# Evolent Clinical Guideline 1510 for Record Keeping and Documentation Standards: Physical Medicine

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| **Guideline Number:**<br>Evolent_CG_1510 | | |
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| **Original Date:**<br>November 2015 | **Last Revised Date:**<br>November 2024 | **Implementation Date:**<br>July 2025 |

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# STATEMENT

## General Information

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit 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.*

## 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 care 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.

## Special Note

Recordkeeping is used to document the condition and care of the patient, 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.

# MEDICAL RECORD CONTENT REQUIREMENTS [1,2,3]

## General Guidelines

- Documentation should clearly reflect why the skills of a 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 (**see below**) 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 chose 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 to the condition(s) being addressed
    - 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/inability to perform everyday tasks.
- In the 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 and 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)*

## 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 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 services 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
  - The frequency and duration must be commensurate with:
    - Patient's level of disability
    - Medical and skilled therapy needs
    - Accepted standards of practice
    - Clinical reasoning and current evidence
    - Frequency and duration of skilled services must also be in accordance with the following [4,5,6]:
      - Intense frequencies (≥ 3x/week) require additional documentation and testing to support a medical need (achieve an identified new skill or recover a function with specific, achievable goals within the requested period)
        - Include details on why a higher frequency is more beneficial than a moderate or low frequency.
        - Higher frequencies may be considered when delays are classified as severe (indicated by corresponding objective measures and/or testing guidelines used in the evaluation)
        - More intensive frequencies may be necessary in the acute phase (progressive decline in frequency is expected within a reasonable time)
      - Moderate frequency (2x/week) should be consistent with moderate delays (established by objective measures and/or the general guidelines of formal assessments in the evaluation)
        - Frequency may be used for ongoing care when documentation supports it as being clinically effective toward achieving the functional goals in the treatment plan within a reasonable time.
      - Low frequency (1x/week or every other week) may be considered when objective measures and/or testing guidelines indicate mild delays or when a higher frequency has not been clinically effective, and a similar outcome is likely with less treatment per week
    - Visits or units requested must not exceed the frequency and duration supported in the plan of care.
- Linked to functional limitations outlined in the most recent valuation or assessment.

- Additional factors may be considered on a case-by-case basis.

- 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 goal (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

**Note:** Treatment must not be focused on returning to activities beyond normal daily living, including but not limited to return 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 preventing 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 the specialized judgement, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.
- It is expected that evidence will be 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, and insufficient detail showing clear evidence supporting recent significant progress with treatment, such as lacking baseline/updated objectives and goals, or specific plan of care) may result in 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.

# CODING AND STANDARDS

## Applicable Lines of Business

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|---|---|
| ☒ | CHIP (Children's Health Insurance Program) |
| ☒ | Commercial |
| ☒ | Exchange/Marketplace |
| ☒ | Medicaid |
| ☒ | Medicare Advantage |

# BACKGROUND

## Medical Necessity [1,2,7]

Medically necessary services are reasonable or necessary services that require the specific training, skills, and knowledge of a physical or occupational therapist and/or speech/language pathologist to diagnose, correct, or significantly improve/optimize as well as prevent deterioration or development of additional physical 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 licensed practitioner.

- Services shall not be considered reasonable and medically necessary if:
  - They can be omitted without adversely affecting the member's condition or their quality of care.
  - Simply 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.
    - The unavailability of a competent person to provide a non-skilled service resulting in the non-skilled service being rendered by a licensed practitioner does not make the service provided a skilled service.
  - 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.
  - They are activities for general fitness and flexibility, sports-specific training enhancement or general tutoring for improvement in academic performance.

Medically necessary care must be:

- **Contractual** – all health care services are determined by the practitioner's contract with the payer and individual health plan benefits.
- **Within Scope of Practice** – all health care services are limited to the scope of practice under all applicable state and national health care boards.
- **Within Standard of Practice** – all health care services must be within the practitioner's generally accepted standard of practice.
- **Considerate of Patient Safety** – all health care services must be delivered in the safest possible manner.
- **A 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.
- **Considerate of Setting** – all health care services must be delivered in the least intensive setting.
- **Considerate of 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.
- **Supported by Clinical Guidelines**– health care services meet all of the Clinical Guidelines of this organization.

# POLICY HISTORY

| Date | Summary |
|---|---|
| November 2024 | ● This guideline replaces Evolent Clinical Guideline 606-01 for Record Keeping and Documentation: Physical Medicine<br>● Updated references |
| December 2023 | ● “Maintenance Section” added |

# LEGAL AND COMPLIANCE

## Guideline Approval

### *Committee*

**Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee**

## Disclaimer

*Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members’ health care coverage may not utilize some Evolent Clinical Guidelines. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.*

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