SUPERIOR HEALTH PLAN

Specific policy administered by National Imaging Associates, Inc. (NIA)

National Imaging Associates, Inc.	
Clinical guidelines **RECORD KEEPING AND DOCUMENTATION STANDARDS: Physical Medicine**	**Original Date: November 2015**
Physical Medicine – Clinical Decision Making	**Last Revised Date: February 2024**
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*** Refers to health plan specific language for Texas Medicaid Members ONLY [7]**

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General Information

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

Statement

Recordkeeping is used to document the condition and care of the member, 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 foregoing indices and submitting the documentation for review in a timely manner.

Purpose

This guideline will assist the physical therapist, occupational therapist, and/or speech-language pathologist in creating and maintaining complete and appropriate clinical records and documentation.

All recommendations in this guideline reflect practices that are evidence-based and/or supported by broadly accepted clinical specialty standards.

Scope

All network practitioners will maintain clinical documentation that clearly supports the medical necessity of all health 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 this organization.

These guidelines apply to all markets and populations, including teletherapy, contracted with this organization through the corresponding state health plans unless a market-specific health plan has been developed.

To be covered, documentation must contain evidence to support medical necessity and the need for skilled services as appropriated by the following descriptions and definitions.

Medical Record Content Requirements [1, 2, 3]

General Guidelines

- Documentation should clearly reflect why the skills of a network practitioner are needed/the care is medically necessary.
- All records (both digital and handwritten) must be legible: the ability of at least two people to read and understand the documents.
- Documentation should be complete and include:
    - Practitioner's signature and credentials
    - Appropriately dated chart entries
    - Patient identifications on each page
- Corrections to the patient's record must be made legibly in permanent ink (single line through the error), dated, and authenticated by the person making the correction(s).
    - Electronic documentation should include the appropriate mechanism indicating that a change was made without the deletion of the original record.
- Services must be documented in accordance with Current Procedural Terminology (CPT®) coding criteria (e.g. location (body region), time component, etc.)
- Adverse events associated with treatment should be recorded in the patient chart

Evaluation/Re-Evaluation

Initial evaluations and re-evaluations including plan of care must be performed by a state-licensed PT, OT, SLP, MD, DO, or DPM and should document:

- Medical need for a course of treatment through objective findings and subjective self or caregiver reporting
- Pertinent history and general demographics including:
    - Past or current treatment for the same condition
    - Baseline evaluation including current and prior functional status (submit for review)
- Copy of discharge summary including a written letter from the member stating when services ended or a specific reference to the date the member choose to end care with a prior provider must be provided if patient has a current authorization with a different provider and is seeking services with a new provider
    - Treatment should not duplicate services provided in multiple settings or disciplines
- Impact of the conditions and complexities on the prognosis and/or the plan for treatment such that it is clear to the peer reviewer that the planned services are reasonable and appropriate for the individual
- Objective measures and/or discipline-specific standardized testing demonstrating delays that are connected to a decline in functional status must be provided
    - Assessment tools used during the evaluation should be:
        - Valid
        - Reliable
        - Relevant

        - Supported by the appropriate national therapy best practices guidelines
    - Scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention
        - Test information must be linked to difficulty with or inability to perform everyday tasks
- In absence of objective measures, the report must include:
    - Detailed clinical observations of current skill sets
    - Patient or caregiver interview/questionnaire and/or informal assessment supporting functional mobility/ADL deficits
    - Medical need for skilled services
    - The reason formal testing could not be completed
- Functional outcome assessment and/or standardized test results to include:
    - Raw scores
    - Standardized scores
    - Score interpretation
- Detailed clinical observations, as well as prognosis and rehab potential, must be outlined.
- Contraindications to care must be listed with an explanation of their current management.
- School programs, including frequency and goals to ensure there is no duplication *(for Habilitative OT/PT/SLP)*
- Information regarding child's involvement in home and community programs *(for Habilitative OT/PT/SLP)*
- Acute PT, OT, and ST Services[2, 7]
    - Acute PT, OT, and ST services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition.
    - Treatments are expected to significantly improve, restore or develop physical functions diminished or lost as a result of a recent trauma, illness, injury, disease, surgery, or change in medical condition, in a reasonable and generally predictable period of time (60 days), based on the prescribing provider's and therapist's assessment of the client's restorative potential.
    - Note: Recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.
    - Treatments are directed towards restoration of or compensation for lost function. Services do not duplicate those provided concurrently by any other therapy. Services must meet acceptable standards of medical practice and be specific and effective treatment for the client's condition.
    - Services are provided within the provider's scope of practice, as defined by state law. Acute is defined as an illness or trauma with a rapid onset and short duration. A medical condition is considered chronic when 120 days have passed from the start of therapy or the condition is no longer expected to resolve or may

