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: December 2021**
Guideline Number: NIA_CG_606-01	**Implementation Date: July 2022**

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, services must be skilled as appropriated by the following descriptions and definitions.

INDICATIONS

MEDICAL RECORD CONTENT REQUIREMENTS FOR ALL PATIENTS

GENERAL GUIDELINES

- 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.
- 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.

* National Imaging Associates, Inc. (NIA) is a subsidiary of Magellan Healthcare, Inc.

- Each date of service must adequately identify the patient and include the treating practitioner's signature and credentials. Each subsequent page in the record must also contain the patient's name or ID number.
- All chart entries must be dated with the month, day, and year.
- Records must also be in chronological order and if handwritten they must be in permanent ink with original signatures. Electronic entries should be made with appropriate security and confidentiality provisions.
- Patient demographics including name, address, home and work telephone numbers, gender, date of birth, occupation, and marital status must be provided.
- Any working diagnosis(es) or condition description similar to the appropriate ICD code must be provided. If one is not applicable/allowed, it must be documented and consistent with the associated findings.
- The reason for the encounter or referral (i.e., presenting complaint(s))
- Each date of service must include the subjective complaint(s), objective findings, assessment, diagnosis, treatment/ancillary diagnostic studies performed, and any recommendations, instructions or patient education.
- 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.
- Copies of relevant reports and correspondence with other skilled practitioners; including, but not limited to diagnostic studies, laboratory findings, and consultations
- Copies of reports and correspondence related to treating practitioner diagnostic studies, laboratory findings, and consultations, including rationale for the service or consult and findings, conclusions, and recommendations
- Copy of discharge summary or written letter from the member stating when services ended 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.
- Appropriate consent forms should be included when applicable.
- 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.
- 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.

EVALUATION

- Initial evaluation or plan of care which includes an evaluation 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.

- Documentation of the evaluation should list the conditions and complexities 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 or other healthcare professionals that the planned services are reasonable and appropriate for the individual.
- The patient's general demographics, prior medical, familial, and social history, including, but not limited to accidents, surgeries, medications, illness, living environment, general health status (self, family or caregiver report), medications, co-morbidities and history or identification of any past or current treatment for the same condition.
- All diagnoses related to the patient's condition and contraindications to treatment as well as safety risks must be provided. This may also include impairment, activity limitations, and participation restrictions.
- Baseline evaluation including current and prior functional status (communication, cognition, vision, hearing, functional mobility, ADL, swallowing)
- Systems review consistent with the nature of the complaint(s) and relevant historical information should be included in documentation.
- 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/chiropractic 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 score, standardized scores, and 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)*

TREATMENT PLAN OR PLAN OF CARE (POC)

The treatment plan should include the following:

- The patient's age, date of birth, and date of evaluation
- Medical history and background
- All diagnoses related to the patient's condition and contraindications to treatment as well as safety risks
- Date of onset or current exacerbation of the patient's condition
- Description of baseline functional status/limitations based on standardized testing administered or other assessment tools (Please see Outpatient Habilitative Physical and Occupational Therapy and/or Habilitative Speech Therapy Guidelines for additional information)
- 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 goals detailing type, amount, duration, and frequency of therapy services required to achieve targeted outcomes. 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.
- Measurable short and long-term functional goals should be SMART: specific, measurable, attainable, realistic, and timed[3, 4] Individualized targeted outcomes that are linked to functional limitations outlined in the most recent evaluation/assessment
- 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]
- Type of modalities and treatment interventions to be provided
- If applicable, caregiver's expected involvement in the patient's treatment
- Educational plan, including home exercises, ADL modifications
- Anticipated discharge recommendations, including education of the member in a home program and, when applicable, primary caregiver education
- Signature and date of treating therapist
- Plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third-party requirements.
- 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.

