HPSO Physical Therapy Spotlight: Documentation

Healthcare Providers Service Organization (HPSO), in collaboration with CNA, has published our *Physical Therapy Professional Liability Exposure Claim Report: 4th Edition*. It includes statistical data and case scenarios from CNA claim files, as well as risk management recommendations designed to help physical therapists and physical therapist assistants reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: hpso.com/ptclaimreport.

This Physical Therapy Spotlight focuses on our analysis and risk recommendations regarding one of the most significant topics in the report: Documentation.

Physical Therapy Risks Related to Documentation

Documentation details the care or services provided to a patient and their response to that care or service, helping to ensure that patients receive appropriate, evidence-based healthcare services. At times it may be difficult for a physical therapist to find time to complete documentation in the patient healthcare record, in addition to all the other clinical and administrative responsibilities of a physical therapy practice. Nevertheless, maintaining consistent, thorough, and timely documentation of care or services provided is one of the physical therapist's primary professional responsibilities. 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.

Allegations related to inadequate healthcare record keeping and documentation comprised 8.2 percent of all license protection closed matters in the *Physical Therapy Professional Liability Exposure Claim Report* 2020 dataset. Patient care assessments, observations, communications and actions should be documented in an objective, timely, accurate, complete, appropriate and legible manner. Documentation should support the treatment plan and satisfy State Board of Physical Therapy (SBPT) regulatory and third-party billing requirements, as evidenced by reviewing the following case studies:

- A third-party payer filed a complaint against the insured physical therapist (PT) with the SBPT, alleging that insurance claims filed by the PT failed to include his name and license number, and he failed to sign his patient notes. During the SBPT investigation, the PT admitted that his documentation skills were "deficient." The SBPT also found that the PT was using an unsecure electronic medical documentation program to maintain his patients' healthcare records. The PT admitted that he had not maintained or contemporaneously signed any of his patients' healthcare records. In light of these findings, the SBPT publicly reprimanded the PT, required him to submit all of his patients' healthcare records to a SBPT-approved monitor for one year, and ordered him to pay a civil fine of $10,000. Furthermore, subsequent to the first SBPT investigation and disciplinary action, a neighboring state where the PT also maintained a license opened its own investigation. The SBPT in the second state also publicly reprimanded the PT's license and issued a civil fine of $1,500. The total incurred cost to represent and defend the PT in these two SBPT investigations was greater than $15,800, and the matters took more than six years to resolve.
- The PT practice where the insured physical therapy assistant (PTA) worked sued an auto insurance company for payment related to the treatment of a patient's injuries sustained in an automobile accident. The PTA was soon notified that the auto insurance company had an expert review the bills submitted by the PT practice, and they filed a complaint with the SBPT alleging that the PTA overutilized physical therapy services in treating this patient. The SBPT's investigation concluded that the PTA's documentation did not support the need for the quantity of care delivered. The PTA admitted that he failed to communicate with the responsible PT during the patient's course of treatment and document those discussions to support the patient's care. The SBPT assessed a $100 fine and ordered that the PTA complete 9 hours of continuing education. The expenses associated with defending the PTA in this case exceeded $3,900. The SBPT also placed the PT practice on probation and fined the practice an unknown amount for failing to appropriately supervise the PTA and inadequate record keeping and documentation.

While documentation deficiencies may result in a professional liability claim and/or a license protection matter, PTs also may be subject to federal and state sanctions for knowingly falsifying healthcare documentation under the federal fraud and abuse laws, including the False Claims Act (FCA). The FCA imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a healthcare provider who submits a bill to Medicare for medical services they know they have not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. For additional information on fraud and abuse laws, please refer to the HHS Office of the Inspector General.

Risk Management Recommendations: Documentation and Record Keeping

Maintaining a consistent, professional patient healthcare record is integral to providing quality patient care, ensuring consistent communication among all professionals caring for the patient, documenting patient care outcomes and response and establishing the basis for an effective defense in the event of litigation. 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, patient healthcare record contents, patient confidentiality and the release and retention of healthcare 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 healthcare record***. Refrain from documenting subjective opinions or conclusions, or inappropriate, derogatory statements about patients, colleagues or other members of the patient care team.
- ***The healthcare record should include, as clinically indicated:***
  - 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 relevant staff members.

The Importance of Documentation

The healthcare record is a legal document. A well documented record can:

1. **Provide an accurate reflection** of patient assessments, changes in clinical state, and care provided.
2. **Guard against miscommunication and misunderstanding** among the interdisciplinary patient care team.
3. **Demonstrate your competence as a provider** and help to bolster your credibility.
4. **May help guard** against a lengthy litigation process.

