



DEPARTMENT OF ECONOMIC SECURITY

*Your Partner For A Stronger Arizona*



# Division of Developmental Disabilities

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# Therapy Service Process Plan of Care 2/2020

# TRUE NORTH

*All Arizonans who qualify receive timely DES services and achieve their potential*

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# SYNOPSIS- PLAN OF CARE

- The Division of Developmental Disabilities (DDD) is implementing the requirement of a Plan of Care (POC)
  - The POC will need to be certified by the member's PCP/NPP
  - The certified Plan of Care (CPOC) will replace the medical prescription/referral for ongoing Therapy services
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# THERAPY SERVICES DEFINED

Medically necessary activities to develop, improve, or restore functions/skills

- **Occupational Therapy:** Addresses the use of the body for daily activities
  - **Physical Therapy:** Addresses movement of the body related to walking, standing, balance and other movements
  - **Speech Therapy:** Addresses receptive and expressive language, articulation, eating, swallowing, social communication and pragmatic language
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## DDD Medical Policy Manual Chapter 1200 Section 1250-E. Services and Settings Therapies (Rehabilitative and Habilitative)

- DDD requires that therapy services are the appropriate:
    - Type
    - Frequency
    - Intensity
    - Duration for the individual needs of the member
-

## DDD Medical Policy Manual Chapter 1200 Section 1250-E. Services and Settings Therapies (Rehabilitative and Habilitative)

- Documentation is read by other providers and claim reviewers from varying backgrounds and experience
  - Notes and reports must:
    - Be clear and legible
    - Justify medical necessity
    - Contain the required information for clinical management and reimbursement
-

# THERAPY SERVICES: OT, PT, ST

- Authorized based on medical necessity and individual needs
  - Factors considered when approving services:
    - Development/functional skills
    - Medical conditions
    - Member's network of support (Family/caregivers, friends, providers, etc.)
    - Age
    - Therapies provided by the school
-

# THE THERAPY SERVICES PROCESS



# THERAPY SERVICES PROCESS

- **Identify Potential Therapy Need-** Support Coordinator (SC) will utilize a Therapy Screening Tool to assist with conversations between the SC, the member and the responsible person
  - If a potential need is identified, the SC instructs the member/responsible person to obtain a **discipline-specific** evaluation prescription order
  - Upon receipt of the evaluation prescription order, the SC updates the ALTCS Member Service Plan and a Vendor Call is initiated
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# PLAN OF CARE

- Ongoing Therapy services must relate directly to a POC, also known as the treatment plan
    - Developed by the evaluating therapist
  - The Centers for Medicare and Medicaid Services (CMS) states the POC shall contain, at a minimum:
    - Diagnoses
    - Long term treatment goals for the entire episode of care
    - Proposed type of service or interventions
    - Amount
    - Duration
    - Frequency of therapy services
-

# PLAN OF CARE

- **POC's are directly related** to objective findings consistent with an evaluation
  - The POC is established by a
    - Physical Therapist
    - Occupational Therapist
    - Speech-Language Pathologist
  - A POC must
    - Have a document date of establishment
    - Contain the signature and professional identity or credentials of the person who developed the POC
    - Be **established** and **certified** before the therapy treatment can begin
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# PLAN OF CARE

## NOTE:

- There must be a POC for **each therapy** if a member is receiving treatment in multiple disciplines (e.g. PT, OT and/or SLP)
  - Each therapist **must** independently establish the impairment/dysfunction that is being treated and the associated functional outcomes/goals
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# DEVisING A PLAN OF CARE

- Create an individualized plan for each member based on evaluation/assessment.
  - Establish a treatment program with specific evidence-based interventions to treat the member's needs
  - Examples include:
    - Therapeutic exercise
    - Functional training
    - Manual therapy techniques
    - NDT
    - SOS
    - Adaptive DEVICES/EQUIPMENT NEEDS
    - Modalities
-

# DEVisING A PLAN OF CARE

- Establish anticipated functional goals, expected outcomes and any predicted level of improvement.
    - Include goal baselines and timelines
  - Determine frequency and duration of care
  - The POC must include a prognosis statement with clearly established and defined discharge criteria
-

