PHYSICAL THERAPY CLAIMS STUDY

An analysis of physical therapist professional liability claims and risk management recommendations

December 1, 1993 through March 31, 2006

CNA

Physical therapists play a key role in optimizing wellness, but in the event of patient injury, they are vulnerable to professional liability claims. This study examines key physical therapy liabilities and presents practical risk management strategies that can be incorporated into clinical practice.

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INTRODUCTION

Physical therapists, also called physiotherapists, play an essential role within the healthcare team. They are responsible for the restoration, maintenance and promotion of optimal physical functioning of their patients/clients. (Both *patient* and *client* are used to denote the person receiving physical therapy services. For the purpose of this study, the term *patient* is used.)

Physical therapists offer essential services to many types of patients in a wide variety of settings. These services, treatments and interventions constitute a portion of the therapy and rehabilitation processes for patients with cardiopulmonary, integumentary, musculoskeletal and neuromuscular diseases, disorders and injuries. Physical therapists examine patients, evaluate and diagnose movement dysfunction, present a prognosis, develop a plan of care, and provide treatments and interventions. Their services may be utilized to prevent the onset of symptoms, impairments and disabilities that accompany certain diseases.

Additionally, physical therapists participate in research and play a key role in optimizing wellness, fitness and quality of life by enhancing movement, strength and physical health. Physical therapists are often called upon to assist patients in regaining the mobility and strength they need to return to work or school, as well as normal life activities, after surgery, debilitating illness or traumatic injury. As the population ages and general life expectancy increases, the demand for physical therapy continues to grow.

In the event of patient injury or other adverse outcomes, physical therapists may be as vulnerable to professional liability claims as other healthcare providers. This potential liability creates clinical, legal, financial and operational challenges for physical therapists in private practice, as well as those employed by physicians, hospitals, long term care facilities, governmental agencies and other healthcare entities. To prevent patient injury and adverse outcomes, and to minimize risk and liability, physical therapists must incorporate effective quality improvement, risk management, infection control and patient safety strategies into their clinical practice.

Physical therapists may be employees of a hospital, school, physician practice or other healthcare organization. They also may practice independently in either individual or group physical therapy practice environments. Since 1996, CNA and its marketing and administration partner, Healthcare Providers Service Organization (HPSO), have recorded the employment choices of its insureds. In 1996, 35.4 percent of CNA/HPSO-insured* physical therapists were employed by others, and 64.6 percent were self-employed. As of June 2005, 55.9 percent of CNA/HPSO-insured physical therapists were employed by others, and 44.1 percent were self-employed. As of June 2005, 77.8 percent of CNA/HPSO-insured physical therapists worked full-time and 22.2 percent worked part-time.

* In this study, all references to CNA/HPSO-insured reflect coverage of an insured issued through a CNA-affiliated underwriting company under a program sponsored by Affinity Insurance Services, Inc., utilizing the brand name of HPSO.

Our goal is to assist physical therapists and those who employ them in identifying the elements of physical therapy that carry the greatest risk. This will enable the profession to focus its risk management resources and efforts in a rational and effective way.

CNA/HPSO has provided professional liability insurance to physical therapists for more than a decade. The number of policies issued by CNA/HPSO has increased from 12,371 in 1993 to 56,971 in 2005. These numbers include both individual policies and policies issued to physical therapy firms.

This study examines the location and circumstances of the most frequent and most severe (i.e., expensive) physical therapist professional liability claims, and analyzes the general litigation environment. Our goal is to assist physical therapists and those who employ them in identifying the elements of physical therapist practice that carry the greatest risk. This will enable the physical therapy profession to focus its risk management resources and efforts in a rational and efficient way.

The financial and risk analysis portions of the claims study use CNA/HPSO-insured physical therapist claims data as a resource to identify high-risk areas for physical therapists. Relevant risk management recommendations follow. See page 8 for a description of the methodology used in the claims selection process and page 37 for an explanation of the terms used throughout the study.

THE LEGAL AND REGULATORY ENVIRONMENT

Like many other healthcare professions, physical therapy practice is subject to a variety of federal, state and local requirements. Each state has enacted professional practice acts specifically tailored either to physical therapists or to healthcare professionals as a whole. Some states also have promulgated regulations and/or guidelines relating to physical therapist licensing, practice requirements and disciplinary procedures. In addition, the American Physical Therapy Association has established educational requirements, standards of practice, standards of professional conduct and a Code of Ethics for its members.

There are differing interpretations as to whether state practice acts grant healthcare professionals the same recognition and legal status as do medical practice acts.[1] Some states have separate practice acts for selected professions and not for others. Such designations become important when determining whether the physical therapist is subject to professional liability malpractice litigation. In Louisiana, for example, physical therapists are categorized as "healthcare providers," meaning they are subject to the same tort rules as all other "healthcare providers." Therefore, all physical therapists should be conversant with the applicable state-specific practice act or other regulations governing their practice.

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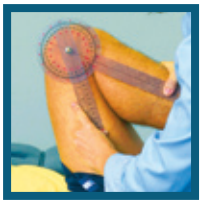

The purpose of healthcare professional practice acts is to recognize and enforce the individual profession's scope of practice in order to ensure that healthcare services are rendered by suitably licensed and/or certified and qualified professionals. These laws also enable the various health professions to define their areas of expertise, as delineated in state scope of practice statutes. The defined area of expertise may be especially important when the practice acts of two or more health professions overlap.[2] In general, licensure as set forth in practice acts establishes professional standards, elevates the profession's image and addresses public interest in quality control.[3]

Scope of Practice

The Centers for Medicare and Medicaid Services (CMS) has created Conditions of Participation that healthcare organizations/professionals must fulfill in order to participate in the Medicare and Medicaid programs. The Conditions of Participation represent the minimal health and safety standards necessary to maintain the quality of care and protect the health and safety of Medicare and Medicaid beneficiaries. In order to be certified under these public programs, certain designated healthcare organizations/professionals must meet these standards.

1. Hilliard & Johnson, supra at 248.
2. Hilliard & Johnson, supra at 250.
3. Id.

The Conditions of Participation for physical therapists are found in the *Code of Federal Regulations*; Title 42: Public Health – Part 485 Conditions of Participation: Specialized Providers; Subpart H – Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services.

Under 485.711 of Conditions of Participation: Plan of Care and Physician Involvement, a written plan of care for patients in need of outpatient physical therapy is required. This plan of care is established by a physician or by the physical therapist who furnishes the services. The plan of care anticipates goals and specifies type, amount, frequency and duration of services. This plan and the results of treatment are reviewed by the physician or the individual who established the plan at least as often as the patient's condition requires. If there is an attending physician, the physical therapist must promptly notify the physician of any change in the patient's condition or in the plan of care.

The physical therapist's specified scope of practice is critical to determine whether liability may attach or the potential allegations that may result in malpractice litigation. It also forms the context within which a court will determine whether negligent conduct occurred and whether the physical therapist acted within the scope of practice. This framework enables a jury to decide whether the physical therapist adhered to or breached the standard of a reasonable and prudent physical therapist in the same or similar circumstances in a specific liability claim.

Along with describing the clinical practices that may or may not be performed, the scope of practice for physical therapists typically defines the educational background, clinical experience and collaborative activities with other healthcare professionals that are necessary for licensure. Different states may have differing scope of practice regulations regarding access to physical therapist care and treatment. In the majority of states, patients are free to access physical therapists directly. The remaining states require the physical therapist to treat patients pursuant to an order from a physician or other licensed independent provider, such as a nurse practitioner or physician assistant.

Under the prevailing legal view, only physicians "diagnose" and "treat" patients.[4] By contrast, non-physician healthcare providers (including physical therapists) perform other specified functions within their scope of practice.[5] In California, for example, the physical therapy practice act states that a "physical therapist may not diagnose diseases, prescribe medications, or practice medicine, surgery or any other form of healing except as specifically authorized."[6]

The American Physical Therapy Association defines "diagnosis" more broadly, as both a process and a label. The diagnostic process requires the integration of known data with examination findings to accurately describe the patient's condition. This description guides the prognosis, the plan of care and the intervention strategies.

