	NC Board of Physical Therapy Examiners [NC PT Practice Act (PA) & Board Rules (BR)]	NC Policies Governing Services for Children with Disabilities	NC Medicaid LEA Policy 10C	APTA Guide to Physical Therapy Practice
EVALUATION	(PA) 90-270.90.4 Definitions. "Physical therapy" means the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function. (omitted text) Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. (BR) 21 NCAC 48C .0101 PERMITTED PRACTICE *[Scope of PT Practice]* (d) The practice of physical therapy includes tests of joint motion, muscle length and strength, posture and gait, limb length and circumference, activities of daily living,	NC 1500-2.11 (b) (9) **Motor Evaluation** Obtains and provides information to assess a student's current level of motoric functioning and any problems encountered in performing motor tasks. This information may be collected through review of educational and medical records; interviews with teachers, parents, and others, including the student; clinical observations; and the administration of formal testing instruments, procedures, and techniques. A motor evaluation should include, but is not limited to, as many of the areas listed below as may be appropriate: (i) musculoskeletal status; (ii) neuromotor/neurodevelopmental status; (iii) gross-motor development and coordination; (iv) fine-motor development and coordination; (v) sensory-motor skills; (vi) visual-motor skills; (vii) bilateral coordination; (viii) postural control and balance skills; (ix) praxis/motor planning skills; (x) oral-motor skills; and (xi) gait and functional mobility skills. Motor evaluations are performed by physical therapists or occupational therapists. Oral motor skills may be assessed by	3.9.3 Evaluation Services are the administration of an evaluation protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol can consist of interviews with parent(s), legal guardian(s), other family member(s), other service providers, and teachers to collect assessment data from inventories, surveys, and questionnaires.	PTs conduct a history, perform a systems review, and use tests and measures to obtain information about all major body systems to determine if there is sufficient information to: • suggest the need for referral to another provider and/or additional medical evaluation (during initial encounter & all interactions) • Indicate the individual would benefit from physical therapy • Develop the PoC • Progress the PoC based on individual's response to intervention The physical therapist's evaluation includes: -History (including symptom investigation & review of systems) -Systems review (musculoskeletal neuromuscular, cardiovascular/pulmonary, and integumentary systems) -Interpretation of individual's response to tests and measures -Integration of all data with other information collected -Determination of diagnosis(es) amenable to physical therapist management

	pulmonary function, cardio-vascular function, nerve and muscle electrical properties, orthotic and prosthetic fit and function, sensation and sensory perception, reflexes and muscle tone, and sensorimotor and other skilled performances...Physical therapy further includes: (1) examining (history, system review and tests and measures) individuals in order to determine a diagnosis, prognosis, and intervention within the physical therapist's scope of practice. Tests and measures include the following: (A) aerobic capacity and endurance; (B) anthropometric characteristics; (C) arousal, attention, and cognition; (D) assistive and adaptive devices; (E) community and work (job/school/play) integration or reintegration; (F) cranial nerve integrity; (G) environmental, home, and work (job/school/play) barriers; (H) ergonomics and body mechanics; (I) gait, locomotion, and balance; (J) integumentary integrity; (K) joint integrity and mobility; (L) motor function; (M) muscle performance; (N) neuromotor development and sensory integration; (O) orthotic, protective and supportive devices; (P) pain;	speech-language pathologists when appropriate. (10) Observation Observations of school aged children usually occur in the regular classroom and/or settings related to the area(s) of concern and must document areas of strength as well as areas of need. Observations of school aged children shall assess academic skills and functional skills, which includes behavior. Observations of preschool children should occur in the natural environment; that is, the setting within the community where preschool children without disabilities usually are found (home, child care, preschool classes, Head Start, etc.) and must document areas of strength and areas which are the focus of concern. Observational data on preschool children may include interactions with persons and objects, and compliance with structure, taking into consideration age-appropriate expectations. Observations may be conducted by a teacher (who is not the teacher of the child), social worker, program coordinator, school psychologist, related services provider or other involved professional. Observations cannot be limited to assessment observations and must include a third-party observation.		-Determination of prognosis and goals for physical therapist management Tests & Measures Means of gathering data to: -rule in or rule out causes of impairment in body structures and functions, activity limitations, and participation restrictions. -confirm or reject hypothesis about contributing factors to current level of function -support clinical judgments about diagnosis, prognosis & PoC and/or -document outcomes of services provided. A physical therapist evaluation must be conducted during the initial session with the individual prior to establishing a physical therapist plan of care. Collection of data and information also is performed as part of each visit to determine any changes since the last visit, current status in specific areas, and whether progression toward goals is as expected. Factors that influence the complexity of the evaluation process include the clinical findings, the extent of loss of function, social considerations, and overall physical function and health status. The evaluation reflects the chronicity or severity of the current problem, the possibility of multisite or multisystem involvement, the presence of preexisting systemic conditions or diseases, and the stability of the condition. Physical

