DOCUMENTATION GUIDELINES: OCCUPATIONAL, PHYSICAL, AND SPEECH-LANGUAGE PATHOLOGY THERAPY SERVICES

Documentation Flowchart for Establishing and Recertifying Therapy Services

REFERRAL FOR EVALUATION

Referral from the member, family member(s), Primary Care Provider (PCP), or another treating provider/Individual Support Plan (ISP) team participant for Occupational (OT), Physical (PT) and/or Speech-Language Pathology Services (SLP), or reevaluation/Evaluation Trigger met.

This will require action from the member/responsible person to obtain a medical prescription from the member's PCP for an evaluation referral.

EVALUATION AND PLAN OF CARE

If the results from an evaluation substantiate a recommendation for medically necessary therapy services, documentation should include a Plan of Care (POC) with discharge criteria for services.

If the results from an evaluation do not substantiate a recommendation for medically necessary therapy services, documentation should include a Plan of Care (POC) with discharge criteria for services.

PLAN OF CARE (POC) AND CERTIFICATION OF THE POC

The Qualified Vendor is required to submit this documentation to the member's PCP for certification. The POC must be signed by the member's PCP and will serve as the medical prescription referral. This may require a face-to-face visit with the PCP.

Upon receipt of the certified POC from the PCP, the Qualified Vendor must provide the member's Support Coordinator (SC) with a copy of the certified POC prior to authorization of services. SC must receive the certified POC within three (3) weeks of the completion of the evaluation.

NO IDENTIFIED NEED

The qualified professional is required to submit the clinical documentation (i.e., therapy evaluation report) to the member's Support Coordinator (SC).

TREATMENT NOTE AND PROGRESS REPORT

The treating provider/vendor, with appropriate supervision if applicable, is required to complete a treatment note for every skilled service encounter. The treating provider(s)/supervisor and the member's parent/guardian signature is required every visit.

A qualified provider must complete a progress note at least once every 90 treatment days (quarterly) or at a minimum by the end of the certification interval. The beginning of the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation, or treatment.

UPDATE TO THE PLAN OF CARE (POC)/RECERTIFICATION
(Completed at the end of the Certification Period)

If objective therapy data and clinical judgment do NOT support ongoing therapy services, documentation should include a discharge note.

This documentation should also include a home functional maintenance program, if applicable.

If objective therapy data and clinical judgment support ongoing therapy services, the qualified provider should update and re-certify the POC, as needed, at least annually, with PCP signature. Determine if an evaluation is necessary (request from Support Coordination if necessary), make additional referrals if necessary. Evaluations are required at a minimum every three (3) years or if Evaluation Trigger is met.

DISCHARGE NOTE

The discharge note shall include all treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge.

The agency/vendor is required to submit this documentation to the member's Support Coordinator and retain all records of service/encounter(s) and ensure compliance with A.R.S. § 12-2297 which provides, in part, that a health care provider shall retain member medical records.

No further action is required from the qualified professional.

See page 8 for EOE/ADA disclosures

Therapy Services: OT, PT, SLP

The Division of Developmental Disabilities (DDD) requires that therapy services are of the appropriate type, frequency, intensity, and duration for the individual needs of the member.

Documentation is read by other providers as well as claims reviewers from various backgrounds and experience. It is important that notes and reports are clear and legible and that they effectively justify that services are medically necessary and document the needed information for clinical management and reimbursement.

Medical Necessity

Documenting medically necessary skilled services is a required element of justifying reimbursement and the need for therapy services. “Medical necessity” as defined in A.A.C. R9-22-101, means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse conditions or their progression, or to prolong life.

