DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
NEW MEXICO DEPARTMENT OF HEALTH

THERAPY DOCUMENTATION GUIDELINES FOR THE NEW MEXICO DEVELOPMENTAL DISABILITIES WAIVER

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THERAPY DOCUMENTATION GUIDELINES

I. GENERAL DOCUMENTATION REQUIREMENTS

A. **General Information:** This guideline refers to reports generated by the therapist. Such reports may be to the IDT or any consulting or reviewing entity.

B. All reports must be titled as to the type of required report per the Therapy Documentation Table, or descriptive of report content, if not a standard required report.

C. Reports must have a heading that includes the following at a minimum:

1. client name
2. client date of birth
3. last 4 numbers of client SS #
4. date of report
5. date(s) of service (if service is a span of time, indicate start and end date of service period that report covers; this would not coincide with exact ISP cycle dates)

    a. example:

ISP cycle:	2/1/12-1/31/13
Annual Re-Evaluation Service Dates:	8/15/11-11/1/11
Semi-Annual Review Dates:	could be 8/8/12

6. case manager name and agency

D. Reports must have a header on each page after page one that states the following information:

1. client name
2. report title
3. report date
4. page number

E. Report must end with the following:

1. licensed therapist's signature (hand written or electronic)
2. professional credentials
3. name of provider agency and contact phone number
4. date of signature

II. INITIAL THERAPY EVALUATION REPORT REQUIREMENTS

A. General Information

Therapists are required to complete an Initial Therapy Evaluation Report whenever a new therapy service is initiated. If the therapy intervention was initiated under a different therapist, it is the responsibility of the new therapist to review the evaluation completed by the previous therapist to determine if another assessment with accompanying evaluation report will be completed or if therapy can proceed with the information contained in the original Initial Therapy Evaluation Report or latest Annual Therapy Re-Evaluation Report.

The IDT initiates the request for an initial assessment. The IDT will specify the assistance required from the therapist. The IDT may request that the therapist conduct a comprehensive assessment to provide generalized support for the individual or the IDT may request that just one targeted area be assessed. (See Targeted Therapy Evaluation Report Requirements) The therapist's initial assessment and the Initial Therapy Evaluation Report will be determined by the IDT's instructions.

If the IDT's request is for the therapist to complete a more global assessment, then the Initial Therapy Evaluation Report will reflect that assessment. An example of this type of assessment would be if a physical therapist was asked to assess an individual and develop Written Direct Support Instructions as needed to help the individual be more mobile in home and day activities and to reach the individual's ISP outcomes. The therapist's Initial Therapy Evaluation Report in this example would be expected to cover a broad spectrum of assessment activities related to mobility and the ISP desired outcomes. Areas covered might include, but would not be limited to, the state of the muscular-skeletal system, findings related to the neurological system, functional motor skills and mobility related assistive technology.

The Initial Therapy Evaluation Report must reflect an assessment that is within the therapist's discipline specific scope of practice and within the DD Waiver scope of services. Initial Therapy Evaluation Reports must be individualized and functionally based. Initial Therapy Evaluation Reports must be written in language that is understandable by other team members and if technical terms are used for specificity, the therapist must explain that term in the report.

In writing the Initial Therapy Evaluation Report the therapist should refer to and incorporate the instructions found in the general documentation requirements for all reports.

B. The Initial Therapy Evaluation Report shall contain:

1. Referral Information
2. Relevant background information regarding medical and social history of the individual
3. Diagnoses that are relevant to the specific therapy discipline
4. Assessment tools and/or processes used and results
5. Interpretation of Assessment Data

6. Recommendations regarding referral to other services if applicable
7. Recommendations regarding the need for services by that therapy discipline
8. Recommendations regarding areas of focus for that therapy discipline's intervention. Note: Specific Therapy Goals/Objectives will be detailed in the Therapy Intervention Plan

C. Timeline and Distribution

The initial assessment must be completed within 30 calendar days following the posting of the evaluation unit in the Medicaid Portal, indicating prior authorization of service. The subsequent Initial Therapy Evaluation Report must be distributed to the IDT within 14-calendar days following completion of the initial assessment. The total time from budget approval to report distribution shall be within 44-days.

