Outpatient therapy services **not** covered/reimbursed by the Division of Medicaid include, but are not limited to, the following:

- Services not certified/ordered by a physician, physician assistant, or nurse practitioner
- Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes
- Services that do not meet medical necessity criteria
- Services that do not require the skills of a licensed therapist
- Services when documentation supports that the beneficiary has attained the therapy goals or has reached the point where no further significant practical improvement can be expected
- 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
- Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members
- Services that duplicate other concurrent therapy (example: occupational therapist and physical therapist providing the same treatment to the same beneficiary)
- Maintenance and/or palliative services which maintain function and generally do not involve complex procedures or the professional skill, judgment, or supervision of a licensed therapist
- Services for conditions that could be reasonably expected to improve spontaneously without therapy
- Services ordered daily or multiple times per day from the initiation of therapy through discharge, i.e., frequency should decrease as the beneficiary's condition improves
- Services provided in multiple settings for the same beneficiary (example: speech-language therapy services provided in both the school and the outpatient clinic).
- Services normally considered part of nursing care
- Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF)
- Separate fees for self care/home management training (beneficiary and caregiver education is inclusive in covered therapy services)
- Services which are related solely to employment opportunities (i.e., on-the-job training, work skills, or work settings)
- General wellness, exercise, and/or recreational programs

- Services provided by students
- Services provided by physical therapist assistants **except** in the outpatient department of a hospital
- Services provided by physical therapist aides
- Group therapy
- Co-therapy
- Services that are investigative or experimental
- Acupuncture or biofeedback
- Services outside the scope/and or authority of the therapist's specialty and/or area of practice
- Services and items requiring pre-certification if the pre-certification has not been requested and/or denied, or the pre-certification requirements have not been satisfied by the provider
- Services not specifically listed as covered by the Division of Medicaid
- Exclusions listed elsewhere in the Mississippi Medicaid Provider Manual, bulletins, or other Mississippi Medicaid publications

Outpatient physical therapy services must meet general coverage criteria as follows:

- Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- The beneficiary must be under the care of and referred for therapy services by a state-licensed physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)
- Services must be provided by a state-licensed physical therapist. Exception: services may be provided by a state-licensed physical therapist assistant under the direct supervision of a state-licensed physical therapist in the outpatient department of a hospital. Refer to Provider Policy Manual Section 47.06 for Therapist Assistant, Aides, and Students policy.
- Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date 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.
- The discipline in which the therapist is licensed must match the order for therapy services, i.e., only a state-licensed physical therapist may evaluate, plan care, and deliver physical therapy services.
- Services must be conducted one-on-one (beneficiary and therapist). Group physical therapy is not covered.
- Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Services must not duplicate another provider's services.

Exclusions

For a list of therapy services **not** covered/reimbursed by the Division of Medicaid refer to Provider Policy Manual Section 47.03 for Exclusions policy.

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to therapy providers and are approved by the Division of Medicaid. Refer to Provider Policy Manual Section 47.09 for Prior Authorization/Pre-Certification Policy.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program policies.

Physical Therapy

Physical therapy services are medically prescribed services designed to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations. Services are concerned with the prevention of disability, and the rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease.

Physical Therapist

Physical therapist is an individual who meets the state and federal licensing and/or certification requirements to perform physical therapy services.

Physical Therapist Assistant

A physical therapist assistant is an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of physical therapy services under the supervision of a licensed physical therapist.

Physical Therapist Aide

A physical therapy aide is an unlicensed individual who assists the physical therapist and the physical therapist assistant in the practice of physical therapy. The physical therapist aide performs services under the supervision of the licensed physical therapist or licensed physical therapist assistant.

Therapist Assistants

The Division of Medicaid will cover services provided by state-licensed physical therapist assistants **only** in the outpatient department of a hospital. Therapist assistants must be under the direct supervision of a state-licensed therapist of the same discipline, i.e., a state-licensed physical therapist must directly supervise a state-licensed physical therapist assistant.

For the purposes of this policy, direct supervision means that the state-licensed therapist is physically on the premises where services are rendered and, if needed, is available for immediate assistance during the entire time services are rendered. The licensed therapist may not supervise more than two (2) assistants at a time. Under no circumstances will the Division of Medicaid recognize contacts by telephone, pager, video conferencing, etc. as any type of or substitution for direct supervision.

The initial evaluation, plan of care, and discharge summary must be completed by a state-licensed therapist. DOM will not reimburse for these services if they are performed by a therapist assistant.

Therapist Aides

Services provided by physical therapist aides, regardless of the level of supervision, are not covered by the Division of Medicaid.

Therapy Students

Services provided by physical therapy students regardless of the level of supervision, are not covered by the Division of Medicaid.

Evaluation is an integral component of physical therapy services. The initial evaluation establishes the baseline data necessary for setting realistic goals, measuring progress, and assessing rehabilitation potential. Periodic re-evaluation is used to assess the beneficiary's progress in relationship to treatment goals. **All evaluations must be performed by a therapist in the discipline, i.e., only a physical therapist may perform a physical therapy evaluation, etc. Therapy providers must use the standardized outpatient therapy evaluation/re-evaluation form specific to the therapy requested.** Forms are available through the UM/QIO.

