11 Therapy Subjective

Last Modified on 08/16/2024 11:28 am EDT

Purpose:

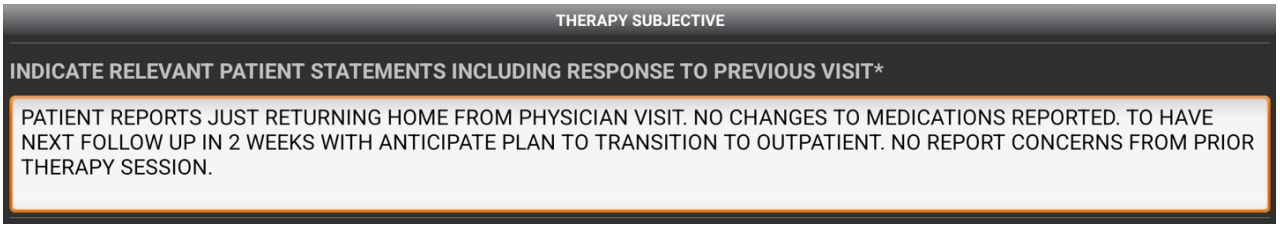
To educate Therapists regarding the focus of the subjective portion of the note is to highlight specific patient statements from visit to visit. This may include but is not limited to:

1. Comments on how patient is feeling
2. Comments from MD follow up
3. Self-reported symptoms and or caregiver/family statements.
4. Per Chapter 7 Medicare Benefit Policy Manual "the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services".
5. Any updated information from a review of the medical record obtained from the patient's chart can also be included.

The therapy subjective section should always be unique for each visit and not cloned from note to note.

Process:

Select the ☐ THERAPY SUBJECTIVE section and it will populate the following statement for the clinician to complete.



Example(s) of acceptable documentation:

1. Patient reports just returning from physician. No changes to medications reported. To have next follow up in 2 weeks with anticipated plan to transition to outpatient. No reported concerns from prior therapy session.
2. No changes reported in medications nor condition since last therapy visit. No reported concerns post therapy session.
3. The patient complaints that after therapy he had increased knee pain after the step-up exercise. Was afraid to continue with home exercises. After further discussion he noted that he was walking without cane after the session, and it started to bother him. Will monitor today's session to see if activity caused pain vs lack of can use. No changes to medication.

Example(s) of unacceptable documentation:

1. No changes.
2. Patient is doing fine.