Getting Ready for ICD-10
John Wallace PT, MS, OCS

We’ll cover
• Transition background
• Differences from ICD-9
• General structure and organization
• Selecting codes and using ICD-10 code book
• When and how to add 6th and 7th digits
• Use of ICD-9 to ICD-10 equivalency mapping

Introduction to ICD-10-CM

Problems with ICD-9-CM
• 30 years old with many changes in medicine and health care occurring in that time
• Many categories are full with 14,025 diagnoses
• Diagnoses not descriptive enough
• Diagnoses not specific enough

Introduction to ICD-10-CM

A new system would:
• Enhance accurate payment for services rendered
• Facilitate evaluation of medical processes and outcomes
• Provide flexibility to quickly incorporate emerging diagnoses and procedures
• Be exacting enough to identify diagnoses and procedures precisely
• Would decrease the need to include supporting documentation with claims.

History of ICD-9-CM
• Developed by World Health Organization for use worldwide = ICD-9
• U.S. developed “clinical modification” = ICD-9-CM
  – Includes expanded number of diagnoses
  – Added procedural coding system (hosp. use only)
• Implemented in 1979
• Updated annually on October 1 for the next calendar year
Introduction to ICD-10-CM

ICD-10 development
• 1990: Endorsed by WHO
• 1994: First full version released
• 2002: Published in 42 languages
• Implementation: 138 countries for mortality and 99 countries for morbidity
• June 2003 U.S. releases ICD-10-CM
• Postponed twice to October 1, 2015

ICD-10 Conventions

ICD-10 Conventions
• ICD-10 is an alphanumeric classification system
  – First character: Letter referencing chapter
  – Second and Third characters: letter or number
  A 3-character category without further subclassification is equivalent to a 3-character code
  – 4th, 5th, 6th characters are subcategories and can be letters or numbers
  – The final level of subdivision is the valid code and can be a letter or a number.

ICD-10 code structure

ICD-10 code structure: examples
• ICD-10-CM codes start with a letter (except U) and are alphanumeric (watch for 0 and O, I and 1)
• Codes can be 3, 4, 5, 6, or 7 characters long with a decimal after the third character
• Examples:
  – I10 – Hypertension
  – M54.9 – Back Pain
  – G81.11 – Spastic Hemiplegia affecting right dominant side
  – G90.511 – Complex regional pain syndrome 1 of right upper limb
  – S72.041A – Displaced fracture of base of neck, right femur, initial encounter for closed fracture
• 6th character extension: laterality
• 7th character extension (i.e. A = initial encounter, D = subsequent encounter, S = sequelae

ICD-10 Conventions
• Punctuation
  – [ ] In tabular list used to enclose symptoms, alternative wording, or explanatory phrases. In the Index, they identify manifestation codes
  – ( ) Used in both Tabular Lists and Index to enclose nonessential modifiers, supplementary words that may be present or absent in the disease without affecting the code number.
  – “colon” or “dash” In Tabular Index used for an incomplete term that needs one or more of the modifiers following the colon to make it a valid code.
ICD-10 Conventions

**Abbreviations:**

- **NEC** “Not Elsewhere Classifiable” and is an "other specified" code. NEC directs the coder to the "other specified" code in the Tabular List (usually a 4th or 6th character 8 and 5th character). Used when detail for a more specific code does not exist.
- **NOS** “Not otherwise specified” used in Tabular List and means unspecified. Uses a code with 4th or 6th character 9 and 5th character 0.
- **X** is a placeholder to allow future code expansion.

