Clinical Practice Guideline: **Quality Patient Management**

Date of Implementation: **April 24, 2003**

Contact: **Clinical Care Management**
Clinical Quality Management

Promoting quality patient management is an American Specialty Health Affiliates (ASHA) mandate. ASHA requires that contracted practitioners adhere to reasonable practice parameters. Diagnosis/evaluation and treatment are two significant parameters of clinical decision-making. The practitioner must demonstrate a clinically appropriate approach to his/her clinical decision-making process. This approach is dependent upon the clinical knowledge and experience of the practitioner, his/her skill in clinical assessment, deductive reasoning, and pattern recognition.

This document, in conjunction with Risk Factor Assessment as described in ASHA Policy QM 7 Patient Safety – The Prevention, Recognition, and Management of Adverse Outcomes, will assist the practitioner in understanding the level of assessment and documentation that is appropriate and how this documentation demonstrates clinical practices consistent with ASHA-approved practice parameters and management of expected clinical outcomes. Once received by ASHA, the clinical data found in the submitted documents serves as the basis for the clinical services manager's evaluation of the practitioner's clinical decision-making in terms of clinical services management decisions and treatment utilization.

Practitioner Involvement in the ASHA Clinical Services Management Program

With the exception of services covered under the practitioners applicable treatment form waiver, clinical information including current pertinent subjective and objective clinical findings must be submitted to ASHA for verification of medical necessity of additional services. The practitioner must include adequate patient demographic information to accurately identify the patient as a member: use of ASHA forms is strongly encouraged to ensure adequate information is submitted. In the event that the documentation is either illegible or incomplete, Clinical Services Management Administration (CSMA) staff contacts the practitioner for clarification: the practitioner is allowed the opportunity to provide the necessary information; failure to do so could result in an administrative non-approval of the submitted treatment/services. Upon successful administrative review, the documentation is sent to a licensed, credentialed, peer clinical services manager for verification of medical necessity.

Treating practitioners are expected to have ongoing communication with a referring health care provider, where applicable, and co-management of the patient's episode of

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care between practitioners is expected. Factors that may affect the expected response of the member are considered. Examples include surgical procedures, member age, co-morbidities, past medical history, response to previous treatment, mode of onset, severity, and psychosocial and occupational factors. ASHA does not set diagnosis-specific treatment frequency or duration limitations. Each case is evaluated considering all pertinent clinical evidence for that member's unique clinical situation. It is understood that similar case presentations may be handled in similar fashion with reasonably consistent results. For a given diagnosis the effect of variability in general health status (age, gender, past medical history, psychosocial factors, and presence of co-morbid conditions) make the use of diagnosis-specific treatment duration and frequency limits inherently untenable. If the member has previously accessed a benefit managed by ASHA, the results of previous case evaluations are available to the clinical services manager.

The practitioner is notified by fax of one of three potential outcomes of the evaluation of the submitted treatment/services. These are: *Approval*, *Partial Approval*, or *Non-approval* of the submitted treatment/services. The notification includes the name, telephone number, and extension of the clinical services manager who completed the evaluation. Clinical services managers are available by telephone to respond to any questions or inquiries regarding the clinical services management program or a specific issue related to a case. In the event the fax transmission is unsuccessful, expedient alternatives for the delivery of the response form are implemented.

Approval: ASHA clinical services management has the responsibility to approve appropriate medically necessary care. The clinical services managers evaluate the clinical data supplied by the practitioner in order to determine whether the initiation or continuation of care has been documented as medically necessary. The purpose of the practitioner's initial assessment and subsequent assessments of the member is to estimate the treatment plan/program needs of the member. The ASHA practitioner is accountable to document the medical necessity of all services submitted/provided. It is the responsibility of the peer clinical services manager to evaluate the documentation in accordance with their training, understanding of practice parameters, and review criteria adopted by ASHA.