# CERTIFICATION OF PLAN OF CARE

- Establishing the POC is different than **certifying** the POC.
  - The Center for Medicare and Medicaid Services states that POC certification requires a **dated signature** by the primary care provider for the patient/client (DDD member). DDD- include the PCP/NPP National Provider Identifier (NPI #).
    - physician or non-physician practitioner
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# CERTIFICATION OF PLAN OF CARE

- Example statements placed under the physician's or non-physician practitioner's signature:
    - "As of the date of this evaluation, I certify the pertinent medical history and the need for skilled services that have been completed in consultation with the evaluating therapist under this plan."
    - "I certify the need for these services furnished under this plan of treatment while under my care."
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# CERTIFICATION OF PLAN OF CARE

In order to avoid an error when submitting the POC documentation must:

- Establish and complete the initial POC
  - Include your signature
  - List your professional identification (i.e. PT, OT, etc.),
  - Include date the POC was established
  - Ensure that the POC is certified (Recertified When Appropriate) with a physician/non-physician practitioner signature and date.
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# PLAN OF CARE- NEXT STEPS

- The CPOC is the medical prescription/order for ongoing therapy services
  - The Qualified Vendor (QV) must provide the member's SC with a copy of the CPOC prior to authorizing ongoing services.
    - Submission may be via secured email or fax
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# PLAN OF CARE- NEXT STEPS

- The SC must receive the CPOC within **three (3) weeks** of the completed evaluation
  - The authorization start date is based on the date the PCP/NPP signs the POC
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# UPDATE TO THE PLAN OF CARE

Updating the POC at end of the certification period:

- If objective therapy data and clinical judgment confirm the need for ongoing services, the Qualified Vendor needs to provide the member's PCP with an updated POC for recertification.
  - Recertification of the POC is required at the end of the certification period.
  - By the end of the certification period- thirty (30) days in advance of the ending of the certification period the therapist will complete an updated POC to assist in avoiding access to care issues.
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# UPDATE TO THE PLAN OF CARE

- If the QV determines an evaluation is needed, a request to the member's SC is required
  - Evaluations are required at a minimum every three (3) years
  - If objective therapy data and clinical judgment do NOT support the need for ongoing therapy, documentation should include a:
    - Discharge Note
    - Maintenance Plan
-

# SYNOPSIS- UPDATING THE POC

- Thirty (30) days in advance of the ending of the certification period the therapist will complete an updated POC
    - Updates are based on objective findings and current functional status
  - Submit the updated POC to the member's PCP/NPP for certification (PCP/NPP dated signature)
  - Submit the CPOC to the SC
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# TIMELINE FOR CPOC PROCESS

- Authorizations for all DDD members are expected to be based on a CPOC no later than **December 31, 2020**
  - Thirty (30) days in advance of the end of the current therapy services, please complete a POC and submit to the member's PCP/NPP for certification
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# EVALUATION TRIGGERS

An evaluation should be considered and a referral/creation of authorization for evaluation to a Qualified Vendor, if the:

- SC identifies and observes a limitation in a functional area.
  - Treating qualified provider or other licensed healthcare professional (within the scope of licensure) identifies a limitation in a functional area
  - Caregiver and/or responsible party identifies a limitation in a functional area
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# EVALUATION TRIGGERS

- The member presents a change in medical status that is not rehabilitative
  - The member has not had an evaluation within the last three (3) years
  - There is a Qualified Vendor change and the member has not had an evaluation within the last (1) year
  - Prior to redetermination of eligibility (age three (3), age six (6), eighteen (18) or at the time of redetermination as determined appropriate
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# THERAPY SERVICES PROCESS- OVERVIEW

- SC, member/responsible person identify potential need and obtain Rx for evaluation
- Vendor Call and Qualified Vendor Identified
- Evaluation performed, POC developed and submitted to PCP/NPP for certification (signature)



# THERAPY SERVICES PROCESS- OVERVIEW

- PCP/NPP certifies the POC and returns it to the therapy qualified vendor
- The CPOC is sent to the SC (within 3 weeks of completion of evaluation)
- SC enters the authorization for ongoing services in FOCUS



# END OF CERTIFICATION PERIOD

- Reassess and update the POC **30 days prior** to the end of the certification and authorization
- If continued services are medically necessary, submit the updated POC to the PCP/NPP for certification
- Upon receipt of CPOC, submit to SC



# POINTS TO REMEMBER

- Certification of a POC is **required** for all ongoing therapy services
  - PCP/NPP signature on the POC completes the certification requirements and proves that a physician is involved in the member's care and available to certify the plan
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# POINTS TO REMEMBER

