National Imaging Associates, Inc.	
Clinical guidelines **PLAN OF CARE**	**Original Date: November, 2015**
Physical Medicine – Clinical Decision Making	**Last Revised Date: July 2019**
Guideline Number: NIA_CG_607	**Implementation Date: January 2020**

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.

Criteria

- 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:
    - 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 (For patients with developmental delay, see Outpatient Habilitative Physical and Occupational Therapy and/or Habilitative Speech Therapy Guidelines)
    - 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
    - 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 (Bailes 2008). 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.
        - Low frequency (1x/week or every other week) may be considered when objective measures and/or testing guidelines indicate mild delays.
        - Additional factors may be considered on a case-by-case basis.
    - Measurable short and long-term functional goals that are achievable within the length of time services are requested
    - 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 (Amini 2018, APTA 2009)
    - 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.

- 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 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
    - 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.

POLICY HISTORY:

Review Date: July 16, 2019

Review Summary:

- Greater detail added to elements of treatment plan
- Updated references

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