CHAPTER 37 THERAPY SERVICES (OCCUPATIONAL, PHYSICAL, AND SPEECH-LANGUAGE)

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PURPOSE

The purpose of this policy is to outline the requirements for Qualified Vendors when providing Medically Necessary therapy services to Division of Developmental Disabilities (Division) Members.

DEFINITIONS

1. "Certified Plan of Care" or "CPOC" means a Plan of Care that is signed and dated by the Member's primary care physician (PCP) that becomes the order or prescription for therapy services.
2. "Caregiver" means, for the purposes of this policy, an adult who is providing for the physical, emotional, and social needs of a child or adult with a developmental disability. Examples of Caregivers can include birth parent(s), foster parent(s), adoptive

parent(s), kin or relative(s), group home staff. Caregivers can be licensed, unlicensed, paid, or unpaid.

3. "Co-treatment" means at least two different therapy disciplines delivering therapy to the same Member simultaneously during the same therapy session by licensed therapists.
4. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or

ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Functional Maintenance Program" means the activities established by a therapist to assist the Member in maintaining the progress made during therapy services, or upon discontinuing therapy services when the condition of the Member is evaluated as insignificant or at a plateau.
6. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and Medicaid Services (CMS) that are applied to claims to reduce improper coding and thus reduce improper payments of claims.
7. "Medically Necessary" means a service given by a doctor, or licensed health practitioner that helps with a health problem, stops disease, disability, or extends life.

8. "Member" means the same as "client" as defined in A.R.S. § 36-551.
9. "National Provider Identifier Standard" or "NPI" means a standard, unique 10-digit numerical identifier mandated for healthcare providers as defined in 45 CFR § 160.103 for administrative and financial transactions.
10. "Occupational Therapy" means the diagnosis and treatment of disorders concerned with fine motor sensorimotor including sensory processing/sensory integration, feeding,reflexes/muscle tone, functional living skills including socio-emotional developmental needs; and equipment including training, adaptation and/or modification.
11. "Oral Motor/Swallowing/Feeding Disorders" means impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based that may or may not result in deficits of speech production) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow.

12. "Physical Therapy" means diagnosis and treatment of gross motor disorders, gait, balance, proprioception, strength, fine motor, muscle tone, neuromuscular, cardiovascular, reflex testing as appropriate, and equipment including training, adaptation, and/or modifications.
13. "Plan of Care" or "POC" means a written statement developed by a qualified provider and certified by the primary care provider or physician outlining a specific course of treatment for a Member. The Plan of Care includes the Member's treatment diagnosis, assessment results, long-term treatment goals as well as the type, duration, and frequency of therapy or home health nursing services and discharge criteria, education and training components, according to the Member's needs.
14. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource

providers, representatives from religious/spiritual organizations, and agents from other service systems.

15. "Prior Authorization" means the process by which the DDD or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost-effectiveness, compliance with the Arizona Administrative Code, and any applicable contract provisions. Prior authorization is not a guarantee of payment.
16. "Procedure Daily Maximum Units" means the maximum units of service that a provider is allowed to claim, per CMS, under most circumstances for a Member on a single date of service.
17. "Progress Report" means a record of the Member's treatment and response to treatment written by the treating therapist at intervals stipulated by the Division that typically states the number of sessions and attendance, services provided, objective measures of progress toward goals, justification of medical necessity for treatment, and changes to the goals or Plan of Care, as appropriate.

18. "Qualified Vendor" or "contractor" for the purposes of this policy means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
19. "Qualified Vendor Agreement" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the relationship between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.
20. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.
21. "Service Authorization Request" means a request by the Member/Health Care Decision Maker, and Designated Representative (DR) or a provider for a physical or behavioral

health service for the Member which requires Prior Authorization (PA) by the Contractor.

22. "Speech-Language Pathology" or "Speech Therapy" means the diagnosis and treatment of communication, cognition, and swallowing disorders. The scope of practice includes, but is not limited to, disorders of speech fluency, production, resonance, voice, language, feeding, hearing, and swallowing for Members of all ages. Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing.
23. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a Member eligible for Arizona Health Care Cost Containment System (AHCCCS) benefits.
24. "Treatment Note" means a record of a therapy treatment session documented by the treating therapist that demonstrates the treatment provided, the Member's progress toward goals, and the need for therapy services.