Locating a code

1. Locate the term in the Alpha Index
2. Verify the code in the Tabular List
   - Be guided by the instructions in the Alpha Index and Tabular List
   - The Alpha Index does not usually provide the full code
   - Selection of the full code including laterality (6th character requirement and applicable 7th character can only be verified in the Tabular List)

6th character: Laterality

- Some ICD-10 codes indicate laterality (left, right, or bilateral). If no bilateral code is provided, and the condition is bilateral, assign codes for both the left and right sides.
  - 0 = Unspecified
  - 1 = Right
  - 2 = Left
  - 3 = Bilateral

*Note: Injury Codes usually don't have Bilateral. With NO Bilateral Code - use L&R

7th Character: Extension for Injuries

**A** - Initial Encounter: while patient is receiving initial/active treatment for condition
   - Direct Access (PT) Initial Assessment for traumatic injury/illness i.e. sprain/strain, fracture
   - Evaluation Or Treatment by New Physician
   - Example: Newly Assessed Acute Tear of Left Rotator Cuff: S43.422A

**D** - Subsequent Encounter: After patient received active treatment of the condition and is receiving routine care during healing or recovery phase *(Used most often when not first visit)*
   - F/U visits for Treatment of Injury
   - Normal healing phase, after the acute condition has been treated
   - Routine subsequent care following a L ACL tear S83.512D
   - Left Sub-trochanteric, Closed, Non-Displaced Fracture w/ ORIF – S72.25xD

7th Character Extension for Injuries

**S** - Sequelae Encounter: complications or conditions that arise as a direct result of an acute condition that is no longer being treated such as *(used in select cases, mostly payer driven):*
   - Right Hemiplegia (dominant side) from a traumatic subdural hematoma, no LOC (bleed was resolved) – G81.91, S06.5X0S
   - Post-traumatic arthritis following old left ankle fracture – M12.572, S82.892S
Chapters
1. Infectious and Parasitic Diseases (A00-B99)
2. Neoplasms (C00-D49)
3. Diseases of the Blood and Blood-forming Organs and Disorders of Immune System (D50-D89)
4. Endocrine, Nutritional, and Metabolic Diseases (E00-E89)
5. Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)

Chapters
6. Diseases of Nervous System (G00-G99)
7. Diseases of Eye and Adnexa (H00-H59)
8. Diseases of Ear and Mastoid Process (H60-H95)
9. Diseases of Circulatory System (I00-I99)
10. Diseases of Respiratory System (J00-J99)
11. Diseases of Digestive System (K00-K95)

Chapters
12. Diseases of skin and Subcutaneous Tissue (L00-L99)
13. Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
14. Diseases of Genitourinary System (N00-N99)
15. Pregnancy, Childbirth, and the Puerperium (O00-O9A)

Chapters
16. Certain Conditions Origination in Perinatal Period (P00-P96)
17. Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)
18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)

Chapters
19. Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88): 7th character
20. External Causes of Morbidity (V01-Y99)
21. Factors Influencing Health Status and Contact with Health Services (Z00Z99)

Signs and Symptoms
- Codes that describe S&S, as opposed to diagnoses, are acceptable for reporting purposes when a related diagnosis has not been established by a medical diagnostician. Chp. 18, Symptoms, Signs and Abnormal Clinical and Laboratory Findings, NEC (codes R00.0 – R99) contain many symptom codes.
Admissions/Encounters for Rehabilitation

First diagnosis should be the condition being treated or chiefly responsible for the episode of care.
• Example:
Patient presents for treatment of Rt hemiplegia following CVA. Code Hemiplegia and hemiparesis following CVA affecting Rt dominate side I69.351

Admissions/Encounters for Rehabilitation

If the condition is no longer present, report the appropriate aftercare code as the primary diagnosis:
• Example:
If a patient with severe degenerative hip osteoarthritis had THR, Report the code for Aftercare following joint replacement surgery Z47.1 and location Presence of artificial hip joint on the right Z96.641

Coding examples: ACL tear

• 41 year old patient presents with a referral from primary care doc with Rt knee pain and possible ACL injury. MRI + for ACL tear. Evaluation confirms.