be slowly progressive over an indefinite period of time.
    - With documentation of medical need physical, occupational, and speech therapy may continue for a maximum of 120 days for an acute medical condition or an acute exacerbation of a chronic medical condition.
    - Once the client's condition is no longer considered acute, continued therapy for a chronic condition will only be considered for clients who are 20 years of age or younger.
- **Chronic Services[7]**
    - Chronic physical, occupational, and speech therapy services are benefits of Texas Medicaid for the medically necessary treatment of chronic medical conditions and developmental delay when a medical need is established for the developmental delay as indicated in this handbook. All eligible clients who are birth through 20 years of age may continue to receive all medically necessary therapy services, with documentation proving medical necessity.
    - The goals of the services provided are directed at maintaining, improving, adapting, or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part, congenital abnormality, degenerative disease, or developmental delay.
    - Services do not duplicate those provided concurrently by any other therapy.
    - Services must meet acceptable standards of medical practice and be specific and effective treatment for the client's condition.
    - Services are provided within the provider's scope of practice, as defined by state law.
    - Treatment for chronic medical conditions and developmental delay will only be considered for clients who are birth through 20 years of age.

Daily notes

Should include the following:

- Clear evidence of skilled treatment interventions that cannot be conducted solely by non-skilled personnel
- Assessment of patient's response or non-response to intervention and plan for subsequent treatment sessions, assessments, or updates
- Any significant, unusual, or unexpected changes in the clinical status

Treatment Plan or Plan of Care

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. This includes the use of telehealth rather than on-site treatment.

The plan of care should include the following:

- Meaningful clinical observations
- Patient's response to the evaluation process
- Interpretation of the evaluation results including:
    - Prognosis for improvement
    - Recommendations for therapy amount, frequency, and duration
- Short and long-term goals that are required to achieve targeted outcomes
    - SMART (specific, measurable, attainable, realistic and time-bound)
    - Detail the type of intervention that must be:
        - Skilled treatment interventions, regardless of level of severity of deficit or delay
        - Evidence-based
        - Chosen to address the targeted goals and/or outcomes
        - Representative of the best practices outlined by the corresponding national organizations
        - If telehealth is included, 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
    - Amount, duration, and frequency [4, 5, 6]
        - The frequency and duration must commensurate with:
            - Patient's level of disability
            - Medical and skilled therapy needs
            - Accepted standards of practice
            - Clinical reasoning and current evidence
- Frequency and Duration Criteria for Therapy Services[7]
    - Frequency must always be commensurate with the member's medical and skilled therapy needs, level of disability and standards of practice; it is not for the convenience of the member or the responsible adult.
    - Exceptions to therapy limitations may be covered if the medically necessary criteria are met for the following:
        - Presentation of new acute condition
        - Therapist intervention is critical to the realistic rehabilitative/restorative goal, provided documentation proving medical necessity is received.
    - When therapy is initiated, the therapist must provide education and training of the member and responsible caregivers, by developing and instructing them in a home treatment program to promote effective carryover of the therapy program and management of safety issues.
    - High frequency (3 times per week) can only be considered for a limited duration (approximately 4 weeks or less) or as otherwise requested by the prescribing provider with documentation of medical need to achieve an identified new skill or recover function lost due to surgery, illness, trauma, acute medical condition, or acute exacerbation of a medical condition, with well-defined specific, achievable

goals within the intensive period requested.