POLICY

A. PROVIDER REQUIREMENTS AND QUALIFICATIONS

1. Vendors shall have an active Qualified Vendor Agreement with the Division to provide Physical Therapy, Speech Therapy, and Occupational Therapy services to Division Members.
2. Qualified Vendors shall comply with all applicable service requirements, service specifications, standard terms and conditions, and all other provisions of the Qualified Vendor Agreement.
3. Qualified Vendors shall ensure the following therapy providers are licensed or provide services under the supervision of a licensed therapist of the same discipline within their scope of practice:
    a. Physical therapists;
    b. Physical Therapy assistants;
    c. Speech-Language Pathologists;
    d. Speech-Language Pathology assistants;
    e. Occupational therapists; and
    f. Occupational Therapy assistants.

B. ESTABLISHING THERAPY SERVICES

1. Qualified vendors shall obtain prior authorization from the Division before providing the following therapy services to Members:
    a. Speech Therapy evaluation;
    b. Occupational Therapy evaluation;
    c. Physical Therapy evaluation;
    d. Feeding or swallowing evaluation;
    e. Speech Therapy sessions;
    f. Physical Therapy sessions;
    g. Occupational Therapy sessions; and
    h. Feeding or swallowing therapy sessions.
2. Qualified Vendors shall ensure therapy services are Medically Necessary based on the supporting documentation of medical need and the appropriateness of the equipment, service, or supply prescribed by the physician or other licensed practitioner of the healing arts.
3. Qualified Vendors shall ensure the amount, frequency, and duration of therapy services are always commensurate with the

Member's medical and therapy needs, level of disability, and standards of practice.

4. Qualified Vendors shall require the following documentation prior to providing therapy services to Members:
   a. An order or prescription from the Member's Primary Care Provider (PCP) with the following information:
      i. The type of therapy requested;
      ii. "Evaluation and treatment as recommended by therapy clinician";
      iii. PCP's signature dated less than one year ago; and
      iv. PCP's NPI number.
   b. A service authorization for therapy evaluation from the Member's Support Coordinator.

C. INITIAL EVALUATION AND PLAN OF CARE

1. Upon meeting the criteria in (B) of this policy, Qualified Vendors who provide therapy services shall evaluate the Member's skills and develop a Plan of Care (POC) to substantiate a recommendation for Medically Necessary therapy services.

2. If a Member requires more than one visit to complete a therapy evaluation, the Qualified Vendor providing therapy services shall complete the following prior to the next evaluation visit:
    a. Provide the Support Coordinator justification in writing;
    b. Request a service authorization from the Support Coordinator; and
    c. Attend a peer-to-peer consultation with requesting Division staff to determine appropriateness in certain cases.
3. Based on the Member's evaluation results, the Qualified Vendor providing therapy services shall include the following information in the POC:
    a. Member's date of birth and age;
    b. Member's medical history and background;
    c. History of prior therapy and referrals as applicable;
    d. Diagnoses;
    e. Date of evaluation;
    f. Baseline objective measurements based on standardized testing, performed or other standard assessment tools;
    g. Type of therapy service;

h. Short term and long term treatment goals for the entire episode of care;

i. Goal baselines and timelines;

j. Proposed type of service or interventions;

k. Home program goals;

l. Session start and stop time;

m. Frequency of therapy services;

n. Member's primary language;

o. Prognosis for improvement;

p. Safety risks;

q. Adaptive equipment or assistive devices, as applicable;

r. Criteria for discontinuing therapy services;

s. Date the POC was established;

t. Requested dates of service for planned treatments after the completion of the evaluation;

u. Responsible Person's expected involvement in the Member's treatment; and

v. Signature, date, and credentials of the therapist who developed the POC.

4. The Qualified Vendor that evaluated the Member for therapy services may use any of the following to document the Member's therapy evaluation and POC:
    a. The DDD-2088A Evaluation Report Plan of Care/Treatment Plan: Certification/Recertification form;
    b. The Qualified Vendor's own clinical form; or
    c. The Qualified Vendor's Electronic Medical System (EMR).