Partial Approval: Occurs when only a portion of the submitted treatment/services is initially approved. The partial approval may refer to a decrease in treatment frequency, treatment duration, DME/supply/appliance, or type of services submitted. This decision may be due to the practitioner's documentation of findings that are inconsistent with the clinical conclusion, and/or treatment dosage (frequency/duration) is not supported by the underlying diagnostic or clinical features. In many cases, the clinical documentation supplied only provides sufficient information to establish the need to initiate a trial of care. In these circumstances, the clinical services manager will provide a partial approval

of the practitioner's submitted treatment/services. Additional submitted treatments/services may be reviewed after evaluating the progress of the initial treatment/services. These procedures allow the member to receive appropriate care but take into account the variable responses that a member may have to the clinical intervention. If the practitioner disagrees with the partial approval to the submitted treatment/services, he/she may contact the clinical services manager listed on their response form to discuss the case, submit additional documentation utilizing the reconsideration process, or submit additional documentation to appeal the decision.

Non-approval: Occurs when none of the submitted treatment/services are approved. The most common causes for a non-approval of treatment/services are administrative/contractual (e.g., ineligibility, reached plan benefit limits). It is appropriate not to approve ongoing treatment/services if the member's condition is no longer responding favorably to the treatment/services being rendered by the treating practitioner.

Additional Care

Approval of an additional course of treatment/services requires submission of additional information, including patient response and updated clinical findings. In those cases where an additional course of treatment/services is submitted, the decision to approve additional treatment/services will be based on the following criteria:

- The member has made clinically significant progress under the initial treatment plan/program. Clinically significant progress may be noted on a reliable and valid outcome tool. Determining that progress is clinically significant requires correlation with the overall clinical presentation, including updated subjective and objective examination findings.
- Additional clinically significant progress can be reasonably expected by continued treatment.
- The member has not reached maximum therapeutic benefit (MTB) or maximum medical improvement (MMI).
- There is no indication that immediate care/evaluation is required by other health care professionals.

Any exacerbation or flare-up of the condition that contributes to the need for additional treatment/services must be documented.

Supportive Care

Supportive care is defined as treatment/services for members having reached maximum therapeutic benefit (MTB) and for whom periodic trials for therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate. Supportive care follows appropriate application of passive and active care, including lifestyle modification.

It is appropriate to approve additional treatment/services if the need for supportive care is demonstrated. Supportive care may be inappropriate when it interferes with other appropriate primary care or when the risk of supportive care (e.g., practitioner dependence, somatization, illness behavior, or secondary gain) outweighs its benefits.

Ancillary diagnostic procedures should be selected based on clinical history and examination findings that suggest the necessity to rule out underlying pathology or to confirm a diagnosis that cannot be verified through less invasive methods.

- Information is expected to directly impact the treatment/services and course of care
- Benefit of the procedure outweighs the risk to the member's health (short and long term)
- Procedure is sensitive and specific for the condition being evaluated (e.g., an appropriate procedure is utilized to evaluate for pathology).

Clinical Decision-Making Process

The goals of the clinical decision making process, which occur at both the practitioner-member interface and the interface between practitioner and ASHA, are to review for approval, as appropriate, those clinical treatments/services necessary to return the member to pre-clinical/pre-morbid health status or stabilize a chronic condition.

The clinical information the clinical services manager expects to see when evaluating the documentation in support of the medical necessity of submitted treatment/services may include but is not limited to:

- History:
  - Past and familial history
  - Chief complaint
    - Onset/Duration
      - Type/Mechanism
      - Insidious/Spontaneous
    - Initial date of onset/surgery
    - Stage/Nature/Cause(s)
      - Acute, sub-acute, chronic
      - Initial occurrence, exacerbation, chronic recurrent
    - Severity of pain/functional limitation
    - Frequency of pain/functional limitation
  - Other co-morbidity and medical or surgical management

- Physical Examination/Evaluation [commensurate with the nature and severity of the presenting complaint(s) and scope of the practitioner of services]:
  - General review of systems
  - Orthopedic assessment

- Neurological assessment
- Biomechanical assessment
- Functional outcome measure
- Nutritional assessment
- Psychosocial/Lifestyle
- Specialty/situation –specific evaluation (traditional oriental medicine, ADLs, disability/impairment rating, etc.)

