

Interpreting Physical Therapy Notes

Sending a patient to physical therapy does not always guarantee that they are going to receive the same treatment. In fact, the same patient with the same diagnosis sent to varying practices most likely will receive a variety of different treatment techniques. While all aimed at decreasing pain, increasing strength, and improving the patients' function, each therapist has their own different methods and techniques in which they feel will lead to the patient's recovery. Even when different therapists see the same patient in the same therapy practice, they often come up with a different plan of care for the patient to follow.

Some therapists may choose a modality oriented therapy approach, while others advocate exercises. Some therapists are overly aggressive with their patients and some insist on passive therapies. Many work injury patients endure an industrial rehabilitation approach while others go through more hands-on therapy. Most therapies have been proven to be successful and often if one approach is not working the therapist will switch gears to concentrate on a different technique. No one can say for sure which therapy technique would be most appropriate until the patient begins therapy.

Since there are so many different types of physical therapy, all aimed at accomplishing similar goals – often it is the case manager who finds themselves attempting to determine whether or not the therapy that the patient is receiving is justified, necessary, and appropriate.

Reading therapy notes

Scrutinizing Physical Therapy notes is an expected part of a case manager's job description. The case manager might need to estimate return to work dates or provide assistance in preparing the patient for return to work. Often, the case manager can provide input to the physician regarding their therapy. All too often this task becomes a struggle as medical terminology, medical abbreviations and what appears to be pure hieroglyphics get in the way.

Most physical therapy notes are written in a basic S.O.A.P. note format. The S.O.A.P. standing for Subjective, Objective, Analysis/Assessment and Plan. While not always defined by the letter, most PT notes will contain the S.O.A.P. information within the note. The case manager should be able to not only read the note, but interpret whether the correct course of action is being followed.



S = Subjective: This is the information that the patient tells the therapist. For example, “I had a much better night sleep last night” is a subjective comment made without any therapist interpretation. There should be no analysis or interpretation in this section. Try to look for the subjective portion of the note to be specific, such as “Pain = Level 4/10 or patient states he has made a 30% improvement overall”. The more specific this section of the note is, the easier the patient’s subjective input will be to follow throughout the course of their therapy.

O = Objective: This is the section of the note where any concrete measurements and treatments performed are recorded. This is the non-disputable portion of the record. For example, an objective section might state 1) Worked on proper positioning for sleeping 2) Lumbar flexion to 45 degrees today 3) Ultrasound 1.5 w/cm² for 10 minutes to lumbar spine with patient in prone. This section must be specific enough for another therapist to pick up and treat the patient should their treating therapist be out for the day.

A= Analysis/Assessment: In this analysis section, the therapists put their own thoughts in writing, such as “Patient appears to be improving” or “question patients’ compliance with home program”. None of this information came directly from the patient, but is extremely relevant as this section can tell you what the therapists’ impression of the situation is. The case manager should look for functional statements that may help determine if the therapy is appropriate. “Tolerated treatment well”... is a commonly used waste of words. It is nice to know that the patient tolerated that day’s treatment well, but what is really important is whether or not the patient is progressing through the overall therapy plan.

P = Plan: This is where the therapist writes what they would like to do going forward. If the treatment is to continue following the original plan from the evaluation/plan of care, then it might just say “Continue with current plan”. If the therapist would like to change a course of action, you might see “Begin more functional lifting activities next visit” written in this section.

As reimbursement issues have decreased the time a therapist is allowed to spend with a patient, note writing has taken a turn for the basic. Now pressed for time, the therapist must write only the basic details in a note – often using charts and flow sheets to reduce the time spent writing a note. These charts and graphs can often be more helpful than sheets of writing in interpreting a physical therapy note.

While a perfectly legal (but non-functional) therapy note might read:



- S = Better.
- O = US, Massage, Hamstring stretch
- A = Tol. Well
- P = Cont.

A good, functional therapy note should read more like this:

- S = Pt. States that he was able to lift his 20 pound son last night. He rates his pain at a 3/10 and feels he has made 60% improvement overall.
- O = 1) Interferential electrical stimulation 80-150Hz X-set up through pain x 20min. in prone.
2) Educated patient on good body mechanics with 10lb. Box lift. For 20 reps.
3) Prone lumbar extensions x 30 reps.
- A = Appears to be muscular, patient responding well to treatment, patient appears compliant with home program.
- P = Continue therapeutic exercise progression towards work simulation. Caution – patient needs constant verbal cueing with body mechanics.

While reading through the physical therapy note, it is helpful to understand the PT terminology and ‘short-hand’. While there is no official standard in PT note writing, many PT’s have adopted some of these common abbreviations. In recent years of declining reimbursement, PT’s have more patients on their schedules and have less time to write, therefore, they have come to rely more and more upon some standard abbreviations to speed up their note writing.

