**Introduction**

The worksheet is designed to assist the provider with the care authorization process for physical medicine services through an overview of key care management components, identifying primary elements and common oversights or errors encountered within the utilization review processes of Healthways Utilization Management Program. Please also refer to specific Medical Policies for Physical and Occupational Therapy which may be accessed at [www.prevea360.com](http://www.prevea360.com). Much of the information contained herein is considered standard components of a practitioner’s formal education and training. Reviewing this information can help to develop a common understanding and expectation of what and how information is to be used in the clinical review process.

**Financial Incentives Statement**

Healthways does not maintain a system for financial compensation, reimbursement, bonuses, or incentives, direct or indirect, to colleagues, peer review consultants or providers who directly deliver Healthways program services to program participants based on consumer utilization of services or utilization management decisions. Specifically, medical necessity review outcomes are not used as an objective or measure for compensation incentives for Peer Reviewers, Medical Directors, or Utilization Management staff.
The following topics are included for discussion:

- Medical Necessity
- Standardized Documentation Expectations
- Common Documentation Errors
- Components of the Clinical Management Process
  1) Patient History
  2) Physical Examination
  3) Outcomes Assessment
  4) Diagnosis Assessment
  5) Goal-Oriented Treatment Plan/Care Plan
  6) Prognosis
  7) S.O.A.P. (Treatment) Notes
- Continued Care Trials
- Appropriate Documents to be Submitted for Clinical Review
Medical Necessity

Medical Necessity, synonymous with Clinical Necessity, means health care services or supplies a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- not primarily for the convenience of the patient or the provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Specialty Society recommendations, and the views of providers practicing in relevant clinical areas and any other relevant factors.

Determination of medical necessity is also dependent upon the following:

- The diagnosis should be substantiated by history, symptoms, and clinical information.
- The diagnosis should be for a condition, which the provider of record can effectively treat, based on scope of license.
- That all body regions of treatment must coincide with a diagnosis established and supported within the clinical record.

| Maintenance Therapy | Physical medicine services performed repetitively to maintain a level of function is not eligible for payment. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. These services generally would not involve complex physical medicine and rehabilitative procedures, nor would they require clinical judgment and skill for safety and effectiveness. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Maintenance therapy should be reported under procedure code |
Medical Necessity

| S8990 (physical or manipulative therapy performed for maintenance rather than restoration). A participating, preferred, or network provider can bill the member for the denied service. |

Standardized Documentation Expectations

A permanent clinical record is an essential part of evidence-based clinical practice. The clinical record is a valuable source of information for the patient, the treating provider, consulting physicians and other healthcare entities involved in the day-to-day management and oversight of clinical care. There is a wide range of information considered as underlying integral components of clinical documentation. The quality and range of clinical information provided is often dependent on the practitioner’s formal training, continuing education, and clinical experience.

Essential Clinical Documentation

Essential Clinical Documentation: Clinical documentation is the chronological recording [Month, Day, and Year] of pertinent facts and observations about the patient’s health history and physical exam of the system(s) applicable to the current encounter. It includes testing, decision making, treatment planning, treatment application details, and outcomes assessments.

As the national standard for clinical record keeping, the basic model of the Problem Oriented Medical Record (POMR) mandates that the clinical record components must be fully legible, organized and complete to allow a practitioner, members of the health care team, successive health care providers or outside parties the reasonable ability to recognize the care being provided and with what results. In addition, if non-standard abbreviations or symbolic entries are used, a key or legend should appear on the forms used or be available for interpretive use. No clinical information should be intentionally obscured from view. The records should also be maintained in a manner that makes them suitable for utilization review and for reimbursement to the provider.

Accordingly, documentation of the patient’s care is often as important as the rendition of the care itself. In the context of medico-legal concerns the record serves as the legal instrument to provide substantive evidence on whether care rendered met the legal standard of care. Medico-legal precedents have established that “If
### Standardized Documentation Expectations

it’s not in the chart, from a legal standpoint, either the procedure didn’t happen or the comment wasn’t made”. No clinical information should be intentionally obscured from view.