Physical therapists use "diagnostic labels to identify the impact of a condition on function at the level of the system (especially the movement system) and at the level of the whole person."[7]

4. Hilliard & Johnson, supra at 251.
5. Id.
6. 36 pt1 Cal. Jur. 3d Healing Arts and Institutions Section 150.
7. Physical Therapist Practice – Second Edition, revised 2003.

Relevant Case Law

Recent cases illustrate that the same rules governing the determination of liability for injuries sustained by a patient while undergoing physical therapy treatment also may apply in medical malpractice cases. Consequently, in an action to recover damages for injuries suffered in the course of a physical therapy procedure, predicated primarily on the alleged negligence of a physical therapist, the courts tend to apply the rules applicable in medical malpractice cases. Thus, judicial decisions recognize that such cases require expert testimony to establish the standard of care or skill ordinarily exercised in the practice of the defendant's profession. However, expert testimony is not necessary to prove negligence in non-technical matters (i.e., areas within the common knowledge of ordinary persons) or where the lack of skill is so obvious as to render that testimony superfluous.[8] The following three cases demonstrate some of the issues that may arise in adjudicating physical therapy lawsuits:

Richey v. Turocy. The lawsuit was brought against the hospital, defendant orthopedic surgeon and the physical therapist. The plaintiff alleged that the defendant's physical therapy treatment caused a subsequent heart attack. The defendant hospital maintained that the defendant physical therapist was experienced, properly trained and should not be expected to make a referral outside the scope of the therapy. The verdict was rendered in favor of all defendants.[9]

Carlos v. CNA Insurance Company. The plaintiff was unable to provide a causal connection between the acts of the physical therapist and the plaintiff's alleged injuries. The court went on to indicate that "although this is a medical malpractice suit, none of the parties mentions a medical review panel. We are unable to determine whether the Medical Malpractice Act applies in this case, because we cannot determine whether the defendants were qualified for the status of healthcare providers under the Act. If not, it is unclear whether the burden of proof set forth in La.R.S. would apply. A healthcare provider who fails to qualify under the Medical Malpractice Act is not covered by its provisions and is subject to liability under the law without regard to the Act's provisions, except for the provisions with respect to the suspension and running of prescription of actions." In this case, however, the applicable standard of care became immaterial, because the defense presented uncontroverted medical evidence that the alleged acts of the defendant were not the cause of plaintiff's injuries and subsequent surgery.[10]

Henry v. Williams. The court determined that the conduct of physical therapists does not fall within the Louisiana Medical Malpractice Act. Therefore, as in any negligence action, a patient alleging physical therapist malpractice must prove that the therapist owed a duty to protect against the risk involved, that the therapist breached that duty, that the patient suffered an injury, and that the therapist's actions were a substantial cause in fact of the injury.[11]

8. 53 A.L.R. 3.d 1250.
9. Richey v. Turocy 1990 WL 1229313, 8 Pa. J.V.R.A. 10:2 (1990).
10. Chad Carlos and Angela H. Carlos v. CNA Insurance Company, Bryan M. Soulie and River Region. Rehab, L.L.C., 900 So.2d 146, (La.App. 5 Cir. 3/1/05).
11. Lenny Grace Henry v. Jennifer Balridge Williams, et al, 892 So.2d 765 (La. App. 2 Cir. 1/26/05).

Current case law shows that in the absence of a uniform practice act, a physical therapist defending against a negligence claim remains subject to the standard of care required of every healthcare provider in rendering professional services. Specifically, the physical therapist must exercise that degree of skill ordinarily employed, under similar circumstances, by the members of one's profession in good standing in the same community or locality. In addition, reasonable care and diligence, along with one's best judgment, must be exercised in the application of his/her skill.[12]

If a physical therapist exceeds the scope of practice authorized by the governing state practice act, both the relevant professional licensing board and the state medical board may investigate and dispense discipline. In such cases, the physical therapist may also confront allegations of the unauthorized practice of medicine.[13]

Litigation

To ensure quality care, physical therapists should develop constructive relationships with other professionals caring for the same patient. Such positive relationships are also important should these professionals become co-defendants in professional liability litigation. Adversarial relationships with other providers ultimately may impede an effective defense.

In addition, physical therapists should be insured at appropriate limits of liability through their professional liability insurance policies. If they are named as co-defendants in professional liability litigation, such coverage is intended to provide an adequate level of protection for potential liability exposure. To that end, physical therapists also should be cognizant of the applicable terms and conditions pertaining to legal defense in their professional liability insurance policies.

Conclusion

The clinical practice of "physical therapists" is not uniformly defined under state scope of practice acts. In some states, the provision of "physical therapy" may include healthcare activities that fall outside the scope of physical rehabilitation, such as wound care, cardiopulmonary intervention, preventive interventions and patient education, among many other activities. In general, state physical therapy practice acts serve as the best source of information regarding applicable guidelines. In the absence of designated guidelines set forth in applicable practice acts, physical therapists can gain additional protection from liability exposure by adhering to a prudent standard of care.

12. Carlos, 900 So.2d 146.
13. Hilliard & Johnson, supra at 251.

REVIEW AND DISCUSSION OF CLAIMS DATA

Database and Methodology

The Financial Analysis section of this study utilizes a database of 2,736 open and closed claims brought against CNA/HPSO-insured physical therapists between January 1, 1993 and March 31, 2006. (The database includes claims brought against physical therapy assistants or physical therapist students if they were under the supervision or covered under the policy of a CNA/HPSO-insured physical therapist.) The Risk Analysis section applies additional exclusion criteria to the original database, which eliminated 1,272 claims. Claims were excluded from the Risk Analysis section for the following reasons:

- The event was an incident only and the adverse event or injury occurred but did not result in a formal legal claim.
- The closed claim did not result in expense or indemnity payment of any kind.
- Deposition assistance was the only service provided to the physical therapist.
- Legal assistance for protection of the physical therapist's license was the only service provided.
- Physical therapist was ultimately dismissed from the legal action.
- No physical therapist liability coverage was provided by CNA/HPSO, either because another entity elected to provide a joint defense among all named parties including the CNA/HPSO-insured party(ies), or because coverage was declined due to policy conditions.

Of the 1,464 claims examined in the study, 1,117 were closed and 347 remain open. A total of $43,367,287 in indemnity and expenses has been paid for the closed claims. The sum of $13,326,657 is currently reserved for the open claims, and about $3 million has been paid for associated expenses.

After exclusion criteria were applied, 1,464 open and closed physical therapist claims were retained in the study. In a small number of the claims included in the final database, it could not be determined whether the named party was a physical therapist or physical therapy assistant. In 0.08 percent of the cases included in the database, the physical therapy assistant was a named party, but the physical therapist was ultimately responsible for supervision of that assistant. Six claims involved a physical therapist student, but again, the physical therapist was responsible for supervision. For these reasons, this study refers to all claims retained in the final database as physical therapist claims.

Any conclusions drawn from this study should take into account the inherent limitations of the database:

- The database includes only CNA/HPSO-insured physical therapists, which may not necessarily represent the entire spectrum of physical therapists insured elsewhere.
- Noted indemnity and expense payments are only those paid by CNA on behalf of its insured physical therapists and do not represent amounts paid by other insurers, non-CNA/HPSO defendants, or by the insureds or other third parties in the form of deductibles or self-insured retentions. In addition, they do not include other types of professionals covered by CNA who may also be included in the claim.
- CNA/HPSO coverage is provided on an "occurrence" basis, which means that claims may occur, be reported and resolved over a period of years. Therefore, the data do not directly correlate the number of insured physical therapists to the number of paid claims for any given policy or loss year. However, the number of insured physical therapists and the overall frequency and severity of claims have all increased over the years covered by this study.

Claim Status

Claim status refers to whether the claim is open (i.e., pending or active) or closed (via a settlement, judgment/award, dismissal, etc.). Of the 1,464 claims remaining in the study, 1,117 were closed and 347 remain open. The status of claims becomes important when determining patterns and/or trends related to claim frequency and severity.

Open claims are assigned an indemnity reserve amount. That reserve is based upon the projected indemnity payment that claim experts estimate will be required to resolve the claim by either settlement or judgment. Reserves are adjusted up or down as the claim investigation and management process develops.

