	10	10	10	10	10	10	10	10	10	10
Bridging	10	10	10	10	10	10	10	10	10	10	10	10
HS Stretch	3x20	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30
Bike	6/22	6/24	6/26	6/29	7/1	7/6	7/8	7/10	7/13	7/15	7/17	7/20
HL LTR	10	10	10	10	10	10	10	10	10	10	10	10
HL Crunches	10	10	10	10	10	10	10	10	10	10	10	10
Bridging	10	10	10	10	10	10	10	10	10	10	10	10
HS Stretch	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30	3x30
Bike	7/27	7/2	7/31	8/3	8/7	8/11						
HL LTR	10	10	10	10	10	10						
HL Crunches	10	10	10	10	10	10						
Bridging	10	10	10	10	10	10						
HS Str.	3x20	3x30	3x30	3x30		3x30						

Does this require the skills of a therapist or can it be performed by patient or with assistance of non-therapists?

Note-treatment is from April to Aug.

# Questions

