Guidelines for Documentation

Purpose

This document establishes the correct procedures for documentation of Rehabilitation Services involvement in each patient's case.

Audience

The information in this document is intended for all members of the Rehabilitation Services staff.

Policy

Rehabilitation Services personnel and students will adhere to departmental guidelines when documenting occupational therapy, physical therapy at UTMB. Documentation of all services will be presented in a clear, concise, complete and timely manner.

- Provide serial and legal record of a patient's condition and course of treatment from admission to discharge,
- Furnish data for use in planning patient treatment, educational experiences, research activities and reimbursement,
- Provide for means of communication with other health professionals in planning and coordinating patient care.

General Procedures

All documentation will be entered into the EMR if available.
Other records for (clinics/programs not currently in EPIC) will be legible, in black ink, signed with first initial, last name and professional designation; dated and timed using military time.

All documents will be clearly labeled for the appropriate service.

Each individual Outpatient document will contain a current encoded billing label. (Billing Sheet, Notes)

All documentation will be signed by a licensed Occupational Therapist (OTR), Certified Occupational Therapy Assistant (COTA), Physical Therapist (PT), Physical Therapist Assistant (PTA).

- PT/OT co-signature is necessary for all entries by physical and Occupational therapy students.

- Copies of patient billing sheets are kept for 1 year.
- Documentation must support billing procedure

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Orders/ Referrals

Orders are to be acknowledged within one calendar day or 24 hours of receipt.

- Response to order is documented in the EMR
- Appointments for the provision of outpatient services made within one day of receipt of an outpatient referral. If this cannot be accomplished, the reasons shall be documented on the consult.

Evaluation

Acute in-patient initial evaluation results and treatment plans will be available in the EMR within one (1) calendar day after orders are received. Specific evaluation templates are available for selected clinical areas and conditions.

- Information to be included on evaluation reports may include the following:
- Diagnosis
- History of prior therapy
- Reason for referral
- History of condition
- Prior level of function
- List of evaluation procedures administered
- Evaluation results/observations summarized as per objective area assessed
- Prognosis for restoration of function
- Pain scale
- List of problems
- List of goal statements objectively worded to reflect patient's goals and anticipated time frame
- List of treatment methods per established protocol
- Frequency and duration of expected treatment
- Documentation of family/provider involvement or absence

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Documenting Patient Progress

Progress notes document the patient response to intervention, progress towards goals, continuing treatment plans, and goals.

Notes are entered into the EMR in SOAP or narrative format.

Treatment goals addressed will refer to goals as numbered in the evaluation report and treatment plan. Progress toward each goal should be summarized.

Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the progress note. The frequency and style of outpatient progress notes will vary depending on the program; Medicare documentation guidelines will be followed.

Treatment Time and Codes

Treatment time and treatment codes are documented.
Items to be documented after each patient treatment session include the following:

- time of treatment (total treatment time and timed treatment time)
- Length of treatment session
- Evaluation and treatment provided

When more than one procedure is performed during the same visit, the time spent in each procedure shall be documented.

If therapist's attempt to see patient and patient is too ill, refuses, etc., then attempt and reason for absence of treatment shall be documented in the EMR.

Patient Education

Therapists must document all patient/family education activity in the in the Electronic Medical Record. A listing of the education provided and a description of the patient/family member's readiness to learn must be included.

Re-Evaluation

- Should include all objective measures of an initial evaluation that demonstrate change, progress or lack of progress
- Requires the same skill level as a initial evaluation
- Review and modify functional goals

- Changes in frequency and duration
- Changes to plan of care to address the findings in the re-evaluation
- Termination of services
- Must be reasonable and necessary
- Significant change in patient status, improved or declined
- Patient not responding to current treatment plan
- New clinical findings

Discharge Summaries

Discharge summaries in acute care must be written within 1 calendar day after patient is discharged. Discharge summaries in out-patient must be written within 30 days after discharge.

Documentation will contain:

- Summary of patient progress toward goals including % met/unmet and explanation of goals not met.
- Date of initiation of treatment
- Reason for treatment
- Patient status at discharge
- Reference to patient education provided
- Goals met and/or percentage of goals met by discharge
- Recommendations for aftercare
- Discharge disposition

Billing Sheets

- **All inpatient** therapists will record daily procedures on a **productivity log**. The log includes:

- Patient's full name (last name first)

- Unit history number

- Procedures billed

- **Outpatient billing sheets** must include encoded billing labels that reflect date of service and current account number.
  - Patient's diagnosis must be marked and identified on outpatient charge slips, including the ICD-9 code as well.
  - Referring physicians name and number must be completed.

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