Learning Objectives

(1) Recall the purpose of therapy documentation for occupational therapists and speech-language pathologists.
(2) Identify the three main components of HIPAA legislation.
(3) List appropriate universal abbreviations to be used in therapy documentation.
(4) Define medical necessity in various healthcare settings.
(5) Recognize the differences between various daily note formats.
(6) Choose the right components for inclusion in a therapy goal.

Introduction

While patient care is the heart of a rehabilitation therapist's work, medical documentation is its necessary counterpart. Effective therapy documentation is crucial for reimbursement, accountability, communication (both within and outside of your profession), and progress tracking. However, it can be overwhelming to strike a balance between being concise and detailed, making this an area many therapists have difficulty with. Many allied health programs do not offer enough hands-on training for documentation and it can be trying to get used to various note-taking styles while fulfilling other basic job requirements and sometimes grueling productivity standards. This course goes through the basic and complex aspects of this type of writing in order to help therapists understand what good documentation consists of.

Section 1: Purpose of Therapy Documentation [1,2,3,4,5,6,7,8,9]

Therapy documentation is integral to the provision of medical services. Firstly, this type of documentation is heavily used by professionals in the healthcare industry. The core (and perhaps most obvious) function of therapy documentation is to serve as a record of the work a therapist has done. In addition, therapy documentation is used to convey the progress patients have made toward their rehabilitation goals. Therapy documentation assists with continuity of care between providers in the same facility and those working in different organizations.

For example, one OT may need to cover another OT’s patients from time to time. In order to effectively do this, the covering OT would need to refer back to each of those patients’ therapy notes to understand their needs and goals before treating them. In addition to being complete, these notes must be easily understood and accurate so the latter therapist can do their job. Similarly, an SLP from Clinic X may need to review a patient’s records from their time treated at Clinic Y. This helps the new provider understand the patient’s treatment history, what led them to seek care elsewhere, and what remaining deficits the patient has. Therefore, documentation also enables therapists to make clinically sound decisions for their patients.

Documentation also allows clinicians to remain in compliance while serving as ethical and legal protection for the work they do. If a patient alleges they did not receive treatment from their SLP on a certain date, that provider can offer proof to the contrary via a signed daily visit note. Documentation is used to record all aspects of the treatment process – from informed consent to patient participation and adherence to their plan of care. In addition, payers rely on documentation to issue reimbursement for services. By creating accurate and timely documentation, this prevents payment delays, denials, and other payment-related complications.

Therapy documentation also extends beyond the medical industry, as reports may be reviewed by state agencies, attorneys, insurance companies and other payers, as well as patients themselves. Each of these parties has a distinct purpose for medical documentation. State agencies (such as local departments of public health) may request and utilize therapy documentation as part of the oversight they provide. Such documentation may be used as part of audits, malpractice investigations, or license renewal reviews. In some cases, therapy documentation may be required as part of the determination for social services such as Medicaid. Lawyers may need therapy documentation to support someone in custody disputes, criminal cases, or personal injury lawsuits. Health organizations, especially large multi-system hospitals, may audit medical records to ensure their providers are offering safe, appropriate, quality care. While it is best practice for organizations to self-audit and verify their documentation is in order, larger bodies perform their own audits. In many cases, such audits are performed for accreditation and certification purposes in alignment with Joint Commission (once known as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO) regulations.

Health insurers conduct various forms of utilization reviews (URs) that may require their staff to assess therapy notes for the sake of coverage determinations. Retrospective reviews involve culling through past medical documentation to confirm that coverage rules apply to the rehabilitation (or other medical) services a patient has received. Prospective reviews require insurance staff to look at records (such as evaluations) before care is rendered to determine if services are needed. Lastly, concurrent reviews are done at various points throughout the patient's plan of care to ensure services are still necessary. Each of these reviews looks at whether or not a patient is progressing and whether or not the patient has a medical condition, illness, or injury that warrants rehabilitation services. If a patient does not demonstrate progress, is progressing very slowly, or does not have any medical needs to address, insurers have grounds to rescind past coverage or stop reimbursing for existing services. These components of a review are used to establish what is called medical necessity. We will discuss medical necessity in greater depth in coming sections, as this is a major consideration therapists must keep in mind when completing documentation. Lastly, patients may request their medical records for personal reference. Most often, these requests are made when patients want a greater understanding of their care and wish to play a more active role in the process.

Electronic Documentation

While some facilities may still use paper documentation, the overwhelming majority of healthcare organizations have turned to electronic record-keeping systems. Electronic medical records (EMRs) are digitized records of the care a patient has received in one healthcare practice. This includes their treatment history and any medical history that has been documented during the plan of care. An electronic health record (EHR) is wider in scope, though its similar name often leads people to use the two terms interchangeably. EHRs are a far more comprehensive compilation of a patient's health data collected from various facilities, including but not limited to laboratories, therapy clinics, surgical centers, hospitals, and specialty providers.

Despite nuances between each type, both forms of electronic record keeping serve the same purposes:

- Enhanced security and privacy of health information
- Improved efficiency in the diagnostic and treatment process
- Fewer medical errors
- Increased communication between providers and patients
- More complete, accurate, and comprehensible health information
- The ability to receive (and use) information in a more timely manner

Regardless of what form therapy documentation takes, it is equally important for therapists to complete, maintain, and safeguard such information according to certain standards. We will discuss this in more detail in the next section.

- **Section 1: Personal Reflection**

In what ways might paper documentation deadlines differ from that of electronic documentation?

- **Section 1: Key Words**

Concurrent review: A medical records review conducted at the start of treatment or a medication course to determine appropriateness and medical necessity

Coverage determination: A series of ongoing decisions made by health plans regarding whether or not specific medical services, procedures, or medications are covered and, if so, to what extent they are covered

Electronic health record: A comprehensive record of a patient's health data across several facilities such as laboratories, clinics, surgical centers, hospitals, specialty providers, and more

Electronic medical record: A record of a patient's health data in one facility such as a single clinic or hospital

Medical necessity: An evidence-based decision of whether or not a given medical service, procedure, or medication is appropriate and directly essential for the diagnosis, management, or treatment of a health condition, illness, or injury; medical necessity determinations are made on the basis of traditionally accepted medical standards, which contributes to standardized and universal decisions; therapists and insurers must monitor medical necessity to manage service utilization

Prospective review: A medical records review conducted before treatment, medication, or other services are provided to determine appropriateness and medical necessity

Retrospective review: A medical records review conducted after treatment, medication, or other services are provided to determine appropriateness and medical necessity

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Section 2: Federal Legislation & Therapy Documentation

10,11,12,13,14,15,16,17,18,19,20

In order to properly complete therapy documentation and ensure security for all parties involved, therapists must be adept in the specifics of the Health Insurance Portability and Accountability Act (HIPAA). First enacted in 1996, HIPAA is a federal law that sets forth standards for the exchange, utilization, privacy, and security of health information. Deidentified health information and protected health information are both covered under HIPAA. This legislation stipulates what are known as Administrative Simplification provisions that apply to health plans, healthcare providers, and healthcare clearinghouses. These parties are known as covered entities.

One of the main purposes of HIPAA is to define and limit the situations in which an individual's protected health information can be provided or used. HIPAA does this through three separate but related rules:

HIPAA Privacy Rule

This rule specifies practices that protect health information by (1) preserving a patient's right to their records and (2) allowing data disclosure only when appropriate and necessary. The privacy rule notes that patients have the following rights:

- The ability to request corrections to their medical records, as needed
- The power to not share medical records with their health plan if those services are self-pay
- The option of requesting and reviewing their medical records electronically or as a hard copy

In order to uphold this rule, healthcare providers must:

- Clearly and continually notify patients about each of the above rights
    - This is most often added to consent form verbiage as part of the patient's medical record and posted in public treatment-related spaces such as clinic waiting rooms.
- Inform patients how their information is being used
- Adhere to all outlined privacy protocols set forth by their organization

Healthcare organizations can remain in compliance with HIPAA's Privacy Rule by:

- Training all of their employees to uphold this rule
- Assigning individuals to continually monitor privacy practices at their organization
- Securing all patient records that contain protected health information

HIPAA Security Rule

Relatedly, the security rule outlines physical, administrative, and technical safeguards that must be followed to keep information out of the wrong hands. According to the Security Rule, providers and organizations must:

- Develop reasonable and appropriate security policies for the protection of health information
- Ensure everyone working in a healthcare facility complies with the aforementioned security policies
- Protect health information against unauthorized uses and disclosures
- Identify and protect electronic health information from potential security concerns
- Review and adjust security measures whenever needed to properly respond to environmental changes
- Continually analyze any security threats and devise appropriate responses
- Ensure confidentiality, integrity, and availability of all protected health information

HIPAA Breach Notification Rule

In the event a privacy or security breach occurs, covered entities are obligated to inform certain parties in accordance with HIPAA. This notification must take place within 50 days of discovering the breach. In order to remain in compliance with this rule, providers and organizations alike must also:

- Perform risk assessments that explore the extent and nature of the health information impacted by the breach, look into who committed the breach, and discover whether or not someone looked at health information leaked via the breach
- Outline the ways in which they acted to minimize risk of data breaches that impact health information

Minimum Necessary Requirement (HIPAA)

As mentioned earlier, one of the main intentions of HIPAA is to protect health information from unauthorized individuals. While many aspects of this regulation involve keeping information out of the wrong hands, HIPAA also includes protective measures for covered entities. The Minimum Necessary Requirement is perhaps the most salient example of this. The Minimum Necessary Requirement states that it is best to disclose as little information as possible in order to fulfill the request for information while still preserving a patient's privacy. The information provided should solely allow designated functions to be carried out, and these vary based on the requestor.

