Magellan Healthcare	
Clinical guidelines PLAN OF CARE	Original Date: November 2, 2015 Page 1 of 3
Physical Medicine – Clinical Decision Making	Last Review Date: June 2017
Guideline Number: NIA_CG_607	Last Revised Date: September 2017
Responsible Department: Clinical Operations	Implementation Date: January 2018

Policy Statement

A properly documented plan of care is a required element of clinical documentation. It is based on the initial evaluation findings and patient's functional status and establishes the medical necessity for treatment. The plan includes diagnoses, expected functional outcomes, specific interventions, and evaluation of progress toward outcomes based on follow up assessment. It is a framework to document critical thinking necessary for evidenced based outcomes.

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

To provide physical medicine practitioners with current documentation requirements for a plan of care.

Scope

Physical medicine participating network practitioners, including rendering chiropractors, physical therapists, occupational therapists, and speech therapists. This policy also applies to out of network practitioners as dictated by the health plan.
Physical medicine participating network practitioners, including chiropractors, physical therapists, occupational therapists, and speech language pathologists.

Definition/Background:

- Plan of care must be included in the clinical documentation. Absence of this required information is considered failure to support the medical necessity of treatment.

- Plan of care must be individualized, goal-oriented, and aimed at restoring specific functional deficits.

- Plan of care elements:
  - Treatment diagnosis and specific contraindications to treatment
  - Baseline/current functional status/limitations, as compared to pre-episode functional status
  - Patient-specific functional goals that are measurable, attainable, time-specific and sustainable. The initial plan of care for a musculoskeletal condition should not exceed 4 weeks.

- Proposed frequency and duration of treatment within a reasonable and generally predictable time period
- Specific therapeutic interventions to be provided: the clinical rationale for each service, a description of the service, the area of the body the service will be provided, goals for each service, and a time component, if indicated.Predicted level of improvement in function (prognosis)
- Specific discharge plan

- Plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third party requirements.

- Updated plan of care elements
  - Time frame for current treatment period
  - Total visits from start of care
  - Change in objective outcome measures and standardized testing compared to baseline and/or most recent re-assessment/updated plan of care
  - Measurable 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
  - Collaboration with other services/professionals

- 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.

REFERENCES

Clinical documentation manual, 3rd ed. American Chiropractic Association.

Clinical practice guideline: medical record documentation. ASHA CPG UM 110. Sept. 20, 2007

CMS Evaluation and Management Services Guide-2015. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Defensible Documentation for Patient/Client Management (www.apta.org) DOI: http://dx.doi.org/10.1016/j.jmpt.2008.04.007

Gregory A. Baker, DC, Ronald J. Farabaugh, DC, Thomas J. Augat, DC, MS, CCSP, FASA Cheryl Hawk, DC, PhD, CHES. Algorithms for the Chiropractic Management of Acute and Chronic Spine-Related Pain. Topics in Integrative Health Care 2012, Vol. 3(4) ID: 3.4007

Guidelines for Documentation of Occupational Therapy (www.aota.org)

Guidelines: Physical Therapy Documentation of Patient/Client Management BOD G03-05-16-41 (www.apta.org.)

Khorsan R., Coulter IA., Hawk C., Goertz-Choate. (2008) Measures in Chiropractic Research: Choosing Patient-Based Outcome Assessments. JMPT June 2008 Volume 31, Issue 5, Pages 355–375. http://dx.doi.org/10.1016/j.jmpt.2008.04.007

Medicare Benefit Policy Manual, Chapter 16, 240.1.2 A- 240.1.3; Documentation Requirements

Paul D., Hasselkus A. (2004) Clinical Record keeping in Speech-Language Pathology for Health Care and Third-Party Payers (www.asha.org)

Recommendations for Chiropractic Documentation, Wisconsin Chiropractic Association.

Treatment Plan for Chiropractic Manipulation Services. WPS Government Health Administrators.

Yeomans SG. The clinical application of outcomes assessment. Appleton & Lange; 2000

Yeomans SG., Liebenson C. Applying Outcomes Management to Clinical Practice. JNMS: Journal of the Neuromusculoskeletal System Vol. 5, No. 1. https://www.yeomanschiropracticeducation.com/PDF%20files/09ClinicalApplication39085A.pdf

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