Policy Statement
Outcome measures and/or pre-determined treatment goals that are specific, measurable, and/or functional must be used with each patient. These goals and outcome measures must be clearly defined in the patient record to ascertain the amount or degree of change over time. The documentation must also provide evidence of lasting, sustainable progress with treatment.

Purpose
This policy will be used to provide minimal clinical thresholds using specific, measurable, and functional treatment goals and/or outcome measures in the determination of improved, lasting and sustained outcomes. These thresholds will assist in medical necessity reviews of billed clinical services by network practitioners.

Scope
Participating network practitioners.

Definition
Treatment Goals:
Determined with the patient and clinician at the initial encounter for each episode of care. Unique for each patient’s clinical presentation based on the evaluation/exam findings and personal preferences.

Specific, Measurable, and Functional and Functional Goals:
Clearly defined goals of treatment that allow measurement of the amount and/or degree of meaningful change over time. These goals are often determined by the use of functional outcome tools.

Outcome Measures:
Objective, measurable assessments by the clinician to determine patient progress with treatment. Examples would include girth, range of motion, strength assessment, and/or special tests.

Lasting, Sustainable Progress:
Documentation must provide evidence to support that progress made by the patient has been maintained at a reasonable level over a reasonable period of time.

Minimally Clinically Important Difference or Minimally Clinically Important Improvement:
Defined according to the patient’s perception of important improvement that is a minimally meaningful change at an individual patient level.
**Maximum Medical Improvement:**
When the patient’s clinical status will not improve with additional treatment. This is achieved when there is no improvement in the patient’s clinical status over a reasonable period of time as assessed with standard measurement outcomes. (Schofferman)

**Patient Acceptable Symptom State (PASS):**
Defined as the point at which the patient considers themselves well, recovered and satisfied with treatment.

**Acceptable Thresholds of Measurable Improvement:**
After a review of the scientific evidence Magellan Healthcare has concluded all practitioner records must evaluate and document whether treatment is resulting in progressive improvement.

The practitioner records must demonstrate clear, specific and measurable improvement in the patient’s pain and function every two weeks, or at regular intervals as appropriate for the documented condition, as measured by one or more of the following examples of methods for each anatomic region. If no functional tool is available for the patient’s condition it is expected the practitioner will develop specific, measurable, and functional goals:

- VAS scores
  - Minimum of a 2 point change on a 0-10 pain scale
- LEFS
  - 10% improvement on the global score
- Oswestry Disability Index
- The minimal detectable change is 10.5 points. Clinically meaningful change is considered to be 30-50%. Neck Disability Index
- The minimal detectable change is 10% (approximately 5 points). Clinically meaningful change is considered to be 30-50% (approximately 15 points). Shoulder Pain and Disability Index
  - 10-30% reduction on the global score
- Activities of Daily Living Scale of the Knee Outcome Survey
  - 10-30% reduction in the global score
- Berg Balance Scale
  - MDC=4-7 points
  - MDC=6.5 points
- Dynamic Gait Index
  - MDC=2.9 points
  - Score of 19 or less found to be predictive of falls
- FOTO or Functional Status (FS) measure:
  - The MCII (Minimally Clinically Important Improvement) and MDC (Minimal Detectable Change) are stated on the assessment report. For significant, minimal improvement, the patient status should increase by the MDC value. FOTO summary report is available upon request.
- Functional Gait Assessment
- MCID=4 points

- **Gait Speed for Older Adults**
  - Small meaningful change=.5m/sec (Perera et al, 2006)
  - Substantial meaningful change=.10m/sec (Perera et al, 2006)
  - Meaningful change for those with stroke undergoing rehab=.175 m/sec

- **6-Minute Walk test (6MWT) for Older Adults**
  - MDC (calculated from standard error of measurement (SEM)) = 58.21 m (190.98 ft) (Perera et al, 2006)
  - SEM Older people with limited mobility: 21 m (Perera et al, 2006)
  - Older people with stroke: 22 m (Perera et al, 2006)

- **Timed Up and Go (TUG)**
  - Cut-off score of 13.5 sec or longer is predictive of falls

- **Tinetti (POMA)**
  - MDC= 5 Points

- **Roland-Morris Disability Questionnaire**
  - Minimal Important Change=5pts
  - A 30% change in RMQ score is considered meaningful with 50% considered substantial.

- **Bournemouth – Back Questionnaire**
  - A change of 17 points or 47% is considered clinically significant improvement.

- **Bournemouth – Neck Questionnaire**
  - A change of 13 points or 34% is considered clinically significant improvement.

- **Patient Specific Functional Scale**
  - Minimum detectable change (90%CI) for average score = 2 points
  - Minimum detectable change (90%CI) for single activity score = 3 points

- **Headache Disability Inventory (HDI)**
  - Authors of the index have determined that a decrease of 29 points or more is considered clinical significant

- **Functional Rating Index**
  - A 10% absolute change represents minimal clinically important change
  - MCIC = 8.4%

- **Pain Disability Index**
  - A decrease of 8.5-9.5 points is considered clinically important

- **Dizziness Handicap Inventory**
  - MDC = 17.18 points

---

Keele STarT Back Screening Tool

The records must compare baseline measures to updated measures and document progress toward measurable goals.

**NOTE: Questionable Outcome tool: Global Rating of Change (GRoC)**

Further work is needed to determine the true value of the GRoC as an outcome measure and in turn as an anchor measure. Several key points have been identified:

1. There is fluctuant temporal stability of the GRoC from week to week.
2. There is poor correlation between the GRoC and functional measures.
3. The GRoC is only correlated to functional measures up to 3 weeks.
REFERENCES