### Common Documentation Errors

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<tr>
<td><strong>Legibility</strong></td>
<td>One of the most essential components of clinical documentation is legibility. The most accurate and clinically useful information becomes very difficult to use when it is not legible. In general, legibility is considered to be the readability of documentation by someone other than the practitioner.</td>
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<tr>
<td><strong>Abbreviations</strong></td>
<td>When abbreviations are included in the clinical documentation, only standard abbreviations should be used. If a practitioner feels they must use non-standard abbreviations or symbols, a key or legend must also be provided.</td>
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<tr>
<td><strong>Date of Service</strong></td>
<td>The date should be easily seen and must include the day, month, and year. These three components can be in any order the practitioner wishes but should be consistent. Also this information is often written very close to the margins of the page and is therefore not captured when making copies or faxing the information.</td>
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## Components of the Clinical Management Process

| **Patient History** | Elements of the patient’s clinical history typically include: Chief Complaint/Present Illness; Review of Systems; Past, Family and Social History.  
| o Chief Complaint / Present Illness / Mechanism of Onset: As a component to the treating health provider’s history interview process with the patient, the patient’s Chief Complaint is expected to reasonably correlate with the patient’s areas of treatment. The patient’s Present Illness parameter details should include: Onset/Mechanism of Onset; Palliative & Provocative Factors; Complaint Quality (i.e.: ache, sharp, dull, etc.); Complaint Severity (i.e., use of the Visual Analog Scale.); and Timing (Frequency the complaint is present during the waking day).  
| o Review of Systems: Constitutional; Skin, Musculoskeletal, HEENT; Endocrine, etc.  
| o Past, Family and Social History: General Health; Immunization; Childhood/Adult Illnesses; Surgeries; Medications; Parent-Sibling health status; Personal/Habit information (marital status; hobbies; diet, sleep, exercise, etc.). |
| **Physical Examination** | Components of the patient’s physical examination are expected to include appropriate standardized Quantitative and Qualitative gauges for comparative value to subsequent evaluations. Typically re-examinations are expected to occur, at a minimum, every 30-days while the patient is under care. Elements of the Physical Examination usually include:  
| o Vital Signs: Temperature, Pulse, Respiration rate; Blood Pressure; Height, Weight.  
| o Inspection: Visual evaluation of: Static Posture, Antalgia, Gait Motion, Cuts, Bruising; Tremor, etc.  
| o Palpation: Regional palpation of the affected body part, if appropriate.  
| o Range-of-Motion: an instrumentation analysis (Goniometer or Inclinometer methods) of the regional joint planes involved. Visual analysis is not considered a valid method of joint motion mensuration. |
## Components of the Clinical Management Process

- **Orthopedic Testing:** The practitioner should be using standardized definitions for positive (+) or Negative (−) results for orthopedic testing. Certain orthopedic tests typically require specific details of the findings elicited versus just a simplified “+” or “−” finding. For example, the Straight Leg Raise test should be reported with the area of pain elicited as well as the angle of inclination where pain appeared. (Left SLR + for lower back pain with radiating pain into the posterior thigh at 23 degrees of leg elevation).

- **Neurological – Sensorimotor Testing:** This would include details discovered on evaluations of: mental screen status; deep tendon reflexes; dermatome sensation; manual muscle strength testing; cranial nerve evaluation; etc.

- **Imaging:** Appropriate details reporting results of: Plain Film Radiography (X-rays), CT, MRI, MRA; Bone scan; PET scan, etc.

- **Laboratory:** Reports of all relevant laboratory testing performed, such as: Urine/Fecal analysis, Blood Studies; etc.

- **Clinical Yellow Flags:** Yellow flags are considered as psychosocial risk factors that should lead to appropriate cognitive and behavioral management. The attending healthcare provider is advised to appropriately consider and correlate “clinical yellow flags” present for the patient’s overall clinical status.