Updated plan of care elements:

- Time frame for current treatment period
- Total visits from start of care
- Change in objective outcome measures
- Overall progress toward each goal (including whether goal has been met or not met). Goals should be updated and modified as appropriate
- Modification of treatment interventions in order to meet goals
- Home program and self-management teaching as well as indication of compliance for maximum benefit of care
- Collaboration with other services/professionals if appropriate

DAILY TREATMENT NOTE

Daily notes should include:

- Standard type format (i.e., SOAP) and contain the date for return visits or follow-up
- 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
- Significant, unusual, or unexpected changes in clinical status

PROGRESS NOTE

Every 30 days or 10 visits, whichever occurs first, or when there is a need to provide evidence to support the authorization of visits, the patient record must include an assessment of improvement or extent of overall progress (or lack thereof) toward each goal for functioning in the appropriate environments at the conclusion of this episode of treatment. Progress reports should include the following:

- Start of care date
- Indication of number of visits attended since the start of care and no shows/cancellations
- Reference to any additional evaluation results and date of administration
- Meaningful clinical observations, 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, updated objective measures, and updated functional outcomes
- Treatment plan revisions and plans for continuing treatment
- Any changes/updates to short- or long-term goals, including current goal status
- Anticipated discharge plan (destination, level of care, assistance, equipment needs, etc.)

RE-EVALUATION

Re-evaluations should not be routine or recurring. While there is broad consensus on the general indications for formal reevaluation of patients, there is less agreement about proposed reasons for reporting patient re-evaluations, i.e., discharge planning, on a routine/prescheduled basis, and/or in meeting regulatory requirements. An established patient evaluation is indicated if any of the following apply:

- The patient presents with a new condition
- There is a significant or unanticipated change in symptoms or decline in functional status
- Assessment of response or non-response to treatment at a point in care when meaningful clinical change can reasonably be detected
- There is a basis for determining the need for change in the treatment plan/goals

The re-evaluation exceeds the parameters of the typical office visit and includes the following:

- Updated history
- Subjective symptoms
- Physical examination findings
- Appropriate standardized outcome tool/measurements as compared to the previous evaluation/reevaluation
- Evidence to support the need for continued skilled care
- Identify appropriate services to achieve new or existing treatment goals

- Revision in Treatment Plan
- Correlation to meaningful change in function
- Evidence of the effectiveness of the interventions provided

UTILIZATION REVIEW

Clinical Guidelines have been developed to support medically necessary treatment as part of the peer review process. Clinical documentation is evaluated when making utilization review determinations. The elements evaluated by a clinical reviewer include, but are not limited to:

- Whether treatment involves an initial trial of care or ongoing care
- Proposed services/procedures for initial trial or ongoing treatment
- Whether the reported condition was acute, sub-acute, or chronic at the onset of care
- Documentation of an exacerbation or significant flare-up, if applicable
- Whether a condition is trauma-related, insidious onset, or repetitive/overuse injuries as a result of activities of daily living
- The date of onset and mechanism of onset is specified
- A history of the current condition is documented
- An interim history is provided for recurrent episodes
- The level, intensity, and frequency of pain is recorded
- Treatment goals that are specific, measurable, attainable, realistic, and timed, should be recorded and monitored
- Outcome Assessment Tools are utilized at pre-determined intervals and treatment does not continue after further meaningful change would be minimal or difficult to measure
- Treatment demonstrates functional improvement that is sustained over time and meets minimum detectable change (MDC) and/or minimum clinically important change (MCIC) requirements
- All services billed meet CPT® coding requirements; are supported by subjective complaints, objective findings, diagnoses, and treatment performed; and meet the requirements according to this organization's Clinical Guidelines
- The record demonstrates the need for skilled services as opposed to home management or unskilled services
- Patients with mild complaints and minimal functional limitations are released to a home exercise program
- Treatment has exceeded 2-3 months for the same or similar condition
- Treatment is provided on patient-directed PRN basis without a treatment plan, functional goals, or 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, such as an initial evaluation, recent progress note and/or the most recent daily treatment notes. 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, speech/language pathologist, or chiropractor 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.

