WSI
North Dakota Workforce Safety & Insurance

Documentation Policy

Physical and Occupational Therapy Documentation

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Responsible Department: Medical Services | Reviewed Date: 11/02/2020

Introduction
Workforce Safety & Insurance (WSI) has adopted the American Physical Therapy Association's *Guidelines: Physical Therapy Documentation of Patient/Client Management* and *Guide to Physical Therapist Practice* when determining medical necessity of therapy services. The purpose of this document is to outline WSI's policy regarding the documentation of physical and occupational therapy services.

Policy
WSI will audit all therapy services based on the criteria outlined in this policy and reduce or deny reimbursement of any billed service authentic medical documentation does not support.

Documentation will vary between clinicians; however, it should support the skill of the therapist by demonstrating the clinical review, decision-making, and judgment of the therapist. Essential documentation elements should include:

- Initial Examination/Evaluation
- Visit/daily treatment
- Re-Evaluation
- Discharge
- Medical Necessity

The following provides detailed guidance on the information WSI reviews for each of the essential documentation elements listed above.

Initial Examination or Evaluation
An initial examination or evaluation is typically the first visit with the patient. WSI's expectation for this encounter is a therapy provider documents the patient's history, objective tests and measures, evaluation, diagnosis, prognosis and plan of care as detailed below.

History should, at minimum, include:

- General demographics
- Reason for referral
- Mechanism of injury
- Current condition or complaint
- Employment or type of work
- Functional status and activity level

Physical and Occupational Therapy Documentation (Continued)

Objective tests and measures may include but are not limited to the following categories:

- Inspection
- Palpation
- Range of motion
- Muscle performance
- Neurological exam
- Gait and balance
- Special tests
- Function
- Specific category applicable to the patient

Documentation of the evaluation should reflect the therapist's interpretation or assessment of the examination findings. The diagnosis should be a physical therapy diagnosis and may include impairments, limitations or restrictions as applicable. The prognosis should detail the patient's anticipated rehab potential and all contributing factors.

Plan of care should include:

- Goals, which are specific, measurable, realistically achievable, time-sensitive and functional
- Planned interventions
- Duration and frequency of visits
- Discharge plan

Visit/Daily Treatment

WSI requires documentation for every visit, which may be in the form of a daily note, treatment note or progress note. Documentation must demonstrate how the therapist is applying skilled therapy intervention and should also include the following:

- Patient self-report
- Specific interventions with description regarding frequency, intensity and/or duration as appropriate
- Flow sheets or exercise log
    - Acceptable as part of the documentation but not in lieu of it
    - If notes reference a flow sheet or exercise log, the flow sheet or exercise log must be part of the submitted documentation
- Change in impairment status
- Response to intervention
- Modification(s) to plan or intervention with rationale
- Compliance
- Communication, instruction or education
- Periodic update to goals
- Plan for ongoing intervention, e.g., progression, modification, revision

Physical and Occupational Therapy Documentation (Continued)

Re-evaluation
Re-evaluation is appropriate when there is a significant and unanticipated change (improvement or worsening) in the patient's condition, a new diagnosis that may change the plan of care, or a lapse of care for at least two weeks.

Documentation should include the updated parts of the examination such as:

- Evaluation (interpretation) of findings
- Goals, if indicated
- Plan of care

Discharge Summary
The discharge summary is necessary at the end of a treatment series and should include:

- Current physical or functional status
- Update to goals
- Discharge plan, e.g., home program, referral, recommendations

Medical Necessity
WSI determines medical necessity for a therapy service based on the patient's clinical condition using evidence-based clinical guidelines from national and state authorities. Below are the minimum elements of documentation WSI requires to establish medical necessity.

- Documentation of an office visit with the primary treating provider dated within three months of requested service. The note may be from a specialist or surgeon if therapy will be for a post-operative condition
- Current order or referral for physical or occupational therapy
- Weekly therapy notes containing the essential elements outlined in the sections above
- Documentation should demonstrate the following:
    - Deficits are present
    - Treatment is progressing the patient's condition at a faster rate than what would be probable in the absence of therapy
    - During the therapy series, rendered treatment utilizes the skills of a licensed therapist

References
American Physical Therapy Association (APTA). May 19, 2014. *APTA's Guidelines: Physical Therapy Documentation of Patient/Client Management.* Retrieved from https://www.apta.org/siteassets/pdfs/policies/guidelines-documentation-patient-client-management.pdf, last accessed 7/17/2020.

Guide to Physical Therapist Practice 3.0. Alexandria, VA: American Physical Therapy Association; 2014. Available at http://guidetoptpractice.apta.org/.