Clinical Practice Guideline: **Quality Patient Management**

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

Product: **Specialty**

Promoting quality patient management is an American Specialty Health – Specialty (ASH) mandate. ASH requires that contracted/credentialed 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 their clinical decision-making process. This approach depends on the practitioner's clinical knowledge and experience, skill in clinical assessment, deductive reasoning, and pattern recognition.

This document, in conjunction with Risk Factor Assessment as described in the *Patient Safety – The Prevention, Recognition, and Management of Adverse Outcomes (QM 7 – S)* policy, will assist the practitioner in understanding the level of assessment and documentation that is appropriate and how this documentation demonstrates clinical practices consistent with ASH-approved practice parameters and management of expected clinical outcomes. Once received by ASH, the clinical data found in the submitted documents serves as the basis for the clinical quality evaluator's assessment of the practitioner's clinical decision-making and treatment plan of care.

PRACTITIONER INVOLVEMENT IN THE ASH CLINICAL SERVICES PROGRAM

Except for services covered under the practitioner's clinical performance system waiver (based on tier assignment), clinical information including current pertinent subjective and objective clinical findings must be submitted to ASH 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 ASH forms is strongly encouraged to ensure adequate information is submitted. If documented administrative information is illegible and/or incomplete, a Medical Necessity/Benefit Administration (MNA) staff person 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 quality evaluator to verify medical necessity.

The practitioner is notified by fax, phone, ASHLink, mail, etc., as appropriate, 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 quality evaluator who completed the evaluation. Clinical quality evaluators are available by telephone to respond to any questions or inquiries regarding the clinical services program or a specific issue related to a case.

Approval

ASH clinical quality evaluators have the responsibility to approve appropriate care for all services as medically necessary. The clinical quality evaluators assess the clinical data supplied by the practitioner in order to determine whether submitted services and/or 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 determine the treatment plan/program needs of the member. The ASH practitioner is accountable to document the medical necessity of all services submitted/provided. It is the responsibility of the peer clinical quality evaluator to evaluate the documentation in accordance with their training, understanding of practice parameters, and review criteria adopted by ASH.

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, Durable Medical Equipment (DME)/supply/appliance, or other type of services submitted. This decision may be due to any number of reasons, such as:

- the practitioner's documentation of the history and exam findings are inconsistent with the clinical conclusion(s)
- the treatment dosage (frequency/duration) submitted for review is not supported by the underlying diagnostic or clinical features
- the need to initiate only a limited episode of care in order to monitor the patient's response to care

Additional services may be submitted and reviewed for evaluation of the patient's response to the initial trial of care. If the practitioner or patient disagrees with the partial approval of services, they may contact the CQE listed on their response form to discuss the case, submit additional documentation through the Reopen process, or submit additional documentation to appeal the decision through the Provider Appeals and Member Grievances process.

Non-approval / Denial

Occurs when none of the services submitted for review are determined to be medically necessary services. The most common causes for a non-approval/denial of all services are administrative or contractual in nature (e.g., ineligibility, reached plan benefit limits, non-coverage). Clinically, it is appropriate to deny continued/ongoing care if the patient's condition(s) are not, or are no longer, responding favorably to the services being rendered

by the treating practitioner, or the patient is not making progress and has reached maximum therapeutic benefit.

ADDITIONAL / CONTINUED CARE

Approval of an additional course of treatment/services requires submission of additional information, including patient response to care and updated clinical findings. In 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. See the *Medical Necessity Decision Assist Guideline for Rehabilitative Care (CPG 12 – S)* clinical practice guideline for more information.

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.
- The benefit of the procedure outweighs the risk to the member's health (short and long term).
- The 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 goal of the clinical quality evaluators during the clinical decision-making process is 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, as supported by the documentation presented.

The clinical information the clinical quality evaluator 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
  - Gait assessment
  - Functional outcome measure/assessment
  - 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, comorbidities and other prognostic factors, 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.

PRINCIPLES OF PRACTITIONERS' DELIVERY OF CLINICAL SERVICES

The first principle of clinical services 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 clinical chronicity should be prevented whenever possible. As applicable, the practitioner should evaluate and monitor psychosocial warning signs and/or avoid over-dependence on in-office procedures and practitioner dependence. A fourth principle is that practitioners must avoid repeated use or reliance on acute care measures alone, as they may foster condition 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, nor should these passive modalities be used for an extended duration.

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 partially or completely performed by the patient (e.g., therapeutic exercise program or lifestyle modification).

It is beneficial to proceed to active care as rapidly as possible to minimize dependency upon passive forms of treatment/care. Using a combination of passive and active care early in the treatment is reasonable for a limited period of time.

If the patient continues to have significant complaints, impairments, and documented functional limitations, one should consider the following:

- Altering the treatment regimen. Such as, utilizing a different physiological approach to the treatment of the condition or withdrawal of predominately passive care (modalities, massage etc.) and increase the active care (therapeutic exercise) aspects of treatment to attain greater functional gains;
- Reviewing self-management program including home exercise programs; and/or
- Referring the patient for consultation by another health care practitioner for possible co-management or a different therapeutic approach.

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 depending on clinical presentation. Dosage (frequency and duration of service) is appropriately correlated with clinical findings, potential complications/barriers to recovery, and clinical evidence. When the practitioner discovers that a member is non-responsive to the applied interventions within a reasonable timeframe, re-assessment and

treatment modification should be implemented and documented. If the member's condition(s) worsen, the practitioner should take immediate and appropriate action to discontinue or modify care and/or make an appropriate healthcare referral.

Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary, even if they are performed or supervised by a practitioner. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.

Successful interaction between the credentialed practitioner and the ASH clinical quality evaluator involves the effective exchange of clinical information. By using ASH clinical practice guidelines and best practices as decision-assist tools and effectively reporting clinical information, the credentialed practitioner will effectively interact within the ASH medical necessity verification process.

CLINICAL INTEGRATION

Treating practitioners are expected to coordinate and integrate care with other contracted practitioners/providers. Clinical integration is most commonly achieved through a clinically integrated network (CIN). A CIN is an active and ongoing program to evaluate and modify practice patterns by clinically integrated practitioners/providers. The CIN creates a high degree of interdependence and cooperation among the clinically integrated practitioners/providers to control costs and ensure quality.

The goal of clinical integration is to benefit consumers via improvements in clinical quality, health outcomes, resource utilization, and cost efficiency. Effects on consumers must be addressed for each of the following key issues: quality improvement, utilization conservation, cost effectiveness, clinical and financial outcomes, and measurement and reporting.

The road to safe clinical integration is through modified practice patterns based on *best practice* clinical guidelines and protocols.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus-driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

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 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. ASH 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, sex, 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 ASH, the results of previous case evaluations are available to the clinical quality evaluator.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the patient to the more expert practitioner.

Depending on the practitioner's scope of practice, training, and experience, a patient's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is essential for the practitioner to refer the patient for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

References

Joint Commission International. (2020). Joint Commission International Accreditation Standards for Hospitals (7th Edition): Joint Commission Resources