The retained 1,464 claims fall into one of three categories:

- Closed with indemnity payment (708)
- Closed with expense payment only, no indemnity payment (409)
- Open/pending claims (347)

Table 1 reflects the number of open and closed claims of each type, the amount of indemnity and/or expense that has been paid for each status type, and the amount of indemnity reserves for the open claims.

Closed claims – A total of $43,367,287 has been paid for indemnity and expense payments related to the included closed claims.

Open claims – In addition to the $13,326,657 currently reserved for the 347 open claims, expenses ($3,028,620) have been paid to date for the investigation and management of these open claims. Indemnity monies of $307,400 have also been paid, although the claims remain open. This may indicate one or more of the following:

- A component of the indemnity payment – such as medical costs – has been paid, but the claim has not been fully resolved.
- One or more open claims are nearing resolution, and partial indemnity payment has been made.
- The claims examiner has not yet completed the claim closure procedure, although indemnity settlement/judgment monies have been paid.

1 Claims by Claim Status

Claim Status Type	Number of open and closed claims	Total paid indemnity	Total paid expense	Total reserves
Closed with indemnity payment	708	$28,218,934	$9,376,230	$0
Closed with expense only	409	$0	$5,772,123	$0
Total Closed Claims	**1,117**	**$28,218,934**	**$15,148,353**	**$0**
Total Open Claims	**347**	**$307,400**	**$3,028,620**	**$13,326,657**
Total	**1,464**	**$28,526,334**	**$18,176,973**	**$13,326,657**

Use of the Category "Unknown"

In each of the tables and analysis sections within the study, there may be a category of "Unknown" claims. Some data elements of a claim may be present while other elements are unknown. For example, it may be known that the claim involves a physical therapy injury to a child, but not known if the injury occurred at school, home, a physical therapy office, etc. Here are some additional reasons why a claim might be missing data and be classified as "Unknown":

- The insured has not identified the information in an open claim report.
- The claim was settled or otherwise closed before the data element was collected.
- The data element could not be determined during the investigation and the analysis of the claim, or is otherwise in dispute.
- Multiple choices for a particular aspect of the claim (for example, multiple providers, multiple locations and/or multiple injuries) were involved in the patient's physical therapy care and the definite location, injury, allegation, etc. have not yet been determined.

This study includes the unknown or unclassified claim elements in each table in order to maintain consistent claim counts and to account for monies spent on these claims.

Reserve amounts of open claims are adjusted up or down

as the claim investigation and management process develops.

ULTIMATE FREQUENCY AND SEVERITY OF CLAIMS BY YEAR OF LOSS

Financial Analysis

The most statistically revealing type of claim financial analysis involves sophisticated actuarial calculations known as *ultimate loss projections*. Ultimate loss projections are based on historical patterns. Ultimate losses represent reported losses to date plus a provision for future loss development.

To establish the ultimate loss information for the CNA/HPSO-insured physical therapist claims database, the actuarial ultimate loss projection process was applied to the database of 2,736 claims brought against CNA/HPSO-insured physical therapists between January 1, 1993 and March 31, 2006. Of the claims that occurred between 1995 and 2004, 713 are actuarially projected to ultimately result in an indemnity payment.

The ultimate total paid indemnity column in Table 2A refers to the projected amount of indemnity monies that will be paid for the total number of claims projected to close with indemnity payments in a specific loss year. For purposes of this table, and for the overall physical therapist claims study, this column is the most predictive figure in projecting severity. The actuarial projection considers future development. However, as no model can predict claim settlement amounts with absolute accuracy and precision, ultimate values may increase or decrease. The first loss year in the table is 1995 rather than 1993, based on the minimal loss incurred for the first two years of the physical therapist insurance program.

The data in Table 2A indicate that the frequency of claims with indemnity payments increased between 1996 and 2004. The increase in frequency is attributed to the increased number of physical therapists insured by CNA/HPSO during this period. Using the ultimate average paid indemnity as the measure of severity, the projected average paid indemnity has increased approximately 8 percent per year based on a statistical regression.

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2A Ultimate Frequency and Severity of Claims by Year of Loss - Indemnity

Loss Year	Number of claims with ultimate incurred indemnity	Ultimate total paid indemnity	Ultimate average paid indemnity
1995	59	$1,796,652	$30,452
1996	41	$1,130,408	$27,571
1997	59	$2,958,215	$50,139
1998	46	$3,892,490	$84,619
1999	58	$2,793,768	$48,168
2000	74	$3,900,000	$52,703
2001	74	$5,000,000	$67,568
2002	83	$5,600,000	$67,470
2003	100	$7,500,000	$75,000
2004	119	$6,500,000	$54,480

2B Ultimate Frequency and Severity of Claims by Year of Loss - Expense

Loss Year	Number of claims with ultimate paid expense	Ultimate total paid expense	Ultimate average paid expense
1995	65	$972,359	$14,878
1996	69	$1,408,957	$20,353
1997	86	$1,988,620	$23,122
1998	81	$1,599,359	$19,730
1999	85	$1,878,624	$22,090
2000	116	$1,970,000	$16,966
2001	112	$2,750,000	$24,550
2002	120	$2,600,000	$21,710
2003	135	$2,850,000	$21,046
2004	128	$2,650,000	$20,763

Although data for losses occurring during calendar years 2005 through March 31, 2006 were collected and used in the Risk Analysis portion of this study, those data were excluded from the Financial Analysis because they were considered statistically too immature for this type of actuarial projection.

RISK ANALYSIS OF PHYSICAL THERAPIST CLAIMS

Analysis of Severity by Year Claim Closed

CNA/HPSO provides professional liability insurance to physical therapists on an occurrence coverage basis. Occurrence coverage protects the physical therapist against any claim that occurs during the year the policy is in effect, regardless of when the claim is reported. Claims are posted to the policy year in which they occur, not when they are reported or resolved. Loss experience for occurrence policies continues to develop over time as claims are reported, investigated and resolved. For purposes of this section of the study, however, claim data are analyzed by the year the claim closed. This methodology permits the study to reflect the loss experience of a specific calendar year.

Table 3 displays the number of firm-based and individual policies issued by CNA for each year. It also reflects the number of closed claims with indemnity and/or expense payments that closed in each policy year. The table shows the total amount of indemnity and expense that were paid for claims that closed in each year.

The year a claim closes is usually different from the year the policy was issued. Additionally, firm policies cover more than one individual. Therefore, the number of policies issued in a given year cannot be directly correlated with the information about claims closing in that year.

As illustrated in Table 3, the number of policies increased each year. With few exceptions, the number of closed claims and the related total incurred (indemnity plus expenses) have increased each year.

Insurance premiums for physical therapists vary depending on their type of employment, whether they are in solo practice or part of a large or small firm, and whether they work full-time or part-time. For purposes of this study, we utilize an overall average premium that considers all physical therapists insured within the CNA/HPSO program. When considering the impact of the total incurred monies paid in relation to premium paid to fund these losses, it is notable that the average premium for a physical therapist in 2005 was $348 per year. In contrast, the average paid indemnity for all closed CNA/HPSO physical therapists claims that included an indemnity payment was $39,857.

Frequency and severity of physical therapist claims is a concern to both insureds and payers in light of the modest average premium collected. Whether self-employed or employed by a hospital, physical therapy corporation, or other entity, physical therapists must become proficient in assessing and managing risk, and ensuring quality patient care in a safe environment within their practices.

The average insurance premium for a physical therapist in 2005 was $348 per year. In contrast, the average paid indemnity for all closed CNA/HPSO physical therapist claims that included an indemnity payment was $39,857.

3 Closed Claims by Year Claim Closed

Year Claim Closed	Number of policies in effect for individuals and firms each year	Number of closed claims with indemnity and/or expense payment	Total incurred (indemnity and expenses)
1993	12,371	1	$2,512
1994	18,839	6	$57,855
1995	21,861	25	$831,886
1996	25,865	18	$282,239
1997	29,783	43	$743,433
1998	31,824	58	$2,193,072
1999	34,572	105	$3,178,561
2000	39,274	78	$2,775,801
2001	43,516	133	$4,403,284
2002	47,944	130	$4,543,978
2003	51,395	141	$6,516,225
2004*	55,142	181	$9,377,085
2005*	56,971	162	$6,811,940
Total		**1,117**	**$43,367,287**

* Experience continues to mature in these years, and the number of claims with expense or indemnity payments and the total incurred are likely to increase.