Coding examples: ACL tear

• Indexes for Diseases and Injuries
  • See “tear”
  • Directed to “sprain”
  • Find “knee” S83.9
    – Cruciate ligament S83.50
    – Anterior S83.51
  Go to Tabular List of Diseases and Injuries

Coding examples: ACL tear

• Tabular List
  • Find: “Sprain of anterior cruciate ligament of knee” S83.50
    – Find: “Sprain of anterior cruciate ligament of right knee” S83.51
    – Note 7th: look back to beginning of category S83: A initial encounter; D subsequent encounter, S sequelae
  • S83.511D = Final code

Coding examples: ACL tear

• S83.511S = Final code primary diagnosis
• If post op then add aftercare code for secondary diagnosis
  – Index “aftercare”
  – Orthopedic NEC Z47.89
  – Check Tabular List
  – No other clarifications
  – Z47.89 = final secondary diagnosis code
Coding example: Chronic Plantar Fasciitis

• 58 year old female with competitive tennis as her avocational activity that most directly affected by her condition other than tightness and pain on rising in the morning.

Coding example: Chronic Plantar Fasciitis

• Indexes for Diseases and Injuries
• See "fasciitis"
• Find "plantar" M72.2
Go to Tabular List of Diseases and Injuries

Coding example: Chronic Plantar Fasciitis

• Tabular List
• Find: "Plantar Fasciitis" under "Plantar fascial fibromatosis"
  – Verify no other subcategories
  – Note no required ✔ 7th
• M72.2 = Final code

Coding example: Cervical Stenosis with Myelopathy

• 67 year male presents with a referral for C5-6 Stenosis with Myelopathy for conservative management.
  – Cause of Stenosis?
    • Herniated Disc
    • Bone spur/hypertrophic disc aka spondylosis: for this example

Coding example: Cervical Stenosis with Myelopathy

• Indexes for Diseases and Injuries
• See "Spondylosis" M47
• With Myelopathy M47.1
  --Cervical M47.12
Go to Tabular List of Diseases and Injuries

Coding example: Cervical Stenosis with Myelopathy

• Tabular List
• Find: M47 "Spondylosis"
• Find M47.1 “Other Spondylosis with myelopathy”
• Find M47.12 “Other Spondylosis with myelopathy, cervical”
• Check other coding positions
• None: Final Code M47.12
So what about General Equivalence Mapping?

- The Centers for Medicare and Medicaid Services (CMS) has developed a bidirectional code reference, referred to as the General Equivalence Mappings (GEMs), between ICD-9-CM and ICD-10-CM/PCS. There are GEMs for over 99 percent of all ICD-10-CM codes.

Potential problems with GEMs

- ICD-10 is far more specific, especially for M/S and Neuro Diagnoses so can’t get a specific match e.g. laterality
- Wide use of Unspecified ICD-10 codes will be problematic and put you at risk for reviews and audit activity
- Using ICD-10 will enable you to be far more specific with diagnosis

There is no simple “crosswalk from I-9 to I-10” in the GEM files. A mapping that forces a simple correspondence—each I-9 code mapped only once—from the smaller, less detailed I-9 to the larger, more detailed I-10 defeats the purpose of upgrading to I-10. It obscures the differences between the two code sets and eliminates any possibility of benefiting from the improvement in data quality that I-10 offers. Instead of a simple crosswalk, the GEM files attempt to organize those differences in a meaningful way, by linking a code to all valid alternatives in the other code set from which choices can be made depending on the use to which the code is put.*

GEMS: Common ICD-9 Diagnoses

- 724.2 LUMBAGO
  - GEM: 724.2 M54.5 Low back pain
    - M54.5 Low back pain
      - Loin pain
      - Lumbago NOS
        - Excludes: low back strain (S39.012)
        - lumbago due to intervertebral disc displacement (M51.2-)
        - lumbago with sciatica (M54.4-)

- 719.41 PAIN IN JOINT, SHOULDER REGION
  - GEM: 719.41 M25.51 Pain in shoulder
    - M25.51 Pain in shoulder
      - M25.51 Pain in right shoulder
      - M25.512 Pain in left shoulder
      - M25.519 Pain in unspecified shoulder
GEMS: Common ICD-9 Diagnoses