- Therapy provided three times a week may be considered for 2 or more of these exceptional situations:
  - The member has a medical condition that is rapidly changing.
  - The member has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery).
  - The member's therapy plan and home program require frequent modification by the licensed therapist.
- On a case-by-case basis, a high frequency requested for a short-term period (4 weeks or less) which does not meet the above criteria may be considered with all of the following documentation:
  - Letter of medical need from the prescribing provider documenting the member's rehabilitation potential for achieving the goals identified.
  - Therapy summary documenting all of the following:
    - Purpose of the high frequency requested (e.g., close to achieving a milestone)
    - Identification of the functional skill which will be achieved with high frequency therapy
    - Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.
- A higher frequency (4 or more times per week) may be considered on a case-by-case basis with clinical documentation supporting why 3 times a week will not meet the member's medical needs.

- Moderate Frequency
  - Therapy provided two times a week may be considered when documentation shows one or more of the following:
    - The member is making very good functional progress toward goals.
    - The member is in a critical period to gain new skills or restore function or is at risk of regression.
    - The licensed 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.
    - The member has complex needs requiring ongoing education of the responsible adult.
- Low Frequency
  - Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
    - The member is making progress toward the member's goals, but the progress has slowed, or documentation shows the

member is at risk of deterioration due to the member's development or medical condition.
    - The licensed therapist is required to adjust the member's therapy plan and home program weekly to every other week based on the member's progress.
    - Every other week therapy is supported for members whose medical condition is stable, they are making progress, and it is anticipated the member will not regress with every other week therapy.
- Expected caregiver involvement in the patient's treatment
- Educational plan, including:
    - Home exercises
    - Activities of Daily Living (ADL) modifications
    - Anticipated discharge recommendations including:
        - Education of the member in a home program
        - Primary caregiver education (when applicable)
- Anticipated discharge planning should be included in plans of care; formal discharge from care should be considered when:
    - Records demonstrate services are unskilled or could be completed as part of a home management program
    - Functional limitations do not support the rate of care requested (stated above)
    - Treatment is provided without a treatment plan, functional goals, or recent sustained improvement

Plan of care should be reviewed at intervals appropriate to the patient and in accordance with state and third-party requirements. This review should include:

- Total visits from the start of care
- Changes in objective measures
- Updated outcome measure scoring and interpretation of results
- Overall quantified progress towards each goals (including if goal has been met or not met)
- Modification of treatment interventions needed to meet goals
- Goals updated as appropriate
- Summary of a patient's response (or lack thereof) to intervention
- Statement (brief) of the prognosis or potential for improvement in functional status
- Updates to the frequency or amount of expected care in preparation for discharge
- In determining whether a service requires the skill of a licensed physical and occupational therapist or speech language pathologist, consideration must be given to the inherent complexity of the service, the condition of the member, the accepted standards of medical and therapy practice guidelines, with consideration of the

following:[7]

- If the service could be performed by the average nonmedical person, the absence of a competent person (such as a family member or medical assistant) to perform it does not cause it to be a skilled therapy service
- If the nature of a service is such that it can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy

Note: Treatment must not be focused on returning to activities beyond normal daily living, including but not limited to sports, recreational activities, and/or work-specific tasks.

Maintenance care

Maintenance level of therapy services may be considered when a member requires skilled therapy for ongoing periodic assessments, consultations, and treatment.

- Goals in the plan of care must reflect that care is focused on maintaining the current level of function and prevent regression rather than progressing or improving function
- Clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided
- The documentation must clearly demonstrate that he specialized judgement, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the same and effective performance of services in a maintenance program
- It is expected that evidence is provided regarding the implementation of a comprehensive home program with indications of compliance by the member to the home program for maximum benefit of therapy

LACK OF INFORMATION

Reviewers can determine that claims or requests have insufficient documentation when the medical documentation submitted is inadequate to support a request for services as medically necessary or requiring skilled services for the requested amount of care. Incomplete notes (e.g., unsigned; undated; insufficient detail, such as lacking updated objectives, updated goals, or specific plan of care) may result in a denial for lack of sufficient information.

