



Magellan Healthcare	
Clinical guidelines RECORD KEEPING AND DOCUMENTATION STANDARDS	Original Date: November 2015 Page 1 of 11
Physical Medicine – Clinical Decision Making	Last Review Date: June 2017
Guideline Number: NIA_CG_606	Last Revised Date: September 2017
Responsible Department: Clinical Operations	Implementation Date: January 2018

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

Physical medicine participating network practitioners, including rendering chiropractors, physical therapists, occupational therapists, speech therapists and their assistants as applicable. 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

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.

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.

GUIDELINES (CHIRO):

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

Code	99201 (10 m)	99202 (20 m)	99203 (30 m)	99204 (45 m)	99205 (60 m)
<i>Medical History</i>	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
<i>Physical Exam</i>	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

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

Code	99211	99212 (10 m)	99213 (15 m)	99214 (25 m)	99215 (40 m)
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	Affected body	Multi-system 8+ body systems

			related organ systems	areas/systematic/ and 5-7 related organ systems	
Medical Decision	Straight forward	Straight forward	Low	Moderate	High

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
- Functional outcome assessment and/or 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

PHYSICAL THERAPY EVALUATION CODE REQUIREMENTS

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	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	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	participation restrictions; and	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 measureable assessment of functional outcome	Moderate complexity as determined by a standardized patient assessment instrument and/or measureable assessment of functional outcome	High complexity as determined by a standardized patient assessment instrument and/or measureable assessment of functional outcome
*Complexity determination is based on least complex level for which all components are present.			
97165 – Physical Therapy Reevaluation	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 measureable assessment of functional outcome		

OCCUPATIONAL THERAPY EVALUATION CODE REQUIREMENTS

Low – CPT 97165	Occupational therapy evaluation, low complexity, requiring these components: <ul style="list-style-type: none"> • An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; • An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and • 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 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.
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	Typically, 30 minutes are spent face-to-face with the patient and/or family.
Moderate – CPT 97166	Occupational therapy evaluation, <u>moderate</u> complexity, requiring these components: <ul style="list-style-type: none"> • An occupational profile and medical and therapy history, which 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 assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and • 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 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 patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
High – 97167	Occupational therapy evaluation, <u>high</u> complexity, requiring these components: <ul style="list-style-type: none"> • An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; • An assessment(s) that identify 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and • A clinical decision-making is of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with

	<p>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. Typically, 60 minutes are spent face-to-face with the patient and/or family.</p>
<p>Re-evaluation – 97168</p>	<p><u>Reevaluation</u> of occupational therapy established plan of care, requiring these components:</p> <ul style="list-style-type: none"> • An assessment of changes in patient functional or medical status with revised plan of care; • An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and • 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. <p>Typically, 30 minutes are spent face-to-face with the patient and/or family.</p>

MEDICAL RECORD CONTENT REQUIREMENTS FOR ALL PATIENTS:

- The reason for the encounter i.e., presenting complaint(s)
- The patient’s prior medical, familial, and social history, including, but not limited to accidents, surgeries, medications, illness, and co-morbidities and history of any past or current treatment for the same or similar presenting complaint
- Patient demographics must also include name, address, home and work telephone numbers, gender, date of birth, occupation, and marital status
- Systems review consistent with the nature of the complaint(s) and relevant historical information
- The working diagnosis(es) must be documented and consistent with the associated findings
- Treatment plan that includes all of the following: diagnosis and contraindications to treatment; description of functional status/limitations; treatment plan with frequency and duration and type of treatment interventions to be provided; educational plan, including home exercises, ADL modifications; treatment goals that are measurable, functional, time-specific, patient-oriented goals; and specific discharge plan. Specific treatment goals (functional/measurable/time-dependent) should be included in the records where care is likely to extend >2 weeks
- Contraindications to care must be listed with an explanation of their current management
- All chart entries must be dated with the month, day, and year.

- Treating practitioner and credentials must be identified on each date of service.
- Records must be in chronological order and written in permanent ink
- Each date of service must include the subjective complaint(s), objective findings, assessment, diagnosis, treatment/ancillary diagnostic studies performed, and any recommendations or instructions given to the patient
- Services must be documented in accordance with Current Procedural Terminology (CPT) coding criteria e.g., location (body region), time component, etc.
- Each patient record must identify the patient and each page in the record must contain the patient's name
- Any corrections to the patient's record must be made legibly in ink, dated, and authenticated by the person making the correction(s).
- The patient record must include periodic measures of treatment response
- Discharge status including the current functional status, degree of goal attainment, home program given, referral or follow up, equipment given, and reason for discharge
- Daily notes should be in a standard type format i.e. SOAP and contain the date for return visits or follow-up
- The patient record should include valid, reliable, and relevant outcome assessment tools, ensuring that a peer reviewer or other healthcare professionals can render a reasonable determination on the baseline status and treatment response
- Adverse events associated with treatment should be recorded in the patient chart
- All records must be legible, which is defined as the ability of at least two people to read and understand the documents.
- Progress toward measurable, functional goals and updated treatment plan goals
- Copies of reports and correspondence with other caregivers; 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
- Appropriate consent forms 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.

All services billed should be described in the patient chart in accordance with Current Procedural Terminology (CPT) coding criteria. Billed services which are not documented in the patient record, are not eligible for reimbursement. The patient record should demonstrate the basis for clinical decision-making, document all services performed, and register the patient's response to treatment.

Reevaluation 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

- 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 reevaluation 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

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.

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
- Whether a condition is trauma-related, the result of activities of daily living, or insidious onset
- 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
- Measurable treatment goals are recorded, appropriate, 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 Magellan’s Clinical Guidelines
- The record demonstrates the need for skilled services, as apposed 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

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.

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.
- Clinical Guidelines**– health care services are considered medically necessary if they meet all of Magellan Healthcare Clinical Guidelines.

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<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>

Defensible Documentation for Patient/Client Management
<http://www.apta.org/DefensibleDocumentation/>

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

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