Medicaid Therapy Services Checklist

Beginning November 1st, 2016, the utilization review process for therapy services will be primarily targeting claims which indicate high utilization, high dollars, adults transitioning to maintenance, feeding therapies and other claims with unusual circumstances. In order to ensure an effective and efficient review process, we are requesting for therapy providers to only submit supporting documents once requested by the department. Please do not submit supporting documentation unless requested by the department. Providers must submit the required documentation within two days of the receipt of the Department's request. Failure to provide the supporting documentation within this timeframe will result in denial of the claim.

The following supporting documentation is essential and required for claim submission and medical necessity determination review.

☐ Current Plan of Care (POC) must include measurable short and long-term goals, frequency and duration of the recommended therapy, and dated signature of the therapist who established the plan. The POC must be consistent with the therapy evaluation and contain, at a minimum:

- diagnoses;
- measurable treatment goals that pertain to the functional impairment identified in the evaluation; and
- type, frequency, and duration of the therapy service.

☐ Physician Orders. All therapy services must be ordered by a physician, nurse practitioner or physician assistant. The order must specify the service to be provided and the frequency and duration. The prescriber can elect to sign the therapy plan of care that includes services to be provided and a frequency and duration within 30 days of the initial order to evaluate and treat for therapy to continue. No claims may be billed until the complete order or the plan of care is signed by the physician, nurse practitioner, or physician assistant.

☐ Current Annual 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 POC. This piece of documentation is an essential component in determining if continued skilled therapy services are medically necessary. The progress report must clearly demonstrate and support measurable and substantial gains, which have been achieved since the previous evaluation.

☐ Maintenance Therapy. Maintenance therapy is covered when an individualized assessment of the participant's condition demonstrates that skilled care is required to carry out the safe and effective maintenance program. To be medically necessary, it must be a service requiring the skills of a therapist to perform the therapy and where the service cannot safely and effectively be done by unskilled personnel. It consists of therapeutic activities and mechanisms to assist a participant in maximizing or maintaining the progress he/she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

Note: Effective January 1, 2017, the therapy limitation amount will increase to $1,960.00.