- 719.46 PAIN IN JOINT, LOWER LEG
  - GEM: 719.46 M25.569
    - M25.56 Pain in knee
      - M25.561 Pain in right knee
      - M25.562 Pain in left knee
      - M25.569 Pain in unspecified knee

GEMS: Common ICD-9 Diagnoses

- 719.45 PAIN IN JOINT, PELVIC REGION & THIGH
  - GEM: 719.45 M25.559
    - M25.55 Pain in hip
      - M25.551 Pain in right hip
      - M25.552 Pain in left hip
      - M25.559 Pain in unspecified hip

GEMS: Common ICD-9 Diagnoses

- 715.16 PRIMARY LOC OSTEOARTHRITIS LOWER LEG
  - GEM: 715.16 M17.10
    - M17 Osteoarthritis of knee
      - M17.0 Bilateral primary osteoarthritis of knee
      - M17.1 Bilateral primary osteoarthritis of knee NOS
        - M17.11 Bilateral primary osteoarthritis, right knee
        - M17.12 Bilateral primary osteoarthritis, left knee
      - M17.2 Bilateral post-traumatic osteoarthritis of knee
      - M17.3 Bilateral post-traumatic osteoarthritis of knee NOS
        - M17.31 Bilateral post-traumatic osteoarthritis, right knee
        - M17.32 Bilateral post-traumatic osteoarthritis, left knee
      - M17.4 Unilateral primary osteoarthritis of knee
        - M17.41 Unilateral primary osteoarthritis, right knee
        - M17.42 Unilateral primary osteoarthritis, left knee
      - M17.5 Unilateral post-traumatic osteoarthritis of knee
        - M17.51 Unilateral post-traumatic osteoarthritis, right knee
        - M17.52 Unilateral post-traumatic osteoarthritis, left knee

GEMS: Common ICD-9 Diagnoses

- 719.47 PAIN IN JOINT, ANKLE AND FOOT
  - GEM: 719.47 M25.579
    - M25.57 Pain in ankle and joints of foot
      - M25.571 Pain in right ankle and joints of right foot
      - M25.572 Pain in left ankle and joints of left foot
      - M25.579 Pain in unspecified ankle and joints of unspecified foot

GEMS: Common ICD-9 Diagnoses

- 719.7 DIFFICULTY WALKING
  - GEM: 719.7 R26.2
    - R26.2 Difficulty in walking, not elsewhere classified
      - Excludes1: falling (R29.6)
      - unsteadiness on feet (R26.81)

GEMS: Common ICD-9 Diagnoses

- 723.1 CERVICALGIA
  - GEM: 723.1 M54.2
    - M54.2 Cervicalgia
      - Excludes1: cervicalgia due to intervertebral cervical disc disorder (M50.−)
GEMS: Common ICD-9 Diagnoses

- 726.10 Disorders of bursae and tendons in shoulder region, unspecified
  - GEM 1: 726.10 M75.100
  - M75.5 Bursitis of shoulder
    - M75.50 Bursitis of unspecified shoulder
    - M75.51 Bursitis of right shoulder
    - M75.52 Bursitis of left shoulder

- 726.10 Disorders of bursae and tendons in shoulder region, unspecified
  - GEM 2: 726.10 M75.50
  - GEM 2: 726.10 M75.50
  - GEM 2: 726.10 M75.50

- 728.87 MUSCLE WEAKNESS (GENERALIZED)
  - GEM: 728.87 M62.81
  - M62.8 Other specified disorders of muscle
    - Excludes2: nontraumatic hematoma of muscle (M79.81)
    - M62.81 Muscle weakness (generalized)