D. CERTIFICATION OF THE POC FOR AUTHORIZATION OF THERAPY SERVICES

1. The Qualified Vendor that evaluated the Member for therapy service shall submit the POC to the PCP that originally ordered or prescribed the therapy evaluation and treatment to request certification of the POC and to initiate therapy services if the therapy evaluation results substantiate a recommendation for Medically Necessary therapy service.
2. The Qualified Vendor shall ensure the Certified Plan of Care (CPOC) contains the following information from the PCP that originally prescribed the therapy evaluation and treatment for the Member:

a. The PCP's dated signature; and

b. The PCP's National Provider Identification (NPI) number.

3. Upon receipt of the CPOC from the Member's PCP, the Qualified Vendor shall submit the following to the Member's Support Coordinator:

a. A copy of the CPOC within 21 calendar days to request a service authorization for therapy services; and

b. A statement of whether or not the Member has Third Party Liability (TPL); and

c. If the Member has TPL, information on the Member's TPL coverage.

4. The Qualified Vendor shall not ask the Member's PCP to attest to agreeing with the POC prior to the date the POC is reviewed.

E. DELIVERY OF THERAPY SERVICES

1. Qualified Vendors shall not provide therapy services without a service authorization from the Support Coordinator.

2. The Qualified Vendor shall ensure therapy services provided are consistent with the Member's CPOC rather than primarily for the

convenience of the Member, Responsible Person, or therapy provider.

3. The Qualified Vendor providing therapy services may allow the Member to make up missed therapy sessions during the service authorization period within 30-calendar days as long as:
   a. The total number of sessions or units delivered does not exceed the amount authorized;
   b. The make-up session occurs on a separate and distinguished date;
   c. Medicaid National Correct Coding Initiative Edits and Procedure Daily Maximum Units are followed; and
   d. The CPOC permits make-up sessions.
4. The Qualified Vendor shall refer to the DDD Qualified Vendor Rate Book for more information about the modifiers specific to the missed therapy sessions and make-up therapy sessions.
5. The Qualified Vendor providing therapy services shall develop a Functional Maintenance Program for Members and their Caregivers to implement therapeutic activities as part of the Member's daily routine.

6. The Qualified Vendor providing therapy services shall review and update the Member's Functional Maintenance Program as part of all therapy sessions.

F. RESPONSIBLE PERSON/CAREGIVER PARTICIPATION

1. The Qualified Vendor providing therapy service shall require the attendance and active participation of the following individuals in the Member's therapy sessions to maximize the benefit of the service, improve outcomes, and carry out the Functional Maintenance Program:
   a. Responsible Person if other than the Member;
   b. Caregiver(s);
   c. Family member; or
   d. Other individual(s) designated by the Planning Team if the Member does not have a Responsible Person, Caregiver, or family member available.
2. The Qualified Vendor providing therapy service shall ensure the Responsible Person informs all other Caregivers regarding the therapeutic activities that comprise the Member's therapy program.

3. If the Responsible Person does not attend the therapy session the Qualified Vendor providing therapy service shall,:
    a. Cancel the therapy session;
    b. Notify the Member's Support Coordinator of the lack of participation of the Responsible Person prior to the next therapy session; and
    c. Document the reason for the cancellation of the therapy session on the quarterly Progress Report.
4. If the Qualified Vendor providing therapy service recommends that the Responsible Person or Caregiver observes the therapy session outside the eyesight of the Member, the therapist shall submit this recommendation to the Support Coordinator via the evaluation and CPOC before this type of participation is used.

G. UPDATE TO THE POC, RECERTIFICATION, AND REEVALUATION

1. The Qualified Vendor providing therapy service shall, if the Member requires Medically Necessary therapy past the service authorization end date, complete the following 30 days in advance of the service authorization end date to avoid gaps in service:

a. Provide the Member's PCP with an updated POC for recertification; and

b. Submit the updated CPOC to Member's Support Coordinator via the Division's FTP site for reauthorization of service.

