

Subjective

- Date of Initial Exam / Start of Care are correct date of initial evaluation.
- Diagnosis code – can list more than one codes; code should start with M (in some cases can start with R, if stated on the referral).
 - Delete “unknown code” and make sure diagnosis and treatment code are the same (can be done using the copy button).
- Check injury/onset date is correct (can make same day as initial eval if unknown).
- History of Present Condition / MOI:
 - This will not be copied over from each visit....only Progress notes and Discharge notes; should include all pertinent subjective history.
- Primary Concern / Chief Complaint:
 - This will be copied over from eval to future daily notes
 - Short, general description of issue here. Example: “Low back pain” or “Post-Op R RTC 5/20/21.” Can include surgeon/doctor follow-up appt dates here.

The screenshot shows a medical form for subjective history. It includes fields for Date of Initial Examination (January 14, 2022), Time In/Time Out (No), Visit # (1), and Diagnosis (M79.605 Pain in left leg). There is a section for Treatment Diagnosis with the same code and description. Below this are checkboxes for Treatment Side (N/A, Left, Right), Specific Physician Orders (No), Injury/Onset Date/Change of Status Date (January 14, 2022), and checkboxes for Chronic, Insidious, New Injury, and No New Aggravation/Injury. There are also checkboxes for Surgery Performed (No), Prior Hospitalization (No), and Pelvic Profile/Speech Profile (Select). A section for Movement-Based Spinal Assessment Questionnaire has a No checkbox. The History of Present Condition/Mechanism of Injury field contains the text: "Pt. began experiencing L LE symptoms 1/3/21. She reports her pain starts in her hip/back area and extend down the leg." The Primary Concern/Chief Complaint field contains the text: "L LE pain".

- Prior Level of Function / Current Functional Limitations – *Medicaid patients only!*
 - Anything patient was completing previously can be checked and anything patient is limited in now can be checked. Example: If patient reports difficulty with folding laundry—Self Care > Household Chores > Laundry should be checked.
- Pain
 - List primary and/or secondary complaints with pain levels. This can be updated during progress notes/re-evaluation.

- Medical History
 - Much of this information will be found on the patient's intake form but still needs to be completed for eval.
 - In the top left corner, under the patient's name, click "eDoc" then open the file labeled "intake."
 - Prescription information is not included in the intake info so will need to be manually added if necessary.
- Patient Goals:
 - Specific goal(s) a patient has for physical therapy or ways in which they report they will know they were successful for therapy- *should be asked with every patient!*

Objective

First, select your examination profile. Scroll to "clinic profiles" to find simple templates designed by RPI employees by body part. For example, for a patient with low back pain, you may choose "EH-LBP."

NOTE: If information from a previous evaluation has already been entered, selecting a new examination template will clear all previous information!

Below the examination profile, you can also add tests. For example, if wanting to add "myotomal testing" this can be added here. Going through and adding tests you anticipate you will want to do can help you develop a plan for the examination.

- Outcome Measurement Tool: Every patient should have an outcome they are completing. If this has been entered by PSS since opening the note, you will need to refresh the browser to add the outcome. Be sure the outcome is the most up to date.
- Observation: Include any pertinent information as well as SFMA Top Tier Info when appropriate.

SFMA
 Cervical Flexion:
 Cervical Extension:
 R Cervical Rot:
 L Cervical Rot:
 R UE Pattern 1:
 L UE Pattern 1:
 R UE Pattern 2:

L UE Pattern 2:
 MS Flexion:
 MS Extension:
 R MS Rotation:
 L MS Rotation:
 R SL Stance:
 L SL Stance:
 Squat:

- Range of Motion: Can be manually entered or with drop-down boxes. If manually entered, all SFMA breakouts are:

Cervical Flexion:		L: /30°
Cervical Spine Rotation:	LL Thoracic Spine Rotation:	
R: /80°	R: /50°	Hip External Rotation:
L: /80°	L: /50°	R: /40°
		L: /40°
Shoulder Flexion/Abduction:	Lumbar Flexion:	
R: /170°		Tibial Internal Rotation:
L: /170°	Lumbar Extension:	R: /20°
		L: /20°
Shoulder External Rotation:	Active Straight Leg Raise:	
R: /90°x	R: /70°	Tibial External Rotation:
L: /90°	L: /70°	R: /20°
		L: /20°
Shoulder Internal Rotation:	Passive Straight Leg Raise:	
R: /60°	R: /80°	Ankle Inversion:
L: /60°	L: /80°	
		Ankle Eversion:
Shoulder Extension:	Hip Flexion:	
R: /50°	R: /120°	CKC Ankle DF:
L: /50°	L: /120°	R: /40°
		L: /40°
Elbow Flexion:	Hip Internal Rotation:	
	R: /30°	

- Strength: Any pertinent strength measurements or stability/motor control limitations found via SFMA breakouts.
- Neuro-Vascular: Any reports of N/T by patient, myotomes, dermatomes, neural tension testing results.
- Special Tests: Can be selected by drop down or manually entered under “additional comments.” This can include functional tests or results from assessments such as FMS, Motor Control Screen, Dynamic Gait Index, Sit to Stands, etc.
- Palpation: Additional comments should include any muscle hypertonicity/tenderness noted or joint mobility observations, such as “hypomobile and painful T4.”