- 847.0 NECK SPRAIN AND STRAIN
  - GEM 1: 847.0 S13.4XXA
  - GEM 1: 847.0 S13.4XXA
  - S13.4XX 7th Sprain of ligaments of cervical spine
    - Sprain of anterior longitudinal (ligament), cervical Sprain of atlanto-axial (joints)
    - Sprain of atlanto-occipital (joints)
    - Whiplash injury of cervical spine
    - S13.8XX 7th Sprain of joints and ligaments of other parts of neck

- 781.2 ABNORMALITY OF GAIT
  - GEM 1: 781.2 R26.89
    - Excludes: ataxia NOS (R27.0)
    - hereditary ataxia (G11.-)
    - locomotor (syphilitic) ataxia (A52.11)
    - immobility syndrome (paraplegic) (M62.3)
    - R26.0 Ataxic gait
      - Staggering gait
    - R26.1 Paralytic gait
      - Spastic gait

- 781.2 ABNORMALITY OF GAIT
  - GEM 2: 781.2 R26.9
    - R26.8 Other abnormalities of gait and mobility
      - R26.81 Unsteadiness on feet
      - R26.89 Other abnormalities of gait and mobility
      - R26.9 Unspecified abnormalities of gait and mobility
GEMS: Common ICD-9 Diagnoses

- 840.4 ROTATOR CUFF SPRAIN AND STRAIN
- GEM: 844.0 S83.429A
  S43.42 Sprain of rotator cuff capsule
  - Excludes1: rotator cuff syndrome (complete) (incomplete), not specified as traumatic (M75.1-)
  - Excludes2: injury of tendon of rotator cuff (S46.0-)
  - S43.4217 Sprain of right rotator cuff capsule
  - S43.4227 Sprain of left rotator cuff capsule
  - S43.4297 Sprain of unspecified rotator cuff capsule

Coding patient severity and involvement
Using diagnostic codes to reflect what's wrong with your patient

- Conditions: primary diagnosis
  - What you are treating or the "PT diagnosis"
- Complexities: secondary and other diagnoses
  - Complicating factors that may influence treatment e.g.
    may influence the type, frequency, intensity, &/or duration of treatment.
  - Represented by:
    - diagnoses as comorbidities
    - patient factors such as age, severity, acuity, multiple conditions, and motivation, or by social circumstances
    such as the support of significant other or the availability of transportation to therapy

Coding patient severity and involvement

- Goal of diagnosis coding
  - Include all complexities that may affect the severity of the patient’s condition and ultimately affect the type, frequency, intensity, &/or duration of treatment
  - These help to clarify and justify the resources required to treat the patient as they cause changes in the intensity of treatment and number of visits in the episode of care
  - May eventually obviate the need for records

Reporting patient diagnostic progression during the episode of care:

- Patient starts with one diagnosis
- The condition either progresses over the course of care or further testing confirms a more complex diagnosis
- Therapist must revise the diagnosis in the medical record and in the diagnosis associated with the billing record.
  - Example: low back pain > hnp with radiculopathy

Implementation planning

Getting Ready

- Most Medicare Administrative Contractors
  - No active LCD for outpatient rehab services
- PQRS Measures
  - 2015 measures with diagnosis codes have the ICD-10 diagnoses already included
- Workers Comp: most states
  - Verify implementation date
Getting Ready

- Staff training in Summer/Early Fall 2015
- For preparation, have them code in ICD-9 now, then once proficient, in ICD-10
- Order 2016 books/tools now
- Check with your software vendors for release dates
- Clearinghouse testing

Questions?

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BMS Practice Solutions
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800 478-2778 x-3105
DIAGNOSIS
Both the process and the end result of evaluating examination data, which the physical therapist organizes into defined clusters, syndromes, or categories to help determine the prognosis (including the plan of care) and the most appropriate intervention strategies.

EVALUATION
A dynamic process in which the physical therapist makes clinical judgments based on data gathered during the examination. This process also may identify possible problems that require consultation with or referral to another provider.

EXAMINATION
The process of obtaining a history, performing a systems review, and selecting and administering tests and measures to gather data about the patient/client. The initial examination is a comprehensive screening and specific testing process that leads to a diagnostic classification. The examination process also may identify possible problems that require consultation with or referral to another provider.