Analysis of Claim Frequency and Severity by State

At least one physical therapist claim was reported in every state. California, New York, Florida, Texas, Pennsylvania, Louisiana, Illinois and New Jersey combined had the highest overall frequency of claims, accounting for 903 open and closed claims, or approximately 61 percent of the 1,464 open and closed claims included in the study. New York and California alone had 32 percent of these 1,464 claims.

4A Frequency of Open and Closed Claims by State

Loss state	Number of open and closed claims	Percent of 1,464 open and closed claims
CA	236	16%
NY	227	16%
FL	93	6%
TX	89	6%
PA	75	5%
LA	72	5%
IL	62	4%
NJ	49	3%

Table 4A reflects the eight states with the greatest frequency of open and closed reported physical therapist claims.

As noted in the discussion of Table 4A, each state experienced at least one reported claim. However, the claims reported in three states (Delaware, North Dakota and Vermont) did not involve an indemnity payment and are, therefore, excluded from Table 4B.

The average paid indemnity for each state's closed claims is reflected in Table 4B. In addition, the overall average paid indemnity for all states (average paid indemnity for those CNA/HPSO-insured physical therapist claims that closed with an indemnity payment) was calculated at $39,857. Sixteen states had an average paid indemnity that was more severe than the overall state average of $39,857.

When considering claim severity by state, it is important to note the total number of closed claims with an indemnity payment. For example, the District of Columbia experienced only two closed claims with indemnity payments, one of which was resolved for $400,000 and the other for $40,000, resulting in an average indemnity payment of $220,000. Based on only two claims, the calculated average is not predictive that a paid physical therapist claim in the District of Columbia will have an indemnity payment in the range of $220,000. However, because New York had 107 claims that closed with an indemnity payment, the average indemnity payment of $37,066 demonstrates higher predictive value.

4B Severity by State

Loss state	Number of closed claims with indemnity payment	Average paid indemnity (closed claims)
DC	2	$220,000
MT	5	$157,249
MO	12	$142,529
KS	4	$137,500
CO	8	$120,628
GA	14	$84,679
AL	6	$82,278
IN	8	$66,963
PA	34	$64,447
NV	7	$56,957
MI	17	$54,108
AK	2	$50,362
KY	11	$47,707
MN	5	$43,632
MA	11	$43,227
VA	9	$41,721
NY	107	$37,066
FL	47	$36,788
TX	36	$35,294
OK	4	$33,250
NJ	29	$31,720
MD	13	$31,496
CA	129	$30,340
AR	1	$30,000
WA	10	$29,424
OH	11	$28,625
AZ	16	$28,322
LA	28	$27,978
MS	5	$27,895
NC	8	$23,625
UT	10	$23,011
TN	7	$21,250
IA	6	$19,378
WV	5	$18,620
NH	4	$17,500
IL	22	$17,337
ID	5	$17,175
CT	14	$16,644
WI	6	$14,671
RI	3	$14,667
SC	6	$14,108
OR	10	$13,697
NM	2	$12,250
HI	2	$10,994
SD	2	$10,306
WY	2	$6,877
ME	1	$3,500
PR	1	$3,000
NE	1	$2,500
Total	**708**	

Analysis of Frequency and Severity by Location of Claim Occurrence

The majority of claims (77 percent) occurred at non-hospital physical therapy offices or clinics. This is consistent with the trend among physical therapists providing more services outside of hospital and physician office practice settings.

5A Frequency by Location

Location	Number of open and closed claims	Percent of open and closed claims
Physical therapy office/clinic (non-hospital)	1,122	77%
Patient home	96	7%
Unknown	92	6%
Nursing home	42	3%
Hospital physical therapy area	34	2%
School	30	2%
Hospital inpatient room	22	1%
Physician office or private clinic	15	<1%
Hospital outpatient area	6	<1%
Hospital ambulatory therapy	4	<1%
Industrial health site	1	<1%
Total	**1,464**	**100%**

While most (77 percent) closed claims with an indemnity payment occurred at non-hospital physical therapy offices or clinics, the most severe closed claims occurred in nursing homes, with an average paid indemnity of $76,215.

While the majority (77 percent) of closed claims with an indemnity payment occurred at non-hospital physical therapy offices or clinics (see Table 5A), the most severe closed claims occurred in nursing homes. In that setting (as noted in Table 5B), the average paid indemnity was $76,215. Claims occurring in industrial health settings, schools, hospital inpatient rooms and patient homes were also, on average, more severe than were paid claims as a whole ($39,857).

5B Severity by Location

Location claim occurred	Number of closed claims with indemnity payment	Percent of closed claims with indemnity payment	Average paid indemnity
Nursing home	18	3%	$76,215
Industrial health site	1	<1%	$75,000
School	17	2%	$65,109
Hospital inpatient room	9	1%	$56,383
Patient home	55	8%	$49,467
Hospital physical therapy area	11	1%	$47,698
Physical therapy office/clinic (non-hospital)	543	77%	$37,948
Physician private office or clinic	7	<1%	$25,110
Unknown	41	6%	$25,086
Hospital outpatient area	4	<1%	$24,316
Hospital ambulatory therapy	2	<1%	$2,642
Total	**708**	**100%**	

Analysis of Frequency and Severity by Primary Injury

Fractures and burns accounted for 45 percent of the closed claims with indemnity payment. Delay in recovery accounted for 11 percent. No other category of injury is associated with more than 9 percent of the open and closed claims.

6A Frequency by Primary Injury

Primary injury	Number of open and closed claims	Percentage of open and closed claims
Trauma including fractures	390	27%
Burns	263	18%
Delay in recovery	166	11%
Additional procedure required	132	9%
Injury not specified	85	6%
Loss of limb or use of limb	84	6%
Abrasion/irritation/laceration	78	5%
Emotional distress (as primary injury)	56	4%
Unknown	42	3%
Bruise or contusion	34	2%
Sprain/strain	29	2%
Neurological related	27	2%
Cracked/broken teeth	17	1%
Death from disease	15	1%
Infection	9	1%
Brain damage and/or paralysis	8	1%
Death from trauma	6	<1%
No injury	6	<1%
Personal injury – e.g., slip and fall, hit by object, etc.	5	<1%
Death not otherwise classified	3	<1%
Loss of organ or organ function	3	<1%
Suicide	3	<1%
Addiction	2	<1%
Cardiopulmonary arrest	1	<1%
Total	**1,464**	**100%**

The most severe primary injuries were loss of an organ or loss of the use of an organ, which involved two claims. These two claims alleged the loss of an eye ($474,000), and loss of function of an unspecified organ ($106,000). Brain damage was the second most severe category, representing only one claim. Unexpected deaths and deaths from trauma were also severe. However, they cannot be considered predictive due to the relatively small number of claims.

6B Severity by Primary Injury

Primary Injury	Number of closed claims	Average paid indemnity
Loss of organ or organ function	2	$235,000
Brain damage and/or paralysis	1	$200,000
Death from trauma	4	$198,563
Neurological related	20	$159,350
Death from disease	6	$102,729
Loss of limb or use of limb	50	$76,423
Trauma including fractures	181	$45,261
Infection	3	$39,583
Personal injury – e.g., slip and fall, hit by object, etc.	3	$37,500
Additional procedure required	52	$35,971
Suicide	3	$33,750
Emotional distress (as primary injury)	31	$33,409
Unknown	25	$31,437
Burns	189	$25,155
Delay in recovery	43	$22,711
Injury not specified	20	$16,923
Abrasion/irritation/laceration	36	$13,774
Sprain/strain	10	$13,149
Bruise or contusion	12	$8,266
Cracked/broken teeth	13	$7,835
Addiction	1	$4,800
No injury	3	$3,558
Total	**708**	

Analysis of Closed Claims by Injury Outcome

Claims with permanent total disability had the greatest severity. Permanent injuries are likely to generate ongoing costs to support the needs of disabled claimants. Death claims had the next highest severity.