This requirement is more general than other HIPAA regulations, which is intentional to offer flexibility for various circumstances. Any individual fulfilling medical records requests must use their judgment to provide just what is needed for each purpose. It is for this reason that requestors must explain why they are requesting records in the first place. We described some of these instances in the first section. For example, other healthcare providers may request records for mutual patients to assist with continuity of care, while state agencies may request records to complete audits on documentation that meets specific criteria.

For example, let's say a law office requests a patient's medical records to assist them in building a personal injury case for a client. In many cases, a requesting party such as this will specify the date of the injury or the date when medical care was provided. In order to fulfill the Minimum Necessary Requirement, the hospital providing these records will release the face sheet to the record of a patient's emergency department visit on the requested date. This allows lawyers and paralegals to confirm the person they are representing in the case did receive treatment. This also shows the patient's diagnosis written in the form of an ICD-10 code. The ICD-10 code indicates that the patient is receiving emergency medical treatment after an incident of some kind, e.g. a motor vehicle accident, assault, etc. Since this is for an isolated incident, hospitals will also provide some documentation that summarizes the injuries the patient sustained and the treatment they received for those injuries. For emergency department records, this documentation is typically brief and may only be a short paragraph. The remainder of the medical record is not included in this request, as it provides billing information, medical history, consents, and other data that is irrelevant to lawyers for their designated function. As you can see, in order to successfully uphold the Minimum Necessary Requirement, emergency department providers must thoroughly and accurately complete their documentation.

Let's use another example to illustrate when even less information may be provided as part of this HIPAA regulation. The Centers for Medicare and Medicaid Services (CMS) may request medical records for a certain patient in order to assist with making a disability determination that would grant them Social Security Disability (SSD) benefits. CMS may request all of a patient's hospital visits from the past 5 years. However, they are looking for information that confirms a patient's disability and severity in order to support a claim for benefits. In this case, a hospital may provide a discharge summary for each hospital admission, which includes the patient's diagnosis code, an overview of the treatment they received in the hospital, and any care recommendations they must follow to maintain their condition afterwards. This offers a form of

medical necessity, which is another key component to keep in mind when completing therapy documentation. We will discuss more about medical necessity in another section.

In the event the requesting parties above (or any other individual/agency requesting records) reaches out to ask for additional information after records have been sent, it is best practice to have a discussion about the purpose of the request. The request's purpose should be indicated from the start, as that helps the person releasing the information to understand what documentation would help fulfill that need. However, some agencies (possibly law offices and other non-healthcare organizations) may not be versed in HIPAA, leading them to request "any and all" medical records for a certain patient. As healthcare professionals know, providing any and all medical records would include a wide range of information that is irrelevant to the requestor and goes against the Minimum Necessary Requirement. In addition, honoring a request such as this would not be a good use of resources such as time and manpower. These are the many reasons why effective therapy documentation is necessary – not only to healthcare providers but others who come into contact with this documentation.

Therapists should be aware that the Minimum Necessary Requirement is **not** applicable in certain circumstances:

- When a patient requests their own medical records
- When a healthcare provider requests medical records for the purpose of treatment (e.g. a PT requests treatment records from a clinic or hospital not part of their health system, state, or other defining criteria)
- When an organization or agency requests medical records with explicit (e.g. written) permission from the patient
- When certain documentation is required in order to comply with any HIPAA Administrative Simplification rules
- When requests come from the Department of Health and Human Services and the request purpose pertains to HIPAA's Privacy Rule
- When requests are required by other state or federal legislation

HITECH Act

Another federal regulation called the Health Information Technology for Economic and Clinical Health Act, or the HITECH Act, complemented HIPAA's efforts. The HITECH Act was enacted in 2009 to encourage organizations toward the meaningful use of electronic health records in their practices. At a time when paper medical records were still the norm, this act was intended to allow for smoother, more efficient exchange of health information across all parties that needed them. The HITECH Act also fortified existing HIPAA legislation by increasing penalties for violations and including business partners as covered entities. The HITECH Act even served to support patients' rights to their own records, which continues to be an important addition. This act offered incentives for providers who adopted EHRs in a way that helped them provide safer, higher quality healthcare services. While HIPAA was already in existence at the time, the HITECH Act played a major role in promoting the importance of privacy and confidentiality in the healthcare arena.

Safeguarding Therapy Documentation

Therapy professionals must take steps to safeguard all patients' medical records because confidentiality and security extend far beyond therapy documentation. These not only allow clinicians to comply with HIPAA and the HITECH Act, but also ensure that all documentation is readily available for their own professional use. Many of these duties fall under the scope of an administrator's responsibilities, though therapists still play a part in upholding such standards to properly store and maintain medical documentation:

- Do not leave any form of medical records in a place where others can see it, which is especially crucial in public spaces, anywhere with a lot of foot traffic, and locations that offer patient care.
    - For paper documentation, this means closing files and placing them face-down when unauthorized individuals are nearby so that all patient identifiers and labels are hidden. To follow this rule for electronic documentation, therapists must lock their computer, tablet, or any other device that contains medical records when not in use.
- When done using any medical record, be sure to return it to the proper location.
    - While people may assume this rule applies to paper documentation and microfilm, many EMRs/EHRs prevent more than one user from editing the same chart at the same time. Therefore, clinicians should ensure they save and leave a patient's record promptly after making edits.
- Properly dispose of any paper documentation that is no longer needed.
    - Paper documentation that fits this criteria must be shredded or placed in a secure area that will later be shredded. Most of the time, this takes the form of a locked receptacle that is removed from the facility at set intervals (often once monthly).
- Paper documentation should be stored in rooms or file cabinets with properly working locks.
    - The keys for these locks should also be stored in a secure location.
- Providers cannot transmit any patient health information using peer-to-peer programs such as instant messengers.
- Clinicians must document their reasoning for sharing information over unencrypted email and limit the information they do share.
    - In many cases, this extends to emails sent to users outside of their own organization.
- When sending health information to anyone via unencrypted or encrypted channels, providers must verify recipient addresses and refrain from automatically forwarding any message for any reason.
- All devices used to create or access medical records must be physically secured.
    - Organizations may take various steps to ensure compliance with this standard. Some may include using locking cables to secure portable devices such as laptops and tablets, electronically tagging desktop computers, and placing storage devices such as flash drives in locking containers.

- Any and all devices used to create or access medical records must, at minimum, be password-protected, up-to-date on protective software, and receive regular system updates according to HIPAA standards.
    - These security measures include but are not limited to firewall, anti-virus software, anti-spyware software, multi-factor authentication, data encryption, regular security patches, regular penetration testing, and cloud computing. Additional measures may be required for video conferencing platforms, remote patient monitoring devices, digital health tools, anything else related to the provision of telehealth. There is also the potential for any databases storing or managing protected health information to require additional levels of security via password protection.
- All health information data – whether cloud-based or not – should be regularly backed up.

- **Section 2: Personal Reflection**

How do information protection responsibilities intersect with a therapist's clinical responsibilities?