OUTCOMES
Results of patient/client management, which include the impact of physical therapy interventions in the following domains: pathology/pathophysiology (disease, disorder, or condition); impairments, functional limitations, and disabilities; risk reduction/prevention; health, wellness, and fitness; societal resources; and patient/client satisfaction.

PROGNOSIS (Including Plan of Care)
Determination of the level of optimal improvement that may be attained through intervention and the amount of time required to reach that level. The plan of care specifies the interventions to be used and their timing and frequency.

INTERVENTION
Purposeful and skilled interaction of the physical therapist with the patient/client and, if appropriate, with other individuals involved in care of the patient/client, using various physical therapy procedures and techniques to produce changes in the condition that are consistent with the diagnosis and prognosis. The physical therapist conducts a reexamination to determine changes in patient/client status and to modify or redirect intervention. The decision to reexamine may be based on new clinical findings or on lack of patient/client progress. The process of reexamination also may identify the need for consultation with or referral to another provider.
## Documentation Review Sample Checklist

**Physical Therapy**

Note: This is meant to be a sample documentation review checklist only. Please check payer, state law, and specific accreditation organization (i.e., Joint Commission, CARF, etc) requirements for compliance.

Therapist reviewed: Privileged and Confidential

<table>
<thead>
<tr>
<th>PT Initial Visit Elements for Documentation</th>
<th>Date:</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td><strong>Examination:</strong></td>
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<td>1. Date/time</td>
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<td>2. Legibility</td>
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<td>3. Referral mechanism by which physical therapy services are initiated</td>
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<td>4. History – medical history, social history, current condition(s)/chief complaint(s), onset, previous functional status and activity level, medications, allergies</td>
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<td>5. Patient/client’s rating of health status, current complaints</td>
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<td>6. Systems Review – Cardiovascular/pulmonary, Integumentary, Musculoskeletal, Neuromuscular, communication ability, affect, cognition, language, and learning style</td>
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<td>7. Tests and Measures – Identifies the specific tests and measures and documents associated findings or outcomes, includes standardized tests and measures, e.g., OPTIMAL, Oswestry, etc.</td>
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<td><strong>Evaluation:</strong></td>
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<td>1. Synthesis of the data and findings gathered from the examination: A problem list, a statement of assessment of key factors (e.g., cognitive factors, co-morbidities, social support, additional services) influencing the patient/client status.</td>
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<td><strong>Diagnosis:</strong></td>
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<tr>
<td>1. Documentation of a diagnosis - include impairment and functional limitations which may be practice patterns according to the Guide to Physical Therapists Practice, ICD9-CM, or other descriptions.</td>
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<td><strong>Prognosis:</strong></td>
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<td>1. Documentation of the predicted functional outcome and duration to achieve the desired functional outcome</td>
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<td><strong>Plan of Care:</strong></td>
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<td>1. Goals stated in measurable terms that indicate the predicted level of improvement in function</td>
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<td>2. Statement of interventions to be used; whether a PTA will provide some interventions</td>
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<td>3. Proposed duration and frequency of service required to reach the goals (number of visits per week, number of weeks, etc)</td>
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<td>4. Anticipated discharge plans</td>
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<td><strong>Authentication:</strong></td>
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<td>1. Signature, title, and license number (if required by state law)</td>
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**PT Daily Visit Note Elements for Documentation**

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<th>Date:</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. Date</td>
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<td>2. Cancellations and no-shows</td>
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<td>3. Patient/client self-report (as appropriate) and subjective response to previous treatment</td>
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<td>4. Identification of specific interventions provided, including frequency, intensity, and duration as appropriate</td>
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<td>5. Changes in patient/client impairment, functional limitation, and disability status as they relate to the plan of care.</td>
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<td>6. Response to interventions, including adverse reactions, if any.</td>
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<td>7. Factors that modify frequency or intensity of intervention and progression toward anticipated goals, including patient/client adherence to patient/client-related instructions.</td>
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<td>8. Communication/consultation with providers/patient/client/family/ significant other.</td>
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<td>9. Documentation to plan for ongoing provision of services for the next visit(s), which is suggested to include, but not be limited to: The interventions with objectives Progression parameters Precautions, if indicated</td>
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<td>10. Continuation of or modifications in plan of care</td>
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<td>11. Signature, title, and license number (if required by state law)</td>
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</table>

