Sample Initial Evaluation
for Medicare Part A or B or other payer source
Complex Disease Management of the Older Adult

Patient Name:	Mary C. Jones	**Date of Evaluation:**	04/01/09
MR #:	010101	**Provider Name:**	ABC Health & Rehab
Reason for Referral:	New onset of decrease in strength & functional mobility secondary to pneumonia; complicated by previously compromised pulmonary status due to COPD. Patient is at risk for continued decline & dependence on others as well as falls/injury.	**Date of Birth:**	01/13/1925
Chief Complaint:	"I feel too weak to get out of bed and participate in my activities"		
History of Present Illness or Injury:	Patient was hospitalized from 03/22/09 thru 03/31/09 with diagnosis of RLL pneumonia. While hospitalized, her insulin injections for DM had to be readjusted and she developed Stage I pressure ulcers on bilateral heels.		
Surgical History	None affecting current condition		
Medications:	Elavil® for depression; Aricept® for Alzheimer's dementia; Corgard® for HTN; Humulin® per sliding scale; 2 L/min O_2 via nasal cannula; Nebulizer q4hrs during the day		
PMHx: Personal History	Resident of ABC Health & Rehab x 18 months. Widowed		
PMHx: Health Status	5'4" female; wt 121 lbs on date of admission; reflects a 5# wt loss since discharge on 03/22/09. H/o HTN, COPD, Type 2 DM on insulin, dx with early stages of Alzheimer's 12 months ago.		
PMHx: Social History	Widowed. Daughter & son-in-law visit regularly.		
Examination Findings:			
Systems Review:	**Cardiovascular/Pulmonary System:** Chest wall mobility symmetrical, but decreased. Breath sounds – coarse rales in RLL. **HR (bpm):** at rest = 82 bpm **Resp Rate (breaths/min):** 24 br/min; upper chest utilized at rest & accessory muscle use with incr. activities **BP (mm Hg):** at rest = 130/90 **Integumentary System:** Stage I pressure ulcers noted on bilat heels. Approxi 3.5 cm in diameter on Rt & 4.0 cm diameter on Lt. Nursing has measures in place to float heels while patient is in bed. Will continue to monitor but no further examination is necessary at this time. **Neuromuscular System:** No further examination is indicated. **Musculoskeletal System:** Further examination is indicated. **Pain:** 4/10 on Visual Analog Scale in bilateral rib area, but patient reports it does not impact her functional activities.		
Communication,	**Communication:** poor breath support, but patient is able to communicate verbally		

Affect, Orientation, Cognition & Learning	**Orientation:** Alert & oriented x 2 (person & place), but is confused about time **Emotional/behavioral responses:** Appear appropriate **Learning barriers:** Patient will benefit from visual and verbal cues more than written ones.
Arousal, Attention, & Cognition	**Level of Consciousness:** fluctuates depending on time of day and medication schedule **Affect:** WFL **Orientation:** as above **Attention:** requires verbal cues to stay on task **Sequencing:** Unable to sequence 2 step commands **Memory:** Fair surrounding recent events; does remember friends here at ABC H&R and the activities she regularly participated in **Communication:** WFL **Initiation of activity:** Impaired initiation of activity **Safety:** Diminished safety awareness
Circulation	**BP:** 130/90 resting **in** sitting **position** **Heart Rhythm:** Regular
ROM	Bilateral shoulder flex approxi 110 degr Bilateral shoulder abd approxi 100 degr Bilateral elbow flex/ext WFL Bilateral hip flex approxi 120 degr Bilateral hip ext approxi -10 degr Bilateral knee ext approxi -20 degr Bilateral knee flex/plantarflexion WFL Bilateral ankle dorsiflexion approxi 0 degr
Joint Integrity	Slight crepitation in shoulders & knees with full AROM
MMT	Measured in sitting: Bilateral shoulder flexors & abductors 3/5 Bilateral elbow flexors 4/5 Bilateral elbow extensors 3+/5. Bilateral hip flexors 3/5 Bilateral knee extensors 4/5 Bilateral knee flexors 3+/5 Bilateral ankle dorsiflexors 4/5. Functional Strength Tests: Chair Rise Test. Patient completed 3 chair rises in 30 sec (norm for 84 yo is 9-14). One repetition max (1RM) of proximal LE muscles is 15 lbs; 1RM of distal LE muscles is 18 lbs
Reflex Testing	Not indicated
Functional Mobility:	**Bed mobility:** PLOF = Indep; CLOF = SBA w/verbal cueing **Supine to sitting:** PLOF = Indep; CLOF = Min assist w/verbal cueing **Transfers/Transitions:** PLOF = Indep; CLOF = Mod assist w/verbal cueing **Wheelchair to bed:** PLOF = Indep; CLOF = Mod assist w/verbal cueing **Sitting Balance:** PLOF = Indep; CLOF = SBA **Standing Balance:** PLOF = Indep with assistive device; CLOF = see test scores **Gait:** PLOF= Modified independence in facility with RW; ambulated throughout facility; on community outings, required SBA for uneven terrain. CLOF = Min assist to

