PT Home Health Documentation Quick Reference

A concise, field-ready guide for Physical Therapists and Physical Therapist Assistants documenting skilled care in the home health setting.

OASIS SOC: PT-Specific Documentation Focus

At the start of care, PT documentation must clearly establish skilled need, functional limitations, and medical necessity. Focus on function, safety, and why skilled intervention is required in the home.

- Compare prior level of function to current presentation using objective measures
- Clearly describe gait, balance, transfer, and endurance limitations
- Tie deficits directly to safety risks and loss of independence
- Describe homebound status using functional language, not diagnosis alone
- Support therapy frequency with objective findings and clinical judgment

Skilled Language That Supports Medical Necessity

Use language that explains why the intervention requires the skill of a licensed PT and cannot be safely carried out by unskilled personnel or independently.

- Requires skilled PT assessment to evaluate gait deviations and fall risk
- Demonstrates impaired motor control requiring skilled cueing and progression
- Interventions require ongoing clinical judgment to prevent injury or decline
- Skilled instruction necessary to modify treatment based on patient response

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Routine Visits, Re-Evaluations, and Discharges

Routine Visit Documentation Essentials

Each routine visit note should demonstrate progression, skilled intervention, and continued medical necessity.

- Document objective measures such as distance, assistance level, and device use
- Clearly state progression or regression since the previous visit
- Describe skilled cues, corrections, or modifications provided
- Document patient response, tolerance, and safety considerations

Re-Evaluation Documentation Essentials

Re-evaluations must justify continued skilled therapy or support discharge planning using updated objective data.

- Compare updated measures to baseline and prior re-evaluations
- Clearly justify frequency changes or continued plan of care
- Revise functional goals as appropriate based on progress

Discharge Documentation That Holds Up

Strong discharge documentation protects both the clinician and the agency.

- State whether goals were met or maximum potential reached
- Document remaining deficits with rationale for discharge
- Include safety recommendations and HEP education completed
- Demonstrate patient or caregiver understanding