848-040-0125

Standards For Initiation Of Physical Therapy

(1) **Except as provided in subsection (5) of this section,** [~~P~~] **p**rior to initiating the first physical therapy treatment, a physical therapist shall perform an initial evaluation of each patient and determine a plan of care as provided in OAR 848-040-0135.

(2) In the course of performing an initial evaluation the physical therapist shall examine the patient, obtain a history, perform relevant system reviews, assess the patient's functional status, select and administer specific tests and measurements and formulate clinical judgments regarding the patient. A physical therapist may incorporate by reference medical history or system review information about the patient prepared by another licensed health care provider and available in the physical therapy treatment record, IEP, IFSP or other designated plan of care.

[~~(2)~~] **(3)** For purposes of subsection (1) of this section, a physical therapist shall perform a separate initial evaluation under the following circumstances:

(a) The patient is returning to care after being discharged from therapy;[~~or~~]

(b) The patient is new to an inpatient or outpatient facility or home health agency**; or**

(c) A current patient presents with a new diagnosis for an unrelated body part.

~~[(3) In the course of performing an initial evaluation the physical therapist shall examine the patient, obtain a history, perform relevant system reviews, assess the patient's functional status, select and administer specific tests and measurements and formulate clinical judgments regarding the patient. A physical therapist may incorporate by reference medical history or system review information about the patient prepared by another licensed health care provider and available in the physical therapy treatment record, IEP, IFSP or other designated plan of care.]~~

(4) Only a physical therapist may perform an initial evaluation. A physical therapist shall not delegate the performance of an initial evaluation to a physical therapist assistant or to an aide.

(5) Under circumstances or situations where a physical therapist is called upon to provide immediate minimal or basic treatment to a person participating in an athletic activity or event, the physical therapist shall examine the person by performing tests and measurements appropriate to the circumstances, assess the person's condition, formulate clinical judgments, and determine the immediate care to be provided. Documentation under this subsection shall include, at a minimum, the person's name, age if available, a brief description of the injury or condition, and disposition or treatment, including recommendation for additional or alternative care. Neither a physical therapy plan of care nor a discharge summary is required in these circumstances.

848-040-0130

Standards For The Documentation Of An Initial Evaluation

Except as provided in subsection (5) of OAR 848-040-0125, [~~T~~]**t**he permanent record of the initial evaluation shall include:

(1) Patient's full name, age and sex;

(2) Identification number, if appropriate;

(3) Referral source, including patient self-referral;

(4) Pertinent medical or physical therapy diagnoses, medications if not otherwise accessible in another part of the patient's medical record, history of presenting problem and current complaints and symptoms, including onset date;

(5) Prior or concurrent services related to the provision of physical therapy services;

(6) Any co-existing condition that affects either the goals or the plan of care;

(7) Precautions, special problems and contraindications;

(8) Subjective information (patient's knowledge of problem);

(9) Patient's goals (with family input or family goals, if appropriate). Goals may be as

provided in an applicable IEP, IFSP, or other designated plan of care; and

(10) Appropriate objective testing results, including but not limited to:

(a) Critical behavior/cognitive status;

(b) Physical status (e.g., pain, neurological, musculoskeletal, cardiovascular, pulmonary);

(c) Functional status (for Activities of Daily Living, work, school, home or sport performance); and

(d) Interpretation of evaluation results.

848-040-0150

Standards For The Documentation of Treatment Provided

(1) **Except as provided in subsection (5) of OAR 848-040-0125,** [~~T~~]**t**he permanent record of treatment for each patient visit shall include at a minimum:

(a) Subjective status of patient;

(b) Specific treatments, **information,** and education provided;

(c) Objective data from tests and measurements conducted;

(d) Assessment of the patient's response to treatment, including but not limited to:

(A) Patient status, progression or regression;

(B) Changes in objective and measurable findings as they relate to existing goals;

(C) Adverse reactions to treatment; and

(e) Changes in the plan of care.

(2) When treatment is provided by a physical therapist assistant, the physical therapist assistant shall record and authenticate those services. If the supervising physical therapist records and authenticates treatment provided by the physical therapist assistant, the physical therapist shall document which services were provided that day by the physical therapist assistant. When treatment is provided or assisted by an aide, the aide may only document in the patient record[~~s~~] objective information about the treatment provided by the aide. When a supervising physical therapist assistant or supervising physical therapist authenticates treatment provided by an aide, the therapist shall document which services were provided that day by the aide.