- **Section 2: Key Words**

Anti-spyware software: A computer application designed to locate, disable, and remove any malicious programming that secretly monitors a computer's activity; this is especially important for confidentiality purposes

Anti-virus software: A computer application created to protect electronic devices from a multitude of virtual threats; this type of application is designed to target malware, ransomware, viruses, adware, worms, trojan horses, and phishing attempts

Cloud computing: The act of delivering a wide variety of computing services virtually through a global network known informally as the cloud; users can access on-demand cloud services such as analytics, data intelligence, servers, software, networking, storage, databases, and more

Covered entities: Parties that must uphold HIPAA principles to protect health information, including healthcare providers, health plans, and healthcare clearinghouses

Data breach: As it pertains to healthcare data, a security breach is any incident where protected health data has been disclosed or used in a non-permitted manner

Deidentified health information: Any data that has been edited to redact or entirely remove components someone may use to trace back to an individual, either directly or indirectly

Face sheet: The first sheet in a patient's medical record that offers a summary of their identifying information, diagnosis, and other information specific to their setting; for example, a face sheet in a hospital may contain the patient's latest vitals while a face sheet in an outpatient clinic will likely show an overview of their open rehabilitation authorizations

Firewall: A computer feature that continually monitors activity and is designed to block unauthorized users and functions while granting authorized users continued access; firewall may be software- or hardware-based

ICD-10 code: A standardized coding system that classifies symptoms, diagnoses, and medical procedures for the sake of statistical analysis and billing

Microfilm: A type of film used to preserve and store records using miniature document images; microfilm is often used at large hospitals that may store decades-old records that predate electronic documentation systems

Multi-factor authentication: A security system that offers additional layers of protection by requiring users to enter more than one form of identification before granting entry to a system or account

Penetration testing: The act of information technology professionals simulating cyberattacks to gain a greater awareness of their system's strengths and weaknesses; also known as pen tests, these allow information technology departments to remediate vulnerabilities and make improvement plans

Protected health information: Any data that communicates healthcare service provision, payment, or health status; this type of information is created, maintained, sent, and received by covered entities, which means it can be readily traced back to patients; also called PHI, protected health information includes data about a patient's mental or physical health conditions; their payment for services provided at any time; services the patient received; and basic demographic identifiers such as birth date, name, and social security number

Self-pay: A term used to describe any healthcare services that are paid for entirely out-of-pocket by the patient with no involvement from third-party payers

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Section 3: Medical Necessity & Its Impact on Therapy Documentation [21,22,23,24,25,26,27,28,29,30,31,32]

Medical necessity is one of the cornerstones of what therapists do as well as the documentation they produce. We've mentioned this term several times in the course so far, as it applies to documentation as well as reimbursement. Medical necessity is just as it sounds: a determination

that a medical treatment, procedure, medication, or service is appropriate and essential for the care of a patient's medical condition. Medical necessity determinations are made by health plans/insurers and are formed using evidence in order to ensure services are utilized responsibly. Medical necessity applies to all practice settings, though specific criteria differ slightly depending on where a patient is being treated. Therefore, a therapist's documentation must correlate with this criteria depending on where they work.

Home Health Medical Necessity

Medical necessity in home health tends to be more clear cut than it is in other settings, making it a good starting point. Many people also like to begin the medical necessity discussion here since this is widely considered the lowest and least restrictive level of care due to it being home-based.

Medical necessity is established for this setting if an individual is homebound. This threshold is met if someone meets any one of the following criteria:

- A doctor or other healthcare professional has advised the patient not to leave their home due to a health condition or illness
- Under normal circumstances, the patient cannot leave their home because it requires considerable effort
- The patient has an illness or injury that prevents them from leaving their home without help from another person, special transportation methods, or an assistive device (including a cane, walker, wheelchair, or crutches)

In order to qualify for home health services, patients must demonstrate a medical need for part-time or intermittent skilled nursing care and home health aide services. This is defined as up to 8 combined hours per day of those services, or a maximum of 28 combined hours per week. Some of the major medical needs that qualify someone for this level of nursing care include patient and caregiver education, injectable medications, monitoring services for serious or unstable illnesses, intravenous nutrition therapy, and wound care for a surgical wound or pressure sores. While all of the above criteria can be managed in other healthcare settings, the key determining factor in home health is that a patient has a medical need **and** cannot access other settings due to their homebound status.

Patients cannot qualify for home health OT alone, as they must also have a demonstrated medical need for home health physical therapy and/or home health speech-language pathology in addition to meeting the above criteria.

Inpatient & Acute Medical Necessity

Medical necessity differs slightly between inpatient and acute medical settings. This difference is due in large part to the frequency of rehabilitation services provided in each setting. Individuals in inpatient hospitals participate in rehabilitation services between 1 and 1.5 hours daily. Acute rehab hospitals, on the other hand, offer more intensive services to help someone regain their

prior level of function after a surgery, illness, or exacerbation of a chronic condition. In acute hospitals, patients can expect to participate in 3 hours of therapy services 5 days each week. In some cases, exceptions may be made for patients to instead receive 15 weekly hours of therapy over the course of 7 calendar days. Documentation is even more essential in instances such as this, as this is not considered the norm for this practice setting.

Even with the aforementioned exception, the disparity between the amount of therapy provided across acute and inpatient rehab is enough to make medical necessity criteria differ. This is because not every patient who is hospitalized can tolerate acute rehabilitation, therefore, it is not considered essential for everyone admitted to the hospital. Therefore, a 3-hour statement is a big part of medical necessity for acute rehab facility admission. A 3-hour statement is a letter written by the patient's referring or primary physician. This letter certifies the patient can tolerate 3 hours of services per day. This statement is important for insurers looking to approve acute rehabilitation services. While rehab therapists are not directly responsible for providing a 3-hour statement, they should understand this component of medical necessity as it pertains to their patient's ability to receive this level of care. For example, if a patient demonstrates increased difficulty actively participating in 3 hours of rehabilitation services each day, a therapist should document this response to intervention. If the patient continues to struggle with these services, therapists may need to speak with the treatment team and make a recommendation that is more appropriate for the patient.

In addition, patients must also meet the below criteria for medical necessity in acute rehabilitation facilities:

- The patient must be able to significantly benefit from participation in a rehabilitation therapy program
- From the start of their admission, the patient should be medically stable enough to participate in the outlined rehabilitation program
- The patient must require ongoing and active intervention from multiple therapy disciplines
    - These disciplines include prosthetics/orthotics, physical therapy, occupational therapy, and speech-language pathology. One of the services the patient is receiving must be OT or PT.
- The patient must require medical supervision from a rehabilitation physician. Medical supervision at this level of care includes meeting face-to-face with a licensed rehabilitation physician at least 3 days per week for the duration of the patient's admission, having both functional and medical assessments completed, and having plan of care modifications made as needed.
- The patient must participate in comprehensive preadmission screenings performed by licensed providers who have been designated by a qualified, licensed rehabilitation physician.

Skilled Nursing Facility Medical Necessity

When treating patients in skilled nursing facilities, therapists must be particularly aware of what constitutes skilled services. OTs, SLPs, and other rehabilitation providers working in skilled nursing facilities must ensure that services are not based solely on the patient's potential and instead due to the patient's need for skilled care. This differs from care in other settings such as outpatient clinics, where a patient's rehabilitation potential and prognosis are considered more pivotal in the care determination process. This is largely due to the nature of institutional settings, as many patients in skilled nursing facilities are there because their treatment team believes they need more support before they can return to their discharge location. As you can see, there is a large onus on providers to ensure a patient's safe re-entry into their home, whereas this obligation is not present with community-dwelling patients.

In any healthcare setting, skilled care is defined as being complex enough that such care must be implemented or supervised by a qualified therapist to ensure proper safety and efficacy. In addition, the following criteria must be met to demonstrate medical necessity:

- All therapy services must correspond to a specific and active plan of care that was formed after an initial evaluation at the time of the patient's admission to the SNF. This plan of care must be approved by a physician in order to be considered valid.
- Therapy services must be provided based on one or more of the following: (1) a therapist's clinical judgment that the patient will demonstrate reasonable improvement in a predictable amount of time, (2) services are needed to create an effective and safe maintenance plan for non-skilled professionals to implement, or (3) services are needed to create and implement an effective and safe maintenance plan.
- The type, duration, and frequency of the services must all be reasonable for the patient's specific condition.
- Any combination of rehabilitation services must be provided between 1 and 2 hours each day, 5 days each week.