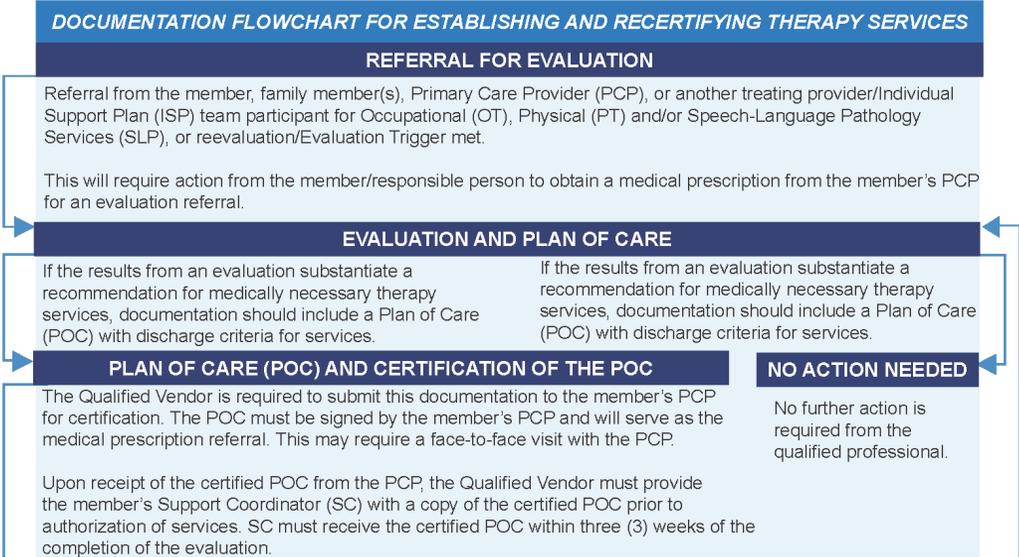
- Authorizations for all DDD members are expected to be based on a CPOC no later than **December 31, 2020.**
  - Providers must use their discretion to determine the format of the POC. May use own EMR or DDD template.
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# DOCUMENTATION FLOW CHART FOR ESTABLISHING AND RECERTIFYING THERAPY SERVICES

A link to the Documentation Flow Chart (guide) can be found in the Qualified Vendor Announcement site, transmittal date 04/24/2019.

Division of Developmental Disabilities

Documentation Guidelines: Occupational, Physical, and Speech-Language Pathology Therapy Services



[https://des.az.gov/sites/default/files/Documentation\\_Guidelines\\_Physical\\_Occupational\\_and\\_Speech\\_Therapy\\_Services.pdf](https://des.az.gov/sites/default/files/Documentation_Guidelines_Physical_Occupational_and_Speech_Therapy_Services.pdf)

# PILOT- ONGOING QUARTERLY PROGRESS REPORTS & POC



**ARIZONA DEPARTMENT OF ECONOMIC SECURITY**  
 Division of Developmental Disabilities  
 ONGOING QUARTERLY PROGRESS REPORT (QPR)  
 PLAN OF CARE/TREATMENT PLAN, CERTIFICATION/RECERTIFICATION

Date Received by Division

**INSTRUCTIONS:** Qualified Vendor/Provider(s) to complete Plan of Care/Treatment Plan at the time for the certification/recertification of therapy services. The Plan of Care is to be sent to the Primary Care Physician of the member to be certified. If the Plan of Care is the result of a recent evaluation, the Certified Plan of Care must be sent with the evaluation to the Support Coordinator.

**Therapy includes the following:** Evaluation of skills; Development of home programs and consultative oversight with the member, family and other providers; Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety; Modeling/ teaching/ coaching parents and/or caregivers specific techniques and approaches to everyday activities, within a member's routine, in meeting their priorities and outcomes; and collaboration with all team members/professionals involved in the member's life.