Often terminology is used interchangeably although often has different meanings. The Dictionary of Occupational Titles (1) has standardized industrial rehabilitation terminology by providing the following definitions for work restrictions:

Work Restriction	Lifting Max	Carrying Frequently
Sedentary work	10lbs.	10lbs.
Light work	20lbs.	10lbs.
Medium work	50lbs.	25lbs.
Heavy work	100lbs.	50lbs.
Very heavy work	Lifting over 100lbs.	

Time restrictions have also been standardized: (1)

No restrictions

Occasionally – activity or condition can be performed up to 1/3 of the time

Frequently – activity or condition can be performed from 1/3 to 2/3 of the time.

Constantly – activity or condition can be performed 2/3 or more of the time.



A therapist using these standardized terms when addressing a patient's ability to return to work will help decrease the chance of any communication problems between the therapist, case manager and employer.

Looking for Function

Medicare requires that all physical therapy performed on a patient be intended to improve the patient's function. Physical therapy note writing must reflect function in order for the physical therapy to be reimbursed. In order to determine whether a course of therapy is appropriate for a patient, make sure that the therapist is using return to function as their guiding light during the therapy.

A therapy evaluation, while noting objective physical findings should also note functional limitations.

For example:

Physical Findings

2/5 ant. Tibialis strength

10 deg external rotation of shoulder

Functional Limitations

Can not clear foot while walking

unable to elevate arm past shoulder level and unable to perform overhead work duties

The therapist should be able to translate the functional limitations into specific goals of therapy. Therapy goals should be reasonable, related to function and easily understood. There must be an expectation of return to function in a reasonable period of time.

For example:

Functional limitations

Can not elevate arm past Shoulder level

Functional Goal

Elevate arm to dress self independently by 2 weeks

The therapist should then translate the goals into effective treatment programs.

For example:

Functional Goal

Elevate arm to dress self independently by 2 weeks

Treatment

Shoulder mobilization, shoulder range of motion home program, modified lifting techniques for work

The therapy program should be continually heading towards the original functional goal. For example, a physical goal might be to reduce a patient's pain, but the functional goal should be to return them to lifting 25 pound boxes at work. Although often important to achieve the physical goal before achieving the functional one, the therapist should be always keeping the functional goal as a part of the design of the treatment program. In our example, even though the patient is experiencing a pain level of 5/10, they may still be able to perform lumbar stabilization exercise in an aquatic therapy pool or practice



good body mechanics with an empty box. It is important that the treatment being performed be oriented towards achieving a functional outcome.

Denying Coverage

Repeated treatments over and over with little to no improvement should be a red flag for a case manager. Ultrasound, when used appropriately can be a tremendous asset to a therapist, but once the patient progresses to a more active phase of therapy, ultrasound treatments can usually be discarded. Continuous hands-on treatments like massage can be abused if they are not used concurrently with an active or exercise oriented treatments. Often patients, who like the feel of the massage during the treatment, will resist doing the active (harder) therapy. Massage techniques should not be allowed to continue indefinitely without the addition of muscular strengthening activities.

Poor demonstration of compliance by the patient should be another cause for concern. The therapy clinic should be documenting both the attended and the missed treatment visits. If the therapy is ordered 3 times per week and the patient is missing every other appointment, then the course of therapy is being severely limited by the patient, and a positive outcome will be harder if not impossible to achieve.

Therapy at home should be an extension or addition to what is performed in the clinic. Question a therapist who does not issue a home program of exercises and/or activities for the patient. A therapist who sees a patient for 3 hours per week can not expect to make permanent lifestyle changes with the patient unless they are incorporating some of what the patient is doing in therapy into their home environment.

Most importantly, watch therapy documentation for signs of improving function. For example, if difficulty sleeping is presented as a problem, then some position education and a cervical pillow would be appropriate therapy aimed at getting an improved functional outcome. The therapist might be contributing to the patient's problem by not addressing sleep as a functional issue. If all of the therapy is aimed at the patient's pain, then it is likely that functional issues are being missed by the therapist.

The Importance of Communication

Open lines of communication with the therapist. The physical therapist is highly trained to design often complex treatment programs that must take into account physical and functional goals, including return to work goals. In addition, it is important to realize that the program that has been designed also reflects the patient's past medical and psychological history as well as tissue healing time. Ligamentous injury may take 3 to 6



weeks to heal, muscle tissue may take 2-3 weeks, and bone injuries can take up to 12 weeks for the tissue to heal enough to start an aggressive rehabilitation program. So any time you begin to question the design of a rehabilitation program, start by questioning the therapist themselves and opening up a line of communication.

The benefits of a highly involved communicative case manager are felt by the therapist, the physician, the employer and most importantly the patient, helping them to achieve the best possible outcome.

Bibliography

1. Dictionary of Occupational Titles, Vol. 1, US Department of Labor, NTC Publishing Group, April 1992.





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