Outcome Expectations Considered in Case Evaluation

Within the context of the expected natural progression of the condition and considering member compliance, submitted treatment/services are evaluated to see if they are expected and likely to:

- Increase rate or quality of tissue repair;
- Accelerate return to functional status or stabilize functional capacities;
- Decrease time to reach pre-clinical status, if clinically appropriate;
- Substantially decrease or resolve pain and/or other symptoms;
- Decrease or prevent adverse sequelae or complications;
- Reduce or eliminate risk of relapse or recurrence.

Ancillary diagnostic procedures should be selected based on clinical history and examination findings that suggest the necessity to rule out underlying pathology or to confirm a diagnosis that cannot be verified through less invasive methods.

- Information derived from the procedures is expected to directly impact the treatment/services and course of care
- The benefit of the procedure should outweigh the risk to the member's health (short and long term)
- The procedure must be sensitive and specific for the condition being evaluated (e.g., an appropriate procedure is utilized to evaluate for pathology).

Principles of Practitioner Clinical Services Management

The first principle of clinical services management is to facilitate the early return to activity with associated reduction of symptoms, decrease of impairments, and the restoration of function. A second principle is that care should provide for improvement/recovery more efficiently than if no care had been delivered (improve upon the expected natural progression of the condition). The third principle is that chronicity should be prevented whenever possible. Psychosocial warning signs and/or over-dependence on the practitioner should be evaluated and monitored as appropriate. A fourth principle is that repeated use or reliance on acute care measures alone may foster chronicity, practitioner dependence by the member, and over-utilization of the practitioner's services. In addition, the use of passive modalities that have redundant physiological effect should not be employed.

The level of the patient's compliance with the recommended treatment regimen can affect the outcome of passive or active care.

Passive Care: Treatment/care that is rendered to the patient by the practitioner.

Active Care: Treatment/care performed by the patient (e.g., therapeutic exercise program or lifestyle modification).

The planning for therapeutically necessary care can be divided into four phases, each having distinct objectives.

Phase 1: Acute Intervention

A. To promote anatomical rest
B. To diminish severity of acute symptoms
C. To reduce inflammation
D. To alleviate pain

Phase 2: Remobilization/Functional Improvement

A. To increase the range of pain-free motion/ADL function
B. To minimize deconditioning

Phase 3: Rehabilitation

A. To restore strength and endurance
B. To increase physical work capacity

Phase 4: Lifestyle Adaptations

A. To modify social and recreational activity, if necessary
B. To diminish work environmental risk factors
C. To adapt psychological factors affecting or altered by the disorder.

The practitioner should keep in mind that these phases will overlap and there may not be clear cut delineation among them. It is beneficial to proceed to the remobilization phase (if warranted) as rapidly as possible and to minimize dependency upon passive forms of treatment/care.

In general, the initiation of care is warranted if there are no contraindications to prescribed care, there is reasonable evidence to suggest the efficacy of the prescribed intervention, and the intervention is within the scope of services permitted by State or Federal law. The treatment submission for a disorder is typically structured in time-limited increments (e.g., 30-day increments with follow-up reporting every 30 days). However, when the practitioner discovers that a member is non-responsive to the applied interventions within a two (2) week interval, re-evaluation and treatment modification should be implemented and documented.

Successful management of the member's treatment plan/program involves the effective exchange of clinical information between the contracted practitioner and the clinical services manager. By following these practice parameters and review criteria as decision-assist tools, the contracted practitioner will effectively interact within the ASHA clinical services evaluation system.

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