D. Considerations for Support of Prior Authorization Process

The following is a list of areas the therapist may wish to consider as possible support for therapy criteria during the prior authorization process;

1. Information regarding health and safety of the individual
2. Assistive technology, environmental modification or durable medical equipment needed
3. Documentation of baseline functional ability
4. Recommendations for support of health and safety and/or ISP outcomes
5. Recommendations from outside the IDT regarding therapy services

III. TARGETED THERAPY EVALUATION REPORT REQUIREMENTS

A. General Information

When a therapist receives a request for a targeted assessment the Targeted Therapy Evaluation Report will be limited to the area covered in the assessment and the title shall reflect the type of evaluation. An example of this type of intervention would be if an occupational therapist were asked to assist only with an environmental modification evaluation. In this example the therapist would assess the individual's need for environmental modification and write an Environmental Modifications Evaluation Report to document findings and recommendations.

B. The Targeted Therapy Evaluation Report shall contain:

1. Referral Information
2. Relevant background information regarding medical and social history of the individual as it pertains to the targeted assessment
3. Relevant ISP outcomes and action steps regarding the targeted area
4. Diagnoses that are relevant to the specific therapy discipline
5. Assessment tools and/or processes used and results
6. Interpretation of Assessment Data related to the targeted area
7. Recommendations regarding referral to other services
8. Information for the IDT regarding the implementation of assessment recommendations within the targeted area

The therapist is responsible for reviewing and incorporating the instructions found in the general documentation requirements for the Targeted Therapy Evaluation Report.

C. Timeline and Distribution

The Targeted Therapy Assessment must be completed within 30 calendar days following the posting of the evaluation unit in the Medicaid Portal, indicating prior authorization of service. The subsequent Targeted Therapy Evaluation Report must be distributed to the IDT within 14-calendar days following completion of the assessment. The total time from budget approval to report distribution shall be within 44-days..

D. Consideration for Support of Prior Authorization

None

IV. ANNUAL THERAPY RE-EVALUATION REPORT REQUIREMENTS

A. General Information

Therapists are responsible for conducting an annual re-assessment and writing an Annual Therapy Re-Evaluation Report for individuals recommended to receive continued ongoing therapy services. The therapist is responsible for reviewing and incorporating the instructions found in the general documentation requirements for each Annual Therapy Re-Evaluation Report.

B. The Annual Therapy Re-Evaluation Report shall contain:

1. The therapy related response to any changes in the individual's living or day activities during the prior year.
2. The therapy related response to any recommendations generated by entities outside of the IDT.
3. The functional status of the individual in any and all areas addressed in therapy during the prior year. For individuals at moderate or high risk for aspiration and an ongoing CARMP, this includes an aspiration risk management re-evaluation.
4. Status of and recommendations regarding continuation, modification, or discontinuation of current therapy goal(s) and objective(s).This may include WDSIs, DSP training, and AT. For individuals at moderate or high risk for aspiration, this includes recommendations for continuation or modification to CARMP strategies.
5. Assessment tools/processes used and results for any other pertinent areas traditionally addressed by that therapy discipline.

C. Timeline and Distribution: The Annual Therapy Re-Evaluation Report must be distributed by the therapist to the individual/guardian and an IDT member from each service provider that appears on the budget, no less than 14-calendar days prior to the annual IDT meeting.

D. Consideration for Support of Prior Authorization

The following is a list of areas the therapist may wish to consider as possible support for therapy during the prior authorization process;

1. Information regarding health and safety of the individual
2. Any assistive technology, environmental modification or durable medical equipment need that is currently being supported or is anticipated to be needed during the next ISP cycle.
3. Documentation of baseline functional ability
4. Progress, decline or maintenance in functional ability, as related to #3 above
5. Recommendations from outside the IDT regarding therapy
6. Training status and any problems related to training.

V. DD WAIVER THERAPY DOCUMENTATION FORM

A. General Information

The DD Waiver Therapy Documentation Form (TDF) is required for initial and ongoing therapy intervention. The TDF combines the Therapy Intervention Plan (TIP), the Semi-Annual Review, and the Therapy Services Prior Authorization Request (TSPAR) Worksheet. The TDF itself contains instructions for completion. There is also an associated instruction sheet to the TDF that contains detailed information. The therapist must follow the instructions and complete each required section of the TDF. The TIP section should be revised during the ISP cycle if there is a significant change in the individual's status that requires significant changes to it.. If there is a change in therapist, the TIP should be reviewed and may be modified as needed. The TSPAR Worksheet may be revised at the same time if a change in units for prior authorization is requested.