	(Q) posture; (R) prosthetic requirements; (S) range of motion; (T) reflex integrity; (U) self-care and home management; (V) sensory integrity; and (W) ventilation, respiration, and circulation. 21 NCAC 48C .0102 RESPONSIBILITIES (l) A physical therapist shall document every evaluation and intervention or treatment including the following elements: (1) authentication (signature and designation) by the physical therapist who performed the service; (2) date of the evaluation or treatment; (3) length of time of total treatment session or evaluation; (4) patient status report; (5) changes in clinical status… [omitted text] (8) interpretation and analysis of clinical signs, symptoms..., [omitted text]			therapists also consider the severity and complexity of the current impairments and the probability of prolonged impairment of body functions and structures, activity limitations, and participation restrictions; the living environment; potential destinations at the conclusion of the episode of care; and social support. Evaluation occurs at the start of care and continues throughout the episode of care to determine the individual's response to interventions and progress toward identified goals.
PLAN of CARE (PoC or Intervention Plan)	(BR) 21 NCAC 48C .0102 RESPONSIBILITIES (a) A physical therapist shall determine the patient care plan and the elements of that plan appropriate for Delegation. [omitted text] (d) A physical therapist shall enter and review chart documentation, reexamine and reassess the patient, and revise the patient care plan if necessary, based on the needs of the patient.	NO RELEVANT REFERENCE	3.10 Treatment Plan (Plan of Care) The Treatment Plan must be established once an evaluation has been administered and prior to the beginning of treatment services. The Treatment Plan is developed in conjunction with the beneficiary, parent(s) or legal guardian(s), teacher and medical professional. The Treatment Plan must consider performance in both clinical and natural environments. Treatment must	The *plan of care* consists of statements that specify the goals, predicted level of optimal improvement, specific interventions to be used, clinical priorities and proposed duration and frequency of the interventions that are required to reach established goals and outcomes. The plan of care culminates the evaluation, diagnostic, and prognostic processes. The plan is based on evaluation, other

	(e) A physical therapist shall establish a discharge plan that includes a discharge summary or episode of care for each patient. [omitted text] (l)(6) identification of specific elements of each intervention or modality provided. Frequency, intensity, or other details may be included in the plan of care and if so, do not need to be repeated in the daily note 21 NCAC 48G .0601 PROHIBITED ACTIONS [omitted text] (26) failing to maintain legible patient records that contain an evaluation of objective findings, a diagnosis, a plan of care including desired outcomes, the treatment record including all elements of 21 NCAC 48C .0102(l) or 21 NCAC 48C .0201(f), a discharge summary or episode of care including the results of the intervention, and sufficient information to identify the patient and the printed name and title of each person making an entry in the patient record		be culturally appropriate. Short and Long Term functional goals and specific objectives must be determined from the evaluation. Goals and objectives must be reviewed at least annually and must target functional and measurable outcomes. The Treatment Plan must be a specific document. Each treatment plan in combination with the evaluation or re-evaluation written report must contain ALL the following: a. duration of the treatment plan consisting of the start and end date (no more than 12 calendar months); b. discipline specific treatment diagnosis and any related medical diagnoses; c. Rehabilitative or habilitative potential; d. defined goals (specific and measurable goals that have reasonable expectation to be achieved within the duration of the treatment plan) for each therapeutic discipline; e. skilled interventions, methodology, procedures, modalities and specific programs to be utilized; f. frequency of services; g. length of each treatment visit in minutes; h. name, credentials and signature of professional completing Treatment Plan dated on or prior to the start date of the treatment plan; and i. treatment plan date, beneficiary's name and date of birth or Medicaid identification number.	gathered data, tests, measures and on the diagnosis determined by the physical therapist. In designing the plan of care, the physical therapist analyzes and integrates the clinical implications of the severity, complexity, and acuity of the pathology/pathophysiology (disease, disorder, or condition), impairments in body functions and structures, activity limitations, and participation restrictions to establish the prognosis. The plan of care includes discharge plans anticipated at the conclusion of the episode of care. In consultation with appropriate individuals, the physical therapist plans for the conclusion of care and provides for appropriate follow-up or referral. The primary criterion for conclusion of care is the achievement of the individual's goals. When the episode of care is concluded prior to achievement of identified goals, the individual's status and the rationale for conclusion of care are documented. For individuals who require multiple episodes of care, periodic follow-up is needed over the lifespan to ensure safety and effective adaptation following changes in physical status, caregivers, environment, or task demands. In prescribing interventions for an individual, the physical therapist includes parameters for each intervention (e.g., method, mode, or device; intensity, load,

