Therapy services must be furnished according to a written plan of care (POC). The plan of care must be **approved** by the prescribing provider **before** treatment is begun. For the purpose of this policy, approved means that the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline, i.e., only a physical therapist may develop a physical therapy ~~evaluation~~ plan of care, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. **Providers must use the standardized outpatient therapy plan of care form specific to the therapy requested.** Forms are available through the UM/QIO.

The plan must at a minimum include the following:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Dates of service (from/to)
- Diagnosis / symptomatology /conditions and related ICD-9 codes
- Reason for referral
- Specific diagnostic and treatment procedures/modalities and related CPT codes
- Frequency of therapeutic encounters (visits per week, day, month)
- Units/minutes required per visit
- Duration of therapy (weeks, days, months)
- Precautions (if applicable)
- Clinical update for concurrent plan of care only (general summary of attendance, progress, setbacks, changes since last plan of care
- Short and long term goals (specific, measurable, age appropriate, and current baseline status for each goal
- Home program
- Discharge plan
- Therapist's signature (name and title) and date

The POC may be developed to cover a period of treatment up to six months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. A POC for a projected period of treatment beyond six (6) months is not acceptable.

The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO. Based on medical necessity, the UM/QIO may approve certification periods for less than **OR** up to six (6)

months. Approved certification periods will not exceed the period of treatment indicated on the POC.

DOM requires a revised POC in the following situations:

- The projected period of treatment is complete and additional services are required.
- A significant change in the beneficiary's condition and the proposed treatment plan requires that (1) a therapy provider propose a revised POC to the prescribing provider, or (2) the prescribing provider requests a revision to the POC. In either case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.
- Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates. In this situation, the UM/QIO is authorized by DOM to request that the therapy provider submit a revised POC. The therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

All therapy plans of care (initial and revised) must be authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

DOM accepts the signature on the revised plan of care as a new order.

The prescribing provider may make changes to the plan established by the therapist, but the therapist cannot unilaterally alter the plan of care established by the prescribing provider.

The initial plan of care and all revised plans of care must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapy assistant.

The servicing provider (licensed therapist) is responsible for providing a copy of the initial plan of care and all revisions to the prescribing provider.

Beneficiary Noncompliance

DOM will not cover therapy services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen. Noncompliance is defined as failure to follow therapeutic recommendations which may include any or all of the following:

- Failure to attend scheduled therapy sessions (i.e., cancellation or 'no show' to three (3) consecutive therapy sessions and/or missing half or more of the scheduled visits without documentation of valid reasons such as personal illness/hospitalization, illness/death in the family)
- Failure to perform home exercise program as instructed by the therapist
- Failure to fully participate in therapy sessions (i.e., refusing to perform activities directed by therapist; late for scheduled therapy sessions or leaving before the session is completed)
- Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance

- Failure to properly use special equipment or adaptive devices (e.g., beneficiary requires the use of ankle-foot orthoses (AFOs) but does not wear them or bring them to therapy sessions)
- Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record