- **Clinical Red Flags:** Red flags are considered as physical risk factors that should lead to appropriate medical intervention. The attending healthcare provider is advised to appropriately consider and correlate “clinical red flags” present for the patient’s overall clinical status.

- **Referrals for Specialized Testing:** Details of the attending healthcare provider’s rationale for referral of the patient for specialized testing as well as the testing outcomes. Examples may include: Electrodiagnostic Testing (NCV, Needle EMG; etc.).
## Components of the Clinical Management Process

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<th>Outcome Assessment Tools</th>
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<td>As a core clinical aid to the health care provider, the basic concept regarding the use of Outcome Assessment tools as a means to record and collect data from the patient, is that the Outcome Assessment tool be used on a consistent basis from the commencement of care to the end of care as well as the required intervals during treatment. The tool must be appropriately scored and most importantly, the tool must be reviewed to make appropriate care decision plans.</td>
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The Healthways physical medicine pre-authorization process is designed to include the Patient Specific Functional Scale (PSFS) for physical or occupational therapy services. The PSFS is a self-reported, patient-specific measure, designed to assess functional change, primarily in patients presenting with musculoskeletal disorders. The scale was developed by Stratford* and colleagues as a self-report measure of function that could be used in patients with varying levels of independence. The advantages of the PSFS include its wide applicability and ease of use clinically, both desirable attributes in an outcome measure.


In addition to this tool, the practitioner may utilize other outcome tools they feel further clarifies the patient’s clinical status. Appropriate scoring and application details should be supplied for these supplementary tools. Outcomes Assessment tools and details of the appropriate application and scoring of the PSFS are made available through the health plan’s or Healthways provider portal or provider resource center.
## Components of the Clinical Management Process

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<th>Diagnosis Assessment</th>
<th>The patient’s clinical diagnoses for the care being rendered is expected to meet the following criteria:</th>
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<td>o Correlate with the clinical details and findings documented in the patient’s case histories, physical exams, laboratory testing, diagnostic testing and medical decision-making components within the patient’s chart.</td>
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<td>o To be at the highest level of clinical understanding and listed in descending order of importance regarding the patient’s clinical condition (i.e. primary, secondary, tertiary, quaternary, etc.).</td>
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<td>o Should be for a condition, which the practitioner of record can effectively treat, based on scope of license.</td>
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<td>o All body regions of treatment must coincide with a diagnosis being established and supported within the clinical record.</td>
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| **Goal-Oriented Treatment Plan** | The patient’s management plan is one of the key elements to establishing medical necessity for the care being rendered to the patient. The patient’s management plan may change during the patient’s care trial. During the acute phase of care the management plan is typically expected to be updated at least every 30-days coinciding with updates to the patient’s clinical histories and physical exams. Less frequent care plan updates may occur for long term or permanently disabling conditions. The management plan is expected to contain:

- The specific goals attempted for accomplishment.
- The objective measures being used to measure the effectiveness of care.
- A schedule of care recommending the duration and frequency of treatment.
- Specific techniques, procedures, modalities, exercises, patient instructions and structural supports being utilized in the patient’s management.
- Projected care alternatives if clinical goals/expectations are not accomplished. |
| **Prognosis** | This is the culmination of the clinical thought processes and must reasonably correlate with the overall information gathered by the clinician about the patient. It should also be based on the available literature about the patient’s condition(s).