Assessing and documenting the following elements provides the justification for reasonable and necessary care and medical necessity:

1. Reasonable: Provided with the appropriate
   1.1. Amount (number of times in a day that type of treatment will be provided);
   1.2. Frequency (number of times in a week that type of treatment is provided);
   1.3. Duration (number of weeks or total treatment sessions) and accepted standards of practice
2. Necessary: Appropriate treatment for the member’s medical and treatment diagnoses and prior or baseline level of function.
3. Specific: Targeted to a specific treatment goal.
4. Effective: Expectation for functional improvement within a reasonable time or maintenance of function in the case of degenerative conditions (member’s prior level of function serves as the baseline).
5. Skilled: Requires the knowledge, skills, and judgment of a qualified professional.

Recommendations for Documenting Skilled Services for Medical Necessity

1. Use terminology that reflects the qualified provider’s technical knowledge.
2. Indicate the rationale (i.e., how does the service relate to the functional goal), type, and complexity of the activity.
   2.1. Objective data showing:
      2.1.1. The progress toward the accurate goal of task performance;
      2.1.2. The speed of response;
      2.1.3. The frequency/number of responses or occurrences;
      2.1.4. The number/type of hierarchical cues;
      2.1.5. The physiological variations in the activity.
   2.2. The specific feedback provided to the member and/or responsible person about performance and how to facilitate carryover and home programming.
   2.3. Indicate additional goals or activities.
   2.4. Indicate dropped or reduced activities.
   2.5. Evaluate the member and/or responsible person’s response to the training and implementation of the home program.
   2.6. Elaborate on the member and/or responsible person’s education or training.

Unskilled Services

Unskilled services do not require the special knowledge and skills of a Qualified Vendor. Skilled services that are not adequately documented may appear to be unskilled.

1. Reporting on performance during activities without describing modification, feedback, or caregiver training that was provided during the session.

2. Repeating the same activities from the previous sessions without noting modifications or observations that would alter future sessions, length of treatment, or Plan of Care (POC).
3. Reporting on an activity without connecting the task to the long- or short-term functional goals.
4. Not reporting and/or providing education to observing caregivers and/or the responsible person without providing education or feedback and/or without modifying the Plan of Care (POC).

Documentation in Health Care for Therapy Services

Documentation should:

1. Establish the variables that influence the member's condition, especially those factors that influence the Qualified Vendor's decision to provide more services that are typical for the member's condition.
2. Establish through objective measurements that the member is demonstrating progress toward functional outcomes/goals.
   2.1. DDD understands that regression and plateaus can occur during treatment and recommends that the reasons for lack of progress be noted and the justification for continued treatment be documented if treatment continues after regression or plateaus.
3. The following types of therapy services documentation are expected and serve as minimum documentation components to be submitted in response to any DDD request for documentation unless otherwise specified:
   3.1. Evaluation;
   3.2. Plan of Care (POC, also called treatment plan);
   3.3. Diagnoses;
   3.4. Long-term treatment goals;
   3.5. Type (e.g., group, individual), amount, duration, and frequency of therapy services;
   3.6. Treatment notes;
   3.7. Progress notes with a home program summary;
   3.8. Discharge note (also called discharge summary).

Evaluation/Plan of Care (POC)/Update to the POC (Recertification)

The initial evaluation, or the POC including evaluation, should document the necessity for a course of therapy through objective findings. Documentation of the evaluation should list the conditions and complexities, and where it is not obvious, describe the impact of the conditions and complexities on the prognosis and/or the plan for treatment so that it is clear to a DDD reviewer that the services planned are appropriate for the individual. Upon receipt of the certified POC from the PCP, the Qualified Vendor must provide the member's Support Coordinator with a copy of the certified POC prior to service authorization within three (3) weeks of the completion of the evaluation.

Evaluation Triggers

An evaluation should be considered and a referral/creation of authorization for evaluation to Qualified Vendor, if any of these evaluation triggers are identified:

1. The member's Support Coordinator identifies and observes a limitation in a functional area.
2. The member's treating qualified provider or other licensed healthcare professional (within the scope of licensure) identifies a limitation in a functional area.
3. The member's caregiver and/or responsible person identifies a limitation in a functional area.
4. The member presents with a change in medical status that is not rehabilitative.
5. The member has not had an evaluation within the last three (3) years.
6. There is a change in Qualified Vendor and the member has not had an evaluation within the last (1) year.
7. Prior to redetermination of eligibility (e.g., age three (3), age six (6), eighteen (18) or at the time of redetermination as determined appropriate).