2. The Qualified Vendor providing therapy service shall include the following information on the updated POC when requesting recertification of services:

a. A progress summary;

b. Date therapy services started;

c. Dates of therapy services requested;

d. Changes in the POC and rationale;

e. Requested change in frequency of visits for changing the plan, if applicable;

f. Documentation of reasons continued therapy services are Medically Necessary;

g. Documentation of Member's and Responsible Person's participation in treatment or adherence to a Functional Maintenance program;

h. Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable;

i. Adaptive equipment or assistive devices, as applicable;

j. Prognosis with clearly established criteria for discontinuing therapy service;

k. Documentation of consults with other professionals and services or referrals made and coordination of service when applicable;

l. The updated POC shall be signed and dated by the therapist responsible for the therapy services;

m. The updated POC shall be signed and dated by the ordering provider; and

n. For recertifications of therapies, if the submitted request is not signed and dated by the ordering provider, the request is accompanied by a valid written order or prescription.

3. The Qualified Vendor providing therapy services shall reevaluate the Member at least every three years, or if any of the following apply:

a. The Member's Support Coordinator identifies a limitation in a functional area.

b. The Member's PCP or other licensed healthcare professional identifies a limitation in a functional area.

c. The Member's Caregiver or Responsible Person identifies a limitation in a functional area.

d. The Member presents with a change in medical status that is not rehabilitative.

e. There is a change in Qualified Vendor and the Member has not had an evaluation within the last year.

f. The Member is undergoing redetermination for eligibility.

4. The Qualified Vendor providing therapy service shall update the POC, obtain recertification of the POC from the PCP, and request reauthorization of therapy services from the Support Coordinator as per G.1 and G.2 of this policy upon completing the reevaluation if Medically Necessary therapy services are required.

5. The Qualified Vendor providing therapy service shall discontinue therapy services as per the requirements in J. of this policy if the Qualified Vendor determines that the Member does not require Medically Necessary therapy services.

H. DAILY TREATMENT NOTES AND PROGRESS REPORTING REQUIREMENTS

1. The Qualified Vendor providing therapy service shall complete a daily Treatment Note for every therapy session with the Member with the following information:
   a. Events of a session;
   b. Member interactions;
   c. The type of therapy;
   d. Any accommodations and modifications to clinical procedures;
   e. The treating therapy provider or supervisor’s signature and credentials; and
   f. Responsible Person’s signature.
2. The Qualified Vendor providing therapy service shall document reasons for visits outside the weekly or monthly frequency

indicated in the CPOC in the Member's daily Treatment Note and quarterly Progress Reports.

3. The Qualified Vendor providing therapy service shall submit a Progress Report to the Division's FTP site at least once every 90 days (quarterly) or by the end of the certification timeframe if the CPOC is less than 90 days.
4. The Qualified Vendor providing therapy service shall submit quarterly Progress Reports to the Division with the required information as outlined in Chapter 35 Progress Reporting Requirement of the DDD Provider Manual.
5. The Qualified Vendor providing therapy service may use the DDD-2063A Ongoing Quarterly Progress Report (QPR) Plan of Care/Treatment Plan: Certification/Recertification form or may opt to use their own clinical form or EMR for submitting quarterly Progress Reports or for recertification of the POC.
6. The Qualified Vendor providing therapy service may use the fourth quarterly Progress Report for updating the POC and submitting the POC to the PCP for recertification.

7. The Qualified Vendor providing therapy service shall document the beginning of the first reporting period as the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, reevaluation, or treatment.
8. The Qualified Vendor providing therapy service shall retain the Member's Progress Reports, Treatment Notes, and all other therapy documentation in accordance with A.R.S. § 12-2297.

I. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The Qualified Vendor shall refer to Chapter 6 of the DDD Provider Manual for information on EPSDT covered services that apply to individuals under the age of 21 who need therapy services.

J. DISCONTINUATION OF SERVICES

1. The Qualified Vendor providing therapy service shall not discontinue the Member's therapy services without agreement from the Planning Team.
2. The Qualified Vendor providing therapy service and Planning Team shall discontinue the Member's treatment when any of the following occur:

a. The disorder(s) resulting in therapy services is remediated;

b. Environmental or behavioral modifications strategies are successfully established;

c. The Responsible Person chooses not to participate in treatment;

d. The Member chooses not to participate in treatment;

e. The Member's attendance to therapy is inconsistent or poor and efforts to address these factors are unsuccessful;

e. The Member moves to another location where therapy services from the current therapy provider are not available;

f. The Member or Responsible Person chooses to seek a different therapy provider.

