Heathcare Providers Service Organization

RISK ADVISOR

FOR PHYSICAL THERAPISTS

Documentation: Risk Management Recommendations for Physical Therapists

Documentation identifies the care or services provided and the patient's response, helping to ensure that patients receive appropriate, high-quality health care services. While it may be difficult to find time to document patient care in addition to the other clinical and administrative responsibilities of physical therapy practice, one of the physical therapist's primary professional responsibilities is to maintain consistent documentation. According to Principle 7E of the American Physical Therapy Association's *Code of Ethics for the Physical Therapist*, "Physical therapists shall… ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided."

Documentation is a tool for the planning and provision of physical therapy services, communication among providers, and demonstration of compliance with federal, state, third-party payer and other regulations. Inadequate documentation may not only impede the quality of patient care, it can also hinder the physical therapist's legal defense in the event of a malpractice lawsuit and can even lead to a physical therapy board license complaint. While some specialized settings, practice arenas, regulations and other areas may require additional types or components of documentation, the following measures can serve to lessen these exposures:

General Recommendations

- ***Every practice needs a written policy governing documentation issues, and all staff members should be trained in proper documentation practices.*** The policy should address, among other issues, healthcare information record contents, patient confidentiality and the release and retention of patient healthcare information records.
- ***Document your patient care assessments, observations, communications and actions in an objective, timely, accurate, complete, appropriate and legible manner.*** Documentation should support the treatment plan and satisfy board regulatory and third-party billing requirements. When more than one requirement applies, adhere to the most stringent policy.
- ***Accurately and contemporaneously document care given in the patient health record***. Refrain from using subjective opinions or conclusions.
- ***At minimum the record should include***:
  - Patient's chief complaint and review of current problems or symptoms.
  - Review of clinical history, including relevant social and family history.
  - Patients' acknowledgment that they agree to the treatment to be provided and are aware of the expected treatment outcome.
  - Documentation of each visit or encounter, documenting the date and time, implementation of the plan of care, changes in patient status, and progressions of specific interventions used.
  - Evaluation of the patient's wound condition, skin integrity, neurological status, and ability to perceive pain or discomfort, if applicable. Document this evaluation and convey any problems to staff.
  - Educational materials, resources, or references provided to the patient.
  - Telephone encounters (including after-hours calls), documenting the name of the person contacted, advice provided, and actions taken.
  - Encounters with healthcare providers, including those via telephone, facsimile, and email, with a summary of the discussion and any subsequent actions taken.
  - Documentation of reexaminations, including data from repeated or new examination elements, to provide useful context for evaluating progress and helping inform plans to modify or redirect interventions.
  - When indicated, document revision of goals and plan of care.
- ***Contact consulting practitioners to confirm that the consulting provider was notified of the consultation request*** and to facilitate the timely provision of the consultation and receipt of the results. Document these actions in the patient's health information record.

- ***Document, date, and authenticate services provided by physical therapy assistant(s)*** who are under direction and supervision, unless physical therapy assistants are permitted to authenticate documentation under state laws/regulations.
- ***Never alter a record for any reason or add anything to a health information record after the fact unless it is necessary for the patient's care.*** If information must be added to the record, accurately label the late entry. However, never add anything to a record for any reason after a claim has been made. If additional information related to the patient's care emerges after becoming aware of pending legal action, discuss the need for additional documentation with your manager, the organization's risk manager and/or legal counsel.

Informed Consent

Before engaging in treatments or interventions, the physical therapist must obtain the patient's informed consent, with all discussions carefully documented:

- ***At a minimum, informed consent discussions should include***:
  - Known risks and benefits of the treatment plan, alternative treatment options and the likely consequences of declining the suggested therapy
  - Disclosure of clinically indicated touching and/or potential discomfort during treatment
  - Patient's/family's questions and responses regarding the care/service plan, as well as the goals and methods of treatment
  - Repetition of important information by the patient to ensure understanding
  - Written confirmation that the patient agrees to the proposed treatment
  - Provision of pertinent patient education materials and corresponding documentation
- ***Document descriptions of patient and family healthcare education encounters***, listing the presence of specific family members and their relationship to the patient.
- ***Document an assessment of the patient's ability to comprehend and repeat information provided*** both initially and after three or more minutes have elapsed.
- ***Maintain a copy of written material provided*** and document references to standard educational tools.
- ***If the patient declines treatment recommendations and refuses care, document the informed refusal process.*** Explain to the patient the consequences and foreseeable risks of refusing treatment and ask the patient's reasons for doing so.
- ***Continue to assess the patient's condition and health status,*** update the patient on changes and needed treatment.

Non-Adherent Patients

Patient noncompliance or non-adherence can come in many forms: unwillingness to follow a course of therapy, repeated missed appointments, rejecting treatment recommendations, refusal to provide information or chronic late payments. If left unchecked, such conduct may result in litigation. Sound documentation and timely intervention are critical to limiting the consequences of defiant, recalcitrant or passive-aggressive patient behavior. For patients displaying signs of non-adherence or noncompliance document:

- ***Signs of non-adherence to the agreed-upon treatment plan***, including missed appointments, refusal to provide information, and rejection of treatment recommendations.
- ***All efforts to follow up with the patient and efforts to educate the patient about the risks of non-cooperation or non-participation with the agreed-upon treatment.*** Place a copy of any written correspondence to or from the patient in the patient healthcare information record.
- ***Counseling of noncompliant patients and/or responsible parties*** regarding the risks resulting from their failure to adhere to treatment regimens.