**PT Progress Report Elements for Documentation **

<table>
<thead>
<tr>
<th></th>
<th>Date:</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Labeled as a Progress Report/Note or Summary of Progress</td>
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<tr>
<td>2. Date</td>
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<tr>
<td>3. Cancellations and no-shows</td>
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<tr>
<td>4. Treatment information regarding the current status of the patient/client</td>
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<tr>
<td>5. Update of the baseline information provided at the initial evaluation and any needed reevaluation(s)</td>
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<tr>
<td>6. Documentation of the extent of progress (or lack thereof) between the patient/client's current functional abilities/limitations and that of the previous progress report or at the initial evaluation</td>
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<tr>
<td>7. Factors that modify frequency or intensity of intervention and progression toward anticipated goals, including patient/client adherence to patient/client-related instructions.</td>
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<tr>
<td>8. Communication/consultation with providers/patient/client/family/ significant other</td>
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<tr>
<td>9. Documentation of any modifications in the plan of care (i.e., goals, interventions, prognosis)</td>
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<tr>
<td>10. Signature, title, and license number (if required by state law)</td>
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</table>

**The physical therapist may be required by state law or by a payer, such as Medicare, to write a progress report. The daily note is not sufficient for this purpose unless it includes the elements listed above.**
<table>
<thead>
<tr>
<th><strong>PT Re-examination Elements for Documentation</strong></th>
<th>Date:</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Date</td>
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<tr>
<td>2. Documentation of selected components of examination to update patients/client's impairment, function, and/or disability status.</td>
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<td>3. Interpretation of findings and, when indicated, revision of goals.</td>
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<td>4. Changes from previous objective findings</td>
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<td>5. Interpretation of results</td>
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<td>6. When indicated, modification of plan of care, as directly correlated with goals as documented.</td>
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<tr>
<td>7. Signature, title, and license number (if required by state law)</td>
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<table>
<thead>
<tr>
<th><strong>PT Discharge/Discontinuation/Final Visit Elements for Documentation</strong></th>
<th>Date:</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Note: discharge summary must be written by the PT and may be combined with the final visit note if seen by the PT on final visit</td>
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<tr>
<td>1. Date</td>
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<tr>
<td>2. Criteria for termination of services</td>
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<td>4. Degree of goals and outcomes achieved and reasons for goals and outcomes not being achieved.</td>
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<tr>
<td>5. Discharge/discontinuation plan that includes written and verbal communication related to the patient/client's continuing care.</td>
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<td>6. Signature, title, and license number (if required by state law)</td>
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<thead>
<tr>
<th><strong>PTA Visit Note Elements for Documentation</strong></th>
<th>Date:</th>
<th>N/A</th>
<th>Yes</th>
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<tbody>
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<td>1. Date</td>
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<tr>
<td>2. Cancellations and no-shows</td>
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<tr>
<td>3. Patient/client self-report (as appropriate) and subjective response to previous treatment</td>
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<td>4. Identification of specific interventions provided, including frequency, intensity, and duration as appropriate</td>
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<tr>
<td>5. Changes in patient/client impairment, functional limitation, and disability status as they relate to the interventions provided.</td>
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<tr>
<td>6. Subjective response to interventions, including adverse reactions, if any</td>
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<tr>
<td>7. Continuation of intervention(s) as established by the PT or change of intervention(s) as authorized by PT</td>
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<tr>
<td>8. Signature, title, and license number (if required by state law)</td>
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