National Imaging Associates, Inc.*	
Clinical guidelines **RECORD KEEPING AND DOCUMENTATION STANDARDS: PHYSICAL MEDICINE**	**Original Date: November 2015**
Physical Medicine – Clinical Decision Making	**Last Revised Date: August 2022**
Guideline Number: NIA_CG_606-01	**Implementation Date: July 2023**

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 foregoing indices and submitting the documentation for review in a timely manner.

These guidelines apply to all markets and populations, including teletherapy, contracted with this organization through the corresponding state health plans unless a market-specific health plan has been developed. To be covered, documentation must contain evidence to support medical necessity and the need for skilled services as appropriated by the following descriptions and definitions.

MEDICAL RECORD CONTENT REQUIREMENTS FOR ALL PATIENTS

GENERAL GUIDELINES

- Documentation should clearly reflect why the skills of a 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 therapist. The deciding factors are always whether the services are considered reasonable, effective treatments requiring the skills of a therapist or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.
- All records (both digital and handwritten) must be legible, which is defined as the ability of at least two people to read and understand the documents.
- Documentation should be complete and include the practitioner's signature and credentials, appropriately dated chart entries, and include patient identifications on

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each page. Any corrections to the patient's record must be made legibly in permanent ink (single line through the error), dated, and authenticated by the person making the correction(s). Electronic documentation should include the appropriate mechanism indicating that a change was made without the deletion of the original record.
- Services must be documented in accordance with Current Procedural Terminology (CPT®) coding criteria (e.g., location (body region), time component, etc.).
- Adverse events associated with treatment should be recorded in the patient chart.

Clinical Documentation

- Initial evaluations and re-evaluations including plan of care should document the medical need for a course of treatment through objective findings and subjective self or caregiver reporting. The evaluation must be performed by a licensed PT, OT, ST, MD, DO, or DPM in the state. Pertinent history and general demographics, including past or current treatment for the same condition and a baseline evaluation including current and prior functional status should be submitted for review. Copy of discharge summary, written letter from the member stating when services ended and/or specific reference to the date the member choosing to end care with a prior provider must be provided if patient has a current authorization with a different provider and is seeking services with a new provider. Treatment should not duplicate services provided in multiple settings or disciplines.
- Documentation of the evaluations should list and describe the impact of the conditions and complexities on the prognosis and/or the plan for treatment such that it is clear to the peer reviewer that the planned services are reasonable and appropriate for the individual.
- Objective measures and/or discipline-specific standardized testing demonstrating delays that are connected to a decline in functional status must be provided. (Note: Treatment must not be focused on returning to activities beyond normal daily living, including but not limited to return to sports or work specific tasks). For patients with developmental delay, see Outpatient Habilitative Physical and Occupational Therapy and/or Habilitative/Rehabilitative Speech Therapy Guidelines. Assessment tools used during the evaluation should be valid, reliable, relevant, and supported by the appropriate national therapy best practices guidelines.
- While outcome assessment measures are preferred, scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention. Test information must be linked to difficulty with or inability to perform everyday tasks.[1]
- In the absence of objective measures, the report must include detailed clinical observations of current skill sets, patient or caregiver interview/questionnaire and/or informal assessment supporting functional mobility/ADL deficits and the medical need for skilled services. The documentation must clearly state the reason formal testing could not be completed.
- Functional outcome assessment and/or standardized test results with raw scores, standardized scores, and score interpretation must be included.

- Detailed clinical observations, as well as prognosis and rehab potential, must be outlined.
- Contraindications to care must be listed with an explanation of their current management.
- School programs, including frequency and goals to ensure there is no duplication *(for Habilitative OT/PT/ST).*
- Information regarding child's involvement in home and community programs *(for Habilitative OT/PT/ST).*
- Daily notes should include clear evidence of skilled treatment interventions that cannot be carried out solely by non-skilled personnel, assessment of patient's response or non-response to intervention and plan for subsequent treatment sessions, assessments, or updates, and any significant, unusual, or unexpected changes in clinical status.