				or tempo; duration and frequency; and progression) described in each plan of care. A ***plan of care*** designed to improve, enhance, and maximize function.
INTERVENTION or SERVICE NOTE	(PA) N/A (BR) 21 NCAC 48C .0101 PERMITTED PRACTICE *[Scope of PT Practice]* [omitted text] (2) alleviating impairment and functional limitation by designing, implementing, and modifying therapeutic interventions that include the following: (A) coordination, communication and documentation; [omitted text] 21 NCAC 48C .0102 RESPONSIBILITIES (l) A physical therapist shall document every evaluation and intervention or treatment including the following elements: (1) authentication (signature and designation) by the physical therapist who performed the service; (2) date of the evaluation or treatment; (3) length of time of total treatment session or evaluation; (4) patient status report; (5) changes in clinical status; (6) identification of specific elements of each intervention or modality provided. Frequency, intensity, or other details may be included in the plan of care and if so, do not need to be repeated in the daily note;	NO RELEVANT REFERENCE	3.11 Treatment Services a. Treatment services are the medically necessary: 1. therapeutic PT, OT, ST, and audiology procedures, modalities, methods and interventions, that occur after the initial evaluation has been completed; 7.2 Documenting Services Description of services (skilled intervention and outcome or beneficiary response) performed and dates of service must be present in a note for each billed date of service; f. The duration of service (length of evaluation and treatment session in minutes) must be present in a note for each billed date of service; g. The signature and credentials of the person providing each service. Each billed date of service must be individually documented and signed by the person providing the service; If group therapy is provided, this must be noted in the provider's documentation for each beneficiary receiving services in the group. For providers who provide services to several children simultaneously in a classroom setting, the documentation must reflect this and the duration of services noted in the chart must	The processes of coordination, communication, and documentation are critical to ensure that individuals receive appropriate, comprehensive, efficient, person-centered, and high-quality health care services throughout the episode of care. Documentation is any entry into the individual's health record—such as consultation reports, initial examination reports, progress notes, flow sheets, checklists, reexamination reports, or summations of care—that identifies the care or services provided and the individual's response to intervention. Documentation should follow APTA's ***Guidelines: Physical Therapy Documentation***.[1] Appropriate documentation of physical therapist service is crucial because it: • Is a tool for the planning and provision of PT services, • Is a vehicle of communication among providers & stakeholders • Serves as a record of care provided • Includes individual's status, PT management, & outcome of PT intervention

