# THERAPY DOCUMENTATION GUIDELINES FOR 
THE NEW MEXICO DEVELOPMENTAL DISABILITIES WAIVER

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>GENERAL DOCUMENTATION REQUIREMENTS</td>
</tr>
<tr>
<td>3</td>
<td>INITIAL THERAPY EVALUATION REPORT REQUIREMENTS</td>
</tr>
<tr>
<td>5</td>
<td>TARGETED THERAPY EVALUATION REPORT REQUIREMENTS</td>
</tr>
<tr>
<td>6</td>
<td>ANNUAL THERAPY RE-EVALUATION REPORT REQUIREMENTS</td>
</tr>
<tr>
<td>7</td>
<td>SEMI-ANNUAL THERAPY PROGRESS REPORT REQUIREMENTS</td>
</tr>
<tr>
<td>8</td>
<td>THERAPY INTERVENTION PLAN REQUIREMENTS</td>
</tr>
<tr>
<td>9</td>
<td>WRITTEN DIRECT SUPPORT INSTRUCTION REQUIREMENTS</td>
</tr>
<tr>
<td>11</td>
<td>TRAINING ROSTER REQUIREMENTS</td>
</tr>
<tr>
<td>12</td>
<td>TRAINER DESIGNATION FORM</td>
</tr>
<tr>
<td>13</td>
<td>BILLABLE SERVICE CONTACT NOTES</td>
</tr>
<tr>
<td>14</td>
<td>DISCONTINUATION OF THERAPY SERVICES REPORT</td>
</tr>
</tbody>
</table>
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: 6/15/11-12/15/11
   Semi-Annual Report Service Dates: 12/16/11-6/14/12

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
   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 shaped 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 that are comprehensive must address all relevant environments frequented by the individual. 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
THERAPY DOCUMENTATION GUIDELINES

5. Interpretation of Assessment Data
6. Recommendations regarding referral to other services
7. Recommendations regarding the need for services by that therapy discipline
8. Initial therapy goals and objectives, if therapy is recommended

C. Timeline and Distribution

The initial assessment must be completed within 30 calendar days following the therapist’s receipt of the approved prior authorization/billing authorization and the subsequent Initial Therapy Evaluation Report must be submitted to the IDT within 14 calendar days following completion of the initial assessment.

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
III. TARGETED THERAPY EVALUATION REPORT REQUIREMENTS

A. General Information

If 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 was 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 all reports in the Targeted Therapy Evaluation Report.

C. Timeline and Distribution

The Targeted Therapy Assessment must be completed within 30 calendar days following the therapist’s receipt of the approved prior authorization/billing authorization. The subsequent Targeted Therapy Evaluation Report must be distributed within 14 calendar days of the completion of the assessment to the individual/guardian and an IDT member from each service provider that appears on the budget.

D. Consideration for Support of Prior Authorization

None
THERAPY DOCUMENTATION GUIDELINES

IV. ANNUAL THERAPY RE-EVALUATION REPORT REQUIREMENTS

A. General Information

Therapists who are providing therapy are responsible for conducting an annual re-assessment and writing an Annual Therapy Re-Evaluation Report. The therapist is responsible for reviewing and incorporating the instructions found in the general documentation requirements for all reports in 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 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 addressed or is anticipated during the next year
3. Progress or decline in functional ability
4. Documentation of baseline functional ability
5. Recommendations from outside the IDT regarding therapy
6. Training status and any problems related to training.
V. SEMI-ANNUAL THERAPY PROGRESS REPORT REQUIREMENTS

A. General Information

For each individual having received a prior authorization for an ongoing therapy service, a Semi-Annual Therapy Progress Report is required.