**MEMBER INFORMATION**

<b>Member Last Name</b>	<b>Member First Name</b>	<b>Member Middle Initial</b>	
<b>Date of Birth</b> <small>MM/DD/YYYY</small>	<b>Assists No./AHCCCS ID.</b>	<b>Diagnosis</b>	
Click or tap to enter a date.		Choose an item.	
<b>Date of Initial/Most Recent Therapy Evaluation</b> <small>MM/DD/YYYY</small>	<b>Authorization Date</b> <small>MM/DD/YYYY</small>	<b>Anticipated Release/Discharge Date</b> <small>MM/DD/YYYY</small>	
Click or tap to enter a date.		Click or tap to enter a date.	
<ul style="list-style-type: none"> <li><b>Therapeutic Dosage:</b> Enter the amount and frequency for the number of visits requested for the duration (if variable, tapering, and/or maintenance dosage is requested within the certification period) of the treatment schedule. (If a variable, tapering, and/or maintenance dosage schedule is requested within this Plan of Care/Treatment Plan, describe the ultimate clinical and functional endpoints you expect to realistically obtain in the corresponding "Dosage Considerations" section).</li> </ul>			
<b>Amount (Requested)</b>	<b>Frequency (Requested)</b>	<b>Duration (If applicable (Requested))</b>	<b>Dosage Considerations (If applicable (Requested))</b>
<b>Special Considerations:</b> Enter and describe any additional information of clinical significance in terms of the member's condition and/or comorbidities that would impact/serve as a barrier the member's ability to access/benefit from therapy services and would delay the estimated functional endpoints for therapeutic release or discharge. (e.g., Emotional/Behavioral Disorders)			
<b>Additional Recommendations/Information</b>			
<b>Number of attended sessions</b>	<b>Number of canceled sessions</b>	<b>Reasons for cancellations</b>	

**BACKGROUND INFORMATION**

**Medical/Therapy History:**  
Please include medical information such as diagnosis, medications, and other pertinent medical information (i.e. seizures). Also include information regarding the history of therapy services.

**Summary of Clinical Findings:**  
Please provide a summary of evaluation/treatment findings. Please provide any other assessments used to validate the submitted diagnosis code, if necessary and appropriate.

**Prognostic Indicators:**  
List any prognostic indicators that may alter the expected length of treatment. (e.g., Therapy attendance and home program participation, Member's network of support (e.g., family/caregivers, friends, providers); Age; and, Therapies provided by the school)

**INTEGRATED HEALTH CARE INFORMATION/COLLABORATION WITH OTHER PROVIDERS**

**QPR SUMMARY: CLINICAL IMPRESSION AND RECOMMENDATIONS (FOR QUARTERLY PROGRESS REPORTS ONLY)**

**Describe the member's clinical strengths and weaknesses within the QPR period:**

- This section may also make note of factors that may warrant follow-up through related services (e.g., additional services, evaluation, etc.), or any additional information of clinical significance in terms of the member's condition and/or comorbidities that would impact/serve as a barrier the member's ability to access/benefit from therapy services and would delay the estimated functional endpoints for therapeutic release or discharge. (e.g., Emotional/Behavioral Disorders)
- If changes to the member's goals/objective behavior(s) and/or therapy dosage are recommended a new Plan of Care/Treatment Plan is required.

**THERAPY GOALS AND OBJECTIVES**

- Goal/Objective Behavior**  
Include: targeted performance behavior, achievement criteria, and baseline measurement.  
Long Term Goal:

Short Term Objective Behavior:

<b>Date of Quarter 1 QPR</b> <small>(MM/DD/YYYY)</small>	<b>Date of Quarter 2 QPR</b> <small>(MM/DD/YYYY)</small>	<b>Date of Quarter 3 QPR</b> <small>(MM/DD/YYYY)</small>	<b>Date of Quarter 4 QPR</b> <small>(MM/DD/YYYY)</small>
Click or tap to enter a date.		Click or tap to enter a date.	

<b>Skilled Treatment/Intervention(s)</b>	<b>Skilled Treatment/Intervention(s)</b>	<b>Skilled Treatment/Intervention(s)</b>	<b>Skilled Treatment/Intervention(s)</b>

<b>Modification(s) to Treatment/Intervention(s)</b>	<b>Modification(s) to Treatment/Intervention(s)</b>	<b>Modification(s) to Treatment/Intervention(s)</b>	<b>Modification(s) to Treatment/Intervention(s)</b>

<b>Objective Data Assessment</b>	<b>Objective Data Assessment</b>	<b>Objective Data Assessment</b>	<b>Objective Data Assessment</b>
- Goal/Objective Behavior**  
Include: targeted performance behavior, achievement criteria, and baseline measurement.  
Long Term Goal:

Short Term Objective Behavior:

<b>Date of Quarter 1 QPR</b> <small>(MM/DD/YYYY)</small>	<b>Date of Quarter 2 QPR</b> <small>(MM/DD/YYYY)</small>	<b>Date of Quarter 3 QPR</b> <small>(MM/DD/YYYY)</small>	<b>Date of Quarter 4 QPR</b> <small>(MM/DD/YYYY)</small>
Click or tap to enter a date.		Click or tap to enter a date.	

