Documentation Guidelines for Children and Youth

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A. DOCUMENTATION TIPS

1. What Is Medical Necessity?

- The therapy is intended to maintain, develop, or improve skills needed to perform ADLs or IADLs (ex: making a meal, taking the bus, community activities, safety issues) which have not (but typically would have) developed or which are at risk of being lost as a result of illness, injury, loss of body parts or congenital abnormality
- Requires the unique knowledge, skills, and judgement of an occupational therapist
- Expectation that the therapy will maintain or improve the level of functioning

2. What Is Not Medically Necessary?

- Therapy aimed at developing, improving, or maintaining functions, which would normally develop
- The therapy is considered routine educational, training, conditioning or fitness. This includes therapy that requires supervision only. These types of services may be appropriate for a consultation model
- Thereapy that does not result in practical improvement in function in a reasonable amount of time
- The documentation fails to objectively verify or maintain functional progress
- Routine re-assessments are not considered re-evaluations (billed under 97004) unless there are new significant findings, rapid change in status, or failure to respond to occupational therapy interventions
- Treatment not supported in peer-reviewed literature

3. Referrals

- Most insurance companies will currently not pay for services unless there is a physician's referral with signature and date
- If results of a (re-)evaluation recommend a different plan or frequency and duration than stated on the original referral then the physician must sign their approval of a new plan

— MORE —

For more information, questions or concerns contact:

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4. Diagnoses

- Medical and Treatment Diagnosis codes from the ICD-9 (ICD-10 starting October 2015) must be written by the physician/NPP/PA on the referral and/or plan of care
- Therapists can treat as many of treatment diagnoses as appropriate for the child, but they must all be approved by the physician

Medical diagnosis codes refer to the child's condition

Ex: Down syndrome, Cerebral Palsy, Autism Spectrum Disorder, and Traumatic Brain Disorder

Treatment diagnosis codes are used to identify the problems being treated

Ex: Lack of coordination, hypotonia, and feeding difficulties

B. DOCUMENTATION: WHAT TO INCLUDE

5. Evaluation Reports

- Date of report
- Diagnoses and onset of date
- Pertinent medical information (past and present) and prior functional level if appropropriate
- Prior therapy and current services from other providers (including school based)
- Basic adaptive and behavioral characteristics
- Current development status based on standardized and non-standardized tests with baseline data addressing all areas of occupation (as outlined in the Occupational Therapy Practice Framework)
    - Fine motor/adaptive sills
    - Gross motor skills
    - Progression
    - ADL and IADL status including oral motor and feeding status
    - Response to sensory input/sensory processing issues
    - Quality of motor behavior
    - Posture: alignment (symmetry or asymmetry), tone, reflexes, and balance
    - Mobility and movement patterns
    - Structural limitations
        - ROM
        - Contractures, scoliosis, torticollis
    - Plan of Care: if services are determined to be medically necessary
        - Measurable and functional short– and long-term goals with time frames based on objective functional findings
            - All goals (including sensory goals) need to be linked to a functional outcome
    - Prognosis/therapeutic potential
    - Frequency/duration
    - Professional signature

6. Daily Treatment Notes

- Date of treatment and total treatment time
- Specific treatment performed that matches the CPT codes being billed
- Response to treatment
- Progress toward goals in objective, measurable terms
- Any problems or changes to the plan of care
- Professional signature

7. Progress Reports

- Date of report
- State of care date
- Time period covered by the report
- Medical and treatment diagnosis codes
- Current status as compared to the prior reporting period including objective progress that relates to the treatment goals
- Changes in prognosis, plan of care and updated goals

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Approved by OTAC Board of Directors October 16, 2014

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