B. The Semi-Annual Therapy Progress Report shall contain:

1. Date range that the provider’s therapy services were provided (date range from last report-current report);

2. Identification of each therapy goal/objective (not ISP goal) listed in the Therapy Intervention Plan;

3. The status of each therapy goal/objective with an identification of one of the following:
   a. Accomplished
   b. Progress
   c. Maintained
   d. Loss of function or lack of progress

4. A description of data collected, outcome measures and/or narrative of the status of the objective(s) addressed as a part of each goal;

5. A List, by title, of Written Direct Support Instructions (WDSIs) and CARMP strategies authored, trained and/or monitored by that therapist;

6. The current training status of each WDSI and/or CARMP strategy listed with an identification of one of the following:
   a. Currently trained
   b. More training needed
   c. Not trained

C. Timeline and Distribution

The Semi-Annual Therapy Progress Report shall be distributed to the individual/guardian and an IDT member from each service provider that appears on the budget, 190 calendar days following the individual’s ISP effective date.

D. Considerations for Support of Prior Authorization Process

None. This report is not a requirement for prior authorization.
VI. THERAPY INTERVENTION PLAN REQUIREMENTS

A. General Information

A Therapy Intervention Plan (TIP) is required for initial and ongoing therapy intervention and shall be updated annually. The TIP must be a separate and distinct document and may not be included as part of another therapy report. The TIP should be revised during the year if there is a significant change in the individual’s status. If there is a change in therapist, the TIP should be reviewed and modified as needed.

B. The Therapy Intervention Plan shall contain:

1. A brief description of the individual’s ISP outcomes and how therapy intervention strategies are related to those outcomes.

2. Measurable therapy goals/objectives as based on the results of the therapy assessment/evaluation and any applicable ISP outcomes/action plans.

3. Intervention approaches and strategies that will be used to assist the individual in meeting therapy goals/objectives including:
   a. Specific Written Direct Support Instructions (WDSI) to be maintained, modified, and/or developed and trained;
   b. AT and/or environmental modifications to be maintained, modified, and/or obtained/developed;
   c. Purpose and anticipated duration of any needed co-treatment.

4. Information regarding fading and/or discontinuation of therapy services, or discussion of why fading and/or discontinuation is not appropriate at this time.

C. Timeline and Distribution

The TIP shall be distributed to the individual/guardian and an IDT member from each service provider that appears on the budget 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

The content of the TIP should support the therapy eligibility criteria identified on the Therapy Services Prior Authorization Request (TSPAR). Areas to consider include:

1. Therapy objectives and intervention strategies should include areas of therapy intervention need identified in TSPAR criteria.

2. 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, and/or a significant change in circumstance.

3. If the therapist identified that a completely new therapy objective is needed on TSPAR criteria the new therapy objective must be included in the TIP.
VII. WRITTEN DIRECT SUPPORT INSTRUCTION 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. WDSIs may be developed to support the individual with health, safety, ISP outcomes and/or increased participation/independence in daily routines. 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 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 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 Dictionaries, 24-Hour Communication Program 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 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.

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 distributed at least three weeks prior to the new ISP effective date. 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 eligibility criteria identified on the TSPAR. 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 agency for which each trainee works.
6. The role of each trainee (home staff, supported employment staff, family, etc.).
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.

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 to be a designated trainer of all or part of a WDSI. This will permit the designated trainer to train other DSP employed by the same agency and must be completed before the DSP can formally train others. 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 how to 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 DSP 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

C. Timeline and Distribution

A copy of the Trainer Designation Record shall be submitted to the agency employing the staff designated to train within 7 calendar days of the designation date. The agency should retain a copy in the designee’s personnel file.

The designated trainer will be responsible for providing the agency which employs them with a roster of those employees 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.

1. When codes, such as 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.

2. 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:

1. treatment or care of any eligible recipient;
2. services or goods provided to any eligible recipient;
3. amounts paid by MAD on behalf of any eligible recipient; and
4. 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 or Semi-Annual Therapy Report if the discharge from therapy occurs at the time that either of these reports 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;
5. How the IDT will accommodate maintenance of therapy strategies provided by the discontinued therapy provider, as appropriate, if the therapy service is being discontinued; and
6. The status of the current budget including the balance of units, by billing code, which has 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 or Semi-Annual Report at the time either of these reports is due. If services are discontinued off cycle of either of these reports, 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.