7 Severity of Injury Outcome

Injury Outcome	Number of closed claims with indemnity payment	Percent of closed claims with paid indemnity	Average paid indemnity
Permanent total disability	11	2%	$256,318
Death	10	2%	$126,063
Permanent partial disability	86	12%	$77,484
Temporary total disability	88	12%	$63,127
Outcome unknown	76	11%	$57,473
No injury	31	4%	$30,606
Temporary partial disability	400	56%	$16,375
Severity unknown	6	1%	$8,885
Total	**708**	**100%**	

Analysis of Frequency and Severity by Primary Allegation

The most frequent allegations were failure to supervise treatment or procedure, injury during manipulation, improper technique, and injury during heat therapy or hot packs.

8A Frequency by Primary Allegation

Primary Allegation	Number of open and closed claims	Percent of open and closed claims
Failure to supervise treatment/procedure	223	15%
Injury during manipulation	166	11%
Improper technique	160	11%
Injury during heat therapy or hot packs	152	10%
Injury during resistance exercise or stretching	102	7%
Allegation unknown	75	5%
Failure to monitor patient	69	5%
Improper management of course of treatment	66	5%
Injury during electrotherapy	66	5%
Inappropriate behavior by clinician*	55	4%
Improper use of equipment	37	3%
Equipment malfunction or failure	34	3%
Improper performance of test	32	3%
Injury during passive range of motion	21	<2%
Improper positioning	19	<2%
Failure to refer/seek consultation	18	<2%
Injury from cold packs/ice massage	16	<2%
Injury during connective tissue manipulation or massage	14	<1%
Failure to report patient's condition	13	<1%
Injury during traction	13	<1%
Iontophoresis related	12	<1%
Provider functioning outside accepted scope of practice	12	<1%
Failure to complete proper patient assessment	10	<1%
Injury during endurance activities**	9	<1%
Injury during gait or elevation training	9	<1%
Injury during active resistance or assistive range of motion exercises	8	<1%
Failure to maintain proper infection control	7	<1%
Premature discharge or abandonment	6	<1%
Failure to respond to patient	6	<1%
Patient injured while carrying out self-care treatment plan	5	<1%
Unnecessary treatment	4	<1%
Failure to follow established policy	4	<1%
Improper maintenance of equipment	3	<1%
Failure to diagnose	2	<1%
Failure to properly test equipment	2	<1%
Injury during aquatic exercise	2	<1%
Lack of informed consent	2	<1%
Retained foreign body	1	<1%
Improper management of surgical patient	1	<1%
Wrong medication administered	1	<1%
Failure to treat	1	<1%
Delay in treatment	1	<1%
Breach of confidentiality or privacy	1	<1%
Inadequate record keeping/documentation	1	<1%
Hydrotherapy-related	1	<1%
Injury during training for assistive devices or equipment***	1	<1%
Improper/inadequate pain management	1	<1%
Total	**1,464**	**100%**

* Including physical, sexual or emotional abuse and/or misconduct

** Including weights, treadmills, ergonomics, etc.

*** Such as canes, crutches, walker or wheelchair

The most severe claims involved the physical therapist's alleged failure to report the patient's condition to a physician or other licensed practitioner responsible for the patient's overall medical care.

The most severe claims involved the physical therapist's alleged failure to report the patient's condition to a physician or other licensed independent practitioner responsible for the patient's overall medical care. Allegations of failure to complete a proper patient assessment, failure to refer the patient and/or seek a consultation, and failure to follow established policy are also among the claims with the highest severity. Each of these allegations relates to the physical therapist's responsibility to properly assess patients. The allegations also relate to the responsibility to communicate with physicians and other healthcare professionals regarding patients' symptoms and clinical issues outside the physical therapist's scope of practice. A second category of high-severity allegations relates to the therapist's failure to prevent injuries from occurring during the patient's treatment/intervention programs.

Another allegation of interest relates to inappropriate behavior on the part of the physical therapist. Physical therapy treatment frequently requires touching the patient. Unless the physical therapist thoroughly explains the exact steps involved in the planned treatment/interventions, as well as the reasons for these steps, patients may misconstrue therapeutic touch as inappropriate.

Unless the physical therapist thoroughly explains the exact steps involved in the planned treatment/interventions, as well as the reasons for these steps, the patient may misconstrue therapeutic touch as inappropriate.

8B Severity by Primary Allegation

Primary Allegation	Number of closed claims with indemnity payment	Percent of closed claims with paid indemnity	Average paid indemnity
Failure to report patient's condition	5	<1%	$277,425
Failure to complete proper patient assessment	6	<1%	$178,919
Failure to follow established policy	3	<1%	$153,750
Retained foreign body	1	<1%	$112,500
Improper positioning	7	<1%	$95,357
Failure to refer/seek consultation	7	<1%	$90,607
Injury during active resistance/assistive range of motion exercises	4	<1%	$89,938
Injury during gait or elevation training	6	<1%	$88,667
Provider functioning outside accepted scope of practice	8	<2%	$81,063
Injury during training for assistive devices or equipment*	1	<1%	$65,000
Improper technique	61	9%	$58,874
Improper management of course of treatment	15	2%	$57,957
Improper use of equipment	20	3%	$55,863
Injury during manipulation	61	9%	$41,882
Inappropriate behavior by clinician**	33	4%	$40,520
Delay in treatment	1	<1%	$40,000
Injury during resistance exercise or stretching	43	6%	$37,480
Patient injured while carrying out self-care treatment plan	4	<1%	$35,875
Failure to supervise treatment/procedure	123	17%	$34,036
Injury during passive range of motion	10	<2%	$31,623
Failure to properly test equipment	1	<1%	$31,000
Injury during heat therapy or hot packs	102	14%	$30,949
Premature discharge or abandonment	2	<1%	$30,000
Equipment malfunction or failure	14	<2%	$29,428
Allegation unknown	42	6%	$28,878
Failure to monitor patient	35	4%	$20,513
Failure to respond to patient	2	<1%	$17,250
Improper performance of test	11	<2%	$16,814
Injury from cold packs/ice massage	12	<2%	$14,531
Injury during traction	5	<1%	$12,025
Injury during electrotherapy	48	7%	$8,724
Lack of informed consent	2	<1%	$5,500
Injury during connective tissue manipulation or massage	2	<1%	$3,875
Iontophoresis related	9	<2%	$3,330
Injury during endurance activities***	2	<1%	$1,325
Total	**708**	**100%**	

* Such as canes, crutches, walker, wheelchair, etc.
** Including physical, sexual or emotional abuse and/or misconduct
*** Including weights, treadmills, ergonomics, etc.

CONCLUSION

As illustrated in this study, professional liability claims brought against physical therapists are notable. In part, this is due to the varying scope of practice for physical therapists from state to state. Therefore, it becomes more difficult to define consistent, specific standards for physical therapists' practice. Also, the demand for physical therapy services is growing as the population ages. Today's physical therapist plays an important role in delivering healthcare in a wide range of clinical settings to all age groups, using ever-evolving techniques and equipment. This expanding and changing role means increasing potential liability.

The first section of this study identified areas where physical therapists are most at risk for professional liability claims. By examining their own practices in light of these findings, physical therapists can better understand their exposures. And by concentrating their risk management efforts on areas of high claim frequency and severity, they can help reduce the likelihood of patient injury and financial loss.

The risk management recommendations outlined in the next section have been developed by risk management professionals. They focus on the areas where CNA/HPSO-insured physical therapists have historically been most vulnerable. The overall goal of these recommendations is to help physical therapists recognize the importance of risk management practices as they provide care to their patients in a safe environment.

Physical therapists will benefit from assuming a proactive risk management approach in their clinical practice. Their efforts should be coordinated with the overall risk management program implemented in their practice setting, whether hospital, long term care facility, physical therapy clinic, school or other milieu. Providing healthcare creates risks, but these risks can be mitigated if awareness of exposures is linked to a commitment to take necessary preventive action.

An analysis of physical therapist professional liability claims and risk management recommendations December 1, 1993 through March 31, 2006

RISK MANAGEMENT RECOMMENDATIONS

Quality Improvement, Risk Management, Infection Control and Patient Safety Disciplines

Whether they are in solo practice, group practice or employed by a larger entity, physical therapists must proactively incorporate quality improvement, risk management, infection control, and patient safety principles and activities into their daily practices. They must implement systems and evidence-based practices designed to enhance the quality of care provided to patients. Finally, they must routinely evaluate and adjust these systems to ensure their continuing effectiveness.