School-Based Medical Necessity

As we mentioned before, medical necessity is the clinical justification for services such as OT and SLP, and is chiefly used by insurers to make reimbursement determinations. Though, therapists should understand that related services provided in school settings are not directly or consistently funded by health insurance companies. Therefore, the term medical necessity is rarely, if at all, used in this setting. However, it is still essential for school-setting documentation to reflect a need for services. Instead of demonstrating a medical need for services to remediate/compensate for deficits or maintain a certain level of functioning, students must have an academic need for services. For example, let's say a child is constantly in motion, has an attention span less than that of their peers, and demonstrates poor mental organization as a result of a recent attention-deficit/hyperactivity disorder (ADHD) diagnosis. If this child is able to complete their academic coursework without modifications and receive average or above-average grades, there is no demonstrable need for OT services in this setting. If the child's clinical presentation is causing difficulty relating to peers, unsatisfactory academic

performance, and behavioral concerns, this shows a distinct need for OT and potentially other services. Another example may be a child who has impaired speech intelligibility but his teachers and peers can understand what he is saying most of the time and his grades are satisfactory. This child will likely not qualify for school-based SLP. However, if this same child has impaired speech intelligibility that is affecting his emotion regulation, ability to socialize with his peers, and his academic performance, he is likely a good candidate for school-based SLP services.

It is important to note that a child may not qualify for OT or SLP services in a school setting, but may qualify for them in an outpatient setting. It is likely this will happen to the child who displays several ADHD-related deficits and is making satisfactory grades without modifications. This is also likely to occur with the child who has speech delays but socializes with peers well, gets good grades, and can communicate with his teacher without concerns.

Mental Health Medical Necessity

Medical necessity in the mental health arena is a bit trickier than it is in other settings because justification often varies based on the patient's payer source and the location where treatment is provided.

Inpatient hospitals are one of these locations. OTs are known to have fixed, full-time positions in some psychiatric hospitals or psychiatric units in hospitals. Their services may be 'all-inclusive' (officially referred to as bundled) in that their billing is lumped in with other services and is mainly determined based on the length of their stay. This is how billing works for patients who are covered by Medicare Part A. When this is the case, OT services are not directly billed despite CPT or HCPCS codes often being used internally for tracking and reporting purposes. Therefore, there are no clearly outlined criteria for medical necessity as there are in other practice areas. This payer does, however, stipulate that OT services are provided to any patient with an established need. This is one of several reasons OTs must still ensure that all of their documentation reflects a patient's functional deficit(s) and details how the provider is addressing those concerns through occupational therapy services.

Some patients who receive inpatient OT services for mental health conditions may be covered through Medicare Part B. Since this component of Medicare traditionally encompasses outpatient care, there are understandably some limitations in place when this occurs. Medicare Part B may also cover some mental health OT services provided via observation for patients who have been admitted through the emergency room, in skilled nursing facilities, and in long-term care centers. Mental health OT services are also often bundled when provided on an outpatient basis such as through Partial Hospitalization Programs (PHPs) and Intensive Outpatient Programs (IOPs).

It is less common for SLPs to have full-time roles in psychiatric facilities, though they certainly may need to consult or even treat patients in these settings who demonstrate speech, language, and/or feeding deficits. This is most common in inpatient hospitals where SLPs from medical units are asked to care for patients in need of services. These services are billed in the same

way that traditional (medical) inpatient services are, so medical necessity must be met according to the criteria for that setting.

- **Section 3: Personal Reflection**

In addition to assisting with reimbursement determinations for third-party payers, what other ways might medical necessity aid in service management within the healthcare industry?

- **Section 3: Key Words**

Acute rehab hospital: An inpatient setting that provides medical supervision and 3 daily hours of intensive, multidisciplinary rehabilitation services (PT, OT, and SLP) to individuals who experienced a major status change after a surgery, serious illness, or injury; these are also known as inpatient rehabilitation facilities, or IRFs

Home health aide services: Direct services provided by a home health aide alongside continual health monitoring; these services include personal care (ADLs, including bathing, grooming, hygiene, dressing, eating, and toileting) and support services (IADLs, including medication administration, grocery shopping, minor home maintenance and cleaning, and meal preparation)

Inpatient hospital: An inpatient setting that provides medical supervision and 1.5 daily hours of multidisciplinary rehabilitation services (PT, OT, and SLP) to individuals who experienced a functional or medical change as a result of a surgery, serious illness, or injury

Intravenous nutrition therapy: A medical procedure that involves delivering nutrition and fluids into the bloodstream via a needle in the veins; this is also known as parenteral nutrition or PN

Least restrictive level of care: A healthcare setting that allows its patients as much freedom and independence as possible while still offering the appropriate frequency, duration, and intensity of healthcare services as is needed for their health condition(s)

Related services: In the school system, any supportive services intended to supplement special education services provided to students with disabilities; PT, OT, and SLP are some of the most common related services, but this category also includes audiology, orthotics/prosthetics, skilled nursing, behavior therapy, psychology, transportation, and more

Skilled nursing care: Medical treatment provided by registered nurses, licensed practical nurses, certified nursing assistants, and potentially other qualified professionals for the management of acute and chronic health conditions; skilled nursing care may include but is not

limited to services such as wound care, vital sign monitoring, and intravenous fluid management; skilled nursing care can be provided in clinics, skilled nursing facilities, hospitals, and in the home, but there are setting-specific limitations in each

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Section 4: Common Terminology & Universal Abbreviations in Therapy Documentation [33,34,35,36]

All therapy professionals are educated on medical terminology as part of the academic training for their respective fields. This education helps therapists develop a discerning eye when it comes to both common and rare health conditions, procedures, and the like. There are many medical terms used within healthcare settings that therapists must have a general understanding of. Medical terminology helps therapists identify health conditions and related symptomatology their patients may display as well as communicate with other healthcare professionals effectively. Medical terminology is not quite as relevant to therapy documentation, as other therapy-specific terms are more pertinent when writing notes.

We mentioned above that many parties (some within healthcare and some from other industries) may need to read therapy notes for various reasons. Therefore, it is essential for therapists to strike an appropriate balance between making their notes comprehensible by the general public and using succinct language that conveys the skilled work they do. This can be difficult to do, though one of the best ways to guarantee this balance is by utilizing universal abbreviations. The following is a substantial but not an exhaustive list of the universal abbreviations and clinical terminology most commonly used in the OT and SLP fields:

- **4WW**: four-wheeled walker, or any mobility device that has four wheels, including rollators and standard walkers
- **AAC**: augmentative and alternative communication, or devices used by people who lack or have poor verbal skills
- **AAROM**: active-assisted range of motion, or exercises/movements that involve a combination of effort from the patient and some external source (a therapist, caregiver, or piece of equipment)
- **ABD**: abduction, or moving a body part away from the body's midline
- **AD**: assistive device, or any piece of equipment that someone with a disability or injury uses to increase or maintain their functional performance;
- **ADD**: adduction, or moving a body part toward the body's midline
- **ADL**: activity of daily living, or basic self-care tasks that include grooming, dressing, eating, hygiene, bathing, and toileting
- **AFO**: ankle-foot orthosis, or a wearable mobility device that stabilizes the ankle joint and foot, which may be worn due to nerve damage or muscle weakness
- **AKA**: above-knee amputation, or a surgical procedure that involves removing the leg above the knee joint

- **AROM**: active range of motion, or exercises/movements that involve full effort from the patient without any external assistance
- **Anomia**: a neurological symptom that impacts someone's ability to name objects, letters, and people
- **Aphasia**: a neurological symptom that causes difficulty with expressive and receptive communication
- **Apraxia**: a neurological symptom that causes difficulty with motor planning
- **Articulation**: the coherent expression of sounds and words
- **B**: bilateral
- **BKA**: below-knee amputation, or a surgical procedure that involves removing the leg below the knee joint
- **Bilabial**: using two lips at the same time
- **Bilateral coordination**: using both sides of the body in a coordinated, purposeful manner; this doesn't always mean both are doing the same thing, sometimes it means one side of the body is doing and the other is supporting
- **C-Collar**: cervical collar, or a brace that immobilizes the neck to allow for healing after an injury or surgery
- **CGA**: contact guard assist, or an assistance level that involves someone lightly supporting a patient with their hand as they walk or move from one spot to another
- **CPM**: continuous passive motion, or a machine that is programmed to passively move a joint to a certain angle
- **CTx**: cervical traction, or the act of gently pulling on the head to relieve pressure between bones in the neck; this may be done manually or with equipment
- **Circumlocution**: talking around or about a word without saying the word
- **Confrontation naming**: a skill involving naming objects when shown their pictures
- **Contralateral**: The opposite side of the body from someone's deficit, injury, etc.
- **Convergent naming**: a skill involving naming an object's category when asked
- **Crossing midline**: using an extremity to cross the midpoint of the body
- **Cue**: any visual, tactile, or auditory feedback that a therapist gives someone to help them do or say something
- **DF**: dorsiflexion, or the upward movement of the foot as the ankle joint bends
- **Deglutition**: swallowing
- **Divergent naming**: a skill involving naming several items in any given category when asked
- **Dysarthria**: a motor speech symptom that involves difficulty moving the structures of the mouth during speech and swallowing
- **EOB**: edge of bed
- **ER**: external rotation, or an outward rotational movement away from the body's midline
- **EXT**: extension, or any movement that creates a larger angle between two bones by moving them further apart; this may also be abbreviated as a slash mark