	stand to walker. Ambulates with RW with SBA with decreased hip & knee flexion resulting in decreased step height, flexed posture, and mild-moderate deviation in path **Functional Test Scores:** Tinetti score 14/28 (<16/28 is high fall risk) Timed Up & Go score 25.2 sec using rolling walker (norm for community dwelling 84 yo is 10-12.7 sec) ***After Gait assessment, Tinetti & TUG tests:*** Borg RPE 16 (on 6-20 scale), HR 95 bpm, BP 140/96 in sitting, and respirations were 28/min. O_2 sat 88% ***After 2 min rest period:*** HR 85 bpm, BP 130/93 in sitting, and respirations were 25/min. O_2 sat 90%
PT Evaluation	**Problem List/Impairments:** Impaired cardiopulmonary performance with functional activities, impaired gait, impaired motor function, poor balance. PT to complete Falls Efficacy Scale and Geriatric Depression Scale on next visit. **Functional Limitations:** Impaired gait, impaired balance, decreased safety during functional activities, limitations in functional capacity and performance **Disability:** Patient is unsafe to function independently in present environment **Prevention:** need to increase activity and implement measures to prevent further development of pressure ulcers on heels & other bony prominences; request referral to occupational therapy for ADL assessment due to limitations in functional performance; request referral to SLP due to 5# weight loss and aspiration risk from cardiopulmonary compromise and cognitive impairment. **Preferred Practice Pattern:** Cardiovascular / Pulmonary Pattern F: Impaired Ventilation & Respiration/ Gas Exchange Associated with Respiratory Failure **Discharge Recommendation:** Anticipate Ms. Jones will return to her PLOF in this facility with an appropriate functional maintenance plan.
Diagnosis:	**Medical Diagnosis:** Pneumonia 486.0 / COPD 496.0 / DM 250.0 **Treatment Diagnosis:** Difficulty walking 719.7; Respiratory abnormality 786.00
Prognosis:	Good
Plan of Care:	5 x week x 8 wks
Interventions	Therapeutic Exercise: *Weight bearing exercise for LE's starting at 40% of 1RM & progressing to 70% of 1RM; stretching exercises to increase hip extension, knee extension & ankle dorsiflexion* Neuromuscular Re-education: *Dynamic balance activities in standing with eyes open & eyes close, different surfaces; activities to challenge limits of stability* Therapeutic Activities: *Transfer training to increase independence & safety* Gait Training: *functional gait training with assistive gait on different surfaces and in variable environmental contexts* Group Therapy: *as indicated to incorporate strengthening exercise and standing dynamic balance* Chest PT to mobilize secretions: *postural draining and breathing exercises* *All as indicated*

STG's (4 weeks)	1. Exhibit improved airway clearance as demonstrate by ability o perform voluntary cough with 5 verbal cues. 2. Increased ventilation as demonstrated by ability to perform segmental breathing in lower lobes with constant tactile cues and only 2-3 verbal cues 3. Increase bed mobility & sit to stand to indep so patient can indep change positions and promote skin integrity 4. Increase 1RM in LE's by 2 lbs to promote improved functional LE strength in order to facilitate independent sit to stand transfers
LTG's (8 weeks)	1. Increase functional LE strength as measured by the Chair Rise Test to 9 reps in 30 sec. 2. Patient to ambulate independently with RW 500' (distance to dining/activities room) without rest and with normal changes in HR, BP & RR 3. Increase TUG score to </= 17.5 sec (MCID is 7.7 sec) to demonstrate increased functional mobility 4. Increase Tinetti score to 20/28 to demonstrate decreased risk for fall 5. Increase transfers in/out bed & chairs to independent to enable patient to move around facility independently
Signature of Therapist	***Ima Therapist, PT***