Program Development and Design

- Develop and/or maintain quality improvement, risk management, infection control and patient safety programs.
- Integrate quality improvement, risk management, infection control and patient safety functions to ensure a unified approach to identifying, assessing and managing risk.
- Actively participate in the practice/facility quality improvement, infection control, risk management and patient safety activities and committees.
- Develop physical therapy quality indicators, as well as policies and procedures, to ensure ongoing monitoring of quality of care.
- Review all accidents, incidents and adverse events, and develop and implement effective plans of correction to prevent injury and loss.
- Adhere to appropriate infection control surveillance and treatment-related protocols, and report, investigate and resolve suspected treatment-related infections.
- Utilize results of monitoring to develop and maintain a professional "custom and practice."
- Comply with established clinical and patient safety protocols, guidelines, treatment standards or critical pathways appropriate to the practice setting and/or area of clinical specialization.

Physical Environment

- Ensure a safe environment that, at a minimum, is
  - accessible to patients with various physical challenges
  - free from obstructions or undue physical dangers
  - actively working to reduce/eliminate healthcare-associated infection
  - staffed by qualified providers who are competent in the provision of physical therapy care
  - properly equipped with functioning clinical equipment for the assessment and treatment of patients
- Perform regular safety rounds and inspection of physical therapy equipment, treatment areas and physical plant to remove potential risks.
- Ensure that parking lots and external walkways have no uneven surfaces, and are well-lit, in good repair, and free of ice, snow and other risks.
- Check that treatment areas and hallways are clean, dry and free of obstacles.

Patient Safety

- Implement policies and procedures that ensure proper patient identification prior to assessment and treatment.

Human Resources

The human resource function plays a critical role in an enterprise-wide risk management program. It ensures that the physical therapist is properly screened and licensed, demonstrates proficiencies and competencies to effectively assess physical therapy treatment needs, and provides appropriate treatment/intervention in a professional and safe manner.

Screening

- Obtain a completed application for each potential employee, then check references, verify licenses and certifications, and account for time gaps in the applicant's work history.
- Do a federal criminal background check and review national sex offender lists or, at a minimum, lists from states where the applicant has worked and/or lived.
- Require that independent and contracted licensed personnel provide a copy of their certificate of professional liability insurance and update coverage verification annually.

Scope of Practice

- Require physical therapists to be conversant with their state-specific scope of practice.
- Review scope of practice statutes at least annually.
- Know and comply with all relevant federal and state regulations and requirements that define and govern a physical therapist's scope of practice.

Proficiencies and Competencies

- Provide a detailed, competency-based job description.
- Mandate demonstrations of essential skills.
- Evaluate each employee's performance initially and, at least annually, through direct observation.
- Require physical therapists to be certified in basic CPR and first aid, and to provide proof of re-certifications, as appropriate.
- Keep track of appropriate type and amount of annual continuing education credits.

Specific Clinical Risks

While all patient care and treatment involves potential risks, patients undergoing physical therapy may be at additional risk for certain types of injuries.

Burns

- Maintain ongoing awareness of the high risk of burns from several commonly used physical therapy treatments/interventions (whirlpool treatment, hot packs, paraffin, cold/ice packs, electrotherapy, etc.).
- Ensure that each of these treatments is clinically appropriate and the indication(s) for their use is/are documented in the health information record.
- Evaluate and document each patient's skin, neurological status, ability to perceive temperature/pain/discomfort, ability to communicate with staff, etc., prior to initiating the treatment and periodically throughout the course of treatment, as appropriate.
- Report any alterations in skin integrity to the clinical team and document all findings and communications in the health information record.
- Routinely monitor and log temperature of whirlpool water, hot pack warmers and paraffin tanks, etc., in accordance with facility policies and manufacturer specifications.
- Test equipment that provides electric current, hot water, hot and cold packs, etc., immediately prior to and during patient treatments.
- Closely supervise and/or monitor patients – including performing skin checks – during treatments that present a risk of burns.
- Provide more frequent monitoring of patients with altered skin integrity and/or neurological, sensory or communication deficits.

Fractures

- Assess each patient, initially and periodically, for the risk of falls that could result in fractures.
- Evaluate each patient, initially and periodically, for the risk of fractures related to physical therapy treatments and equipment use.
- Ensure correct patient positioning and secure patient placement on treatment tables and/or equipment.
- Employ an appropriate degree of force and/or resistance in treatment or intervention design, considering any additional risks related to patient diagnoses or disease processes.
- Train staff and patients in the use of equipment and have them demonstrate proper use to avoid fractures.
- Educate patients regarding the correct clothing and footwear for use during treatment/intervention.

- Prohibit patients without appropriate apparel or shoes from using equipment.
- Closely monitor patients during treatment/intervention. Respond to signs or symptoms of a possible fracture by promptly communicating with physicians regarding the need for additional medical evaluation.
- Utilize appropriate safety devices such as gait belts, floor and treatment table pads, safety belts, equipment alarms, etc.

Failure to Supervise Treatment/Procedure

- Adequately supervise each patient in order to ensure a safe therapeutic process.
- Prior to leaving the patient's side, tell the patient where you are going and for how long.
- Remain in the patient's line of vision when possible.
- Ensure adequate staffing for supervision of patients during brief absences of the assigned physical therapist.
- Schedule patients in intervals that allow for continuous supervision.
- Document supervision of patients in the progress notes of the health information record.

Perception of Inappropriate Behavior by Physical Therapists

- Provide a detailed explanation of each treatment/intervention that requires the physical therapist to touch the patient and ask the patient to repeat the description.
- Obtain and document the patient's consent or refusal to proceed with the proposed treatment/intervention.
- Maintain patient dignity by ensuring that the patient's body is appropriately covered whenever possible, exposing only the part being treated.
- When needed, have a second staff member observe therapist behavior during those treatments/procedures in which therapeutic touching could be misinterpreted as intimate touching.
- Honor patient requests for a second staff member or a family member to be present during procedures that require touching.
- Cease treatment/intervention if the patient expresses emotional discomfort or experiences the touching as inappropriate, excessive or abusive in any way.
- Reassure patients by giving them the opportunity to ask additional questions regarding the treatment, make a complaint, request another therapist, etc.
- Report patient allegations relating to inappropriate behavior to a supervisor, manager, physician, etc.
- Complete a confidential incident report and investigate all patient complaints relating to touching or other perceived inappropriate touching of a sexual, emotional or physical nature.
- Prohibit inappropriate or questionable personal contact and conversations between physical therapists and patients.
- Refer to American Physical Therapy Association resources related to professional behavior and ethics.

Collaborative and Referral Relationships

Physical therapists frequently identify signs and symptoms requiring assessment by other healthcare providers, making it important for them to foster a rapport with a wide variety of clinicians. Here are some guidelines for maintaining effective referral relationships and agreements with physicians and other healthcare professionals:

- Refer patients on a timely basis to other professionals/providers when required for additional clinical assessment, diagnosis and treatment.
- Use referral criteria that are, at minimum, specific and formalized enough to meet relevant state regulations.
- Ensure that collaborating and supervising professionals, professional partners and facilities employing or contracting with physical therapists maintain adequate professional liability insurance limits as required by practice setting, state law or regulations.

Patient Assessment, Physical Therapy Diagnosis and Plan of Care

Physical therapists examine patients, evaluate and diagnose movement dysfunction, present a prognosis, develop a plan of care, and provide treatments and interventions. The goals of their interventions are to restore, improve, maintain and promote optimal functioning for their patients.

Clinical Decision-making Process

- Document physical therapy diagnosis(es) or label(s) in the patient's health information record, as well as supportive analysis and the clinical decision-making process used.
- Incorporate clinical practice guidelines or clinical protocols related to establishing a physical therapy diagnosis, plan of care and treatment(s)/intervention(s) when applicable or available.
- Incorporate clinical practice guidelines or clinical protocols related to reporting patient's condition to the patient's primary care and/or referring physician.
- Document clinical justifications for any change in the plan of care when deviating from established clinical guidelines and protocols.

