Physical Medicine Handbook

Introduction

This document is designed to assist the provider with the care authorization process for physical medicine services through an overview of key care management components, identifying primary elements and common oversights or errors encountered within the utilization review processes of WholeHealth Networks, Inc. (WHN) Utilization Management Program. Much of the information contained herein is considered standard components of a practitioner's formal education and training. Reviewing this information can help to develop a common understanding and expectation of what and how information is used in the clinical review process.

The following topics are included for discussion:

- Medical Necessity
- Standardized Documentation Expectations
- Common Documentation Errors
- Components of the Clinical Management Process
    1. Patient History
    2. Physical Examination
    3. Outcomes Assessment
    4. Diagnosis Assessment
    5. Goal-Oriented Treatment Plan/Care Plan
    6. Prognosis
    7. S.O.A.P. (Treatment) Notes
- Continued Care Trials
- Appropriate Documents to be Submitted for Clinical Review

Medical Necessity

Medical Necessity, synonymous with Clinical Necessity, means health care services or supplies a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and are:

- in accordance with generally accepted standards of medical practice.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- not primarily for the convenience of the patient or the provider, and not more costly than an alternative service, sequence of services, or site of service, and at least as likely to produce equivalent therapeutic or diagnostic results given the nature of the patient’s diagnosis, treatment, illness, injury, disease, the severity of the patient’s symptoms, or other clinical criteria.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Specialty Society recommendations, and the views of providers practicing in relevant clinical areas and any other relevant factors.

Determination of medical necessity is also dependent upon the following:

- The diagnosis should be substantiated by history, symptoms, and clinical information.
- The diagnosis should be for a condition, which the provider of record can effectively treat, based on scope of license and training.
- All body regions of treatment must coincide with a diagnosis established and supported within the clinical record.

Maintenance Therapy

Physical medicine services performed repetitively to maintain a level of function may not be eligible for payment. 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 and rehabilitative procedures, nor would they 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 functional progress is apparent or expected. Maintenance therapy should be reported under procedure code S8990 (physical or manipulative therapy performed for maintenance rather than restoration).

Standardized Documentation Expectations

A permanent clinical record is an essential part of evidence-based clinical practice. The clinical record is a valuable source of information for the patient, the treating provider, consulting physicians and other healthcare entities involved in the day-to-day management and oversight of clinical care. There is a wide range of information considered as integral components of clinical documentation.

Essential Clinical Documentation

Clinical documentation is the chronological recording [month, day, and year] of pertinent facts and observations about the patient’s health history and physical exam of the system(s) applicable to the current encounter. It includes testing, decision making, treatment planning, treatment application details, and outcomes assessments.

As the national standard for clinical record keeping, the basic model of the Problem Oriented Medical Record (POMR) mandates that the clinical record components must be fully legible, organized and complete to allow a practitioner, members of the health care team, successive health care providers or outside parties the reasonable ability to recognize the care being

provided and the results. In addition, if non-standard abbreviations or symbolic entries are used, a key or legend should appear on the forms used or be available for interpretive use. No clinical information should be intentionally obscured from view. The records should also be maintained in a manner that makes them suitable for utilization review and for reimbursement to the provider.

Accordingly, documentation of the patient's care is often as important as the rendition of the care itself. In the context of medico-legal concerns the record serves as the legal instrument to provide substantive evidence on whether care rendered met the legal standard of care. Medico-legal precedents have established that "If it's not in the chart, from a legal standpoint, either the procedure didn't happen, or the comment wasn't made".

Common Documentation Errors

Legibility

One of the most essential components of clinical documentation is legibility. The most accurate and clinically useful information becomes very difficult to use when it is not legible. In general, legibility is considered the readability of documentation by someone other than the practitioner.

Abbreviations

When abbreviations are included in the clinical documentation, only standard abbreviations should be used. If a practitioner feels they must use non-standard abbreviations or symbols, a key or legend must also be provided.

Date of Service

The date should be easily seen and must include the date, month, and year. These three components can be in any order the practitioner wishes but should be consistent. Date of service entries must be made in a contemporaneous methodology without any line gaps or open spaces wherein additional information can be added at a later date.

Goals

Goals should be functional, measurable, and appropriate for patient's lifestyle and prognosis. Goals should be updated in response to patient's progress.

Objective Measures

Document meaningful objective measures relevant to the patient's condition. Avoid vague information, such as "the patient feels better." Objective data should complement the stated subjective improvement to demonstrate clinically significant improvement within a course of treatment.

Service Provider

Documentation must clearly indicate the printed and signed provider of record legal name and the credential of the licensed professional rendering the service, whether it is the M.D., D.O., N.P., P.A., D.C., P.T., PTA, OT, COTA/OTA, etc.

Components of the Clinical Management Process

Patient History

Elements of the patient's clinical history typically include Chief Complaint/Present Illness; Review of Systems; Past, Family, Social, and Functional History.

