

Therapy Provider Checklist

Name: _____

Recipient ID: _____

Chronological Age: _____

Medical Necessity Criteria

Are the Services:

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Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain	
Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs	
Consistent with generally accepted professional medical standards as determined by the Medicaid program, not experimental or investigational	
Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide	
Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider	

Prescription/Evaluation/Plan of Care/Visit Documentation Requirements

Physician Prescription

Recipient Diagnosis	
The specific type of evaluation requested or the specific type of service	
Duration and frequency of the therapy treatment period	
The physician's MediPass authorization number, if applicable	
Recipient's renewed plan of care reviewed every one to six months depending on the authorization period for which the services were approved	

Evaluation

Standardized tests/professionally accepted technique	
Plan of care written based on evaluation results	
1 re-evaluation in 6 months	
Reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist	

Plan of Care

Initiated, developed, submitted by licensed physical, occupational and respiratory therapists or a licensed or provisionally licensed speech-language pathologist	
All treatment services included in plan of care	
Reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist	
Patient name, DOB, Medicaid # included	
Achievable, measurable, time-related long and short term goals and objectives that are related to	



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the functioning of the recipient and are based on the primary care provider's, ARNP's or PA designee's or designated physician specialist's prescription	
Medications, treatments, equipment required	
Description of condition, including most specific ICD-9	
Frequency, length of each treatment and the duration of the treatment	
Therapy methods and monitoring criteria	
Diet as indicated	
Methods of demonstrating and teaching, which include the family and other relevant caregivers who are involved with the recipient	
How the treatment will be coordinated with the other service needs prescribed for the recipient	

Visit Documentation

Time period	
Type of service rendered	
Progress achieved	
Change in recipient's status due to treatment	

Reviewer: _____

Date: _____