Treatment plan or Plan of Care
Include the following:

- Meaningful clinical observations; the patient's response to the evaluation process; and interpretation of the evaluation results, including prognosis for improvement and recommendations for therapy amount, frequency, and duration of services.
- The plan of care must include measurable short- and long-term functional SMART (specific, measurable, attainable, realistic and time-bound[3,4]) goals detailing type, amount, duration, and frequency of therapy services required to achieve targeted outcomes, linked to functional limitations outlined in the most recent evaluation/assessment. The frequency and duration must also be commensurate with the patient's level of disability, medical and skilled therapy needs as well as accepted standards of practice while reflecting clinical reasoning and current evidence.[2]
- Visits or units requested must not exceed the frequency and duration supported in the plan of care
- Frequency and duration of skilled services must also be in accordance with the following:
    - Intense frequencies (3x/week or more) will require additional documentation and testing supporting a medical need to achieve an identified new skill or recover function with specific, achievable goals within the requested intensive period.[2] Details on why a higher frequency is more beneficial than a moderate or low frequency must be included. Higher frequencies may be considered when delays are classified as severe as indicated by corresponding objective measures and/or testing guidelines used in the evaluation. More intensive frequencies may be necessary in the acute phase; however, progressive decline in frequency is expected within a reasonable time frame.
    - Moderate frequency (2x/week) should be consistent with moderate delays as established by objective measures and/or the general guidelines of formal assessments used in the evaluation. This frequency may be used for ongoing care when documentation supports this frequency as being clinically effective

toward achieving the functional goals in the treatment plan within a reasonable time frame.
    - Low frequency (1x/week or every other week) may be considered when objective measures and/or testing guidelines indicate mild delays or when a higher frequency has not been clinically effective, and a similar outcome is likely with less treatment per week.
    - Additional factors may be considered on a case-by-case basis.
    - Requested frequency/duration must be supported by skilled treatment interventions regardless of level of severity of deficit or delay.
- Intervention selections must be evidence-based, chosen to address the targeted goals and representative of the best practices outlined by the corresponding national organizations.[5,6] Treatment plan should include the type of modalities and treatment interventions to be provided, any expected caregiver involvement in the patient's treatment, educational plan, including home exercises, ADL modifications, and anticipated discharge recommendations, including education of the member in a home program and, when applicable, primary caregiver education.
- Plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third-party requirements. This review should include total visits from the start of care, changes in objective outcome measures, overall progress towards each goal (including where goal has been met or not met), and any modification of treatment interventions in order to meet goals. Goals should be updated and modified as appropriate. The plan of care update should outline a summary of a patient's response (or lack thereof) to intervention and a brief statement of the prognosis or potential for improvement in functional status, and any update to the frequency or amount of expected care, in preparation for discharge.
- The plan of care should clearly support why the skills of a professional are needed as opposed to discharge to self-management or non-skilled personnel without the supervision of qualified professionals. If telehealth is included, the plan of care should clearly support why the skills of a professional are needed as opposed to discharge to self-management or non-skilled personnel without the supervision of qualified professionals.
- Anticipated discharge planning should be included in plans of care. Formal discharge from care should be considered when records demonstrate services are unskilled or could be completed as part of a home management program, functional limitations do not support the rate of care requested (stated above) or treatment is provided without a treatment plan, functional goals, or recent, sustained improvement.

LACK OF INFORMATION

Reviewers determine that claims/requests have insufficient documentation when the medical documentation submitted is inadequate to support a request for services as medically necessary or requiring skilled services for the requested amount of care. Incomplete notes (e.g., unsigned; undated; insufficient detail, such as lacking updated objectives, updated goals, or specific plan of care) may also result in a denial for lack of sufficient information.

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 to perform a review of services.

BACKGROUND

Definition

Medical Necessity

Reasonable or necessary services that require the specific training, skills, and knowledge of a physical or occupational therapist and/or speech/language pathologist in order to diagnose, correct, or significantly improve/optimize as well as prevent deterioration or development of additional physical and mental health conditions. These services require a complexity of care that can only be safely and effectively performed by or under the general supervision of a skilled licensed professional.

