Physical Medicine Request Tip Sheet/Checklist

Information Required at Intake

Questions will vary depending on the condition being treated. As you proceed to the additional clinical questions, below are some general guidelines:

Member Name: _____ DOB: _____ Evaluation Date: _____ Surgery Date: _____

1. ICD10: a)_____ b)_____ c)_____ d)_____
2. Cause for therapy: Traumatic, Repetitive, Work Related, Motor Vehicle, Unspecified (choose one)
3. Select the type of service:
    a. Physical therapy (PT)
    b. Occupational therapy (OT)
    c. Speech therapy (ST)
    d. Chiropractic services
4. Type of therapy: Rehabilitative | Habilitative | Neuro Rehabilitative
5. Authorization start date (if different from the evaluation date)
6. Date of onset/injury
7. Planned number of sessions: 1, 2 or 3+ visits
8. Body regions being treated, quantity: 1, 2, or 3+
9. Body regions being treated, location(s): Head/neck, upper extremity, spine, lower extremity, wound, vestibular, balance/falls
10. Identify the level of functional deficit the member exhibits (mild, moderate or severe) supported by the evaluation findings or standardized test scores
11. How many visits are you requesting?

Submitting Recommended Documentation

Initial Authorization Request:

If a case pends for clinical information:

- Initial evaluation with the plan of care for clinical review

Subsequent Authorization Request:

If requesting additional visits on an existing authorization:

- Most recent evaluation/re-evaluation (if *not* previously submitted)
- Most recent progress note with updated plan of care
- Two to three of the most recent daily notes

Habilitative Request beyond a year of care (annual re-evaluation is required):

Clinical documents should include:

- Re-evaluation
    - Including start of care and progress compared to baseline measures
    - Summary of prior episode(s) of care and/or therapeutic break(s)
    - Information regarding additional services if being provided
    - Updated standardized testing as applicable
- The most recent progress note with updated plan of care
- Two to three of the most recent daily notes

Documentation Details Checklist:

- ☐ Initial Evaluation
  - Past medical history (mechanism of injury/illness/disability, date of onset and/or exacerbation of condition, prior level of function)
  - Subjective Information (current level of function as well as underlying impairments)
  - Objective measures, standardized test scores and/or functional outcome scores appropriate for condition
  - Individualized assessment (detailed clinical interpretation of findings and expected progress of care)

  If habilitative care, must also include:
  - Summary of prior episode(s) of care and/or therapeutic break(s)
  - Information regarding additional services if being provided
- ☐ Detailed Plan of Care
  - Evidence-based treatment selections
  - Frequency and duration commensurate with level of disability
  - Specific, measurable, and time-oriented goals targeting identified functional deficits
  - Anticipated discharge recommendations
- ☐ Progress Note
  - Updated objective measures and overall functional progress toward goals
  - Summary of member's response to treatment (or lack thereof and why)
  - Explanation of any changes in the plan of care
- ☐ Daily Notes
  - Evidence of skilled treatment interventions that cannot be performed by a layperson

Common Reasons Medical Necessity Criteria are Not Met

National Imaging Associates, Inc. (NIA) issues authorizations in accordance with NIA Clinical Guidelines and Milliman Care Guidelines for therapy. A link to these clinical guidelines can be found on https://www.radmd.com under *"**Solutions/Physical Medicine**."* NIA Guidelines for therapy services are based on evidence-based research, generally accepted industry standards and best practice guidelines established by the corresponding national organizations.

Lack of Information *

Initial Evaluation

*Required at the **initial** OR **subsequent request** after a RadMD approval:* Document medical need for a course of therapy through objective findings and subjective self/caregiver reporting.
Include current/prior functional status, objective measures and/or age and discipline-specific standardized testing showing a delay or decline in functional status, and detailed clinical observations.

Recent Progress Note

Must be completed at regular intervals: Documentation should include assessment of overall progress (or lack thereof) toward each goal, changes in objective outcome measures/standardized testing, clinical observations, and treatment plan revisions, including frequency and duration of treatment.

- If a recent progress note is not available or cannot be completed, the information above can be captured and reported in a daily note.

Objective Measures

Objective measures and/or age-appropriate standardized testing showing delays or their connection to a decline in function. These should be completed at the initial evaluation to assess progress.

Lack of Skilled Therapy *

Records do not support skilled therapy in the treatment interventions, goals or plan of care.

Services must be reasonable or necessary and require the specific training, skill and knowledge of a licensed therapist.

The following do *NOT* support medical necessity:

- Diagnosis alone: Providers must explain why skilled care performed by a therapist is required.
- Services that can be self-administered or safely and effectively carried out by an unskilled person, without the direct supervision of a therapist.
- The unavailability of a competent or willing person to provide a non-skilled service does not indicate a need for more skilled care.
- Repetitive activities which do not require a licensed professional's expertise and can be learned and performed by the member or caregiver.
- Activities for general fitness and flexibility, sports specific training enhancement or general tutoring for improvement in educational performance.
- Members with mild complaints and minimal functional limitations that may be released to a home exercise program.