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 Chiropractors (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.

New Patient:
The patient has not been seen at any time by any practitioner within the same group practice, for any purpose, within the last 3 years.

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

Code	99211	99212 (10m)	99213 (15m)	99214 (25m)	99215 (40m)
Medical History	Problem focused CC HPI: 1 ROS: none PFSH: None	Problem focused CC HPI: 1-3 ROS: none PFSH: None	Expanded Problem Focused CC HPI: 1-3 ROS: related to CC PFSH: None	Detailed CC HPI: ≥ 4 ROS: 2-9 PFSH: 1 item any area	Comprehensive CC HPI: ≥ 4 ROS: 10-14 PFSH: 1 item each area
Physical Exam	Affected body area	Affected body area	Affected body areas and 2-4 related organ systems	Affected body areas/systematic/ and 5-7 related organ systems	Multi-system 8+ body systems

Medical Decision	Straight forward	Straight forward	Low	Moderate	High

Complexity Level	Low – CPT 97161	Moderate – CPT 97162	High – 97163
Duration	Typically ≤ 20 minutes face-to-face with patient and/or family; and	Up to 30 minutes face-to-face with patient and/or family; and	Up to 45 minutes face-to-face with patient and/or family; and
History	No personal factors and/or comorbidities that impact the plan of care; and	1-2 personal factors and/or comorbidities that impact the plan of care; and	3 or more personal factors and/or comorbidities that impact the plan of care; and
Examination	An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; and	An examination of body system(s) using standardized tests and measures addressing 3 or more elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; and	An examination of body system(s) using standardized tests and measures addressing 4 or more elements from any of the following: body structures and functions, activity limitations and/or participation restrictions; and
Clinical Presentation	Stable and/or uncomplicated characteristics; and	Evolving clinical presentation with changing characteristics; and	Unstable and unpredictable characteristics; and
Decision Making	Low complexity as determined by a standardized patient assessment instrument and/or measurable assessment of functional outcome	Moderate complexity as determined by a standardized patient assessment instrument and/or measurable assessment of functional outcome	High complexity as determined by a standardized patient assessment instrument and/or measurable assessment of functional outcome
*Complexity determination is based on least complex level for which all components are present.			

97165 – Physical Therapy Re-evaluation	Requires an examination including a review of history and use of standardized tests and measures; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome

Complexity Level	Low - (97165)	Moderate - (97166)	High - (97167)
Level of Profile and History	An occupational profile and medical and therapy history that includes a brief history, including review of medical and/or therapy records relating to the presenting problem	An occupational profile and medical and therapy history that includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance	An occupational profile and medical and therapy history that includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance
Occupational Performance Assessment	An assessment(s) that identifies 1 to 3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that results in activity limitations and/or participation restrictions	An assessment(s) that identifies 3 to 5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that results in activity limitations and/or participation restrictions	An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that results in activity limitations and/or participation restrictions
Clinical Decision Making	Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of	Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment	Clinical decision making of high analytic complexity, which includes an analysis of the occupational profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment

	treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component	options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable completion of evaluation component	options. Patient may present with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component
Number of Treatment Options	Consideration of a limited number of treatment options	Consideration of several treatment options	Consideration of multiple treatment options
Typical Face-to-Face Time* with Patient and/or Family	30 minutes	45 minutes	60 minutes
97168 – Occupational therapy re-evaluation	Assessment: An assessment of changes in patient functional or medical status with revised plan of care Occupational Profile: An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals Plan of Care: A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status, or a significant change to the plan of care is required.		

