



Fact Sheet

Medicare's Treatment Plan Requirements

The purpose of a treatment plan is to identify in your documentation how you plan to restore the patient to pre-condition or full functional status. Medicare has very specific guidelines for what should be included in the documentation. KMC University recommends that providers follow these guidelines for all documentation, not just that for Medicare.

The treatment plan is a necessary part of initial Evaluation and Management (E/M) documentation. It's the manifestation of the doctor's decision-making, as well as the description of the recommended treatment that is the natural outcome of the findings from this evaluation visit. The treatment plan should be documented at the beginning of the episode of care, and again when there is a change to the treatment, such as at periodic re-evaluations or when the patient has a new condition.

Medicare requires the following elements in a treatment plan:

- Recommended level of care (duration and frequency of visits)
- Specific, functional treatment goals
- Objective measures to evaluate treatment effectiveness, such as Outcome Assessment Tools (OATS)
- The date of the beginning of this plan

Consider the following when documenting your treatment plan:

Recommended Level of Care

Essentially, this means how many visits you anticipate for the active portion of the treatment and how often you plan to see the patient over what period of time. It should also outline all treatments you intend to render, including modalities, procedures, home exercises, etc. Remember, nobody expects you to have a crystal ball. This is an estimate based on the findings from the evaluation and your experience with similar cases. Some providers prefer to give the frequency and duration for the first part of the plan only (e.g., three times per week for 12 visits) and conduct a re-evaluation at the end of that timeframe. The re-evaluation produces a new, updated recommended level of care. Medicare acknowledges that treatment of particularly acute injuries may occur more frequently at the onset of care and then taper off over time.

Specific Treatment Goals

The goals are an outline of the patient's specific functional deficits with an end point in mind. Because Medicare's definition of medical necessity includes "the reasonable expectation of recovery or improvement of function," it makes sense that the treatment goals be functional. Avoid less specific goals such as "increase range of motion" or "reduce pain." These are not measurable. Specific treatment goals should be outlined for adjustments as well as any ancillary services you plan to provide (e.g., manual therapy, exercises, or other modalities). For example, if you're ordering electric muscle stim, describe why and your expected outcome. If it's a reduction in pain or spasm, indicate that, and outline how it will be measured. A short-term goal could be what you expect to accomplish within 30 day period.



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Example: (Taken from your Outcomes Assessment Tool (OAT) Neck Disability Index Form). If the patient reported that their sleep was disrupted 40% during the night, a reasonable and measurable short-term goal might be to “improve sleep to less than 20% disruption.” A long-term goal could be what you expect to accomplish by the end of the treatment plan. Using the appropriate OAT might yield the goal: “Increase the patient’s ability to stand without pain for up to three hours.”

Update these goals as needed at each re-evaluation.

Objective Measures to Evaluate Treatment Effectiveness

How can you show that treatment is working? This portion of the plan outlines your intention. We recommend using OATs for this measurement. Score the outcome tool you’re using, and note the beginning score. Choose a goal score that can be accomplished by the end of the treatment plan. If the Oswestry Low Back Questionnaire score was 65% disability at the onset, a goal score of 10% or better is a reasonable outcome to expect. Repeat the OATs at each re-evaluation to prove functional (clinical) improvement and treatment effectiveness. If the patient continues to show improvement during the time between the administration of the OATs—usually at intervals matching the re-evaluation—it implies that treatment is effective and should be continued. In most cases an outcome assessment questionnaire is considered active and current if it is less than 30 days old.

Date of Treatment Plan

Treatment segments are best divided into incidents, bursts of care, or episodes of care. The date of the initial treatment is the date of the beginning of the plan, the first date of treatment, or the date of evaluation. The date of initial treatment goes in **Box 14** of the CMS 1500 form. Always date treatment plans, and work forward in the episode of care.