- Chief Complaint / Present Illness / Mechanism of Onset: As a component to the treating health provider's history interview process with the patient, the patient's Chief Complaint is expected to reasonably correlate with the patient's areas of treatment. The patient's Present Illness details should include Onset/Mechanism of Onset; Palliative & Provocative Factors; Complaint Quality (i.e.: ache, sharp, dull, etc.); Complaint Severity (e.g., use of the Visual Analog Scale.); and Timing (frequency the complaint is present during the waking day).

- Review of Systems: Constitutional; Integumentary, Musculoskeletal, Cardiopulmonary; Neurological, etc.

- Past, Family, Social, and Functional History: General Health; Childhood/Adult Illnesses; Surgeries; Medications; Parent-Sibling health status; Personal/Habit information (marital status; hobbies; diet, sleep, exercise, etc.), and Functional history.

Physical Examination

Components of the patient's physical examination are expected to include appropriate standardized quantitative and qualitative gauges for comparative value to subsequent evaluations. Typically, re-examinations are expected to occur, at a minimum, every 30 days, or every 10 visits for Medicare Advantage patients (PT/OT), while the patient is under care. In cases limited only to the pediatric developmental delay population, a formal, standardized re-assessment is administered at 6-month intervals for comparative analysis and functional outcome tracking data. Elements of the physical examination may include:

- Vital Signs: Temperature, Pulse, Respiration rate; Blood Pressure; Height, & Weight.

- Inspection: Visual evaluation of: Static Posture, Antalgia, Gait, Cuts, Bruising; Tremor, etc.

- Palpation: Regional palpation of the affected body part, if appropriate.

- Range-of-Motion: An instrumentation analysis (goniometer or inclinometer methods) of the regional joint planes involved is acceptable, whereas, given the complete lack of inter-

rater reliability, visual analysis is not considered a valid method of joint motion measurement.

- Orthopedic Testing: The practitioner should be using standardized definitions for positive (+) or negative (-) results for orthopedic testing. Certain orthopedic tests typically require specific details of the findings elicited versus just a simplified "+" or "—" finding. For example, the Straight Leg Raise test should be reported with the area of pain elicited as well was the angle of inclination of the lower extremity where pain appeared. (e.g., Left SLR + for lower back pain with radiating pain into the posterior thigh at 23 degrees of leg elevation).

- Neurological : This would include an evaluation of mental and cognitive status; deep tendon reflexes; dermatome sensation; manual muscle strength testing; cranial nerve evaluation; etc. The term "WNL" or "Within Normal Limits" should be avoided as it provides no clinical detail to the examination findings.

- Imaging: Appropriate details reporting results of: X-rays, CT, MRI, video fluoroscopic swallowing exam, bone scan, etc.

- Laboratory: Reports of relevant laboratory testing performed, such as, urinalysis, blood studies, etc.

- Clinical Yellow Flags: Yellow flags are considered as psychosocial risk factors that should lead to appropriate cognitive and behavioral management. The healthcare provider is advised to appropriately consider and correlate "clinical yellow flags" present for the patient's overall clinical status.

- Clinical Red Flags: Red flags are considered as physical risk factors that should lead to appropriate medical intervention. The treating provider is advised to consider and correlate "clinical red flags" present for the patient's overall clinical status.

- Referrals for Specialized Testing: Details of the treating provider's rationale for referral of the patient for specialized testing as well as the testing outcomes. Examples may include: electrodiagnostic testing (NCV, needle EMG; etc.).

Outcome Assessment Tools

Outcome Assessment tool(s) must be used on a consistent basis throughout the episode of care. The tool must be appropriately scored, interpreted, and reviewed to formulate appropriate care plans. Outcomes tools must be used in the original format that they were developed and published in peer-reviewed journals.

The WHN Physical Medicine pre-authorization process is designed to include the Patient Specific Functional Scale (PSFS) for PT/OT and manipulative therapy services. The PSFS is a self-reported, patient-specific measure, designed to assess functional change, primarily in patients presenting with musculoskeletal disorders. The scale was developed by Stratford and colleagues

as a self-report measure of function that could be used in patients with varying levels of independence. The advantages of the PSFS include its wide applicability and ease of use clinically, both desirable attributes in an outcome measure. Assessment tools and details of the appropriate application and scoring of the PSFS are available through the health plan's provider resource center or WHN provider portal.

Providers may utilize other outcome tools they deem appropriate for the patient's clinical status. Appropriate scoring and application details should be supplied for these supplementary tools. For example, in addition to National Outcome Measurement System (NOMS), a speech therapist may utilize other outcome tools relevant for the patient's clinical condition. Appropriate scoring and application details should be supplied for these outcome tools.

Diagnosis Assessment

The patient's clinical diagnoses and care plan should meet the following criteria:

- Correlate with the clinical details and findings documented in the patient's case histories, physical exams, laboratory testing, diagnostic testing and medical decision-making components within the patient's chart.
- Should be specific for a condition, which the practitioner of record can effectively treat, based on scope of license.
- All treatment must coincide with a diagnosis being established and supported within the clinical record.