Diagnostic Tests, Referrals, Consultations

- Perform necessary diagnostic tests/procedures/interventions to confirm or eliminate diagnoses, and track and acknowledge results.
- Consult with clinical specialists, as needed, to ensure that all appropriate and reasonable diagnostic possibilities are considered. Address recommendations in writing in the patient's health information record.
- Refer patients to clinical specialists for appropriate diagnostic testing or procedures, and track follow-up as needed.

Patient Communication

- Utilize proper therapeutic communication and listening skills to elicit the patient's information and obtain an interpreter, if needed.
- Elicit patient-stated goals when developing the treatment plan. Objectively evaluate and document patients' motivation, progress and satisfaction with their therapy plan.
- Document the discussion of diagnostic test results (normal and abnormal results) with the patient and/or surrogate decision makers.
- Carefully explain to the patient the physical therapy diagnosis, plan of care, prognosis and recommended treatments/interventions.
- Encourage patients to ask questions at their level of understanding.
- Confirm and document that the patient was able to repeat back the plan accurately.

Continuum of Care

- Document patient assessment findings accurately and legibly, making sure that pre-printed forms utilized are completed properly, with no blank spaces.
- Document receipt of all test results from all sources, both normal and abnormal, and indicate how those results are incorporated into the patient's plan of care.
- Update the patient's problem list with every change in physical therapy diagnosis.
- Document results of tests/treatments/interventions. Indicate the specific reasons or clinical rationale for their continuation, modification and/or termination.
- Document reports of patient condition provided to the patient's primary care and/or referring physician.
- Document requests for services that are to be provided by other disciplines/services.
- Discuss and document the fees and costs for physical therapy treatments and interventions to ensure patient awareness of responsibility for treatment costs, including co-payments and deductibles. Knowledge regarding reimbursement under both public and private programs enhances the understanding of benefits that may become exhausted or otherwise unavailable.
- Discuss the fact that third-party reimbursement may end before the patient/family believes the patient has reached full potential in therapy. Ensure that patients understand that when third-party coverage for treatment ends, they will be responsible to pay for any continued treatment.
- Relay the content of patient/family discussion and telephone calls to other members of the clinical care team. Document discussions and related actions in the health information record.

Informed Consent Process – General

While some diagnostic tests, treatments and interventions involve little or no risk to the patient, others may involve higher risk of adverse outcome or injury. Others also may call for extensive touching by the physical therapist, which may be distressing for some patients. Before engaging in treatments or interventions that involve significant risk, physical therapists must obtain the informed consent of patients, as described below:

- Comply with all state laws relating to informed consent.
- Ensure that the patient is fully aware of the physical therapy diagnosis and current clinical findings or symptoms that necessitate the proposed test, treatment or intervention.
- Describe in detail the test/treatment/intervention to the patient and explain why it is recommended.
- Discuss the risks, benefits and alternatives to the proposed test/treatment/intervention.
- Discuss the risks of not performing the indicated test/treatment/intervention.
- Allow patients to ask questions to their satisfaction, until they can repeat the information correctly to the physical therapist.
- Document the informed consent discussion and the patient's desire to accept or refuse the proposed test/treatment/intervention.
- Obtain the patient's signature for informed consent or refusal of treatment, as appropriate. Retain in the patient's health information record.
- Prepare and distribute written patient education materials, including diagrams and directions, and ascertain patient understanding.
- Maintain a copy of all written materials provided to patients in their health information record.
- Document the content of discussions concerning treatment costs and fees.

Informed Consent Process – Physical Therapy Research Protocols Utilizing Human Subjects

When medical research includes human research subjects, study protocols mandate that additional concerns must be addressed in the informed consent discussion between the physical therapist and the patient. At a minimum, the consent process must include all the potential risks, benefits and alternatives to the treatment provided by the research protocol. The consent process should also include a discussion to ensure that patient participants understand the costs of care and treatment related to the study. They should be cognizant of those costs that will be covered by the study and those costs borne by the patient. Those services that will and will not be available to the patient following completion of the study protocol should be clarified. In addition, the consent must clearly indicate

- the purpose of the treatment and its experimental nature
- the expected duration of the course of treatment
- the possibility that the treatment may not be beneficial to the patient and may even be harmful
- any adverse or side effects that may occur
- means of obtaining emergency treatment in the event of adverse response to the treatment
- who is financially responsible if emergency treatment is required
- the patient's rights to withdraw from or refuse to participate in the research protocol without jeopardizing any other aspect of care with the participating physical therapist or facility

Physical Therapy Equipment

Physical therapy facilities must provide equipment to properly deliver the full range of services and manage the types of disabilities in patients accepted for evaluation and/or treatment. At a minimum, physical therapy equipment must support therapeutic exercises utilizing heat, cold, water and electricity. The following strategies can minimize equipment-related risks:

- Maintain and have readily available all warranties, manuals and instructional materials provided with equipment at the time of purchase.
- Inspect all equipment for obvious defects/damage, and immediately remove any damaged or broken equipment.
- Ensure appropriate training for all equipment users (both staff and patients) and require the user to demonstrate proficiency.
- Ensure that, at a minimum, equipment is monitored, maintained and serviced in accordance with manufacturer recommendations, including recommended cleaning and disinfection products and techniques.
- Utilize appropriate infection control practices, including terminal disinfection between users of whirlpools, electrodes, hot packs and other equipment that comes into direct contact with multiple patients.
- Know and comply with the reporting requirements for adverse events related to equipment under the federal Safe Medical Devices Act of 1990, 21 U.S.C.A. §301 et.seq.
- Perform and maintain written documentation of equipment inspection, preventive maintenance and repairs, including treatment tables, exercise equipment, assistive devices, etc.
- Complete and maintain written documentation of staff training and patient education related to the use of equipment.

Health Information Records

The patient health information record is the primary mechanism for patient-focused communication among members of the clinical care team. Because the patient's health information record is often the most critical tool in the defense of any malpractice litigation, physical therapists must maintain documentation related to every aspect of the patient's physical therapy care. Consistency in content, format and entry timing are crucial to ensuring an accurate and complete health information record.

Record Order and Maintenance

- Develop and adhere to a standard format and order for every patient health information record.
- Use binders or closed-type patient health information records that protect against the loss of pages.
- Maintain patient health information and health information records in a confidential manner.
- Retain patient health information records as long as reasonably possible but at least in accordance with state and federal law related to health information record retention, including the state statute of limitations for medical malpractice claims.
- Perform periodic audits of patient health information records to identify departures from appropriate practice and to identify opportunities for future improvement.

Contents of Patient Health Information Record

- Record the patient's name and record number on every page of the patient health information record.
- Prohibit alterations in the health information record.
- Utilize only approved procedures to correct or amend documentation.
- Eliminate the use of facility-specific abbreviations and consider prohibiting the use of all abbreviations.

- Develop and maintain each patient's health information record in a manner that reflects a comprehensive picture of the patient, the clinical thought processes involved in his/her entire assessment and findings, and the development of the care/treatment/intervention plan and prognosis. Minimally, the record should include
  - demographic information
  - treatment initiation mechanism (e.g., direct access, referral from another professional including contact information, etc.)
  - patient's history (e.g., social, work, growth and development, living environment, general health status, family history, medical, surgical, etc.)
  - current condition(s)/chief complaint(s)
  - communication skills, cognitive ability, primary language and ability to express needs
  - documentation of informed consent for high-risk treatment/interventions
  - initial and ongoing evaluation and physical findings (systems review)
  - results of all functional testing and measurements
  - documentation of the patient's current medications and information obtained regarding potential side effects, adverse reactions, etc.
  - allergies conspicuously noted (include medication, food and environmental allergies)
  - laboratory and diagnostic test results
  - supervision of patient during treatment
  - patient condition reported to primary care and/or referring physician, including physician name, date and time information was provided
  - referral and consultation requests and results
  - written consent to release private medical and social information to the patient's other healthcare providers
  - physical therapy diagnosis
  - plan of care that includes type, amount, frequency and duration of treatment/interventions and prognosis
  - patient and physical therapist rehabilitation goals, including indications and contraindications
  - treatment notes updated at each patient contact, including telephone and face-to-face discussions
- Upon discharge, ensure that the record contains (at a minimum) a summary of treatments/interventions, including objective results achieved, patient's response assessed, discharge referrals made and patient discharge instructions provided.

