

## Medicaid Therapy Services Checklist

The following documentation is essential and required for Prior Authorization review. When all of the documentation is submitted initially, the review process is much more efficient and will ensure that therapy services are not denied solely for lack of documentation. Furthermore, in submitting all of the documentation listed below, Medical Care Unit personnel will have all the needed information to make a determination of medical necessity.

Please be sure to include the following documentation in your submission:

Current Plan of Care to include **measurable** short and long term goals, frequency and duration of the recommended therapy, and dated signature of both therapist and physician or midlevel practitioner. The Plan of Care must also include a Home Exercise Program (HEP) and a discharge plan. The plan must have reasonable and reachable goals within an appropriate time frame. For example, if an individual has a diagnosis that precludes them from reaching any further functional progress and the Plan of Care goals are to reach functional levels within normal limits for his/her age, medical necessity criteria is not met. This would be considered a maintenance program.

Most current Evaluation/Assessment. The Evaluation should include general health status and diagnosis, medical/surgical history and current conditions. The Evaluation should include a standardized, norm referencing assessment. If a standardized evaluation is not appropriate for the participant, the evaluation should include therapist's observations, parental/caregiver's observations, description of the participant's deficiencies and strengths, and the medical necessity for skilled therapy services. The Evaluation must be completed annually and must be signed and dated by the therapist administering the assessment.

Current Progress Report. The Progress Report may be included in the current plan of care. This piece of documentation is an **ESSENTIAL** component in determining if continued skilled therapy services are medically necessary. The Progress Report must clearly show measurable and substantial gains which have been achieved since the previous evaluation.

Therapy Daily Treatment Notes from the last 30 days which include the specific drills, techniques, exercises, treatments, or activities that were completed during that session and the participant's response to those treatments.

Some of the more common reasons for denial of additional skilled therapy are due to the following:

- The participant has reached a functional level that shows very minimal or no progress.
- The participant can be discharged to Home Exercise Program where the parent(s) and/or caregiver(s), having been educated by the therapist, can follow through with the treatments or exercises in the home environment.
- Group therapy is being provided.
- The therapy being provided is not medically necessary. Medical necessity is defined in IDAPA rule 16.03.09.011.14.a-c. as:
  - The service must be reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction.
  - There is no other equally effective course of treatment, which is more conservative or costs substantially less, that is available or suitable for the participant.
  - Medical services must be of a quality that meets professionally recognized standards of health care.