Assessment

- Include all pertinent information about the patient, their diagnosis, noted limitations, and anticipated prognosis.
 - *Example: Patient is a 50 year-old male who reports to physical therapy with primary complaints of R hamstring pain, that recently began with running. Patient's symptoms are consistent with a grade I hamstring strain, secondary to limitations in posterior mobility, bilateral hip ER, and bilateral thoracic mobility. Pt. also has deficits in hamstring strength and pelvic/core motor control. Pt. is otherwise healthy As patient's symptoms began only recently and are mild at this time, I expect him to respond well to physical therapy. Patient would benefit from continued skilled physical therapy in order to address the above limitations and LE strengthening and work towards returning to PLOF.*

- Under “Problem List” you can list all issues pertinent to patient’s care. These can be listed separately or together.
 - *Example: Pain, mobility and stability/strength deficits, and decreased ability to perform daily functional and recreational activity.*
- Short and long term goals should also be created for the patient; some goals have been auto generated in Smart Text.
 - *Example: Patient demonstrates good understanding of home exercise program.*
- For those insurances requiring authorization, please ensure you have a functional activity linked to each goal.
 - *Example: Patient will demonstrate 40 degrees of CKC dorsiflexion in order to squat to pick up object from ground and perform stairs reciprocally without pain.*

Plan

- Check “complete plan of care document.”
- Fill in a frequency and duration.
- Make sure dates are correct to match duration and that the dates begin the same day as the initial examination.

Billing

- Billing Rules:
 - Cash
 - Bill as you normally would but be sure insurance listed is “self pay.”
 - Private Insurance: For a 40 minute appointment, at least 4-5 units should be billed. Below are the rules *per unit*. An example is below.
 - 0-15 minutes: 1 unit
 - 16-30 minutes: 2 units
 - 31-45 minutes: 3 units
 - 46-60 minutes: 4 units
 - Medicaid/Medicare: 8 Minute Rule
 - 8 to 22 minutes: 1 unit
 - 23 to 37 minutes: 2 units
 - 38 to 52 minute: 3 units
 - 53 to 67 minutes: 4 units
 - 68 to 82 minutes : 5 units
 - 83 to 97 minutes: 6 units

Below are examples of what a similar treatment session with private insurance vs. medicare/medicaid may look like.

1	Therapeutic Exercise	Additional Modifiers
8	Minutes	
Patient education regarding diagnosis, prognosis, and plan of care. HEP Education & Demonstration SFMA		
2	Neuromuscular Re-Education	Additional Modifiers
<input type="checkbox"/> Proprioception/Balance Training <input type="checkbox"/> Canalith Repositioning <input type="checkbox"/> Posture		
18	Minutes	
ASLR w/ PA + chin tucks PNF Posterior Chain		
<input type="checkbox"/> Aquatic Exercise <input type="checkbox"/> Gait Training <input type="checkbox"/> Massage		
1	Manual Therapy	Additional Modifiers
<input type="checkbox"/> Strain-Counterstrain		
8	Minutes	
IASTM + eStim R Hamstring, Piriformis, B Suboccipitals		
Therapeutic Activity/Kinetic		
1	Self Care- ADLs	Additional Modifiers
6	Minutes	
Training modifications Education regarding hot/cold and use of compression		

1	Therapeutic Exercise	Additional Modifiers
14	Minutes	
Patient education regarding diagnosis, prognosis, and plan of care. HEP Education & Demonstration SFMA Training modifications; education regarding modalities		
1	Neuromuscular Re-Education	Additional Modifiers
<input type="checkbox"/> Proprioception/Balance Training <input type="checkbox"/> Canalith Repositioning <input type="checkbox"/> Posture		
18	Minutes	
ASLR w/ PA + chin tucks PNF Posterior Chain		
<input type="checkbox"/> Aquatic Exercise <input type="checkbox"/> Gait Training <input type="checkbox"/> Massage		
1	Manual Therapy	Additional Modifiers
<input type="checkbox"/> Strain-Counterstrain		
8	Minutes	
IASTM + eStim R Hamstring, Piriformis, B Suboccipitals		
Therapeutic Activity/Kinetic		

Other Important Reminders

- Any initial evaluations or progress notes that state “AUTH REQ” on the schedule should be prioritized and completed by the end of the same day as they require our billing team to submit information to the insurance company for authorization.
- Progress notes, generally speaking, are completed about every 30 days. I will sometimes complete these earlier or later if a patient has a follow-up with a referring provider, such as a surgeon, and fax the note to the provider.