Evaluation

The evaluation shall include:

1. Diagnosis and description of the specific problem(s) to be evaluated and/or treated.
   1.1. The diagnosis should be specific and as relevant to the problem to be treated as possible
2. The treatment diagnosis may or may not be identified by the therapist, depending on their scope of practice.
3. DDD advises the use of a condition description similar to the appropriate ICD-10 code.
4. The record shall contain documentation to indicate objective, measurable member physical function, e.g.,
   4.1. Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or
   4.2. Functional assessment scores (and comparisons to prior assessment scores) from tests
   4.3. Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

When an evaluation is the only service provided in an episode of treatment, the evaluation serves as the POC if it contains a diagnosis and a description of the condition from which a diagnosis may be determined by the referring Primary Care Provider (PCP). The goal, frequency, intensity, and duration of treatment are implied in the diagnosis and one-time service. The referral and/or order of a PCP is the certification that the evaluation is needed and the member is under the care of a physician or other licensed practitioner.

Initial Plan of Care (POC)/Certification of the POC

1. The POC shall be consistent with the related evaluation. The evaluation and plan may be reported in two separate documents or a single combined document.
2. The Certified Plan of Care (CPOC) ensures that the member is under the care of a PCP.
3. The POC must be signed by the member's PCP and will serve as the medical prescription referral. This may require a face-to-face visit with the PCP.
4. Long term treatment goals should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care. The POC shall contain, at minimum, the following information:
   4.1. Diagnoses;
   4.2. Long term treatment goals; and
   4.3. Scheduling Recommendations/Considerations: Type, amount, duration, and frequency of therapy services.

Update to the Plan of Care (POC) at end of the certification period

1. If objective therapy data and clinical judgment support ongoing therapy services, the Qualified Vendor should update and provide the member's PCP with the update to the PCP to recertify the POC, as needed.
   1.1. Recertification of the POC is required at 1-year or at a minimum by the end of the certification interval.
   1.2. If the Qualified Vendor determines a reevaluation is necessary, a request to the member's Support Coordination is necessary.
   1.3. Revaluations are required at a minimum every three (3) years.
2. If objective therapy data and clinical judgment do NOT support ongoing therapy services documentation should include a Discharge Note and should also include a Home Functional Maintenance Program, if applicable.

Scheduling Recommendations/Considerations

Dosage

Dosage refers to the frequency, intensity, and duration of treatment. Dosage depends largely on member needs and the task level (e.g., learning basic skills requires more clinic room training than does generalization). Scheduling concerns, cost and insurance reimbursement also are likely to be factors affecting dosage. Given these potential issues, determining dosage often comes down to the professional opinion of the Qualified Vendor, with the appropriate documentation to substantiate the dosage recommendation, and the needs of the member and family.

1. The amount of treatment refers to the number of times in a day the type of treatment will be provided.
2. The frequency refers to the number of times in a week the type of treatment is provided.
3. The duration is the number of weeks or the number of treatment sessions.

Dosage Considerations

The frequency or duration of the treatment may not be used alone to determine medical necessity but should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the member's goals.

Under clinically determined circumstances, it may be clinically appropriate, medically necessary and most efficient and effective to provide short term intensive treatment or longer term, less frequent treatment depending on the individual's needs. It may be appropriate for Qualified Vendors to taper the level of frequency or establish a Home Functional Maintenance Program as the member progresses toward an independent or caregiver assisted self-management program with the intent of improving outcomes and limiting treatment time.