Initial Evaluation

A Certificate of Medical Necessity for Initial Referral/Orders must be completed by the prescribing provider and it must be received by the therapist **prior to** performing the initial evaluation.

Before therapy is initiated, a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan. **The initial evaluation must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapist assistant**. The evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

Initial evaluations should at minimum contain the following information:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Date of the evaluation
- Diagnosis/functional condition or limitation being treated and onset date
- Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, comorbidities (complicating or precautionary information)
- Prior therapy history for same diagnosis/condition and response to therapy
- Level of function (prior and current)
- Clinical status: cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance (sitting and standing), transfer ability, ambulation (level and elevated surfaces), gait analysis, assistive/adaptive devices (currently in use or required), activity tolerance, presence of wounds (including description and incision status), assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children (e.g., chronological age/corrected age), motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy

- Special/standardized tests including the name, scores/results, and dates administered
- Social history: effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy
- Discharge plan including requirements to return to home, school, and/or job
- Impression/interpretation of findings
- Physical therapist's signature (name and title) and date

The initial evaluation and the first therapy session should not be done on the same day to allow time to develop a plan of care and, if necessary for the applicable CPT code(s), obtain pre-certification from the UM/QIO.

Re-Evaluation

The Division of Medicaid will cover re-evaluations based on medical necessity. All re-evaluations must be pre-certified through the UM/QIO. Documentation **must** reflect significant change in the beneficiary's condition or functional status. Significant change is defined as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

The components of the re-evaluation and the documentation requirements are the same as the initial evaluation, but are focused on assessing significant changes from the initial evaluation or progress toward treatment goals and making a professional judgment about continued care, modifying goals and/or treatment, or termination of therapy services. Documentation should include improvements and setbacks, as well as interventions required to treat any medical complications. When expected progress has not been realized and continued therapy is planned, the re-evaluation needs to include valid indications to support the expectation that significant improvement will occur in a reasonable and predictable time frame.

In all cases other than termination of therapy services, re-evaluation findings must be reflected in revisions to the therapy plan of care.

The servicing provider (licensed therapist) is responsible for providing a copy of the initial evaluation and all re-evaluations to the prescribing provider.

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 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 therapist 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

Outpatient therapy services **not** covered/reimbursed by the Division of Medicaid include, but are not limited to, the following:

- Services not certified/ordered by a physician, physician assistant, or nurse practitioner
- Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes
- Services that do not meet medical necessity criteria
- Services that do not require the skills of a licensed therapist
- Services when documentation supports that the beneficiary has attained the therapy goals or has reached the point where no further significant practical improvement can be expected
- 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
- Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members
- Services that duplicate other concurrent therapy (example: occupational therapist and physical therapist providing the same treatment to the same beneficiary)
- Maintenance and/or palliative services which maintain function and generally do not involve complex procedures or the professional skill, judgment, or supervision of a licensed therapist
- Services for conditions that could be reasonably expected to improve spontaneously without therapy
- Services ordered daily or multiple times per day from the initiation of therapy through discharge, i.e., frequency should decrease as the beneficiary's condition improves
- Services provided in multiple settings for the same beneficiary (example: speech-language therapy services provided in both the school and the outpatient clinic).
- Services normally considered part of nursing care
- Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF)
- Separate fees for self care/home management training (beneficiary and caregiver education is inclusive in covered therapy services)
- Services which are related solely to employment opportunities (i.e., on-the-job training, work skills, or work settings)
- General wellness, exercise, and/or recreational programs

- Services provided by students
- Services provided by physical ~~therapy~~ therapist assistants **except** in the outpatient department of a hospital
- Services provided by physical ~~therapy~~ therapist aides
- Group therapy
- Co-therapy
- Services that are investigative or experimental
- Acupuncture or biofeedback
- Services outside the scope/and or authority of the therapist's specialty and/or area of practice
- Services and items requiring pre-certification if the pre-certification has not been requested and/or denied, or the pre-certification requirements have not been satisfied by the provider
- Services not specifically listed as covered by the Division of Medicaid
- Exclusions listed elsewhere in the Mississippi Medicaid Provider Manual, bulletins, or other Mississippi Medicaid publications

Outpatient physical therapy services must meet general coverage criteria as follows:

- Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- The beneficiary must be under the care of and referred for therapy services by a state-licensed physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)
- Services must be provided by a state-licensed physical therapist. Exception: services may be provided by a state-licensed physical ~~therapy~~ therapist assistant under the direct supervision of a state-licensed physical therapist in the outpatient department of a hospital. Refer to ~~Section 47.06 of this manual.~~ Provider Policy Manual Section 47.06 for Therapist Assistant, Aides, and Students policy.
- Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date 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.
- The discipline in which the therapist is licensed must match the order for therapy services, i.e., only a state-licensed physical therapist may evaluate, plan care, and deliver physical therapy services.
- Services must be conducted one-on-one (beneficiary and therapist). Group physical therapy is not covered.
- Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Services must not duplicate another provider's services.