Goal-Oriented Treatment Plan

The patient's treatment plan is one of the key elements to establishing medical necessity and may change during the patient's care trial. During care of the patient, the treatment plan is typically expected to be updated every 30 days, or at least every 10 visits for Medicare Advantage members (PT/OT). The treatment plan is expected to contain:

- the specific treatment goals
- the objective measures to assess the effectiveness of care
- a schedule of care recommending the duration and frequency of treatment
- specific techniques, procedures, modalities, exercises, patient instructions used in the patient's management

Prognosis

This is the culmination of the clinical thought processes and must reasonably correlate with the patient information gathered by the clinician. It should also be based on the available literature about the patient's condition(s).

Clinicians should avoid using generic prognostic language, such as "guarded": This prognostic statement has proliferated and evolved to the endpoint of being a matter of custom versus true clinical value. It is, in actuality, a statement that indicates, "*I don't know*". Accordingly, this prognostic statement adds opacity versus clarity to the clinical management approach and should be distinctly avoided in the formation of a prognostic statement.

S.O.A.P. Notes

As a component to the POMR, the daily S.O.A.P. or treatment note is an essential element to demonstrating the patient's visit-to-visit encounters and to demonstrate the incremental changes to the patient's clinical condition as a response to treatment. Daily S.O.A.P notes are expected to meet the following criteria:

- Health Care Providers' notes are created with a problem-oriented record using the **SOAP** format (S = Subjective, O = Objective, A = Assessment, P = Plan).

- Daily S.O.A.P. / Treatment notes, including documenting patient progress, should be generated at the time of service ("contemporaneously"). This type of clinical documentation is required for each patient encounter including the initial visit, each subsequent visit, any patient communications extraneous to an office encounter, and at discharge.

- Patient-based functional outcome measurements, such as functional status tools or pain rating scales are to be used in records of outpatient episodes of care.

- All records that are reviewed for medical necessity or medical appropriateness must be legible and written in English and must accurately reflect the patient's condition.

- Copies of original office notes created by the practitioner should accompany records that are transcribed for medical audit or review and must be so designated when submitted for review.

Electronic Medical Records

To ensure the clinical information and data elements are specific to the date of service:

- Copying and pasting clinical information may make the information lengthy and not necessarily relevant to the specific date of service; erroneous information may be copied, which can lead to error in treatment.
- Carrying over or auto populating the clinical contents can make it appear as if the patient received more treatment than actually rendered, and not accurately reflect the level of care.

- If copy and paste is used, make sure the information is correct and specific to the patient's condition and date of service. Use free-form text to document decision making processes when necessary.

Continuation of Care

When a practitioner requests **additional or continued treatment** within an episode of care, the following criteria are reviewed:

- Initial and current symptoms as described by the patient including severity, frequency, and character.
- Examination and re-examination findings, results of diagnostic tests, daily notes, and other objective data.
- A complete initial and current diagnostic impression.

Authorization of continuation of care requests will depend upon:

- Clinically significant improvements within outcomes assessment tool applications.
- Improvement in ability to perform activities of daily living.
- Reduction in symptom severity/frequency and/or significant positive changes in the character of the symptoms.
- Improvement as clinically established by functional outcome assessments, objective tests, such as joint range of motion, muscle strength, or speech intelligibility.
- Clinically significant improvements in the above noted criteria and a reasonable objective benefit anticipated from further treatment must be established. Expected improvement, rate of change and duration/frequency of treatment vary by diagnosis, age of the patient, mechanism of onset, and presence or absence of complicating factors, and chronicity of the condition.
- Treatment is aimed at achieving a specific diagnosis-related goal for a patient who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time.
- The patient's need for skilled care.

Appropriate Documents to be Submitted for Clinical Review

It is expected the treating provider uses reasonable discretion to supply a cross-section of clinical documents that will accurately and efficiently allow for a clear understanding of the patient's presentation status, clinical findings and overall responses to the care trial applied. This typically includes the submission of:

- Clinical Records including Initial History & Examination Findings and any Re-Evaluation History & Examination Findings for this episode of care (if not previously submitted)
- Goal-Oriented Treatment Plan
- Diagnostic Test Results (MRI, Labs, X-Rays, etc.); if applicable
- Treatment Notes (in S.O.A.P. format)
- Current and Prior Outcomes Assessment Documents (e.g., PSFS, or a Referral Form if required by Patient's Health Plan)
- Other Relevant Clinical Findings or Pertinent Information that will Support the Present Diagnosis(es)

Clinical Documentation Requirements for Medicare Advantage

Physical/ Occupational/ Speech Therapy

Medical necessity determination for skilled therapy is focused on the member's need for skilled care, rather than the presence or absence of a member's potential for improvement. Documentation should be clear as to why skilled therapy is necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

Manipulative Therapy

In establishing a fundamental need for chiropractic care, 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.

Medicare requires the primary ICD-10 diagnosis is a spinal subluxation code (M99.XX), followed by a secondary neuromusculoskeletal diagnosis code.

Medical necessity should be supported by three elements of documentation:

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

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.

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. However, P.A.R.T. is not intended to replace a sufficiently conducted clinical History, Physical Examination, and Goal Oriented Treatment Plan.

At least 2 of the 4 P.A.R.T. criteria must be met, with at least one of them being the "A" or "R" component.

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