Lack of Progress *

The practitioner records must demonstrate clear, specific, and measurable improvement in the member's pain and function every two weeks, or at regular intervals as appropriate for the documented condition.

Discharge from a rehabilitative or habilitative episode of care is expected once Maximum Therapeutic Benefit (MTB) has been reached. This can be determined when:

- Member has returned to their prior level of function.
- Meaningful improvement has occurred; however, there is no basis for further meaningful improvement or continued treatment.
- Record no longer demonstrates meaningful clinical improvement or meaningful improvement has not been achieved.

Excessive Request (partial denial) *

The plan of care submitted is excessive for the documented condition and/or does not allow for demonstration of progress towards goals and improved function at regular time frames. After approved visits have taken place, the provider should submit current notes for review that support the ongoing skills of a licensed therapist are required. These records will be reviewed for medical necessity. The records submitted could include (as appropriate):

- Progress note with updated objective measures, status of functional goals, updated plan of care with frequency and duration of treatment, and the reason for skilled care.
- Standardized testing.
- Daily notes showing treatment interventions and the member's response to care.

Excessive Frequency *

Requested frequency and duration must be supported by skilled treatment interventions regardless of severity level or deficit/delay.

Intense frequencies (3x/week or more)

Severe delays/deficits or specialized treatment protocols may be appropriate during initial phase, but progressive decrease in frequency is typical. Will require additional documentation/testing to support why a higher frequency is more beneficial than a moderate or low frequency.

Moderate frequency (2x/week)

Frequency should be consistent with moderate delays as established by objective measures and/or the general guidelines of formal assessments used in the evaluation. Documentation must explain why the therapist needs to adjust the member's therapy plan and home program weekly or more often than weekly based on the member's progress and medical needs.

Overlapping Authorizations *

Treatment should not duplicate services provided in multiple settings.

When skilled services are also being provided by other therapy providers, community service agencies and/or school systems, the notes must show how the requested services are working in coordination with these agencies and not duplicating services.

If the requested therapy is duplicative or overlaps another authorization, notes from the previous clinic/provider are required to show end of care and may include ONE of the following: Discharge summary from previous provider; written and signed note from the member with last date of treatment; call from the previous provider confirming the last date of treatment.

Habilitative Therapy *

Testing (records are not showing a significant delay in function)

Diagnosis or test scores alone do not support a medical need for skilled services. Providers must explain why skilled care performed by a therapist is required. Formal testing must be age-appropriate, norm-referenced, standardized, and specific to the therapy provided. Test scores should establish presence of a motor or functional delay.

Test scores should be at or below the 10th percentile or standardized scores greater than or equal to 1.5 standard deviations below the mean in at least one subtest area.

Age equivalents, percent delay, raw scores or scaled scores will not necessarily be accepted as a measure of delay. Standard deviations from standardized testing are preferred. Notes should also relate specific skill deficits to functional delays in the member's daily routine.

In the absence of standardized testing or when test scores show skills within normal ranges though functional delays are present, records must include detailed clinical observations of current skill sets supporting functional deficits and the medical need for skilled care. The documentation must clearly state the reason formal testing could not be completed.

Goals and Plan of Care (goals written are not age-appropriate or functional)

Treatment goals must be realistic, measurable, functional and promote attainment of developmental milestones commensurate to member age and circumstance.

Progress

Clinical records must demonstrate clear, specific, and measurable functional improvement at regular intervals as appropriate for the documented condition.

It is understood that members with severe deficits or complex diagnoses may progress at a slower rate; however, documentation still must show progress over time. These cases will be reviewed by therapists experienced in pediatric and habilitative care.

Episodic Care Model (records are showing a steady state of function)

For members no longer showing functional improvement, a weaning process of 1-2 months should occur. Periodic episodes of care may be required over a lifetime to address specific needs or changes in condition resulting in functional decline.

Discontinuation of therapy will be expected when the maximum therapeutic value has been achieved and/or functional improvement is not evident or expected to occur.

** NIA Clinical Guideline: Record Keeping and Documentation Standards (NIA_CG_606) ⋆ NIA Clinical Guideline: Outpatient Habilitative Speech Therapy (NIA_CG_602) ⋆ NIA Clinical Guideline: Outpatient Habilitative Physical and Occupational Therapy (NIA_CG_603) ⋆ NIA Clinical Guideline: Measurable Progressive Improvement (NIA_CG_605)*

Non-therapy providers (MD, DO, DPM, DC, etc.) are exempt from the NIA program and authorization requests are managed by Health Plan.