Release of Patient Health Information

- Release medical and health information only with written permission of the patient/authorized agent or as medically necessary in a medical emergency for continuity of care purposes and in accordance with HIPAA and state legal requirements.
- Require special additional written authorization to release patient information related to treatment for HIV and AIDS, alcohol and substance abuse, and mental/behavioral illness.
- Manage legal demands for patient health information such as subpoenas, summons and complaints, court orders, and other legal documents with a single, designated, authorized individual.
- Identify an individual – usually the risk manager in a hospital setting, practice administrator, health information records administrator and/or legal counsel – to consider legal demands and review the health information record prior to releasing the health information.
- Immediately notify the insurance broker of the receipt of any legal notice.
- Sequester or maintain the original patient health information record when releasing authorized copies.

Record Retention

- Retain health information records for at least the period determined by state statute, or in the absence of such statutes, at least five years from the date of discharge for adults and, for minors, three years after the patient reaches the state's age of majority.

Physical Therapy Documentation

Documentation issues/requirements have been noted throughout this study, and are summarized below for the reader's convenience. Maintaining a consistent, professional patient health information record is essential to effectively communicating with other clinical care team members, providing quality patient care and establishing an effective defense should litigation arise.

Documentation – General Principles

- Make sure entries are in ink and are legible, signed, dated and timed.
- Define "signature" to include the full name, professional designation and title, and, in the case of electronic signatures, any required identification number and/or security codes.
- Obtain required countersignatures.
- Prohibit subjective comments regarding the patient or other healthcare providers.
- Document all actions and patient discussions as soon as possible after the event.
- Never leave lines blank or data spaces unfilled.
- Identify late entries and make sure they are dated and timed contemporaneously.
- Prohibit late entries for any reason after a lawsuit has been initiated.
- Contact the risk manager, insurance company or legal counsel to obtain advice about proper drafting of a written addendum if there is a legitimate need to do so.
- Never alter a health information record for any reason.
- Use only approved methods for correction of documentation errors and never erase, obliterate, or use correction fluid in any portion of the health information record for any reason.
- Eliminate the use of facility-specific abbreviations and consider prohibiting the use of all abbreviations.

Documentation – Clinical

- Document initial evaluation, history and physical examinations, including at a minimum
  - chief complaint
  - allergies
  - past medical history
  - past and current medications and other treatment
  - review of systems
  - positive examination findings
  - pertinent negative findings
  - family, social, work/school and growth/development histories
  - functional status and activity level
  - pain assessment, including a description of the patient's current and prior self-prescribed pain relief practices
  - use of alternative therapies or over-the-counter remedies
  - use of orthotic, protective or supportive devices
  - referral source or self-referral
  - patient's ability to comprehend and carry out instructions
- Document contemporaneous actions and patient diagnostic, treatment and intervention events, including
  - summary of patient's current condition and response to treatment(s)/intervention(s)
  - presentation of problem(s)
  - clinical findings, assessment, physical therapy diagnosis and prognosis
  - required supervision of patient during treatment
  - plan of care/treatment(s)/intervention(s)
  - patient's response to treatment(s)/intervention(s) and resulting modifications to the plan of care
  - patient condition that indicates need to contact primary care and/or referring physician
- Document all discussions with the patient regarding results (normal and abnormal), progress in achieving prognosis, and recommendations for continued treatment intervention, as well as the patient's response.
- Document patient telephone encounters, including after-hours interactions, summary of discussion, advice provided and action(s) taken.

Documentation – Diagnostic Tests, Referrals, Consultations

- Include evidence of patient's consent for the physical therapist to provide other healthcare professionals with physical therapy findings, care plan, response to treatments/interventions, etc.
- Document discussions related to the patient's responsibility for the costs of care and treatment.
- Note receipt of results and subsequent actions involving tests, interventions, procedures, referrals and consultations, ensuring that the physical therapist has signed or initialed the results after reviewing and prior to filing.
- Document referrals for consultation or testing, checking first that referrals include
  - the name of the test, consultant or provider
  - the patient's ability to understand and repeat the reasons for the referral, consultation or testing
  - instructions to help the patient arrange the appointment, consultation, etc.
- Document discussions with, and reports and test results sent to, the patient's primary care physician (if the patient is self-referred) and/or the referring physician.

Documentation – Medications and Prescriptions

- Maintain a current medication list and acknowledge these drugs' actual and/or potential impact on the patient's physical therapy plan of care/response to treatment/prognosis.
- Document current pain management medications and the patient's level of relief from current regime.

Documentation – Patient Tracking and Patient Education

- Record missed appointments, including documentation of all efforts to contact patient.
- Describe patient education efforts, keeping copies of written materials provided to the patient, as well as patient-signed receipts for educational materials.
- Note the patient's primary language and whether a translator is needed; if so, include the interpreter's name and contact information.
- Document the patient's ability to comprehend and accurately repeat oral and written information.
- Maintain a list of family members or authorized persons who also received education related to patient's plan of care.

EXPLANATION OF TERMS

For purposes of this study, the following definitions are used:

Abuse Physical, sexual, emotional and/or verbal mistreatment of a patient.

Allegation A statement asserting that the physical therapist has done something wrong or illegal, but which has not yet been proven.

Breach of Confidentiality Failure to maintain patient information related to clinical, personal or financial information in a private manner in accordance with legal requirements.

Claim Legal action/proceeding against a CNA/HPSO-insured physical therapist alleging professional liability resulting in allegation(s) of patient harm or injury.

Closed Claim A legal action/proceeding where financial compensation has been sought based upon the legal liability of the healthcare professional pursuant to error, omission or negligence in the performance of professional services, and the matter has been resolved through a judgment, settlement or verdict with or without payment of a damages award.

Death Death that is unexpected, not expected as a result of the course of patient's disease/illness, or a result of alleged negligence or malpractice. The facts and circumstances do not include death that occurred as a result of the natural course of the patient's disease or illness.

Expense Payment Monies paid in the investigation, management and/or defense of a claim.

Failure to Monitor Harm or injury to a patient when the physical therapist should have provided closer or one-to-one monitoring throughout a physical therapy treatment/intervention.

Failure to Supervise Failure to watch over the patient during a therapeutic intervention, or failure to oversee a student who is providing therapeutic services.

Failure to Treat Failure of the physical therapist to provide treatment/intervention in accordance with the established plan of care.

Frequency The number of open and closed claims with the specified attribute.

Improper Management Failure of the physical therapist to provide or otherwise obtain appropriate care, diagnostic tests, consultation and/or referral for a patient.

Indemnity Payment Monies paid in the settlement or judgment of a claim.

Injury Harm or damage to the patient as a result of an accident, incident or other adverse event.

Lack of Informed Consent Failure of the physical therapist to provide the patient/legal representative with a clear description of the physical therapy diagnosis or condition, proposed treatment (includes treatment, diagnostic procedure, or medication), risks, benefits, and alternatives to the proposed treatment, reasonable expectations for the desired effect/result, and risks and benefits of failing to obtain treatment; and/or the discussion failed to include adequate opportunity for the patient/representative to ask questions to the level of his or her satisfaction.

Open Claim A legal action/proceeding that has been asserted against a claimant alleging damages for personal injuries claimed to have been caused by an error, omission or negligence in the performance of professional services, where financial compensation has been sought, but which remains unresolved.

Physical Therapy Diagnosis Physical therapy labels utilized to identify the impact of a condition on functioning at the level of the system (especially the movement system) and for the whole person.

Severity The average paid indemnity for closed claims that involved indemnity payment(s) resulting from a settlement or jury verdict of a claim.

Violation of Patient Rights Purposeful or inadvertent infringement on a patient's legal rights.

Healthcare Providers Service Organization (HPSO) is the nation's largest administrator of professional liability insurance coverage to physical therapy professionals. Healthcare Providers Service Organization is a registered trade name of Affinity Insurance Service, Inc., an affiliate of Aon Corporation. For more information about HPSO, or to inquire about professional liability insurance for physical therapists, visit HPSO online at www.hpso.com or call 1-800-982-9491.

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