Sample Less Than Optimal Initial Evaluation
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<table>
<tr><td>Patient Name:</td><td>Mary C. Jones</td><td>Date of Evaluation:</td><td>04/01/09</td></tr>
<tr><td>MR #:</td><td>010101</td><td>Provider Name:</td><td>ABC Health & Rehab</td></tr>
<tr><td>Reason for Referral:</td><td>Recently hospitalized – now weak</td><td>Date of Birth:</td><td>01/13/1925</td></tr>
<tr><td>Chief Complaint:</td><td colspan="3">"I feel too weak to get out of bed and participate in my activities"</td></tr>
<tr><td>History of Present Illness or Injury:</td><td colspan="3">Patient was hospitalized from 03/22/09 thru 03/31/09 for pneumonia.</td></tr>
<tr><td>PMHx: Health Status</td><td colspan="3">5'4" female; wt 121 lbs on date of admission; reflects a 5# wt loss since discharge on 03/22/09. H/o HTN, COPD, Type 2 DM on insulin, dx with early stages of Alzheimer's 12 months ago.</td></tr>
<tr><td colspan="4">Examination Findings:</td></tr>
<tr><td>Systems Review:</td><td colspan="3">Cardiovascular/Pulmonary System: on oxygen
Integumentary System: Stage I pressure ulcers noted on bilat heels.
Neuromuscular System: No further examination is indicated.
Musculoskeletal System: Further examination is indicated.
Orientation: A&O x 2</td></tr>
<tr><td>Vital Signs</td><td colspan="3">BP: 130/90 ; HR 85 bpm</td></tr>
<tr><td>ROM</td><td colspan="3">B. Sh ✓& / WFL
B. elbow ✓& / WFL
B. hip ✓& / WFL
B knee ✓& / WFL</td></tr>
<tr><td>MMT</td><td colspan="3">See OT eval for UE strength
B hip ✓& / 3+
B knee ✓& / 4-</td></tr>
<tr><td>Functional Mobility:</td><td colspan="3">Bed mobility: SBA
Transfers: Mod assist
Sitting Balance: P
Standing Balance: P-
Gait: Unable</td></tr>
<tr><td>PT Evaluation</td><td colspan="3">Problem List/Impairments: Poor balance and gait. Decreased strength. Patient will benefit from PT
Discharge Recommendation: SNF</td></tr>
<tr><td>Prognosis:</td><td colspan="3">Fair to Good for stated goals</td></tr>
<tr><td>Plan of Care:</td><td colspan="3">5 x week x 8 wks</td></tr>
<tr><td>Interventions</td><td colspan="3">Ther Ex; Ther Acti; Gait; Group Therapy</td></tr>
<tr><td>STG's (4 weeks)</td><td colspan="3">1. Bed mobility increased to indep
2. Transfers to min assist
3. Strength in LE's to 4/5</td></tr>
<tr><td>LTG's (8 weeks)</td><td colspan="3">1. Transfers to indep</td></tr>
</table>

	2. Sitting & Standing balance to F+ 3. Strength in LE's to 4+/5 **4.** Ambulate with LRD 500' with SBA

Weaknesses in this documentation:

- Reason for referral:
    - Too vague. One might think that a patient can recover from a hospitalization without physical therapy intervention.
    - It should describe the functional problems the patient may now be having and therefore explain why PT is necessary.
- History of present illness or injury:
    - Again, the documentation is too general and doesn't explain why this patient's condition requires skilled services.
- Past Medical History:
    - There is no mention of medications and no mention of social history.
    - It is important to assess social history as an indicator of quality of life even though the patient is likely to be a resident of a long term care facility.
- Systems Review:
    - Very little in the area of Cardiovascular/Pulmonary System review even though the patient's most recent hospitalization was due to pneumonia.
    - Record of vital signs does not indicate conditions under which they were taken.
    - Very brief review of integumentary system even though it is noted the patient has Stage 1 pressure ulcers.
    - No mention of patient's learning needs or communication. This is especially important given the recent diagnosis of Alzheimer's disease.
    - No mention of pain or documentation if it was assessed.
- Objective Findings
    - Too many abbreviations.
    - Muscle testing very generalized without an explanation of why.
    - No functional muscle testing tests used.
    - Physical therapists should evaluate upper extremities rather than delegating it to the OT.
    - Very vague with functional mobility (transfers where?) leaving many unanswered questions.
    - No qualifiers on the movement.
    - No objective measures of balance.
    - Gait was not assessed. No explanation of why the patient was unable. Yet there is a goal for it on the POC. How can a goal be written when the patient's current level is unknown? How will progress be compared? How will safety be insured?
- Assessment
    - The assessment doesn't pull together the findings and explain the reason PT is medically necessary.
    - Impairments and functional limitations are not documented/
    - No diagnosis.

- PT prognosis is not meaningful; PT sounds unsure.