	(7) equipment provided to the patient; and (8) interpretation and analysis of clinical signs, symptoms, and response to treatment based on subjective and objective findings, including any adverse reactions to an intervention. [omitted text] (g) A physical therapist's responsibility for patient care management includes first-hand knowledge of the health status of each patient and oversight of all documentation for services rendered to each patient, including awareness of fees and reimbursement structures. SECTION .0600 – DISCIPLINARY ACTION 21 NCAC 48G .0601 PROHIBITED ACTIONS (1) recording false or misleading data, measurements, or notes regarding a patient; [omitted text] (10) failure to file a report, filing a false report, or failure to respond to an inquiry from the Board within 30 days from the date of issuance, required by the rules in this Subchapter, or impeding or obstructing such filing or inducing another person to do so (11) revealing identifiable data, or information obtained in a professional capacity, without prior consent of the patient, except as authorized or required by law; [omitted text] (24) failing to record patient data within a reasonable period of		accurately reflect how much time the provider spent with the beneficiary during the day. Practitioners and clinicians shall keep their own records of each encounter, documenting the date of treatment, time spent, treatment or therapy methods used, progress achieved, and any additional notes required by the needs of the beneficiary. These notes must be signed by the clinician and retained for future review by state or federal Medicaid reviewers.	• Can demonstrate compliance with federal, state, payer, and local regulations • Can be used as evidence in potential legal situations • May demonstrate appropriate service utilization & reimbursement for third-party payers • May be used for policy or research purposes, including outcome analysis APTA Resource: https://www.apta.org/DefensibleDocumentation/Overview/

	time following evaluation, assessment, or intervention; [omitted text] (26) failing to maintain legible patient records that contain an evaluation of objective findings, a diagnosis, a plan of care including desired outcomes, the treatment record including all elements of 21 NCAC 48C .0102(l) or 21 NCAC 48C .0201(f), a discharge summary or episode of care including the results of the intervention, and sufficient information to identify the patient and the printed name and title of each person making an entry in the patient record SECTION .0200 – PHYSICAL THERAPIST ASSISTANTS 21 NCAC 48C .0201 SUPERVISION BY PHYSICAL THERAPIST [omitted text] (d) A physical therapist assistant may document care provided without the co-signature of the supervising physical therapist. [omitted text] (f) The physical therapist assistant must document every intervention/treatment, which must include the following elements: (1) Authentication (signature and designation) by the physical therapist assistant who performed the service; (2) Date of the intervention/treatment; (3) Length of time of total treatment session; (4) Patient status report;			

	(5) Changes in clinical status; (6) Identification of specific elements of each intervention/modality provided. Frequency, intensity, or other details may be included in the plan of care and if so, do not need to be repeated in the daily note; (7) Equipment provided to the patient or client; and (8) Response to treatment based on subjective and objective findings, including any adverse reactions to an intervention.			
PROGRESS REPORT	(PA) N/A (BR) 21 NCAC 48C .0102 RESPONSIBILITIES [omitted text] (d) A physical therapist shall enter and review chart documentation, reexamine and reassess the patient, and revise patient care plan if necessary, based on the patient needs. [omitted text] (g) A physical therapist's responsibility for patient care management includes first-hand knowledge of the health status of each patient and oversight of all documentation for services rendered to each patient, [omitted text] (m) At the time of reassessment, the physical therapist shall document: (1) the patient's response to therapy intervention; (2) the patient's progress toward achieving goals; and (3) justifications for continued treatment.	NC 1503-4.1 (a)(3) A description of-- (i) How the child's progress toward meeting the annual goals described in paragraph (2) of this section will be measured; and (ii) That periodic reports on the progress the child is making toward meeting the annual goals will be provided concurrent with the issuance of report cards;	3.1 (b)(7) The IEP, IFSP, IHP, BIP or 504 Plan requirement of parent notification must occur at regular intervals throughout the year as stipulated by NC Department of Public Instruction. Such notification must detail how progress is sufficient to enable the child to achieve the IEP, IFSP, IHP, BIP or 504 Plan goals by the end of the school year;	Evaluation occurs at the start of care and continues throughout the episode of care to determine the individual's response to interventions and progress toward identified goals. The PT is responsible for determining if there is sufficient information to progress the PoC based on the individual's response to intervention. The PT engages in outcome data collection and analysis—that is, the methodical analysis of outcomes of care in relation to selected variables (e.g., age, sex, diagnosis, interventions performed)—and develops statistical reports for internal or external use. Measurement and Outcome: http://guidetoptpractice.apta.org/content/1/SEC3.body