> *E.g., treatment may be provided 3-times a week for 180-days, then 2-times a week for the next 90-days, then once a week for the last 90-days. Depending on the member's condition, this flexibility for treatment may result in better outcomes or may result in earlier discharge than routine treatment 3-times a week for 52-weeks.*

When a tapered frequency is planned, the exact number of treatments per frequency level is not required to be projected in the plan, because the changes should be made based on the assessment of daily progress and documented on the treatment notes. Instead, the start and end frequencies shall be planned. The amount, frequency, and duration may be documented as appropriate for the therapy service and clinical judgment determinations.

> *E.g., "1-hour of speech-language pathology services 1x-daily, 3-times a week tapered to 2x a week over 180-days".*

Changes to the frequency may be made based on the Qualified Vendor's clinical judgment and documented on the progress report and does not require re-certification of the POC by the member's PCP unless requested by the PCP.

Treatment Note/Progress Report

Treatment Note

The treatment note is a record of all encounters of skilled intervention. Documentation is required for every treatment day, every therapy service, and must include the following information:

1. The name of the treatment, intervention, or activity provided;
2. Total treatment time;
3. Signature of the professional furnishing the services.

If treatment is added or changed between the POC intervals, the change must be recorded and justified as an update to the POC. Frequent professional judgments resulting in upgrades to the member's activity show skilled treatment. Objective measurement showing improvement is required.

If there is no improvement, the Qualified Vendor(s) should provide information explaining the setbacks, illness, new condition, or social circumstances that are impeding progress and why it is judged that progress is still attainable.

Progress Note

The progress note provides justification for the medical necessity of treatment based on the cumulative data documented on the treatment note(s) over a reporting period.

A Qualified Vendor must complete a progress report at least once every 90-treatment days (quarterly) or at a minimum by the end of the certification interval.

1. The beginning of the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation, or treatment.

Progress notes should contain:

1. An assessment of improvement, or the extent of progress (or lack thereof) toward each goal;
2. Plans for continuing treatment, reference to additional evaluation results and/or treatment plan revisions; and
3. Changes to long-or short-term goals, discharge or an updated Plan of Care (POC) that is sent to the PCP for certification of the next interval of treatment.

Documentation should justify the necessity of the services provided during the reporting period and include, for example, objective evidence or a clinically supportable statement of expectation that the member's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

Objective evidence consists of standardized member assessment instruments, outcome measurements tools, or measurable assessments of functional outcomes. Use of objective measures at the beginning, during, and/or after treatment is recommended to quantify progress and support justifications for continued treatment. These tools are not required, but their use will enhance the justification for needed therapy.

Discharge Note

The discharge note is required and shall be a progress report written by a Qualified Vendor to cover the reporting period from the last progress report to the date of discharge.

The discharge note shall include all treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge.

Home Program

A home program is a DDD requirement, as per The Division of Developmental Disabilities Medical Policy Manual (1250-E) and the Provider Policy Manual Chapter 37, and should be part of the member's daily routines, reviewed, and updated by the provider as part of all treatment sessions, and objectively documented and updated if needed on each quarterly progress note.

Qualified Vendors approved to provide skilled intervention services must ensure that a caregiver/responsible person is present and participates in all therapy sessions.

The Division requires a caregiver/responsible person or other caregivers (paid/unpaid) to be present and participate in all therapy sessions in order to:

1. Maximize the benefit of therapy services including implementing a home program;
2. Improve outcomes; and
3. Adhere to legal liability standards. The member's caregiver/responsible person is expected to instruct all other caregivers regarding the therapeutic activities that comprise the home program.

If the parent/family member/caregiver does not participate in a therapy session:

1. The therapy session shall be canceled;
2. The qualified provider shall contact the Support Coordinator to discuss the lack of parent/family member/ caregiver participation prior to the next therapy session; and
3. The qualified provider shall document the reason for the cancellation on quarterly progress notes.

Home Functional Maintenance Program

When the member no longer demonstrates clinical progress in the therapy program, the member has attained maximal potential, or the member no longer requires skilled therapy intervention, the therapist is required to formulate and implement a home functional maintenance program with the member and member's care providers to support the generalization of skills across environments.