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 to perform a review of services.

BACKGROUND

Medical Necessity [1, 2, 7]
Reasonable or necessary services that require the specific training, skills, and knowledge of a physical or occupational therapist, speech/language pathologist, or chiropractor in order to diagnose, correct, or significantly improve/optimize as well as prevent deterioration or development of additional physical and mental health conditions. These services require a complexity of care that can only be safely and effectively performed by or under the general supervision of a skilled licensed professional.

- Services shall not be considered reasonable and medically necessary:
    - If they can be omitted without adversely affecting the patient's condition or their quality of care
    - Merely because a licensed practitioner furnishes it
        - If a service can be self-administered or safely and effectively conducted by an unskilled person, without the direct supervision of a practitioner, then it cannot be regarded as a skilled service even though a licensed practitioner rendered the service
    - If the unavailability of a competent person to provide a non-skilled service results in the non-skilled service being rendered by a licensed practitioner
    - If they include repetitive activities (exercises, skill drills) which do not require a licensed practitioner's expertise (knowledge, clinical judgment and decision-making abilities) and can be learned and performed by the patient or caregiver
    - If they are activities for general fitness and flexibility, sports specific training enhancement or general tutoring for improvement in educational performance

Medically necessary care must be:

- **Contractual** – all covered medically necessary health care services are determined by the practitioner's contract with the payer and individual health plan benefits.
- **Scope of Practice** – medically necessary health care services are limited to the scope of practice under all applicable state and national health care boards.
- **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.
- **Member Safety** – all health care services must be delivered in the safest possible manner.
- **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.
- **Setting** – all health care services must be delivered in the least intensive setting.
- **Cost** – the practitioner must deliver all health care services in the most cost-

effective manner as determined by this organization, 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 the Clinical Guidelines of this organization.

POLICY HISTORY

Date	Summary
December 2023	"Maintenance Section" added
August 2022	• Revised policy statement to include "documentation must contain evidence to support medical necessity and the need for skilled services…" • General Guidelines: Changed "network practitioner" to "practitioner" and "licensed chiropractor or rehabilitation therapist" to "licensed therapist • General Guidelines: described documentation requirements for all patients • "Clinical Documentation" heading replaced "Evaluation" heading • Clarified specific documentation requirements in the Clinical Documentation section • Clarified treatment plan/plan of care requirements • Removed Daily Treatment Note, Progress Note, Re-Evaluation, Utilization Review sections • Removed CPT Code and Complexity Level Charts • Removed reference to chiropractor throughout. • References updated.

References

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[2] American Speech-Language-Hearing Association, "Documentation in health care [Practice Portal]," n.d.[Online]. Available: https://www.asha.org/practice-portal/professional-issues/documentation-in-health-care/. [Accessed August 2023].

[3] American Physical Therapy Association, "APTA Guide to Physical Therapist Practice 4.0," 2023. [Online]. Available: https://guide.apta.org.

[4] Academy of Pediatric Physical Therapy, "Intensity of service in an outpatient setting for children with chronic conditions," 2012. [Online]. Available: https://pediatricapta.org/includes/fact-sheets/pdfs/12%20Intensity%20of%20Service.pdf. [Accessed August 2023].

[5] A. F. Bailes, R. Reder and C. Burch, "Development of guidelines for determining frequency of therapy services in a pediatric medical setting," *Pediatric Physical Therapy,* vol. 20, no. 2, pp. 194-198, 2008.

[6] A. Houtrow and N. Murphy, "Prescribing physical, occupational, and speech therapy services for children with disabilities," *Pediatrics,* vol. 143, no. 4, 2019.

[7] Texas Medicaid & Healthcare Partnership. *Texas Medicaid Provider Procedures Manual Volume 2 Provider Handbooks: Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.* March 2024. https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2024/2024-03-march/2_16_pt_ot_st_srvs.pdf

Reviewed/Approved by NIA Clinical Guideline Committee

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