- Services shall not be considered reasonable and medically necessary if they can be omitted without adversely affecting the member's condition or the quality of medical care.
- A service is also not considered a skilled service merely because it is furnished by a skilled licensed professional or by an assistant under the direct or general supervision, as applicable, of that professional. If a service can be self-administered or safely and effectively carried out by an unskilled person, without the direct supervision of a trained professional, as applicable, then the service cannot be regarded as a skilled service even though a licensed professional actually rendered the service.
- Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a skilled licensed professional renders the service.
- Services that include repetitive activities (exercises, skill drills) which do not require a licensed/registered professional's expertise (knowledge, clinical judgment and decision-making abilities) and can be learned and performed by the patient or caregiver are not deemed medically necessary.
- Activities for general fitness and flexibility, sports-specific training enhancement or general tutoring for improvement in educational performance are not considered medically necessary.

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 this organization.

Medically necessary care includes the following elements:

- **Contractual** – all covered medically necessary health care services are determined by the practitioner's contract with the payer and individual health plan benefits.
- **Scope of Practice** – medically necessary health care services are limited to the scope of practice under all applicable state and national health care boards.
- **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.
- **Patient Safety** – all health care services must be delivered in the safest possible manner.
- **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.
- **Setting** – all health care services must be delivered in the least intensive setting.
- **Cost** – the practitioner must deliver all health care services in the most cost-effective manner as determined by this organization, 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.
- **Clinical Guidelines**– health care services are considered medically necessary if they meet all of the Clinical Guidelines of this organization.

POLICY HISTORY

Date	Summary
August 2022	• Revised policy statement to include "documentation must contain evidence to support medical necessity and the need for skilled services…" • General Guidelines: Changed "network practitioner" to "practitioner" and "licensed chiropractor or rehabilitation therapist" to "licensed therapist • General Guidelines: described documentation requirements for all patients • "Clinical Documentation" heading replaced "Evaluation" heading • Clarified specific documentation requirements in the Clinical Documentation section • Clarified treatment plan/plan of care requirements

	• Removed Daily Treatment Note, Progress Note, Re-Evaluation, Utilization Review sections • Removed CPT Code and Complexity Level Charts • Removed reference to chiropractor throughout. • References updated.

December 2021	• Added "General Information" statement
	• Original Record Keeping and Documentation Standards guideline was split into two separate guidelines:
	  ○ Record Keeping and Documentation Standards: Physical Medicine
	  ○ Record Keeping and Documentation Standards: Chiropractic Care
	• Deleted "For patients with developmental delay" from section on Treatment Plan to broaden "Description of baseline functional status/limitations based on standardized testing administered or other assessment tools"
	• Added option of written letter from member when seeking services from new provider under the General Guidelines
	• Added requirement that initial evaluation must be performed by a licensed PT, OT, ST, MD, DO, or DPM
	• Added examples of returning to activities beyond normal daily living
	• Added that "units" requested must not exceed frequency and duration supported in POC
	• Clarified "if appropriate" regarding collaboration with other services/professionals within the updated POC elements
	• Changed to state that progress note should be performed every 30 days or 10 visits, whichever occurs first, to align with CMS guidelines
	• Clarified contents of progress notes
	• Added G2250 (New code, effective 1/1/2021)

October 2020	• Added teletherapy in the policy statement • Added start of care be listed on progress note requirements • Moved CPT codes to background • Added indication of home program compliance for max benefit of therapy as part of updated POC • Added accommodative language to be inclusive of chiropractic care in medical necessity definition • Added support for excessive frequency/duration requests being in accordance with accepted standard of practice

	• Added parenthetical evaluation section to clarify that treatment should not focus on return to activities beyond normal daily living (sport/recreation/work) • Added that visits requested must not exceed the frequency and duration supported in the plan of care • Added qualifier for proof of skilled treatment for requested frequencies regardless of level of severity of delay
January 2020	• No edits made to guideline in response to the review of the evidence base
July 2019	• Definitions moved to the background so that relevant information is more readily available • Organization of material into subcategories as well as formatting CPT code tables and deleting repetitive information for consistency and readability • Clarification and grammar edits to provide greater detail • Additional caveats for medical necessity/non-skilled interventions included as greater support for lack of skill denials • Updated references

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ADDITIONAL RESOURCES

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Reviewed/Approved by NIA Clinical Guideline Committee

GENERAL INFORMATION

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.