1. A home functional maintenance program is an individualized series of specific activities that members and their responsible person/caregiver can complete at home to maintain the therapeutic gains provided by Therapy services;
2. A home functional maintenance program is a level of service that may be managed by the member and/ or responsible person/caregiver, with updates by the skilled therapist as deemed medically necessary. This level of service is considered reasonable and appropriate when a member does not require skilled therapy;
3. Per the Division of Developmental Disabilities Medical Policy Manual Chapter 1200, Section 1250-E: Therapy services provide medically necessary activities to develop, improve, or restore functions/skills. Therapy services require a prescription/Certified Plan of Care (CPOC), are provided or supervised by a licensed therapist, and are not intended to be long term services, is outcome driven and consultative in nature; and
4. Per RFQVA DDD-71000, January, 2020: When therapy is no longer reasonable and necessary on a regular basis, a therapist shall access and establish a functional maintenance program for the member to achieve the outcomes. 5.1 The therapist shall reassess and revise the maintenance program as needed.

Signature Requirements

DDD therapy services provided/ordered must be authenticated by the author in the form of a signature. This includes orders and medical record documentation of all services provided.

The signature must include the credentials of the individual and be dated. The method used shall be a handwritten (may be faxed) or an electronic signature completed on a certified EHR technology. Stamped signatures are not acceptable. DDD and CMS permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a DDD reviewer of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

If the signature is illegible, evidence in a signature log or attestation statement or other documentation will be considered. If the signature is missing from an order, the order shall be disregarded during the review of the claim. If the signature is missing from any other medical record documentation, a signature attestation will be accepted from the author of the medical record entry.

Electronic Documentation Systems

Qualified Vendors and other health providers adopt electronic medical records to standardize the collection of member data, improve coordination of care, and facilitate reporting of quality measures. For medical review purposes, DDD requires that services provided/ordered be authenticated by the author. This is to ensure compliance with the Centers for Medicare & Medicaid Services (CMS) policy regarding signature requirements.

Signature Log

Providers may submit a signature log that lists the typed/printed name of the author associated with initials or illegible signatures. The signature log may be included on the actual page where the initials or illegible signature is used or may be a separate document. The signature should include the credentials of the provider.

Attestation Statements

The attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Attestation statements will not be accepted where there is no associated medical record entry.

Attestation statements from someone other than the author of the medical record entry in question are not acceptable. Two individuals in the same group may not sign for the other in medical record entries or attestation statements. An attestation after the date of service is acceptable in most cases.

Compliance with AHCCCS Guide to Language in Notices of Adverse Benefit Determination (NOA).

Notification of Review Determinations

1. Upon receipt of the request and supporting documentation, DDD has 14-calendar days to complete the review.
2. DDD will provide written notifications of clinical review determinations to the member's Therapy Coordinator and Support Coordinator via email. DDD will notify members by a separate mailed letter.
    2.1. If the authorization request is approved in its entirety, DDD will send the member's provider/ agency a notification letter identifying the number of visits/units and treatment period approved.
    2.2. When the number of visits and/or services requested on a Treatment Plan is modified or denied, written notification will include the following:
        2.2.1. Number of visits approved and the treatment period during which such visits may be used.
        2.2.2. Clinical reasons for the decision.
        2.2.3. Instructions for appealing a determination, including your right to submit additional information.
        2.2.4. Time limits for submitting an appeal request.
        2.2.5. If the number of units requested is modified, and the member is in agreement with the clinical rationale, provide treatment up to the number of visits authorized.
3. If a decision regarding a request cannot be determined for services due to the lack of information submitted for review, DDD will send a written notification, "Notice of Extension", from the Support Coordinator to the provider/agency via email letter. DDD will notify members by a separate mailed letter.
    3.1. The letter will describe the information required and the length of time you have to submit it.
    3.2. Additional documentation should be submitted to the member's Support Coordinator.
    3.3. If DDD does not receive the requested information within the designated time period, the authorization request may be denied.
    3.4. If a response is not received, the authorization request will be reviewed using the original documentation submitted.