



WholeHealth Networks (WHN)

CLINICAL CRITERIA TO DETERMINE MEDICAL NECESSITY PHYSICAL MEDICINE SERVICES

The purpose of this document is to provide the basic framework for clinical reviewers to use in order to identify the clinical appropriateness and medical necessity of physical medicine services. When considering clinical information submitted for medical necessity review, the following data elements and corresponding details are evaluated to ensure correlation to the presenting diagnosis and proposed care plan:

- Chief Complaint(s)
- Past Medical History
- Age
- Mechanism of Onset
- Duration of Symptoms (acute or chronic)
- Evaluation and Re-evaluation findings
- Current and Prior Functional Status
- Results of Diagnostic Testing (if applicable)
- Diagnostic Impression
- Complicating Factors (conditions or circumstances that may affect the patient's response to care)
- Prior and/or Concurrent Treatment History
- Evidence of appropriate referral or specialty consultation for difficult diagnostic or complex and comorbid therapeutic challenges
- Prognosis
- Plan of Care

Physical Medicine is considered **medically necessary** when provided for the purpose of preventing, minimizing, or eliminating impairments, functional limitations, or participation restrictions. Physical Medicine services are not provided exclusively for the convenience of the patients or providers, for relaxation, or for personal lifestyle enhancement. These services must require the specialized knowledge, clinical judgment, and skills of a qualified physical medicine provider. In addition, the type, amount, and duration of services outlined in the care plan must reasonably result, or expected to result in increased function, minimizing loss of function, or decreased risk of injury and symptoms.

The services provided must require the providers to exercise prudent clinical judgment, treating the patient in a manner that is:

- Safe and effective according to generally accepted standards of health care practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, condition, or disease;
- Not primarily for the convenience of the patient or the provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent clinical outcomes.

For these purposes, "**generally accepted standards of health care practice**" means standards that are 1) based on credible scientific evidence published in peer-reviewed literature, 2) consistent with guidelines and recommendations published by the relevant clinical and professional societies and/ or 3) represent the consensus views of providers practicing in related clinical practice areas.

Determination of medical necessity is also dependent upon the following:

- The choice of intervention should be supported by the patient history, physical examination, symptoms, diagnostic findings, diagnosis, prognosis and other relevant clinical information;
- The referral or presenting problem should be for a diagnosis or condition which the provider can effectively treat, based on scope of license; and
- The plan of treatment must coincide with a diagnosis established and supported within the clinical record.

When a provider determines that **additional or continued treatment** is indicated within an episode of care, the following criteria are reviewed:

- Initial and current subjective symptoms and functional limitations, as described by the patient;
- Examination and re-examination findings, results of diagnostic tests, daily treatment notes, and objective data;
- The initial and current diagnostic impression; and
- The prognosis, goal status, and plan of care to include expected treatment period and frequency.

Clinically significant improvement is defined as objectively measurable clinical and functional improvement in a patient's health outcome as reflected by a decrease in symptoms and an increase in specific functions that show positive correlation with an improvement in objective clinical findings. During the process of determining the clinical outcome of a course of treatment for a specific condition and episode of care, a Problem Oriented Medical Record (POMR) should reflect the patient's clinical improvement.

Examples of clinically significant improvement include, but are not limited to:

- Regaining the ability to perform specific functional tasks that were quantified during the initial evaluation and/or in a subsequent re-evaluation.
- Improvement in outcomes, such as a clinically significant change in symptom severity or in scores on appropriately applied, validated outcome-assessment questionnaires;
- Elimination or reduction of a previously positive examination finding;
- Minimal detectable changes in scores or measurements as established through valid objective clinical measurement methods or devices.

Clinically significant improvements from physical medicine services can be expected within a 4-week period from the onset of care for an acute condition or an acute exacerbation of a chronic condition. The expected level of improvement, rate of change, and required duration and frequency of care vary by diagnosis in concert with the patient's age, mechanism of onset, duration of condition, contributing past history, and the presence or absence of complicating or comorbid factors.

In the event an individual patient's response to physical medicine treatment for their condition is less than expected based on the clinical presentation, additional consideration will be given to best practices for management of that condition. In cases where best practices include additional medical or psychological management, the clinical records should indicate that there has been consideration of these other treatments and/or referral to the patient's primary care physician or appropriate medical specialist.

Maximal Medical Improvement (MMI) is defined as the point at which the patient's clinical condition has stabilized and further physical medicine treatment is unlikely to result in clinically significant functional improvement. Ongoing care after a patient's condition has stabilized or reached a clinical plateau is called **maintenance therapy**.

Maintenance Therapy means services performed repetitively to maintain a level of function. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. These services generally would not involve complex physical medicine procedures, nor would they typically require clinical judgment and skills for safety and effectiveness. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional long-term functional progress is apparent or expected to occur with the form, style or nature of the physical medicine treatment being rendered.

Manipulative Therapy

In establishing a fundamental need for **manipulation**, the treating provider must maintain a clinical record that includes an appropriate new and/ or established patient history and physical examination, and a goal-oriented care plan with measurable treatment goals. This collectively will be considered the key-components of an evaluation and management service.

Examples of clinically significant improvement include, but are not limited to:

- Corresponding reduction and/or mitigation in subjective symptoms;
- Measured improvement in objective findings (i.e., orthopedic tests, neurologic signs, joint specific and region specific ranges of motion, musculoskeletal asymmetry at rest, palpation of tender and sensitive zones, tissue texture changes, muscle strength metrics); and
- A qualitative and/or quantifiable improvement in the patient's ability to perform specific functional tasks and/or activities of daily living as measured by the **Patient-Specific Functional Scale (PSFS)** or similar validated patient reported clinical outcome measure. For example, a clinically relevant improvement in the PSFS can be indicated by a change of at least 2 points in the average score of all activities or at least a 3-point change in a single activity over the reported baseline within a 4-week period.

For **Manipulative therapy services**, **Medicare** requires the primary diagnosis to be a spinal subluxation diagnosis code, followed by a secondary neuro-musculoskeletal diagnosis code. Medicare mandates that the physical exam must demonstrate a causal relationship between the spine and the patient's presenting complaint, which demonstrates medical necessity for spinal manipulation.

Medical necessity for manipulative therapy services should be supported by three elements of documentation:

- Presence of a spinal subluxation;
- Evidence of the subluxation by X-ray or physical examination; and
- Documentation of the initial and subsequent visits.

Medicare requires the acronym P.A.R.T. (Pain, Asymmetry, Range of Motion, and Tissue/Tone) must be used to describe the examination components indicating that a patient is suffering from a spinal condition amenable to manipulation. At least 2 of the 4 P.A.R.T. criteria must be met, with a least one of them being the "A" or "R" component.