Clinical Practice Standards for Therapy Documentation

Standard	Audit Criteria
Documentation of assessment is adequate to demonstrate medical necessity for the requested service.	• Assessment is conducted by an appropriately qualified (licensed and/or certified, as applicable) clinician. • Assessment methods conform to best practice standards of the relevant therapy discipline. • Objective assessment documentation supports the medical necessity for the treatment by the requested discipline. • Formal assessment measures administered are appropriate to the individual member. • Documentation is sufficiently current to establish medical necessity for the requested service (within the last 90 days). • In the case of evaluation or re-evaluation requests, all required documentation is present based on the member's age and the discipline to be evaluated.
The treatment plan is appropriate to meet the member's needs.	• The plan of care includes the frequency and duration of recommended treatment. • The plan of care conforms to best practice standards of the relevant therapy discipline. • The plan of care reflects use of evidenced-based treatment approaches which are effective in treating the member's diagnosed condition or impairment. • The plan of care includes treatment goals. • The treatment goals are specific to the individual member's needs. • The treatment goals are written in the SMART (Specific, Measurable, Achievable, Realistic and Timely) format. • The recommended services are within the scope of practice of the clinician who will perform the services.
Progress has been documented, in the case of continued treatment requests.	• Objective progress is reported which demonstrates that the member has obtained significant benefit over the previous period of treatment. • An explanation/rationale is provided for any modifications to the plan of care which may relate to the member's progression in treatment. • An objective explanation of any specific barriers is provided in the event the member is not progressing as anticipated.
Clinical documentation is free of any clinical irregularities.	• No irregularities are noted which impact the reliability or validity of the information reported. • No irregularities are noted which act as potential triggers for suspected fraud/waste/abuse of therapy services. • All information reported is true and correct to the best knowledge of the reporting clinician.