- **E-stim**: electrical stimulation, or a physical agent modality that involves placing electrodes on muscles to provide a low electrical current that assists with managing pain and swelling
- **Expressive language**: how you communicate with others through writing or talking
- **FIM**: functional independence level, or a standardized 7-point Likert scale used in many institutional settings to measure the amount of assistance someone needs to perform certain tasks
- **FLEX**: flexion, or any movement that creates a smaller angle between two bones by moving them closer together; this may also be abbreviated as a check mark
- **FWB**: full weight-bearing, or a weight-bearing precaution given after an injury or surgery that involves placing all of your body weight on a given limb
- **FWW**: front-wheeled walker, or a mobility aid that has two wheels on the front and two fixed legs on the back without any brake
- **Fine motor skills**: a skill involving control over small muscles and functions of the hands
- **Fluent aphasia**: using grammatically appropriate sentences that have errors or don't entirely make sense
- **Gross motor skills**: a skill involving movements of the large muscles in the body
- **H/o**: history of, or an indication of any past illnesses, injuries, surgeries, or conditions a patient has
- **HEP**: home exercise program, or any activity/recommendation a therapist gives a patient to do outside of sessions
- **HOB**: head of bed
- **I**: independent
- **IADLs**: instrumental activities of daily living, or complex tasks individuals must complete to live independently; these include medication management, driving, laundry, money management, grocery shopping, and meal preparation
- **IR**: internal rotation, or an inward rotational movement toward the body's midline
- **Intelligibility**: Often written in a percentage to express how much of someone's speech is able to be understood by an unfamiliar listener
- **Interoception**: a sense that allows someone to determine the need for internal bodily functions such as being cold, feeling hungry, and using the bathroom
- **Ionto**: iontophoresis, or a physical agent modality that delivers pain-relieving medication using gentle electrical currents
- **Ipsilateral**: The same side of the body as someone's deficit, injury, etc.
- **KAFO**: knee-ankle foot orthosis, or a wearable mobility device that stabilizes the knee and ankle joints along with the foot, which may be worn due to nerve damage or muscle weakness
- **LBQC**: large base quad cane, or a mobility device that has four small legs that offer a wider base than a traditional cane; also sometimes written 'WBQC' for wide base quad cane or 'QC' for quad cane
- **LE**: lower extremity, or the collective lower body including all parts of the legs

- **LOA**: level of assistance, or the amount of support someone needs for a given task
- **LTG**: long-term goals, or general objectives that are set for prolonged periods of time
- **MFR**: myofascial release, or a manual therapy technique that involves applying slight pressure to the outer layer of the muscles called the fascia
- **MHP**: moist hot pack
- **MLU**: mean length of utterance, or the average sentence length someone speaks with
- **Mm**: muscle
- **MMT**: manual muscle test, or a standardized measure of each muscle's strength either on its own or against resistance
- **Manipulation**: a skill involving holding and moving objects with the hand
- **Max A**: maximum assist, or an assistance level that involves someone doing between 50 and 75% of a task for a patient
- **Min A**: minimum assist, or an assistance level that involves someone doing around 25% of a task for a patient
- **Mob**: mobilization, or a hands-on technique a therapist uses to address joint pain and movement
- **Mod I**: modified independent, or an assistance level that involves a patient completing a task independently but with some modifications such as added time or with the use of equipment
- **Motor planning**: a skill that involves sequencing, organizing, and executing movements appropriately and effectively
- **Muscle tone**: a neurological feature that allows the body to remain slightly tense and resist movement even at rest
- **NMES**: neuromuscular electrical stimulation, or a physical agent modality that uses electrical current to stimulate movement after a neurological injury
- **NPO**: nothing by mouth, or a medical status where a patient cannot take any medication, food, or liquid orally
- **NWB**: non-weight bearing, or a weight-bearing precaution given after an injury or surgery that involves not placing any weight on a given limb
- **OOB**: out of bed
- **PF**: plantarflexion, or the downward movement of the foot as the ankle joint bends
- **PICC**: peripherally inserted central catheter, or a flexible tube inserted in the upper arm that can be used to give medications, fluids, nutrition, etc.
- **PMHx**: past medical history
- **PNF**: proprioceptive neuromuscular facilitation, or a therapeutic approach used to improve motion, strength, and flexibility in those who have sustained neurological injuries
- **POC**: Plan of care
- **PRAFO**: pressure relief ankle foot orthosis, or a wearable mobility device used to preserve skin integrity on the lower leg

- **PROM**: passive range of motion, or exercises/movements that are entirely completed by an external source (a therapist, caregiver, or piece of equipment) and require no effort from the patient
- **PUW**: pick-up walker, or a mobility device with four rubber-tipped legs that must be lifted in the air as someone walks
- **PWB**: partial weight bearing, or a weight-bearing precaution given after an injury or surgery that allows a patient to place some of their body weight on a given limb; doctors should specify the exact percentage when giving this precaution, usually written as '25%WB' or '50%WB'
- **Pfin**: paraffin bath, or a heat-based physical agent modality that involves covering a portion of the extremity in wax
- **Phono**: phonophoresis, or a physical agent modality that delivers pain-relieving medication using therapeutic ultrasound
- **Phrase level**: Often written in a percentage to express how much of someone's speech is in multi-word phrases
- **Pragmatic language**: a skill involving using language for social purposes
- **Pronation**: inward rotation of a joint; if related to the forearm, this movement ends with the palm of the hand face down
- **Prone**: face down
- **Q**: every; for example, QD means every day, QID means four times a day, and BID means two times a day
- **RD**: radial deviation, or movement of the thumb side of the hand toward the body
- **RICE**: rest, ice, compression, elevation
- **ROM**: range of motion, a measurement in degrees of a joint's movement in one of several directions
- **Receptive language**: a skill involving the ability to understand what someone says to you
- **Rollator**: A mobility aid that has four wheels and hand brakes, but may or may not have a seat that is functional and can be used for storage
- **SB**: side bending, or an exercise that involves lateral bending of the torso
- **SBA**: stand-by assist, or an assistance level that involves someone standing nearby to offer assistance for or ensure safety during a given task, if needed; stand-by assistance may also be called supervision
- **SC**: straight cane, or a mobility aid that has a hooked handle at the top and a single leg at the bottom to offer added stability while walking
- **SLR**: straight leg raise, or an exercise that involves lifting a straightened leg up in the air while in supine
- **STG**: short-term goals, or smaller and more specific objectives that are set for short periods of time (2-3 weeks) and address skills that relate back to long-term goals
- **STM**: soft tissue mobilization, or any hands-on technique (with or without equipment) that can relieve pain and muscular tension
- **STS**: sit-to-stand, or an exercise that involves moving from sitting to standing without the use of your hands

- **SUP**: supination, or the outward rotation of a joint; if related to the forearm, this movement ends with the palm of the hand face up
- **Sensory modulation/processing**: a skill that involves processing senses and responding appropriately
- **Supine**: face up
- **TB**: TheraBand, or any elastic resistance band used during exercises and therapeutic activities
- **TENS**: transcutaneous electrical neuromuscular stimulation, or a physical agent modality that uses electrical current to relieve pain
- **THA**: total hip arthroplasty, or a surgical procedure that involves replacing a fractured or degenerative hip joint with an artificial joint; also called a THR or total hip replacement
- **TLSO**: thoracic lumbar sacral orthosis, or a wearable mobility device that immobilizes and supports the mid- to lower-back
- **TM**: treadmill
- **TTWB**: toe-touch weight bearing, or a weight-bearing precaution given after an injury or surgery that involves lightly placing the tip of the foot on the ground but not placing any significant pressure on it; also referred to as TDWB or touch-down weight bearing
- **Ther Ex:** therapeutic exercise, or any exercise completed during a therapy session that is aimed at a certain functional impairment
- **Total A**: total assist, or an assistance level that involves someone else doing 100% of a task for a patient
- **Trxn**: traction, or a hands-on therapeutic technique used to create more space within a given joint
- **UBE**: upper body ergometer, or a type of gym equipment that uses the arms to give a cardiovascular workout; also called an arm bike
- **UD**: ulnar deviation, or movement of the pinky side of the hand away from the body
- **UE**: upper extremity, or the collective upper body including all parts of the arms
- **US**: ultrasound, or a physical agent modality that uses high-frequency sound waves to create heat that stimulates healing in inflamed or injured tissues
- **Vestibular**: one of the body's senses that helps with balance, movement
- **W/c**: wheelchair, which may be used as-is when referring to manual wheelchairs or written as 'power w/c' if the mobility aid is motorized
- **WFL**: within functional limits, or an indication that a certain skill may or may not be typical for a healthy person of the patient's age, but such performance does not impact the patient's ability to function; WFL is most often used in reference to range of motion
- **WHO**: wrist hand orthosis, or a wearable mobility device that stabilizes the wrist joint to allow for healing
- **WNL**: within normal limits, or an indication that a certain skill is typical for a healthy person of the patient's age; WNL is most often used in reference to range of motion

