Physical Medicine Tip Sheet/Document Checklist

- Clinical documentation is required when the request pends for review
- Documents can be submitted via **upload on RadMD** (faster) **or fax** using an Evolent Coversheet

Documentation Recommendations

Initial Authorization Request:

- **Initial evaluation** with the plan of care. Please ensure the following requirements are met:
- Information includes prior level of function as well as date of onset of current condition
- Plan of care includes frequency and duration of the request
- Goals are written in S.M.A.R.T. form (Specific, Measurable, Achievable/Attainable, and Time-bound)
- There is no open authorization at other or current facility. (Attestation Template available on RadMD)

Subsequent Authorization Request (requesting additional visits, change in plan of care, adding new diagnosis on an existing authorization

- Most **recent progress note/re-evaluation** with updated plan of care including objective measures towards all goals (Created within the past 30 days for rehabilitative care; habilitative care within 90 days).
- Plus two to three most recent **daily notes**
- Initial evaluation, if not previously submitted.

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

- **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 being provided, if applicable
- Updated standardized testing and/or functional outcome measures as applicable
- The most **recent progress note** with updated plan of care including objective measures/data for all goals as well as any applicable changes to the plan of care
- It may be helpful to list the date a goal was initiated and date mastered; however, this is not required
- Plus two to three of the most recent **daily notes**

Documentation Recommendation Details:

- Initial Evaluation
- Past medical history (mechanism of injury/illness/disability, date of onset and/or exacerbation of condition, prior level of function, any relevant information/assessments related to current diagnosis)
- 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 and plan of care.
- Specific, measurable, and time-oriented goals targeting identified functional deficits
- **Habilitative** Short Term Goals (STGs): Typically set for 3-6 months

- **Habilitative** Long Term Goals: (LTGs): Typically, set for 6-12 months
- 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
    - It may be beneficial to ensure your plan of care is set to an appropriate timeframe and matches your authorization request, to ensure goals remain relevant, reflect current progress, and evolve as the member advances through skilled care.
- Daily Notes
    - Evidence of skilled treatment interventions that cannot be performed by a layperson

Peer-to-Peers (P2P)

- The treating provider may accept visit(s) being approved without scheduling a P2P call.
- A P2P is optional and intended for clarification and consultation only. Additional documentation is typically required to approve more visits.

Common Reasons Medical Necessity Criteria are Not Met

Evolent issues authorizations in accordance with Evolent Clinical Guidelines and Milliman Care Guidelines for therapy. A link to these clinical guidelines can be found on RadMD.com .

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.

For subsequent requests, please send new documents that have not been reviewed.

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.
- For chronic conditions, documentation must reflect therapy that remains functional, skilled, and shows reasonable progression.
- 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:

- The member has returned to their prior level of function; although improvement occurred, the record no longer supports further meaningful clinical improvement or continued treatment.
- For chronic conditions, while meaningful improvement may not be sustained, periodic episodes of care may be required over a lifetime to address functional decline or changes in condition.

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 and/or functional outcome measures
- 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. Goals that are low complexity and/or repetitive may not require the skills of a therapist at a higher frequency.

- **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, and/or community service agencies, 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 the previous provider
- Call from the previous provider confirming the last date of treatment
- Written and signed note from the member with last date of treatment (Attestation template is available on RadMD).

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 and interpretation should establish the presence of a significant delay.

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.

For members in care for an extended period of time, it is expected that the plan of care shows evolution with goals and treatment interventions. Continuing to address the same goals over an extended period of time without modification does not justify skilled care.
There must be evidence of member and/or caregiver training and/or implementation of a home exercise program, to ensure generalization of skills can occur within the member's natural environment

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 and evolution of the plan of care 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)

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.

After a reasonable break in care has occurred, member has demonstrated regression, and/or is on the brink of meeting a new milestone, care may be re-initiated at that time.

** Evolent Clinical Guideline: Record Keeping and Documentation Standards (Evolent_CG_1510) · Evolent Clinical Guideline: Outpatient Habilitative Speech Therapy (Evolent_CG_1505) · Evolent Clinical Guideline: Outpatient Habilitative Physical and Occupational Therapy (Evolent_CG_1506) · Evolent Clinical Guideline: Measurable Progressive Improvement (Evolent_CG_1504)*

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