<b>Skilled Treatment/Intervention(s)</b>	<b>Skilled Treatment/Intervention(s)</b>	<b>Skilled Treatment/Intervention(s)</b>	<b>Skilled Treatment/Intervention(s)</b>

<b>Modification(s) to Treatment/Intervention(s)</b>	<b>Modification(s) to Treatment/Intervention(s)</b>	<b>Modification(s) to Treatment/Intervention(s)</b>	<b>Modification(s) to Treatment/Intervention(s)</b>

<b>Objective Data Assessment</b>	<b>Objective Data Assessment</b>	<b>Objective Data Assessment</b>	<b>Objective Data Assessment</b>
- Goal/Objective Behavior**  
Include: targeted performance behavior, achievement criteria, and baseline measurement.

# PILOT- ONGOING QUARTERLY PROGRESS REPORTS & POC

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR (MM/DD/YYYY)	Date of Quarter 2 QPR (MM/DD/YYYY)	Date of Quarter 3 QPR (MM/DD/YYYY)	Date of Quarter 4 QPR (MM/DD/YYYY)
Click or tap to enter a date.			
Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)
Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)
Objective Data Assessment	Objective Data Assessment	Objective Data Assessment	Objective Data Assessment

**4. Goal/Objective Behavior**  
Include: *targeted performance behavior, achievement criteria, and baseline measurement.*

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR (MM/DD/YYYY)	Date of Quarter 2 QPR (MM/DD/YYYY)	Date of Quarter 3 QPR (MM/DD/YYYY)	Date of Quarter 4 QPR (MM/DD/YYYY)
Click or tap to enter a date.			
Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)
Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)
Objective Data Assessment	Objective Data Assessment	Objective Data Assessment	Objective Data Assessment

**5. Goal/Objective Behavior**  
Include: *targeted performance behavior, achievement criteria, and baseline measurement.*

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR (MM/DD/YYYY)	Date of Quarter 2 QPR (MM/DD/YYYY)	Date of Quarter 3 QPR (MM/DD/YYYY)	Date of Quarter 4 QPR (MM/DD/YYYY)
Click or tap to enter a date.			
Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)	Skilled Treatment/Intervention(s)
Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)	Modification(s) to Treatment/Intervention(s)
Objective Data Assessment	Objective Data Assessment	Objective Data Assessment	Objective Data Assessment

HOME PROGRAM GOALS AND OBJECTIVES					
To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, parents/family or other caregivers (paid/unpaid) are required to:					
<ul style="list-style-type: none"> <li>Be present and actively participate in all therapy sessions; and,</li> <li>Carry out the home program.</li> </ul>					
Goals and/or objectives to support the generalization of therapy skills across settings	Responsible Person	Progress			
1.		Choose an item.			
2.		Choose an item.			
3.		Choose an item.			
4.		Choose an item.			
5.		Choose an item.			
SIGNATURE SECTION: QUALIFIED PROVIDER(S)					
Qualified Provider (Last Name)	Qualified Provider (First Name)	State of Arizona License No.	NPI No.	Signature (Include credentials)	Date (MM/DD/YYYY)
1.					Click or tap to enter a date.
2.					Click or tap to enter a date.
3.					Click or tap to enter a date.
SIGNATURE/CERTIFICATION SECTION: PRIMARY CARE PROVIDER					
I certify that the above services are required and authorized by me and that the plan of care and therapies outlined above are medically necessary for the treatment schedule start and end dates identified on this Plan of Care Document.					
My signature below indicates I have no changes to this plan of care.					
Return Fax No. _____					
Email: _____					
ATTN: _____					
Primary Care Provider (Last Name)	Primary Care Provider (First Name)	State of Arizona License No.	NPI No.	Signature (Include credentials)	Date (MM/DD/YYYY)
					Click or tap to enter a date.



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**Thank You**