Policy Statement
Recordkeeping is used to document the condition and care of the patient, avoid or defend against a malpractice claim and support the concurrent and/or retrospective medical necessity requiring the provision of skilled services. The provider is responsible for documenting the evidence to clearly support the aforementioned indices and submitting the documentation for review in a timely manner.

Initial Clinical Reviewers (ICRs) and Physician Clinical Reviewers (PCRs) must be able to apply criteria based on individual needs and based on an assessment of the local delivery system.

Purpose
Provide network practitioners with current medical record documentation criteria and requirements.

Scope
Participating network practitioners.

Definition
Medical History: (Applicable to all Network Providers)
The Medical History includes all of the following:
- The history of Present Illness (HPI) includes the location, quality, severity, duration, timing, context, modifying factors that are associated with the signs and symptoms
- A Review of Systems (ROS) – 13 systems (musculoskeletal/neurological, etc.) and constitutional symptoms. Should also address communication/language ability, affect, cognition, orientation, consciousness
- Past Medical, Family and Social History (PFSH) that includes the patient’s diet, medications, allergies, hospitalizations, surgeries, illness or injury, the family health status, deaths, problem related diseases, and
- The patient’s social status that includes marital status, living conditions, education/occupation, alcohol/drug use, sexual history

Physical Examination (PE): (Applicable to Chiro)
Examination of the body areas that includes the head, neck, chest, abdomen, back and extremities and the organ systems (11), constitutional, eyes, ENT, CV, GI, GU, musculoskeletal, skin, neurological, psychiatric, lymphatic, immunological, and hematological.
GUIDELINES (CHIRO):

I. New patient Evaluation and Management (E/M) coding requirements – must have 3 of 3:

<table>
<thead>
<tr>
<th>Code</th>
<th>99201 (10 m)</th>
<th>99202 (20 m)</th>
<th>99203 (30 m)</th>
<th>99204 (45 m)</th>
<th>99205 (60 m)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical History</strong></td>
<td>Problem focused CC</td>
<td>Expanded Problem Focused CC</td>
<td>Detailed CC</td>
<td>Comprehensive CC</td>
<td>Comprehensive CC</td>
</tr>
<tr>
<td></td>
<td>HPI: 1-3 ROS: none PFSH: None</td>
<td>HPI: 1-3 ROS: related to CC PFSH: None</td>
<td>HPI: ≥ 4 ROS: 2-9 PFSH: 1 item any area</td>
<td>HPI: ≥ 4 ROS: 10-14 PFSH: 1 item each area</td>
<td>HPI: ≥ 4 ROS: 10-14 PFSH: 1 item each area</td>
</tr>
<tr>
<td><strong>Physical Exam</strong></td>
<td>Affected body area</td>
<td>Affected body area and 2-4 related organ systems</td>
<td>Affected body areas/systematic/ and 5-7 related organ systems</td>
<td>Multi-system 8+ body systems</td>
<td>Multi-system 8+ body systems</td>
</tr>
<tr>
<td><strong>Medical Decision</strong></td>
<td>Straight forward</td>
<td>Straight forward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

II. Established patient E/M coding requirements – must have 2 of 3:

<table>
<thead>
<tr>
<th>Code</th>
<th>99211</th>
<th>99212 (10 m)</th>
<th>99213 (15 m)</th>
<th>99214 (25 m)</th>
<th>99215 (40 m)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical History</strong></td>
<td>Problem focused CC</td>
<td>Problem focused CC</td>
<td>Expanded Problem Focused CC</td>
<td>Detailed CC</td>
<td>Comprehensive CC</td>
</tr>
<tr>
<td></td>
<td>HPI: 1 ROS: none PFSH: None</td>
<td>HPI: 1-3 ROS: none PFSH: None</td>
<td>HPI: 1-3 ROS: related to CC PFSH: None</td>
<td>HPI: ≥ 4 ROS: 2-9 PFSH: 1 item any area</td>
<td>HPI: ≥ 4 ROS: 10-14 PFSH: 1 item each area</td>
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<td>Multi-system 8+ body systems</td>
</tr>
<tr>
<td><strong>Medical Decision</strong></td>
<td>Straight forward</td>
<td>Straight forward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

**PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH THERAPY INITIAL EVALUATION**

- Identified problems
- Treatment diagnosis and date of onset as well as contraindications
- Brief current and past medical history (see previous page)
- Summary of previous therapy
- Baseline evaluation including current and prior functional status (communication, cognition, vision, hearing, functional mobility, ADL, swallowing)
• Objective tests and measures appropriate to each discipline
• Standardized test results with raw score, standardized scores and interpretation
• School programs, including frequency and goals to ensure that there is not duplication *(for habilitative)*
• Information regarding home and community programs child is involved in *(for habilitative)*
• Treatment diagnosis, prognosis and rehab potential

**DEFINITIONS APPLICABLE TO ALL NETWORK PRACTITIONERS:**

Medical Record content requirements for all patients:

**Chief Complaint:**
The Chief Complaint is the diagnosis, condition, problem, symptom and/or reason for the encounter.

**New Patient:**
The patient has not been seen at any time, for any purpose within the last 3 years.

A. Patient identification must include name, date of birth, and medical record number.

B. Patient demographics must also include address, home and work telephone numbers, gender, and marital status.

C. All records must be legible which is defined as the ability of at least two people to read and understand the documents.