3. The Qualified Vendor providing therapy services shall advise the Planning Team, Member, and Responsible Person if other than the Member of the likely outcomes should discontinuation of therapy services occur.

4. If the Planning Team does not mutually agree upon the Qualified Vendor's request for release, the Qualified Vendor may submit a

request for release from service authorization to the DDD Customer Service Center as outlined in the Provider Manual, Chapter 50, Section II.G.

5. The Qualified Vendor providing therapy services shall:
   a. Review and analyze the treatment provided to the Member by the treating therapist to identify specific modification(s) that have the greatest probability of yielding improved outcomes; and
   b. Based on (a) implement those improvements with ongoing monitoring when considering discontinuing therapy treatment in situations other than those described in this section.
6. The Qualified Vendor providing therapy services shall document in the Member's final Progress Report that the following factors have been addressed before discontinuation of therapy:
   a. Intervention goals and objectives were specified;
   b. Instructional time was provided;

c. Current and suitable intervention methods or materials were used;

d. Functional performance data were collected and analyzed on an ongoing basis to monitor and evaluate progress;

e. Assistive technology or other technology supports were provided when necessary;

f. A plan to address the needs and concerns of culturally or linguistically diverse members and families (e.g., use of interpreter or translator) has been addressed if necessary;

g. Relevant and accurate criteria were used to evaluate the intervention; and

h. Health, educational, environmental, or other supports relevant to communication interventions were provided.

7. The Qualified Vendor providing therapy service shall refer the Member to professionals with specific expertise in the area of concern prior to discontinuing therapy service if any of the following situations occur:

a. The provision of treatment is beyond the expertise of the individual therapist.

b. The therapist's recommendations are not acceptable to the Responsible Person.

c. Treatment no longer results in measurable benefits and any reasonable prognosis for improvement with continued treatment is not evident. Reevaluation should be considered at a later date to determine whether the Member's status has changed or whether new treatment options have become available.

d. The Member is unable to tolerate the treatment because of a serious medical, psychological, or other condition.

e. The Member demonstrates behavior that interferes with improvement or participation in treatment providing those efforts to address the interfering behavior has been unsuccessful.

8. Upon discontinuing therapy services, the Qualified Vendor shall complete and submit via the Division's FTP site to the Support Coordinator a final Progress Report that includes the following:

a. All treatment provided since the last Progress Report to the date therapy services were discontinued;

b. A statement indicating the therapist reviewed all Treatment Notes; and

c. A statement indicating the therapist agrees to discontinue services.

K. FUNCTIONAL MAINTENANCE PROGRAM UPON DISCONTINUING THERAPY SERVICES

1. The Qualified Vendor shall formulate and implement a Functional Maintenance Program for the Member upon discontinuing therapy services to maintain therapeutic gains.
2. The Qualified Vendor shall, upon discontinuing therapy service, instruct the Responsible Person, family member, or Caregiver as appropriate in the established Functional Maintenance Program components.

3. After a Functional Maintenance Program is implemented, the Qualified Vendor shall not bill for services, except for prior authorized reassessments and POC revisions.
4. The Qualified Vendor providing therapy service shall reassess and revise the Member's Functional Maintenance Program as needed.

L. CO-TREATMENT

1. The Qualified Vendor providing therapy services shall include Co-treatment in the CPOC when it is Medically Necessary for the Member to receive therapy from two different therapy disciplines simultaneously.
2. When performing Co-treatment, the two performing therapists shall designate a primary therapist.
3. The Qualified Vendor shall maintain the following Co-treatment documentation requirements in the Member's medical records as follows:
    a. Medical necessity for the individual therapy services before performing Co-treatment;

b. Co-treatment goals and how Co-treatment will help the therapist achieve the therapist's goals for the Member, for each therapy discipline; and

c. Justification of the Member's need to receive Co-treatment.

4. The Qualified Vendor shall cooperate with requests from the Division for retrospective review of the Member's therapy records.

M. BILLING

The Qualified Vendor providing therapy services shall refer to Provider Manual Chapter 12, Billing and Claim Submission for requirements for submitting therapy service claims.