848-040-0155

Standards For Performing [~~The Required~~] A **Reassessment**

(1) A physical therapist shall perform a reassessment **of a patient as follows:** [~~for each patient to update patient status, evaluate progress and to modify or re-direct physical therapy services. In the course of performing the required reassessment, the physical therapist shall personally examine the patient, assess the patient's functional status, select specific tests and measurements, and formulate clinical judgments regarding the patient. The physical therapist may delegate to a physical therapist assistant the gathering of data for the reassessment as provided in OAR 848-015-0030(1)(b).~~]

[~~(2) A physical therapist shall perform a reassessment for each patient:~~]

(a) **Anytime there are significant changes in the patient's condition or status that would result in a change in the goals or the plan of care;** [~~At least every 30 days, or at every visit if the patient is seen less frequently;~~]

(b) **When a physical therapist has not directly treated the patient within the previous 30 days;**

(c) At every visit when the interval since a patient's last visit is 30 days or longer; or

[~~(b)~~] **(d)** At least every 60 school days if the **patient is a** student **who** is being treated in an educational setting **and a physical therapist has not treated the student within 60 school days,** or at every visit if the student is seen less frequently.[~~; or~~]

[~~(c) Anytime there are significant changes in the patient's condition or status that would result in a change in the goals or the plan of care.~~]

(2) In the course of performing the reassessment, a physical therapist shall personally examine the patient, assess the patient's functional status, select specific tests and measurements, formulate clinical judgments regarding the patient, and update the goals or plan of care.

(3) Only a physical therapist may perform [~~the required~~] **a** reassessment. A physical therapist shall not delegate the performance of a [~~required~~] reassessment to a physical therapist assistant or to an aide. **However, a physical therapist may delegate to a physical therapist assistant the gathering of data for a reassessment as provided in OAR 848-015-0030(1)(b).**

848-040-0160

Standards For The Documentation Of ~~The Required~~ A Reassessment

(1) When [~~A~~] **a** physical therapist is required to perform [~~and document the~~]**a** reassessment [~~as required~~] under OAR 848-040-0155**, the permanent record of the reassessment shall include at a minimum:**

~~[(2) The permanent record of each reassessment shall include at a minimum:~~]

(a) Subjective status of patient;

(b) Objective data from tests and measurements conducted;

(c) Functional status of patient;

(d) Interpretation of above data;

(e) Any change in the plan of care; [~~and~~]

(f) Any change in physical therapy goals (including patient goals)**; and**

(g) A notation that the record is of a reassessment.

[~~(3)~~] **(2)** After a physical therapist performs **and documents** a reassessment, **either the physical therapist or** a physical therapist assistant may prepare a **progress** summary of the patient's physical therapy status based upon the physical therapist's performance of ~~the required~~ **a** reassessment.

848-040-0165
Standards For Discharging A Patient From Therapy

(1) A physical therapist shall discharge a patient from **an episode of** physical therapy treatment when **the therapist determines**:

(a) The patient has reached all physical therapy goals and additional goals are not identified;

(b) The patient will not further benefit from physical therapy**, regardless of whether additional visits are ordered or authorized**; [~~due to a lack of progress or a plateau in progress;~~]

(c) The patient declines to continue treatment or self-discharges;

(d) Physical therapy is [~~no longer appropriate for the patient or is~~] contraindicated; [~~secondary to medical or psychosocial reasons;~~] **or**

(e) The referring provider directs or instructs that the patient be discharged **from the episode of treatment**.

(2) Only a physical therapist may make the decision to discharge a patient from therapy. A physical therapist shall not delegate the decision to discharge a patient to a physical therapist assistant or to an aide.

(3) A physical therapist assistant shall not independently make the decision to discharge a patient from therapy. However, a physical therapist assistant may make recommendations regarding discharge to the supervising physical therapist based on the physical therapist assistant's treatment of the patient.

848-040-0170
Standards For Discharge Records

(1) Within 30 days following the patient's last scheduled visit or last contact, the physical therapist or physical therapist assistant shall document a final summary of the patient's physical therapy status upon discharge **from the patient's current episode of treatment**.

(2) The discharge summary shall include, but is not limited to:

(a) Date and reason for discharge, or self discharge, if known;

(b) Degree of goal achievement or reasons for goals not being achieved;

(c) Summary of the patient's status at the time of discharge; and

(d) Recommendations for follow-up care, if any.

(3) A discharge summary is not required when another licensed medical professional documents a patient's discharge from an acute inpatient care facility as that term is defined in ORS 442.470(1).

848-040-0190
Standards for Community Education, Prevention, Health Promotion, and Wellness Services

(1) A licensee may provide non-individualized instruction to a group of persons in the community or group of employees in a workplace:

(a) To promote and teach physical activity with an emphasis on movement and function to improve health outcomes or prevent falls or injuries; or

(b) To teach and promote wellness, fitness, healthy lifestyles and behaviors, and self management, for the reduction of risk, prevention, or management, of disease, injury or disability.

(2) Service provided under this section is not physical therapy treatment or intervention and does not require or involve performance of an initial evaluation, preparation of a plan of care, or creation of a patient treatment record.