Codify BY AAPC

Eli's Rehab Report

Reader Questions: Determine State Scope of Practice for Assistant Documentation

Question: What is the level of medical record documentation assistants can perform in an inpatient setting? Currently, we have assistants modifying and updating the therapist's plan of care and doing discharge summaries, as well as the MDS initial evals and the ongoing MDS assessments. Is this OK, or should the assistants be doing less?

Maryland Subscriber

Answer: Among the things assistants cannot do are assessments, changes to the plan of care, and changes to the goals, so you should re-consider what your assistants are documenting in the medical record. And this question really becomes a state scope-of-practice and legal issue, especially if your state licenses rehab providers and assistants.

If we're talking skilled nursing Part B, and you're required to write progress reports, assistants can do components of the progress reports (the "S" and the "O" of the SOAP note), but once every 10 visits or once each certification interval, one progress report has to be completely written by a clinician (PT, OT, SLP). Assistants in outpatient settings can also do components of a re-eval and components of a discharge, but the therapist is responsible for updating the plan of care, the frequency and duration of therapy, and determining discharge. Bottom line, assistants can't do evaluations due to scope- of-practice issues. A therapist must complete evaluations.

-- Reader Questions were answered by **Rick Gawenda, PT,** director of PM&R at Detroit Receiving Hospital and owner of Gawenda Seminars.

CPT® 2023 American Medical Association. All rights reserved.