MAXIMUS Federal Services

PATIENT RECORD NO. **(From Facility Key document)** _____ - _____ - _____

MEDICAL REVIEWER INITIALS: _____

Physical Therapy Peer Review Instrument

SECTION A: Complete questions 1-9 for the INITIAL EVALUATION with the Physical Therapist for the specific problem (if the Initial evaluation is not in the record, use the EARLIEST visit in the record

1. Is the Chief Complaint adequately documented?
- **1** Chief Complaint not documented adequately
- **5** Chief Complaint documented adequately
- **IL** Illegible

2. Was the history of present illness (HPI) appropriately documented in the medical record?
- **1** HPI not appropriately documented
- **5** HPI appropriately documented
- **IL** Illegible

3. Were patient medications, allergies and past medical history documented?
- **1** None of the elements were documented
- **3** Some of the elements were documented
- **5** All of the elements were documented
- **IL** Illegible

4. Provider name printed or stamped, signature and ID number provided?
- **1** Provider printed name, signature and ID number were not provided
- **5** Provider printed name, signature and ID number were provided
- **IL** Illegible

5. Physical therapy evaluation appropriately completed for present complaint
- **1** The evaluation was not appropriately completed for the present complaint
- **3** The evaluation was somewhat appropriately completed for the present complaint
- **5** The evaluation was fully and appropriately completed for the present complaint
- **IL** Illegible

6. Does the initial evaluation include short tem goals (STG) and long term goals (LTG)?
- **1** Neither STG or LTG were addressed
- **3** One of the two were addressed
- **5** Both STG and LTG were addressed
- **N/A** Initial evaluation not in record
- **IL** Illegible

7. Were the plans appropriate to the diagnosis?
- **1** Plans were inappropriate to the diagnosis
- **3** Some of the plans were appropriate to the diagnosis
- **5** All plans were appropriate to the diagnosis
- **IL** Illegible

8. Was the patient's understanding of the treatment plan adequately documented?

1 Patient understanding of the treatment plan was not documented
5 Patient understanding of the treatment plan was adequately documented
IL Illegible

9. Was patient education documented?

1 Patient education not documented
3 Some aspects of patient education documented
5 Patient education fully documented
IL Illegible

SECTION B: Complete questions 10-15 after reviewing ALL of the visits for that patient to the Physical Therapist within the LAST 12 MONTHS.

10. Pain level assessed and addressed at every visit?

1 Pain level not assessed or addressed at any visit
3 Pain assessed and addressed at some visits
5 Pain level assessed and addressed at all visits
IL Illegible

11. Are changes to STG and LTG documented?

1 No changes to STG or LTG documented
3 Some changes to STG or LTG documented
5 All changes to STG or LTG documented
IL Illegible
N/A STG and LTG did not change

12. Are changes to the treatment plan appropriately documented?

1 No changes to treatment plan documented as appropriate
3 Some changes to treatment plan documented as appropriate
5 All changes to treatment plan documented as appropriate
IL Illegible
N/A Treatment plan did not change did not change

13. Are the notes part a part of the electronic medical record (EMR)?

1 None of the notes are a part of the EMR
3 Some of the notes are a part of the EMR
5 All of the notes are a part of the EMR

14. Is documentation sufficient for continuity of patient care?

1 Documentation is not sufficient for continuity of patient care
3 Documentation is somewhat sufficient for continuity of patient care
5 Documentation is sufficient for continuity of patient care
IL Illegible

15. Was the patient referred back to the provider appropriately?

1 The patient was not referred back to the provider appropriately
5 The patient was referred back to the provider appropriately
IL Illegible
N/A Not appropriate for patient to be referred back to the physician at this time