Documenting Discharge/Discontinuation of Care

Irrespective of the circumstances preceding the discontinuation of physical therapy interventions, to satisfy ethical and professional obligations, the treating physical therapist should document the following:

- ***An assessment of the patient's current physical/functional status.***
- ***Include copies of all pertinent correspondence*** in the patient healthcare information record.
- ***Review degree of goals achieved.*** Document reasons or rationale for any goals that were not achieved or abandoned.
- ***Any plans related to the patient's continuing care***, including any referrals for additional services, recommendations for follow-up physical therapy care, patient and/or family/caregiver training, and equipment or educational materials provided.

Record Retention

Federal and state regulations grant patients' rights protecting the confidentiality, security, integrity, and availability of their healthcare information. It is incumbent upon all healthcare professionals, including physical therapists, to properly store patient records to ensure reasonable access following patient discharge. When implementing a records retention policy, physical therapists should consider the following risk control recommendations:

- ***Implement appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of all patients' personal health information.***
- ***Retain all types of healthcare records for at least the minimum time established by state and federal laws, licensure laws and policies, and third-party contracts; whichever guideline is most stringent.*** Contact the licensure board in the state(s) where you practice for record retention guidelines.
- ***If there is no set minimum record retention period in the state(s) where you practice***:
  - Consider retaining records for a minimum of seven years for adult patients.
  - For patients receiving Medicare, Medicaid or other forms of federal assistance, retain their records for at least 10 years, since federal "false claims" actions can be brought against a healthcare provider for up to 10 years.
  - For child/adolescent patients, retain records until the time they reach the age of majority (usually age 18) plus three years (or the applicable length of time that pertains to the statute of limitations where you practice).
- ***Apply discretion and deliberation before destroying records that may be required by a court of law or licensing board***, such as any notes that could pertain to an adverse patient event.

References and Additional Resources:

- **American Physical Therapy Association (APTA): Defensible Documentation**
  This site takes a detailed look at all the elements of a patient/client visit, explaining—with illustrative examples—how best to document each element to reflect best practice and meet legal regulatory, and payer requirements.
  Visit: APTA.org/DefensibleDocumentation/
- **APTA Core Ethics Documents**
  Access the APTA's Code of ethics for the Physical Therapist, the Guide for Professional Conduct, and more.
  Visit: APTA.org/Ethics/Core/
- **HHS: HIPAA For Professionals**
  Find information about the HIPAA Rules, guidance on compliance, enforcement activities, and FAQs.
  Visit: HHS.gov/HIPAA/for-professionals/index.html
- **HPSO Healthcare Perspective: Risk Management Resources for the Healthcare Practice**
  Stay well informed on the latest risk education and practice issues that healthcare businesses confront every day. Issues of *Healthcare Perspective* cover such areas as caring for minor/adolescent patients, medical error disclosure, cyber liability, patient noncompliance, professional boundaries and more.
  Visit: HPSO.com/risk-education/businesses/perspective
- **HPSO and CNA Claim Report: Physical Therapy Professional Liability Exposures**
  HPSO and CNA's third physical therapists' liability report provides access to data for malpractice and license defense claims. By analyzing actual claim reports, HPSO provides healthcare professionals with the knowledge needed to help reduce their liability risks while improving patient outcomes.
  Visit: HPSO.com/risk-education/individuals/claims-reports

Risk Control Self-Assessment Checklist

The following abbreviated checklist, selected to focus on documentation, is designed to serve as a starting point for physical therapy professionals seeking to assess and enhance their patient safety risk control practices. For additional risk control tools and information, visit www.cna.com and www.hpso.com.

Self-Assessment Topic	Yes/No	Comments/Action Plans
Documentation		
I ensure that my clinical documentation practices comply with standards promulgated by physical therapy professional associations, state practice acts, federal guidelines and facility protocols.		
I am aware of my responsibility to authenticate patient examinations/evaluations, encounters, re-examinations, discharges and discontinuation summaries.		
I document every encounter with a patient. This includes telephone calls, emails and text messages.		
I document no-shows and cancellations.		
I correct my charting errors in accordance with my organization's policy and procedure.		
I document concurrently and make a late entry only if it is necessary for the safe continued care of the patient, ensuring that it is clearly labeled as a late entry.		
I refrain from documenting inappropriate, subjective opinions, conclusions or derogatory statements about patients, colleagues or other members of the patient care team.		
My documentation: • Is consistent with treatment plans and includes skilled services that are medically necessary. • Justifies the services billed. • Reflects established coding procedures and billing codes. • Meets federal, state and local law, as well as all applicable professional and ethical guidelines.		
I contact my manager, risk manager and/or legal department/counsel for assistance with documentation concerns or questions, especially if they may have liability or regulatory implications.		
Clinical Records		
I retain patient records in accordance with relevant state and federal law and consult state-specific recommendations issued by professional associations.		
I perform periodic audits of clinical records to identify departures from documentation standards and determine opportunities for improvement.		
I safeguard patient healthcare records from loss and/or unauthorized access.		