- **WBAT**: weight-bearing as tolerated, or a weight-bearing precaution given after an injury or surgery that involves placing as much pressure/weight on a given extremity as the patient can comfortably tolerate

This list of abbreviations and shorthand phrases is by no means exhaustive. It's also important to note that some abbreviations may have more than one meaning. This is especially true when entering the realm of medical diagnoses. Some examples include: CP, which can stand for chest pain and cerebral palsy; and MS, which can stand for multiple sclerosis and mental status.

It is important to take context into consideration when reading medical documentation, as this can shed light on such discrepancies. For instance, a provider may add to the subjective part of their daily note that a patient started off the session with reports of CP (chest pain). A patient will not report something such as cerebral palsy, rather it will be added to their medical history if it pertains to them. This is an example of when it is fairly obvious what an abbreviation refers to. However, it may not always be that easy to discern. In all cases, it is a therapist's responsibility to ensure they have all the information they need to correctly do their job. This may mean reaching out to the healthcare provider who wrote a particular note, evaluation, or other piece of documentation to clarify what a certain abbreviation refers to.

One large-scale way to avoid these concerns is by creating and implementing a facility-wide list of universal abbreviations. This can be integrated into medical records to simplify the note-taking process while preventing any miscommunication. In the next few sections, we will discuss this in more detail along with other ways to streamline the documentation process while not sacrificing the integrity of medical documentation.

- **Section 4: Personal Reflection**

Is it appropriate for a therapist to perform an Internet search to determine the meaning of shorthand or a universal abbreviation in a patient's medical record? If so, what steps might they need to take to ensure the information they receive is credible?

- **Section 4: Key Words**

Universal abbreviations: Shorthand, often including acronyms and phrases, used in medical documentation to conserve space and time while maintaining fluid communication with any parties involved

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Section 5: Documentation Styles and Examples

37,38,39,40,41,42,43,44,45,46,47,48,49

One of the reasons therapy documentation can be so complex is due to the variation in writing formats, specifically pertaining to daily notes. Most often, these vary between practice settings rather than organizations, which does provide a sense of predictability to therapists who may hold multiple roles. In many cases, facilities have templates to follow for lengthier pieces of documentation such as evaluations, progress notes, and recertifications. These are intended to simplify the process and keep the focus on completing a comprehensive overview of a patient's status.

There are several acronym-based styles for daily notes, many of which convey what therapists need to record about their sessions. There are not necessarily major downsides to using one style versus the other, rather some are simply more suitable for certain settings. For example, shorter styles such as DAP, PIE, BIRP, SBAR, and SOAP are preferred in fast-paced settings such as acute care, inpatient rehab, and SNFs. These styles also often carry over to adult outpatient settings, though most pediatric and mental health outpatient clinics use narrative notes, which are more appropriate for their client base.

Here is a brief overview of these note styles:

- DAP (**D**ata, **A**ssessment, and **P**lan): DAP notes are commonly used in the mental health field, so allied health professionals in psychiatric facilities may use this format.
- PIE (**P**roblem, **I**ntervention, and **E**valuation): PIE is another popular choice for writing daily notes in the mental health field, but this format is also often used by nursing professionals and some allied health professionals.
- BIRP (**B**ehavior, **I**ntervention, **R**esponse, and **P**lan): As another mental health daily note type, this format is somewhat more akin to traditional styles therapists are used to.
- SBAR (**S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation): This is common with nursing professionals, but can be used in many clinical settings.
- SOAP (**S**ubjective, **O**bjective, **A**ssessment, and **P**lan): SOAP notes are the most commonly used documentation style for daily session notes. This style is used most in acute, inpatient, SNF, and outpatient settings. Subjective sections are suited for patient complaints or a summary of the patient's condition at the start of the encounter. The objective part of a SOAP note should include measurements, vital signs, results of a basic physical exam, modalities provided, and activities/exercises performed. Assessment sections are meant to summarize the therapist's findings including response to treatment, symptoms displayed, and any goal progress made since the last visit. The last section is where therapists should note their plan for addressing remaining symptoms and deficits. This typically includes continued treatment but can also incorporate referrals, education provided to the patient and/or caregiver, doctor follow-ups, home exercise programs (newly established ones or modifications), equipment, or general recommendations.

- Narrative: These notes may be stereotyped as lengthy and more difficult to write than some of the others we reviewed. This is often due to the lack of structure given, leading to a more freeform nature. Narrative notes contain the same information as most structured notes, while allowing for a bit more elaboration. For this reason, they are more common in mental health settings where additional details may be necessary to delve into patient concerns.

Evidence on Documentation Styles Across Disciplines

Regardless of what style is used, research supports uniformity in documentation. This aligns quite a bit with the information we've already covered, especially in regards to HIPAA compliance and medical necessity. Ebbers et al. (2022) looked at whether or not documentation quality differed between structured and unstructured notes. With quality scores ranked on a 100-point scale, results showed that unstructured notes averaged a score of 64.35 while standardized and structured notes had a mean score of 77.2. Interestingly enough, this study also found that structured notes (such as DAP and SOAP styles) were significantly lengthier than unstructured notes – such as those that follow a narrative format. Even so, structured notes were determined to be more succinct and clearer than their unstructured counterparts.

Studies have also looked at how collaborative documentation impacts person-centered care. In behavioral health settings, Stanhope et al. (2024) found that the use of sentence fragments and similar practices in daily notes can encourage a more person-centered approach. This also helps contextualize notes for readers with a non-clinical background. These results can be used to inform practice in other healthcare settings by increasing the efficiency and integrity of documentation. These researchers also found that leveraging Neuro-Linguistic Programming (NLP) techniques can better highlight value gleaned from narrative clinical notes.
Toftdahl et al. (2023) explored the experiences of OTs and PTs when completing EHR documentation for patients with lower back pain. Providers in this study found it's infeasible to have an EHR used equilaterally for quality improvement, research, and treatment purposes. These struggles with EHR appropriateness led therapists to have difficulty properly conveying and addressing patient concerns through their documentation, regardless of their note-taking style and efficiency. This is an important area to keep in mind, as many therapists are tasked with multiple responsibilities that may indirectly present barriers to documentation.

Researchers are exploring healthcare documentation as a potential application for artificial intelligence (AI). Amenyo et al. (2025) compared therapy notes generated by two specific tools (KAUWbot and Copilot) to manually-written documentation in pediatric rehabilitation. Results from a blind test showed that SOAP note quality was very similar across the board. This study also identified the potential for combining therapist expertise with AI tools to maximize outcomes and improve treatment of more complex conditions.

Setting-Specific SOAP Notes

As we mentioned, SOAP notes are the most common style of daily documentation in healthcare settings where OTs and SLPs treat patients. We will offer several examples of notes written

using this style in various practice settings. These sample notes will also serve to express medical documentation for those settings.

Acute/Inpatient SOAP note

In an acute or inpatient setting, a daily OT using the SOAP format might look as follows:

Patient reported being ready for session, but wanting to get discharge updates. Performed 5 rounds of green UB theraband exercises (bicep curls, overhead triceps extensions) in standing to assist with transfers. Card sorting activity x8 minutes total with mod verbal cues to maintain PWB status. Required seated rest breaks x2 during this time due to dyspnea. Sit <> stand transfers x15 with min A for hand placement. Able to restart task each time with adequate safety awareness and no cueing. UB dressing seated at EOB with min verbal cues to maintain upright posture. Patient demo'd improved endurance today with less instances of shortness of breath and better engagement. OT asked SW to discuss discharge plan with patient. Continue POC as tolerated.