B. The DD Waiver Therapy Documentation Form shall contain:

1. Header and Footer Information on each page as outlined in the TDF and associated instructions.
2. The Therapy Intervention Plan as outlined in the TDF and associated instructions.
3. The Semi-Annual Review as outlined in the TDF and associated instructions.
4. The TSPAR Development Worksheet as outlined in the TDF and associated instructions.
5. The therapist must sign (with credentials) and date the TIP and the Semi-Annual Review when each is submitted. Since the TDF must be transmitted electronically, signatures must be electronic scans or may be original if the document is scanned for submission.

C. Timeline and Distribution

1. The Therapy Documentation Form : TIP and TSPAR Worksheet Sections shall be distributed to the CM within 44-calendar days of an approved prior authorization for an initial therapy assessment, or 14 calendar days following the annual IDT meeting for an ongoing service.

2. The Therapy Documentation Form : Semi-Annual Review Section shall be distributed to the Individual/Guardian and a representative from each provider agency appearing on the individual's budget 190-days following the individual's ISP effective date.

D. Considerations for Support of Prior Authorization Process

1. At least one Therapy Goal or Objective must support at least one ISP Vision or Outcome as outlined in your TIP.

2. Include any new information from the Annual IDT meeting that may support therapy criteria such as: new ISP outcomes, plans for a new job, plans to move to customized in-home supports, plans for new assistive technology and/or a significant change in circumstance.

3. If you claim units on the TSPAR Worksheet for one of the Deliverables (WDSIs, support for daily routines, AT, collaboration, CARMP areas) you must briefly outline plans in those areas as instructed on the TDF.

VI. THERAPY SERVICES PRIOR AUTHORIZATION REQUEST (TSPAR) FORM

A, General Information

The TSPAR Form is also known as the TSPAR Coversheet. This form summarizes the therapist's request for therapy units on the individual's budget that were identified in the TSPAR worksheet section of the TDF. The TSPAR Form itself contains instructions for completion. There is an associated instruction sheet to the TSPAR Form that also contains detailed information. The therapist must follow the instructions and complete each required section of the TSPAR Form. The TSPAR Form may be revised during the year if there is a significant change in the individual's status that requires significant changes to the TIP and results in a requested budget revision..

B. The TSPAR Form shall contain:

1. Header and Footer information as outlined on the TSPAR Form and associated instructions.

2. A Summary of therapy units requested in each area as outlined on the TSPAR Form and associated instructions.

3. A notation of supporting documentation submitted as outlined on the TSPAR Form and associated instructions.

4. The attestation box must be checked. "I attest that services requested are appropriate within funding parameters of the DD Waiver and are supported by documentation".

5. The therapist must sign (with credentials) and date the TSPAR Form when it is submitted. Since the TSPAR Form must be able to be transmitted electronically, signatures must be electronic scans or may be original, if the document is scanned for submission.

C. Timeline and Distribution

The TSPAR Form shall be distributed to the CM within 44 -calendar days of an approved prior authorization for an initial therapy assessment, or 14-calendar days following the annual IDT meeting for an ongoing service.

D. Considerations for Support of Prior Authorization Process

1. The therapist should make sure that requests match those indicated on the TSPAR Worksheet section of the TDF with the following exception:

    a. The therapist may request more than the suggested units in any category. If doing so the therapist should submit a letter of justification outlining why more units are needed to complete the TIP in that area. The therapist should also submit any additional documentation that they feel may provide clinical justification for the request.

VII. WRITTEN DIRECT SUPPORT INSTRUCTION (WDSI) REQUIREMENTS

A. General Information

Therapists are required to develop Written Direct Support Instructions (WDSIs) for all areas in which direct support personnel (DSP) need guidance to incorporate therapy instructions into the individual's daily life routines and targeted activities. WDSIs may be developed to support the individual with health, safety, ISP outcomes and/or increased participation/independence in daily routines and to support portions of ISP Visions and Outcomes. Therapists must use professional judgment to determine which strategies are appropriate and safe for DSP to implement. These strategies would not include skilled therapy services. WDSIs become the basis for training sessions with DSP and are an outline of the areas for DSP training. WDSIs are prioritized and developed gradually based on therapy assessment, the individual's needs and preferences, as well as interactive trials of various strategies with the individual, the therapist and DSP to determine their effectiveness.