D. Treating practitioner and credentials must be identified on each date of service.

E. All chart entries must be dated with the month, day, and year.

F. Patient history includes both the present illness and past history that includes the past and current treatments of the presenting condition.

G. Working diagnosis is supported by clinical findings.

H. Treatment plan that includes all of the following:
   • Diagnosis and contraindications to treatment
   • Description of functional status/limitations
     Therapeutic plan – frequency and duration and type of treatment interventions to be provided
   • Educational plan – Home exercises, ADL modifications
   • Treatment goals – Measurable, functional, time-specific, patient-oriented goals
   • Specific discharge plan
   • Subsequent plans of care/progress notes should include the following
     • Home program and self-management teaching
     • Collaboration with other professionals/services
• Measurable progress toward functional goals with updating as indicated
• Modifications to the initial plan of care
• Plans for continuing care
*Documentation should clearly reflect why the skills of a network practitioner are needed. The service is considered a skilled service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the supervision of a licensed chiropractor or rehabilitation therapist. The deciding factors are always whether the services are considered reasonable, effective treatments requiring the skills of a therapist or chiropractor or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.

I. All services and dates of each service must be documented.

J. Response to care is demonstrated by a series of daily notes on a visit-to-visit basis

K. Daily notes include SOAP documentation – must have all of the following:
   • Subjective – Impression of the patients condition
   • Objective – Observations and measurable information from the treatment session, description of the interventions provided for each procedure, and rationale including why the skills of network practitioner are needed to deliver the intervention
   • Assessment – A descriptive judgment of the patients’ condition and/or diagnosis
   • Plan – What treatment was performed and a plan or course of future treatment

L. Ancillary diagnostic studies including imaging, laboratory, and consultation reports that have all of the following:
   • Facility and practitioner where study was performed
   • Patient information that includes the name, address, DOB
   • What area of the body was imaged and what views were taken (if applicable)
   • Clinical rationale for the study
   • Study findings and conclusions
   • Recommendations based on clinical and study findings

M. Copies of reports and correspondence with other caregivers.

N. Appropriate consent forms when applicable.

O. A key or summary of terms when non-standard abbreviations are used. Another practitioner should be able to read the record and have a clear understanding of the patient’s condition and treatment rendered.
P. A key or summary of terms when non-standard abbreviations are used. Another practitioner should be able to read the record and have a clear understanding of the patient’s condition and treatment rendered.

Q. Confidentiality of Records: All contracted practitioners will treat patient identifiable health information according to HIPAA standards to ensure the confidentiality of the record and provide the minimum necessary information when requested by Magellan Healthcare to perform a review of services.

R. Performance Goals to Assess Quality

MEDICAL NECESSITY

All network practitioners will maintain clinical documentation that clearly supports the medical necessity of all health care services. In addition, all network practitioners are required to provide additional clinical documentation and/or explanation regarding medical necessity of services at the request of Magellan Healthcare.

Medically necessary care includes the following eight elements:
1. **Contractual** – all covered medically necessary health care services are determined by the practitioner’s contract with the payer and individual health plan benefits.
2. **Scope of Practice** – medically necessary health care services are limited to the scope of practice under all applicable state and national health care boards.
3. **Standard of Practice** – all health care services must be within the practitioner’s generally accepted standard of practice and based on creditable, peer-reviewed, published medical literature recognized by the practitioner’s relevant medical community.
4. **Patient Safety** – all health care services must be delivered in the safest possible manner.
5. **Medical Service** – all health care services must be medical, not social, or convenient for the purpose of evaluating, diagnosing, and treating an illness, injury, or disease and its related symptoms and functional deficit. These services must be appropriate and effective regarding type, frequency, level, duration, extent, and location of the enrollee’s diagnosis or condition.
6. **Setting** – all health care services must be delivered in the least intensive setting.
7. **Cost** – the practitioner must deliver all health care services in the most cost-effective manner as determined by Magellan Healthcare, the health plan, and/or employer. No service should be more costly than an alternative diagnostic method or treatment that is at least as likely to provide the same diagnostic or treatment outcome.
8. **Treatment Guidelines/Clinical Policy Bulletins** – health care services are considered medically necessary if they meet all of Magellan Healthcare Treatment Guidelines.
REFERENCES

American Chiropractic Associations Clinical Documentation Policy
http://www.acatoday.org/level2_css.cfm?T1ID=10&T2ID=117 (accessed November 2, 2011)

Chirocode Deskbook: Chirocode Institute, Inc. (2011). Phoeniz, AZ


NCQA Guidelines for Medical Record Documentation. http://www.ncqa.org


(Guidelines for Documentation of Occupational Therapy http://aota.org)
Clinical Record keeping in Speech-Language Pathology for Health Care and Third-Party Payers (http://asha.org)

Reviewed/Approved by Michael Pentecost, MD, Chief Medical Officer