Here is an example of a daily SLP note using the SOAP note format in this same setting:

Patient was brought to therapy gym for today's session and presented as labile with several attempts to get out of wheelchair while moving. Patient responded well to selecting from preferred videos. Demo'd good visual attention and ability to carry out 1-step directions during 5-minute follow-along videos. Object identification activity matching picture cards to actual items with 80% accuracy and min verbal cues needed to assist with attention toward the end. Patient was alert, calm at the end of session. SLP returned patient to room and helped transfer into bed. Continue POC as tolerated.

Skilled Nursing SOAP note

In a skilled nursing facility, a speech-language pathologist might write the following daily note:

Patient continues with unintelligible speech production. RN reports patient gets frustrated due to inability to make needs known. 40% intelligibility at single-word level, 30% at phrase level during this session. Patient benefits from verbal cues to lower speech rate to 1–2 word MLU. Patient also educated to point to first letter of first word before saying it. Patient demo'd improved self-awareness of intelligibility difficulties compared to last session. Continue POC as tolerated.

An OT's daily note in a skilled nursing facility may read something like this:

Patient demos increased difficulty getting out of bed this morning, but agrees to come to therapy gym for session. Mod/max A x2 for slideboard transfer from bed to w/c. UBE x10 minutes with 2 rest breaks due to dyspnea. 10/10 trials of balance activity in standing with mod A (for LOB). Patient avoided use of LUE with significant L neglect present. Visual-spatial deficits appeared to have mod impact on task completion and lead to continual safety concerns during sessions. OT discussed potential discharge plans with social worker, noting major concerns regarding discharge to home without support. Continue POC as tolerated.

Outpatient SOAP note

An SLP working in an outpatient setting might write the following SOAP note:

Patient calmly presents to therapy and makes eye contact with therapist to start. Word-level responses to wh- questions related to ADLs with 60% accuracy and abstract questions with 40% accuracy. Patient demo'd improved performance after initial syllable cues but could not self-prompt. Able to name verbs with more success than nouns. Patient able to attempt written response with limited success to help their verbal output. SLP to attempt written responses again next session. Patient word-level responses improved during today's visit. Continue POC as tolerated.

This is an example of a possible OT SOAP note for a patient being seen in an outpatient clinic:

Patient selected card activity, completed in 4/5 trials with min physical assist to improve L hand pinch pattern. Patient required min A to maintain focus on task, mod A to improve sitting posture and LUE purposeful movement. Intention tremors had mild impact on task completion. Patient minimally responsive to cueing in second set of 1/5 trials, reported anxiety, wished to stop. Short break, then resumed with fasteners. OT offered verbal cueing to begin unbuttoning x4 which patient did with min verbal cues in 3 minutes. OT assisted in stretching digits before patient moved to buttoning x5 with one visual cue for initial hand placement and min/mod verbal cues for the remainder. Buttoning was completed in 5 minutes. Patient efficiency in buttoning and pinch-related tasks is steadily improving. Patient left in care of PT Stephanie. Continue POC as tolerated.

Mental Health SOAP note

An OT working in a mental health setting might write the following note. This note is a blend between narrative style and the SOAP format, as it adds slightly more detail than SOAP notes do but isn't quite as long as most narrative notes are. Either way, this is an appropriate note for an OT in this setting:

Patient participated in 90 minutes community reintegration training. He appropriately picked out 8/10 recipe ingredients with min/mod A to improve attention to task and decrease impulsivity. He completed checkout process with SBA using appropriate currency. During checkout, he independently demo'd appropriate affect, impulse control, turn-taking, and expressive communication with cashier and bagger. Upon return to apartment, patient demo'd sharp increase in arousal with perseveration on what the cashier from earlier was wearing. Patient responded well to progressive muscle relaxation and use of manipulatives to calm him. Transitioned to last part of session, where the patient categorized 9/10 ingredients with min verbal cueing for attention. He was able to place ingredients in proper pantry and fridge spots with 90% accuracy. Patient given task to call mother and ask for chicken casserole recipe. Will start cooking next session. Continue POC as tolerated.

Home Health SOAP note

An OT working in home health might write the following SOAP note in this setting:

Patient presents in pajamas seated EOB with caregiver present when OT arrives. Patient completes 4/4 trials of morning ADLs with set-up assist and reports of VAS 4/10 shoulder pain limiting reach to upper shelves. Med management with 50% cognitive assist for short-term recall and sequencing. Able to functionally ambulate bedroom <> bathroom using RW with SBA due to poor navigation around clutter and cords in hallway. Patient able to demonstrate HEP with assist from caregiver. OT increased HEP repetitions to 20 daily from 10, as patient appears to be tolerating current HEP well. OT again emphasized the importance of the caregiver clearing obstacles from walkways to minimize fall risk. Continue POC as tolerated.

In home health, an SLP might write a SOAP note such as this:

Patient found in living room recliner with caregiver when SLP arrived. Patient greeted SLP appropriately. SLP used spaced retrieval to train patient on location of wall clock, calendar, whiteboard to assist with organization and planning. Patient able to answer temporal orientation questions regarding their personal history with 70% accuracy and current daily schedule with 50% accuracy. She needed mod verbal cues from SLP, who trained caregiver in providing these same cues outside of sessions only when needed. Caregiver reports patient has been more visually attentive to the location of calendar and clock, but struggles with recognizing and properly using the whiteboard even with assist. Patient participated in verbal rehearsals to reinforce use of compensatory strategies and record time and date with max A in the form of visual aid. Patient appeared fatigued toward end of session, but demo'd slight improvements today. Continue POC as tolerated.

School-Based note

An occupational therapist might write the following daily note for a student seen in school-based therapy:

Teacher reports child demonstrates difficulty writing letters during class. Child completes 4/6 trials of fine motor activity with min A to prepare for writing, with s/s of moderate hand fatigue d/t facial grimacing and rest breaks. She is able to write her name in 2/2 trials with visual cues (boxes) and mod A from OT to stabilize paper with ipsilateral UE. OT educates child in use of universal cuff for RUE pencil grip in 2/3 trials. Child willing to break for 10 trials of gross motor/sensory activity with min A for motor planning. Teacher updates OT that sensory strategies have been very effective to moderate frustration tolerance during class. OT to continue trialing universal cuff next session. Continue POC as tolerated.

The following is an example of an SLP SOAP note in a school setting:

Student is being seen by SLP to address delayed speech and language skills. Student presents in a very happy mood. SLP screen shares bathroom vocabulary and student manipulates Bluey

character to complete bathroom tasks. ~85% accuracy for this activity. Letter sound matching bingo on computer with good visual attention and min A to help with selection between two options. 70% accuracy during this activity. Student tolerated today's visit well overall and demo'd 2-word combo independently for the first time, which is great progress! Continue POC as tolerated.

OT & SLP Goal Writing

Goal writing is another important aspect of documentation that is integral to the plan of care for OT and SLP patients. Just as with documentation of daily notes, therapists can use one of several goal formats to create measurable, appropriate goals for their patients. Again, variations in goal writing are present across different facilities and settings. The aim of goal setting is similar to documentation in that clarity is paramount, though succinct is not always the best practice in this area.

Goals must have enough specifications for therapists to determine whether or not patients have achieved them. Therefore, more detailed goals usually tend to be better as long as they are still readily understood by other providers. Many therapists have difficulty with this balance, which is why some research has been done on goal-setting in rehabilitation. Baker et al. (2023) found that four elements should be included in best practice guidelines, regardless of what format or style is used. These elements included a focus on the client, incorporating an action plan and review of goals on a periodic basis, creating goals that are meaningful to the client as well as specific enough to be achieved consistently, and having the team focus on some common goals. Therapists should keep this in mind when setting goals for their patients, regardless of their discipline and the format their goals follow. There are four main styles of goals, each of which incorporates important details that should be added to all goals:

- **SMART**: This is the most common goal format for rehabilitation providers and is even used in other industries. This stands for goals that are: **S**hort, **M**easurable, **A**chievable, **R**ealistic, and **T**ime-Sensitive. This means that they must be measurable and within the realm of possibility for the patient to achieve in order to be fitting. It is also important to have a time component included, as this helps payers and other providers understand when the goals may be achieved by. This also helps differentiate between short-term and long-term goals, as they are both written in much the same way.
- **FEAST**: This stands for **F**unction, **E**xpectation, **A**ction, **S**pecific conditions (assist levels, adaptations, equipment, etc.), and **T**imeline.
- **COAST**: This is another common goal, specifically within the OT field, as it specially includes occupation in its format. However, SLPs and even other healthcare professionals can also write COAST goals. This stands for goals that mention: **C**lient, **O**ccupation, **A**ssist level, **S**pecific condition, and **T**imeline. Therapists must identify the client before discussing the occupation in question, amount of assistance the client needs, conditions under which the client must complete the occupation, and the timeline for the goal to be achieved in.
- **RUMBA**: Lastly are RUMBA goals, which stand for goals that are: **R**elevant/**R**ealistic,

Understandable, **M**easurable, **B**ehavioral, and **A**chievable/**A**greed. There are many similar components here but perhaps the two that stand out the most are Understandable and Behaviorable. Understandable relates back to what we've mentioned early in the course about anyone being able to pick up your documentation and immediately understand what has been written. Behavioral connects the goals back to a particular action being done, which is what makes this goal format a good fit for SLPs, OTs, and other professionals such as behavior therapists.