WDSIs shall be written with distinct titles that address individual areas of instruction. WDSIs should not be combined so that all areas of instruction for a therapy discipline are combined into one global WDSI. WDSIs shall be developed with user-friendly language that is easily understood by those implementing the instructions. The use of bullet lists, diagrams and photos are good strategies for effective WDSIs.

Therapists are required to develop at least one WDSI within the first six months of receiving a therapy budget for ongoing intervention with an individual. Additional WDSIs shall be developed for all appropriate areas as described above and according to the Therapy Intervention Plan and discipline-specific needs. WDSIs shall be reviewed annually and revised as needed.

Examples of common WDSIs that therapists may consider include:

- PT: positioning throughout the day, wheelchair positioning, care of the wheelchair, functional ambulation, home exercise/activity plan.
- SLP: Communication Dictionary, 24-Hour Communication System instructions, Interactive Communication Routine instructions.
- OT: self-care and daily activity instructions, environmental access and AT instructions, sensory support instructions, splint use instructions.

The Comprehensive Aspiration Risk Management Plan (CARMP) integrates instructions for aspiration risk management from many clinical disciplines into one document. Documentation requirements for development of the CARMP are described in separate DDSD Aspiration Risk Management Policies and Procedures.

B. Written Direct Support Instructions shall contain:

1. A distinct title that describes the individual area of instruction.
2. The most recent date the plan was developed, reviewed or revised.
3. An outline of strategies that are to be carried out by the DSP.
4. Frequency or under what circumstances the strategies should be implemented.
5. The name and credentials of the author and contact information for the author.
6. A header for each page of the document containing the title of the specific WDSI, the name of the individual and the date.

C. Timeline and Distribution

New WDSIs are due following strategy development and before DSP implementation. Ongoing, continued or maintenance WDSIs should be reviewed and revised as needed and re-distributed 3-weeks prior to the ISP effective date for a new ISP cycle. These WDSIs may be revised and re-distributed as needed within the ISP annual cycle.

All WDSIs shall be distributed to the case manager, to IDT members responsible for developing Teaching and Support Strategies and to all agencies where the instructions will be implemented.

D. Considerations for Support of Prior Authorization Process

WDSIs should support the therapy criteria. Areas to consider include:

1. WDSIs reflect areas of active therapist intervention.
2. WDSIs support that therapy intervention is occurring in areas of need identified by the therapist in the context of daily routines. IE: health, safety, areas related to ISP outcomes, and functional ability.

VIII. TRAINING ROSTER REQUIREMENTS

A. General Information

Therapists are required to submit Training Rosters to document all formal therapy training that occurs. When a therapist conducts a training session all persons attending the training session shall be asked to sign a training roster to record his or her attendance.

B. The Training Roster shall contain:

1. The name of the individual receiving DD Waiver services.
2. The date of the training.
3. The topic for the training (WDSIs trained or general informational topics pertaining to the individual).
4. The signature of each trainee.
5. The role of each trainee (home staff, supported employment staff, family, etc.).
6. The location of the training.
7. The signature and credentials of the trainer.

Competency-based training is required for all training related to the CARMP. A competency based training roster includes all information above but also includes the level of training (awareness, knowledge, or skilled) the trainee has attained. (See ARM Procedure for details).

C. Timeline and Distribution

A copy of the training roster shall be submitted to the agency employing the staff trained within 7 calendar days of the training date. The original will be retained by the therapist.

D. Considerations for Support of the Prior Authorization Process

Training of DSP is referenced in other therapy documentation and supports the therapist's active intervention in the area of therapy need.

IX. TRAINER DESIGNATION RECORD REQUIREMENTS

A. General Information:

A Trainer Designation Record is required when a therapist trains a DSP or another IDT member to be a designated trainer for all or part of a WDSI. This will permit a designated DSP trainer to train other DSP employed by the same agency or the IDT member to train DSP. The Trainer Designation Record must be completed before others can be formally trained by a designee. The designee must agree to be a designated trainer. The therapist must use clinical judgment to decide what WDSIs or parts of WDSIs would be appropriate for training by a designated trainer. The therapist must train the designated trainer to implement the WDSI and be assured that the designated trainer is able to effectively train others on WDSI implementation.