Exclusions

For a list of therapy services **not** covered/reimbursed by the Division of Medicaid ~~may be found in Section 47.03 of this manual.~~ refer to Provider Policy Manual Section 47.03 for Exclusions policy.

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to therapy providers and are approved by the Division of Medicaid. Refer to ~~Section 47.09 of this manual.~~

Provider Policy Manual Section 47.09 for Prior Authorization/Pre-Certification Policy.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program policies.

Physical Therapy

Physical therapy services are medically prescribed services designed to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations. Services are concerned with the prevention of disability, and the rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease.

Physical Therapist

Physical therapist is an individual who meets the state and federal licensing and/or certification requirements to perform physical therapy services.

Physical ~~Therapy~~ Therapist Assistant

A physical ~~therapy~~ therapist assistant is an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of physical therapy services under the supervision of a licensed physical therapist.

Physical ~~Therapy~~ Therapist Aide

A physical therapy aide is an unlicensed individual who assists the physical therapist and the physical ~~therapy~~ therapist assistant in the practice of physical therapy. The physical ~~therapy~~ therapist aide performs services under the supervision of the licensed physical therapist or licensed physical ~~therapy~~ therapist assistant.

~~Therapy~~ Therapist Assistants

The Division of Medicaid will cover services provided by state-licensed physical ~~therapy~~ therapist assistants **only** in the outpatient department of a hospital. ~~Therapy~~ Therapist assistants must be under the direct supervision of a state-licensed therapist of the same discipline, i.e., a state-licensed physical therapist must directly supervise a state-licensed physical ~~therapy~~ therapist assistant.

For the purposes of this policy, direct supervision means that the state-licensed therapist is physically on the premises where services are rendered and, if needed, is available for immediate assistance during the entire time services are rendered. The licensed therapist may not supervise more than two (2) assistants at a time. Under no circumstances will the Division of Medicaid recognize contacts by telephone, pager, video conferencing, etc. as any type of or substitution for direct supervision.

The initial evaluation, plan of care, and discharge summary must be completed by a state-licensed therapist. DOM will not reimburse for these services if they are performed by a ~~therapy~~ therapist assistant.

~~Therapy~~ Therapist Aides

Services provided by physical ~~therapy~~ therapist aides, regardless of the level of supervision, are not covered by the Division of Medicaid.

Therapy Students

Services provided by physical therapy students regardless of the level of supervision, are not covered by the Division of Medicaid.

Evaluation is an integral component of physical therapy services. The initial evaluation establishes the baseline data necessary for setting realistic goals, measuring progress, and assessing rehabilitation potential. Periodic re-evaluation is used to assess the beneficiary's progress in relationship to treatment goals. **All evaluations must be performed by a therapist in the discipline, i.e., only a physical therapist may perform a physical therapy evaluation, etc. Therapy providers must use the standardized outpatient therapy evaluation/re-evaluation form specific to the therapy requested.** Forms are available through the UM/QIO.

Initial Evaluation

A Certificate of Medical Necessity for Initial Referral/Orders must be completed by the prescribing provider and it must be received by the therapist **prior to** performing the initial evaluation.

Before therapy is initiated, a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan. **The initial evaluation must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a ~~therapy~~** therapist **assistant**. The evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

Initial evaluations should at minimum contain the following information:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Date of the evaluation
- Diagnosis/functional condition or limitation being treated and onset date
- Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, comorbidities (complicating or precautionary information)
- Prior therapy history for same diagnosis/condition and response to therapy
- Level of function (prior and current)
- Clinical status: cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance (sitting and standing), transfer ability, ambulation (level and elevated surfaces), gait analysis, assistive/adaptive devices (currently in use or required), activity tolerance, presence of wounds (including description and incision status), assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children (e.g., chronological age/corrected age), motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy

- Special/standardized tests including the name, scores/results, and dates administered

- Social history: effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy

- Discharge plan including requirements to return to home, school, and/or job

- Impression/interpretation of findings

- Physical therapist's signature (name and title) and date

The initial evaluation and the first therapy session should not be done on the same day to allow time to develop a plan of care and, if necessary for the applicable CPT code(s), obtain pre-certification from the UM/QIO.

Re-Evaluation

The Division of Medicaid will cover re-evaluations based on medical necessity. All re-evaluations must be pre-certified through the UM/QIO. Documentation **must reflect significant change** in the beneficiary's condition or functional status. Significant change is defined as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

The components of the re-evaluation and the documentation requirements are the same as the initial evaluation, but are focused on assessing significant changes from the initial evaluation or progress toward treatment goals and making a professional judgment about continued care, modifying goals and/or treatment, or termination of therapy services. Documentation should include improvements and setbacks, as well as interventions required to treat any medical complications. When expected progress has not been realized and continued therapy is planned, the re-evaluation needs to include valid indications to support the expectation that significant improvement will occur in a reasonable and predictable time frame.

In all cases other than termination of therapy services, re-evaluation findings must be reflected in revisions to the therapy plan of care.

The servicing provider (licensed therapist) is responsible for providing a copy of the initial evaluation and all re-evaluations to the prescribing provider.

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 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~~ therapist 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