Regardless of what style therapists use to write their goals, they should ensure the following areas are covered:

- A subject
    - In many cases, this means goals will begin by saying, "The patient will…," but some goals are focused on caregiver training and education so they may instead start with "The caregiver will…"
- The expected functional outcome
- Any factors that must be remediated to achieve the functional outcome
- Circumstances under which the functional outcome will be performed
- The degree to which the functional outcome will be demonstrated in order to be considered achieved
    - The quantifiable outcome is important for consistency and reimbursement. Therapists should include data such as, "... in 4 out of 5 trials," "...75% of the time," "...with 80% accuracy," "...with no more than 3 verbal cues," "...for 8-10 minutes," etc.

- **Section 5: Personal Reflection**

Is it advisable to use universal abbreviations when writing goals? Why or why not?

- **Section 5: Key Words**

Collaborative documentation: The shared creation of clinic visit notes between consumers and providers, common in behavioral health practices

Neuro-Linguistic Programming: A blended field that incorporates aspects of communication and psychology to help people understand how the internal representations of our surroundings impact our experiences

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Section 6: Documentation Best Practices [50,51,52]

We've covered quite a bit of information thus far, so it's fitting to end with some best practices that serve as good takeaways for the topic of documentation. Here are some final action points to keep in mind when creating any type of therapy documentation:

- Documentation should include the following details, as needed:
    - Severity, especially regarding chronic diseases and symptoms such as pain or swelling
    - Anatomical locations and laterality, especially for any physical agent modalities or manual techniques therapists provide or when documenting symptoms such as pain and swelling
    - Patient concerns that are both acute and chronic in nature
    - Comorbidities, which is particularly important when patients are being actively treated for conditions being worsened by comorbidities (such as diabetes and hypertension)
    - Complications, as they may presently impact the plan of care or stand to do so in the future
    - Contributing factors, which may be intrinsic (other health conditions, family history, age, etc.) or extrinsic (such as lifestyle choices and environment)
    - Cause and effect relationships, as these stand to impact services; this can be done using terms such as 'secondary to,' 'due to,' and 'associated with.'
- Whenever possible, add details that will help others understand the scope of a patient's condition.
    - For example, instead of saying a patient had a total hip replacement, mention the time frame. Treatment implications will differ between a THR that occurred 6 months ago and a THR from 2 years ago.
    - The same goes for health conditions. Instead of simply stating the patient has congestive heart failure, mention this along with their status (e.g. stable on medications, poorly managed, etc.).
- Treatment spaces should be designed or used in a way that accommodates point-of-service documentation while maintaining a strong focus on the patient, such as:
    - Providers may want to position their tablet or computer so they can alternate between looking at the patient and looking at their screen without needing to move their body much
    - Therapists should avoid having their back to the patient as much as possible so they can pick up on non-verbal cues that may aid in the evaluation and treatment process
    - During telehealth visits, providers may want to consider a two-screen set-up and dedicate one monitor to the visit and one to taking notes or split their screen between notes and the visit
- Plan before each visit as much as possible to assist with documentation during and after the session, which may mean jotting down important updates from chart reviews

beforehand so you can easily turn those into the subjective section of what then becomes a visit note

- Regular and ongoing EHR training is essential to help providers use technology as efficiently and responsibly as possible
    - Patient questionnaires, pick lists, macros, templates, and other features can all greatly aid in the documentation process while saving therapists a lot of time. In addition, each of the aforementioned features can often be customized to your needs and client list. Therapists in administrative positions should help their staff make these changes while individual contributors are urged to advocate for these changes.
    - Turn off all autocorrect and autofill features to prevent errors.
    - Ensure cloned notes are not being accidentally entered as new visit notes.
    - Allow timestamps on each and every piece of documentation, even for actions as small as simple chart updates. This ensures for accountability and safety. If there is no timestamp feature on your EHR or you are using paper documentation, all therapists should separate note updates using new paragraphs or bullet points with dates and initials.
- Self-auditing is a very helpful process that allows therapists to catch documentation mistakes before governing bodies, payers, and other third parties do.
    - Directors of rehabilitation can use standard medical audit tools to randomly assign charts for review, which ensures no one is reviewing their own documentation. Any audit results should be used to improve compliance and processes, as this is the only way a self-audit is valuable.
- Organizations and directors of rehabilitation are jointly responsible for developing medical records policies that comply with federal and state guidelines.
- All pieces of documentation should conclude with a clear signature (including their credentials) from the therapist who offered the treatment.
- Be sure to only use standardized abbreviations and acronyms in notes while keeping in mind that there is some crossover.
    - For example, CD can be used for conduct disorder and Crohn's disease. Therefore, using full names is important in lengthier documentation such as evaluations and standardized abbreviations are advised in daily notes and places where shorthand is more acceptable.
    - Symbols may be used in the subjective part of treatment notes as needed, but are not acceptable elsewhere in documentation.
- Avoid adding symptoms or patient complaints to documentation without also noting what you did to address those symptoms.
- Be sure to add preventive measures (e.g. educating on fall risk, techniques to avoid episodes of choking, etc.) to your documentation, since those are equally important as direct care.
- Always ensure that documentation is written in person-first language.
- A plan of care should include a prioritized problem list that addresses the patient's symptoms and/or deficits and short- and long-term goals that correlate with each item on the problem list.

- Patients may be discharged for any of the following reasons: they met their goals, they have attained the maximum benefit from therapy and no longer require skilled services due to performing at a functional level, they have moved to another facility or level of care (a lower level may be indicated due to an improvement in their medical status or a higher level is needed to manage a chronic disease exacerbation or major medical event such as a fall), they are no longer following therapist recommendations, they opt to discontinue services themselves, or they have reached the allotted length of stay for their current setting.
- Therapy discharges should be accompanied by any home exercises, strategies, or equipment recommendations the therapist wants their patient to continue performing or using; any client or family education; follow-up recommendations along with related rationales; and referrals to other agencies, if indicated.
- Avoid consistently using the following terms in documentation. Some of these terms are vague and offer no information as to a patient's functional progress while others suggest a patient's progress has stalled and can lead to claims denials. If a patient does begin to demonstrate behavior that aligns with these phrases, therapists must take appropriate actions, which may include discharging the patient from therapy services, adjusting the plan of care so that goals are more realistic for the patient's status, and/or recommending medical follow-up.
    - Undecided
    - Maintaining
    - Slight change in status
    - Plateau
    - Poor rehabilitation potential
    - Custodial care
    - Unconfirmed
    - Less pain
    - More pain
    - Noncompliant
    - Feeling/doing better
    - Feeling/doing worse
    - Uncooperative
    - Unmotivated

One of the major takeaways regarding therapy documentation is the need for therapists to properly convey the skilled, essential work they have done or plan to do. When therapists keep that in mind, the sometimes daunting task of creating effective documentation becomes much more manageable and can rightfully sit alongside patient care as one of the cornerstones of healthcare provision.

- Section 6: Personal Reflection

If a therapist used the phrase 'poor rehabilitation potential' in a patient's re-evaluation, what

supporting evidence should they include to justify a continuation of services?

- **Section 6: Key Words**

Custodial care: Assistance with activities of daily living that is non-medical in nature

Laterality: Related to a particular side of the body; for example, appropriate laterality involves treating a patient's left wrist to address a fracture at that location

Macros: Single-command automation used to replace repetitive tasks that involve multiple clicks and keystrokes

Pick list: A pre-made list of options available within an EHR; also known as drop-down lists, pick lists can be used by healthcare providers to quickly choose items such as billing codes, medications, and procedures.

Point-of-service documentation: The act of completing patient documentation and updating patient information while the patient is present; abbreviated POS documentation, point-of-service documentation is often completed with tablets or laptops and helps improve provider efficiency as long as it is done professionally and does not interfere with patient care

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