- “GUARDED”: This prognostic statement has proliferated and evolved to the endpoint of being a matter of custom versus true clinical value. It is, in actuality, a statement that is essentially defined as: “I don’t know”. Accordingly, this prognostic statement adds opacity versus clarity to the clinical management approach and should be distinctly avoided in the formation of a prognostic statement. |
| **S.O.A.P. Notes** | As a component to the POMR, the contemporaneously recorded Daily S.O.A.P. or Treatment note is an essential element to demonstrating the patient’s visit-to-visit encounters and to demonstrate the incremental changes to the patient’s clinical condition as a response to treatment. Daily S.O.A.P. Treatment notes are expected to meet the following criteria: |
| | o Health Care Providers’ interval notes are created with a problem-oriented record using the **SOAP** format (S = Subjective, O = Objective, A = Assessment, P = Plan).

| | o Contemporaneously recorded Daily S.O.A.P. / Treatment notes are required for each patient encounter including the initial visit, each subsequent care visit, any patient communications extraneous to an office encounter, and at the patient’s discharge.

| | o Patient-based functional outcome measurements, such as functional status tools or pain rating scales are to be used in records of outpatient episodes of care.

| | o All records that are reviewed for medical necessity or medical appropriateness are expected to be legible and written in English. Transcriptions of notes are acceptable.

| | o Copies of original office notes created by the practitioner should accompany records that are transcribed into English for medical audit or review and must be so designated when submitted for review.
## Continuation of Care

When a practitioner requests **additional or continued treatment** within an episode of care, the following criteria are reviewed:

- Initial and current symptoms as described by the patient including severity, frequency, and character;
- Examination and re-examination findings, results of diagnostic tests, daily office notes, and other objective data submitted by the practitioner;
- A complete initial and current diagnostic impression.

**Review involving continuation of care requests will assess:**

- Reduction in symptom severity/frequency and/or significant positive changes in the character of the symptoms;
- Improvement as clinically established by orthopedic and neurological signs and tests;
- Improved joint range of motion;
- Improved muscle strength metrics;
- Reduced palpable spasm and tenderness on palpation;
- Reduced paresthesia;
- Improvement in ability to perform activities of daily living;
- Ongoing positive subjective symptoms and objective findings;
- Clinically significant improvements within outcomes assessment tool applications.

Sufficient improvements in the above noted criteria and a reasonable objective benefit anticipated from further treatment and based upon the treatment already rendered to the patient must be established. Expected improvement, rate of change and duration/frequency of treatment vary by diagnosis, age of the patient, mechanism of onset, and presence or absence of complicating factors.

Treatment is expected to be aimed at achieving a specific diagnosis-related goal for a patient who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time.
**Appropriate Documents to be Submitted for Clinical Review**

It is expected the attending health care provider uses reasonable discretion to supply a cross-section of clinical documents that will accurately and efficiently allow for a clear understanding of the patient’s presentation status, clinically findings and overall responses to the care trial applied. This typically includes the submission of:

- Clinical Records including Initial History & Examination Findings and any Re-Evaluation History & Examination Findings for this episode of care (if not previously submitted)
- Goal-Oriented Treatment Plan
- Diagnostic Test Results (MRI, Labs, X-Rays, etc.); if applicable
- Treatment Notes (in S.O.A.P. format)
- Current and Prior Outcomes Assessment Documents (e.g., PSFS, etc.)
- Referral Form (if required by Patient’s Health Plan)
- Other Relevant Clinical Findings or Pertinent Information that will Support the Present Diagnosis(es)

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<th>Medical Record Summary Form</th>
<th>Many attending health care providers find it is helpful to submit a Medical Record Summary Form when requesting a continuation of care to assist in the understanding of the patient’s care management. This type of form helps highlight the areas of change and improvement. The Medical Record Summary Form however, is not expected to be submitted in lieu of the above noted documents; the use of this type of form is optional.</th>
</tr>
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</table>
Reference Sources


- Apollo Managed Care Guidelines, Physical/Occupational/Speech Therapy and Rehabilitation Care, 8th Edition.


Reference Sources


  http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Practice/DocumentationPatientClientMgmt.pdf


• Medicare 220.3 – Documentation Requirements for Therapy Services. 

• Medicare Outpatient Physical and Occupational Therapy Services (L26884). 
  http://apps.ngsmedicare.com/lcd/LCD_L26884.htm

• Official Disability Guidelines, (ODG); Work Loss Data Institute, LLC, 2013; Encinatas, CA.