  - 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 any other healthcare practitioners and providers, including those via telephone, email, text messages, and patient portal communication and facsimile, with a summary of the discussion and any subsequent orders and physical therapy interventions.
  - 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 healthcare 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 healthcare record for any reason or add anything to a 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.
- ***Note use of an interpreter,*** including the interpreter's contact information, as well as the patient or family member's willingness to communicate with an interpreter.

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 (as clinically indicated):***
  - The nature of the treatment plan, as well as the goals and methods of treatment;
  - Reasonable alternatives to the proposed intervention(s), including declining the suggested therapy, and the relevant risks, benefits, and uncertainties of each alternative;
  - Disclosure of clinically indicated touching and/or potential discomfort during treatment;
  - Patient's/family's questions and responses regarding the treatment plan;
  - Repetition of important information by the patient to ensure understanding;
  - Assessment of the patient's understanding;
  - The patient's decision relative 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/family member's ability to comprehend and repeat information provided*** using a "teach back" approach, both initially and after a few minutes have elapsed to test accurate recall.
- ***Provide a written assessment of the patient's appropriate demonstration of any home exercises*** that are part of the patient's home exercise program (HEP).
- ***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 non-adherence, non-participation, or non-acceptance of recommended treatment can come in many forms: unwillingness or inability to follow a course of therapy, repeated missed appointments, rejecting treatment recommendations, refusal to provide information or chronic late payments. If left unaddressed, such conduct may increase the risk of litigation. Sound documentation and timely intervention are particularly critical to limiting the consequences of patients demonstrating defiant, recalcitrant or passive-aggressive 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-adherence or non-participation with the agreed-upon treatment.*** Place a copy of any written correspondence to or from the patient in the patient healthcare record.
- ***Counseling of non-adherent patients*** and/or responsible parties regarding the risks resulting from their failure to adhere to treatment regimens.

For more information on responding to non-adherent patients, including communication strategies to encourage cooperation and participation, see the HPSO and CNA publication, Patient Compliance: A Self-Assessment Checklist

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 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 protect patients' rights regarding the confidentiality, security, integrity, and availability of their healthcare information. It is incumbent upon all healthcare professionals, including physical therapists, to properly store patient healthcare 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.

Physical Therapy Spotlight:

For risk control strategies related to:

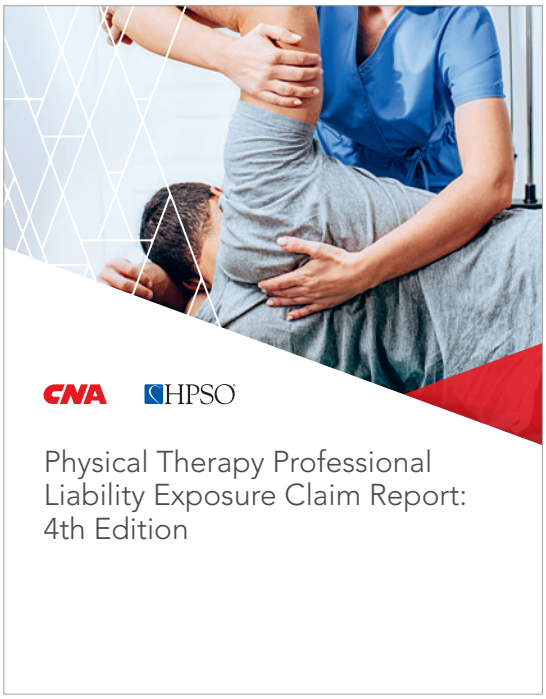
- Protecting Your License
- Home Care
- Telehealth
- Falls
- Liability for Business Owners and Supervisors
- Burns (video legal case study)

Visit hpso.com/ptclaimreport

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, frequently asked questions, and more.
  Visit: HHS.gov/HIPAA/for-professionals/index.html
- **HHS: A Roadmap for Providers: Fraud & Abuse Laws**
  Information on important Federal fraud and abuse laws, including the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Ethics in Patient Referral Act (Stark law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL).
  Visit: https://oig.hhs.gov/compliance/physician-education/01laws.asp
- **HPSO Healthcare Perspective: Risk Management Resources to Manage Liability in the Healthcare Practice**
  HPSO and CNA's fourth physical therapists' liability report provides access to data for malpractice claims and license defense matters. The report offers:
  - Professional liability claims data and analysis
  - License protection claim data and analysis
  - Legal case studies
  - Risk management recommendations

  Visit: HPSO.com/PTClaimReport



To download HPSO and CNA's full report, *Physical Therapy Professional Liability Claim Report: 4th Edition*.
www.hpso.com/ptclaimreport

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In addition to this publication, CNA and Healthcare Providers Service Organization (HPSO) have produced numerous studies and articles that provide useful risk control information on topics relevant to physical therapy professionals, as well as information relating to physical therapy professionals insurance, at www.hpso.com. These publications are also available by contacting CNA at 1.866.262.0540 or at www.cna.com.

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