92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92610	Evaluation of oral and pharyngeal swallowing function
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech. Under Medicare, applies to tracheoesophageal prostheses (e.g., Passy-Muir Valve), artificial

	larynges, as well as voice amplifiers. Use 92507 for training and modification of voice prostheses.
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
92626	Evaluation of auditory rehabilitation status, first hour
92627	Evaluation of auditory rehabilitation status, each additional 15 minutes
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
G0451	Developmental testing, with interpretation and report, per standardized instrument form; Medicare-specific code to be used instead of 96110
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment. effective January 1, 2021.
92607	Evaluation for prescription of speech-generating AAC device, first hour

POLICY HISTORY

Date	Summary

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

REFERENCES

1. Herzinger CV, Campbell JM. Comparing functional assessment methodologies: a quantitative synthesis. *J Autism Dev Disord*. Sep 2007;37(8):1430-45. doi:10.1007/s10803-006-0219-6
2. Bailes AF, Reder R, Burch C. Development of guidelines for determining frequency of therapy services in a pediatric medical setting. *Pediatr Phys Ther*. Summer 2008;20(2):194-8. doi:10.1097/PEP.0b013e3181728a7b
3. Bovend'Eerdt TJ, Botell RE, Wade DT. Writing SMART rehabilitation goals and achieving goal attainment scaling: a practical guide. *Clin Rehabil*. Apr 2009;23(4):352-61. doi:10.1177/0269215508101741
4. Bowman J, Mogensen L, Marsland E, Lannin N. The development, content validity and inter-rater reliability of the SMART-Goal Evaluation Method: A standardised method for evaluating clinical goals. *Aust Occup Ther J*. Dec 2015;62(6):420-7. doi:10.1111/1440-1630.12218
5. Amini D, Furniss J. The Occupational Therapy Practice Framework: A Foundation for Documentation. American Occupational Therapy Association (AOTA). Updated October 2018. Accessed September 22, 2021. https://www.aota.org/~/media/Corporate/Files/Publications/CE-Articles/CE-Article-October-2018.pdf
6. American Physical Therapy Association. Physical Therapy Documentation of Patient and Client Management. American Physical Therapy Association (APTA). Updated May 18, 2018. Accessed September 22, 2021. https://www.apta.org/your-practice/documentation

ADDITIONAL RESOURCES

1. American Medical Association. CPT(r). American Medical Association (AMA). Updated September 14, 2021. Accessed September 22, 2021. https://www.ama-assn.org/practice-management/cpt
2. American Medical Association. New Occupational Therapy Evaluation Codes. *CPT(r) Assistant*. 2017;27(2):3-8.
3. American Physical Therapy Association. Tiered Physical Therapy Evaluation and Reevaluation CPT Codes. American Physical Therapy Association (APTA). Updated June 13, 2020. Accessed September 22, 2021. https://www.apta.org/your-practice/payment/coding-billing/tiered-evaluation-codes
4. American Speech-Language-Hearing Association. The Practice Portal. American Speech-Language-Hearing Association (ASHA). Updated 2021. Accessed September 22, 2021. https://www.asha.org/practice-portal/
5. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health
Services. Centers for Medicare and Medicaid Services (CMS). Updated March 24, 2021. Accessed September 22, 2021. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

6. Centers for Medicare and Medicaid Services. Complying With Medical Record Documentation Requirements. Centers for Medicare and Medicaid Services (CMS). Updated January 2021. Accessed September 22, 2021. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160Text-Only.pdf
7. National Committee for Quality Assurance. Guidelines for medical record documentation. National Committee for Quality Assurance (NCQA). Updated July 2018. Accessed September 22, 2021. https://www.ncqa.org/wp-content/uploads/2018/07/20180110_Guidelines_Medical_Record_Documentation.pdf
8. Paul D, Hasselkus A. Clinical Record Keeping in Speech-Language Pathology for Health Care and Third-Party Payers Minnesota Department of Human Services (MN DHS). Updated 2004. Accessed September 22, 2021. http://www.dhs.state.mn.us/main/groups/manuals/documents/pub/dhs16_158228.pdf

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.