B. The Trainer Designation Record shall contain:

1. The name of the individual receiving DD Waiver services.

2. The name of the person who has agreed to be the designated trainer.

3. The name of the WDSI to be trained.

4. The elements or parts of the WDSI that may be trained by the designated trainer.

5. The name and signature of the therapist.

6. The name and signature of the designated trainer(s).

7. The Date Designated and the Date Rescinded, as appropriate

C. Timeline and Distribution

A copy of the Trainer Designation Record shall be submitted to the agency employing the DSP staff designated to train or to the agencies whose staff will be trained within 7 calendar days of the designation date. The agency should retain a copy in the designee's personnel file or (if the designated trainer is not agency staff) in the file of the individual whose WDSIs will be trained.

The designated trainer will be responsible for providing a training roster to the agency whose staff is trained, within 7-days of each training conducted.

D. Considerations for Support of the Prior Authorization Process

Training of DSP is referenced in other therapy documentation and supports the therapist's active intervention in the area of therapy need.

X. BILLABLE SERVICE CONTACT NOTES

Per MAD-MR:08-11 Medicaid General Provider Policies, General Provider Policies; effective: 9-15-08
§ 8.302.1.17 Record Keeping and Documentation Requirements: *A provider must maintain all the records necessary to fully disclose the nature, quality and amount of services furnished to an eligible recipient who is currently receiving or who has received services in the past . [42 CFR 431.107(b)]. Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act. NMSA 1978 section 27-11-1, et. seq., and a crime punishable under the Medicaid Fraud Act, NMSA, section 30-44-5. See 8.351.2 NMAC, Sanctions and Remedies.*

A. ***Detail required in records:*** *Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name; level and quantity of services; length of a session of service billed and diagnosis.*

a. *When codes, such the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.*
b. *Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.*

B. ***Documentation of test results:*** *Results of tests and services must be documented, which includes results of procedures or progress following therapy or treatment.*

C. ***Services billed by units of time:*** *Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during the time unit.*

D. ***Recipient funds accounting systems:*** *NA for NMMDDW*

E. ***Record retention:*** *A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:*

a. *treatment or care of any eligible recipient;*
b. *services or goods provided to any eligible recipient;*
c. *amounts paid by MAD on behalf of any eligible recipient; and*
d. *any records required by MAD of the administration of Medicaid.*

Summary

Billable Services Notes are required for each service for which the provider will request reimbursement.

Each page of service notes must be labeled with the following:

1. -type of service provided (e.g. occupational therapy, physical therapy, speech-language pathology)
2. -name of the provider agency
3. -name of the individual being served
4. -last 4 numbers of client SS#

Entries must be sufficiently detailed to document the services provided during the time unit(s) billed and include the following:

1. -date of service
2. -start and end time of service
3. -sufficient detail to describe the service provided
4. -signature of the service provider with credentials

XI. DISCONTINUATION OF THERAPY SERVICES REPORT

A. General Information:

A Discontinuation of Therapy Services Report is required when any ongoing therapy service is stopped, within or at the end of an ISP service cycle. This report may be combined with the content of the Annual Re-Evaluation Report if the discharge from therapy occurs near the time that this report is due to the IDT. In this case, the report title will be Discontinuation of Therapy Services Report and the content will be included in the appropriate therapy report.

B. The Discontinuation of Therapy Services Report shall contain:

1. Date that the provider's therapy services were discontinued;
2. Reason for discontinuation of therapy services delivered by the current therapy provider;
3. The status of most recent therapy goals;
4. Recommendations from the current therapy provider regarding therapy, use of assistive technology, implementation of specific therapy strategies, other services that may be needed; and
5. The status of the current budget including the balance of units, by billing code, which have not been used by the discharging therapist.

C. Timeline and Distribution

The Discontinuation of Therapy Services Report shall be distributed to all IDT members with the content of the Annual Re-Evaluation at the time this reports is due. If services are discontinued off cycle of this report, the Discontinuation of Therapy Services Report is due within 14-calendar days following the end of services.

D. Considerations for Support of the Prior Authorization Process

If a reason for discharge is that prior authorization criteria are no longer met by the individual, this should be stated in the Discontinuation of Therapy Services Report.