- Plan
  - The plan includes no detail. It would be difficult for the PTA (or anyone else besides the evaluating PT) to step in and treat this patient without talking with the PT and finding out more information or spending additional time with the patient before treating her to become more well-informed.
- Goals
  - Goals do not use objective measures.
  - Goals do not have a functional component to them.
  - ST and LT goals are repetitive of each other.
  - Goals don’t address overall functional activities the patient will need to achieve – only parts of them.

Sample Visit Note
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Patient Name:	Mary C. Jones	**Date of Evaluation:**	04/01/09
MR #:	010101	**Provider Name:**	ABC Health & Rehab
Reason for Referral:	New onset of decrease in strength & functional mobility secondary to pneumonia; complicated by previously compromised pulmonary status due to COPD. Patient is at risk for continued decline & dependence on others as well as falls/injury.	**Date of Birth:**	01/13/1925
Date of Service:	April 2, 2009 10:15 am Patient brought to therapy gym by PT Aide in WC form treatment		
Patient Comments:	Patient states she is ready to feel strong again.		
Vital Signs:	BP sitting at rest: 135/92 Radial pulse: 85 bpm Resp Rate: 24 br/min Patient on 2 L nasal O_2 ; Pulse Ox: 98%		
Skilled services provided	Therapeutic Activities: Patient instructed in stand-pivot transfers from WC to mat table. Patient required 100% verbal cues for using UE's to push up from WC and for foot placement. Patient required moderate physical assistance to stand, pivot and sit down on the mat table. Patient sat on edge of mat table for approxi 2 minutes, then was instructed in using arms to lower UB down. Patient required max assist to lift LE's up on mat. Therapeutic Exercise: In supine, patient performed LE strengthening exercise all at 1 set x 8 reps: Heel slides & hip abd/add with 6# wts; TKE's with 7# wts. Rolled to sidelying for hamstring curls using 7# wts – patient required 75% verbal cues & 50% physical assistance for correct motion. Half bridges performed 2 s x 5 reps Gait Training: Patient received gait training with RW with SBA 50' x two (with 2 min rest between). Pt required 75% verbal & manual cues to advance walker safely, increase head and hip extension, and to increase step length. Chest PT: Following exercise and gait training, when vital signs returned to baseline, patient was positioned sidelying on left side for approximately 10 min. She received vibropercussion to RLL, followed by verbal cues to cough and instruction in diaphragmatic breathing.		
Total Treatment time	50 minutes		
Signature of Therapist	***John Hancock, PTA***		

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Patient Name:	Mary C. Jones	**Date of Evaluation:**	04/01/09
MR #:	010101	**Provider Name:**	ABC Health & Rehab
Date of Service:	April 2, 2009		
Patient Comments:	"I don't feel like doing this"		
Vital Signs:	BP: 135/92 Pulse : 85 bpm Patient on 2 L nasal O_2		
Skilled services provided	Transfer training WC to mat table. Worked on sitting balance on edge of mat table. LE exercise on mat - all at 1 set x 8 reps – with 2# wt: HS, Hip Ad/Ab, TKE's, HC, bridges Patient ambulated with RW with SBA 50' x two (with 2 min rest between). Pt has decreased step length and trouble using the walker		
Total Treatment time	50 minutes		
Signature of Therapist	***John Hancock, PTA***		

Weaknesses in this documentation:

- It would be helpful to state where the patient is treated
- Subjective:
  - The Patient's comment could probably be left out since it does not contribute to the patient being in therapy. It might be better to ask the patient about level of pain, or if she was feeling dizzy, etc.
- Objective:
  - No mention of position vital signs were taken in.
  - It isn't documented where the pulse was taken.
  - A patient on nasal oxygen should have respiration rate and O_2 Sats monitored too.
  - Description of transfer training and sitting balance activities are vague and do not describe the skilled nature of treatment that required a PTA to be with the patient.
  - LE exercise – does not document position of exercises, verbal cues or manual cues necessary that would require a PTA perform these with the patient. Since no objective measure of strength was taken at evaluation, how did the PTA determine that 2# was appropriate and safe to use with the patient?
  - Gait analysis is documented, but if gait training (97116)is going to be billed, there must be documentation of what 'training' was provided, rather than documentation of "ambulating" with the patient.

    - No description of CPT codes that will be billed is in included
    - The documentation does not support the 'intensity' (i.e. 50 minutes) of services to be billed; i.e. after reading the documentation, does it seem as though it would take 50 minutes to perform those activities?
- Assessment & Plan
    - Note these sections are left out of the daily note since Medicare Part B guidelines state that only a PT can write these parts of the note.