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Unit

To : County California Children Services (CCS) Administrators, Medical Consultants, and Chief/Supervising Therapists and State Children's Medical Services (CMS) Medical and Therapy Consultants

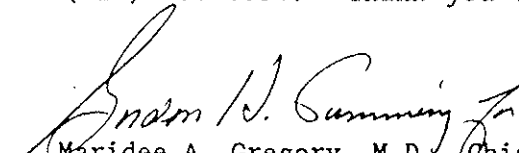
Subject: Utilization Review for Outpatient Rehabilitation Center Certification

The utilization review (UR) standards, procedures, and forms required in the process to certify the medical therapy units (MTUs) as Outpatient Rehabilitation Centers have been completed by State CCS and have been piloted in four independent counties (two in Southern and two in Northern California), and in the Sacramento Regional Office (dependent counties). Statewide UR training will begin in October 1994, and will be organized by the regional offices prior to implementation.

UR brings the certification process into full compliance with Title 22, Article 3, Section 51213 (g) (2-5). Once UR has been implemented and monitored for a short time, recertification survey visits will begin to be scheduled. We apologize for the inconvenience of some MTUs who will be resurveyed in less than the two-year period allowed, but we are trying to space out the resurveys in order to better allocate scarce manpower resources.

Quality assurance is still on the CCS agenda, but will be kept apart from the UR process. Meeting Medi-Cal's UR requirement for billing purposes was the motivating factor for CCS to develop the UR guidelines, which are based on CCS philosophy, and therefore, will be required whether or not the MTU is a certified Outpatient Rehabilitation Center. We will be creating quality assurance standards from the ground up and the counties will be invited to participate in the committees that will be developing this process. This will be done after the UR process is fully implemented.

Enclosed in this packet are the directions for implementation of the UR process and the forms that will be used. If you have any questions regarding this process, please contact Jeff Powers at (916) 657-0834. Thank you for your assistance in this task.


Maridee A. Gregory, M.D., Chief
Children's Medical Services Branch

Enclosures

California Children Services (CCS)
Guidelines for Utilization Review

I. Composition of the Utilization Review Team (URT)

The URT shall be composed of a physician, a physical and an occupational therapist.

Independent counties--The team will be made up of the county medical consultant, the supervising/chief therapist, and a therapist of the opposite discipline. If the independent county cannot supply the team required, they are to contact their regional office. The county medical consultant is the lead member for the team. The county may select therapists from within the county CCS program to serve on the team as appropriate.

Dependent counties--The regional office medical and therapy consultants will serve as the URT for dependent counties in their region. The county/regional office medical consultant is the lead member and will oversee the UR process. The regional office may utilize medical consultants and therapists from the county CCS program to serve on the team as appropriate.

II. The Utilization Review (UR) Process

The UR meeting must be held a minimum of once a month. The team will notify each MTU of the patients that will be reviewed in the meeting and request the information required to complete the review. The URT may meet in an MTU or a more central location. Patient charts shall not be removed from the MTU for use by the URT, and the URT should give the MTU enough advance notice to allow them to make copies of the requested information. The MTU will be responsible for providing the information requested in a timely manner and document the review date in the patient chart. The URT will review the information, document their findings, and forward them to the appropriate MTU. A member of the URT will be assigned to follow up on the review. The MTU will be responsible to then respond to the findings.

III. The Time Table

The URT findings must be reported to the MTU within five (5) days of the review. The MTU must respond to the URT within 30 days. This time table will continue to be used until the MTU response is accepted by the URT.

IV. Quantity of UR to be Performed

The county will not be given a definite target number of cases to review. The goal is to review 10 percent of total county caseload annually. The only standard to be considered is that each MTU in the county receives an equal amount of UR in comparison to the others. This will be reviewed

during the bi-annual survey (once every two [2] years) by the therapy consultants for compliance. Since the UR process is a Medi-Cal requirement, the percentage of Medi-Cal patients reviewed should approximate the percentage of Medi-Cal clients in the county.

USING THE UR FORMS

V. UR Checklist (UR-1), URT Monthly Meeting Log (UR-2), and CCS Medical Therapy Plan/Prescription (UR-3):

A) The UR checklist (UR-1)

This form is filled out by the UR team with the exception of the MTU response to UR team findings section which is completed by the MTU. One form is filled out for each chart reviewed. After the UR team has given approval to the MTU response, the UR materials (Forms UR-1 [copy] and UR-2 [original]) are to be kept in a UR binder at the county/regional office. Steps 4 and 5 will be repeated until the UR team gives its approval to the MTU response. The MTU shall keep the original UR-1 forms in a separate file and send a copy to the county office.

Patient Information

The date CCS or private therapy services began refers to when the child initially began to receive therapy services from that source. It is a historical view of all therapy services the child has received and the dates they began and ended. Treating diagnosis is the MTP-eligible treating diagnosis.

Review of Documentation

Section A: Prescribing Physician's report.

- 1) *Current physician evaluation and report of that evaluation* are defined according to CCS policy currently in use (Chapter 4.4.2 F). Children receiving active therapy services (one time a week or more) require current physician evaluation and report a minimum of once every six months. Children receiving therapy services less frequently must receive current physician evaluation and report a minimum of once a year. Current evaluation, report and prescription are required whenever orders are changed.
- 2) *Relevant medical information* is information that is necessary to justify the treatment plan. It must address the child's MTP-eligible condition. This information (rehabilitation potential, benefits of previous therapy, etc.) has a significant impact on the amount and types of services that are allowed under Medi-Cal. The information must meet the six month or one year criteria in Chapter 4 (4.4.2 F) in order to be relevant to the current prescription.

- 3) *Documentation of rehab potential* is indicated as good, fair or limited. Rehab potential is the physician's statement of how well he/she feels the patient will respond to therapeutic input.

Good--Rehabilitation potential indicates that a child should respond well to therapeutic intervention and make significant progress toward established functional goals over a set period of time.

Fair--Potential indicates that a child should respond satisfactorily to therapeutic intervention and may make steady progress toward functional goals set for them.

Limited--Potential indicates that a child is not expected to benefit from active therapy intervention, but may require periodic checks or consultation to assess current function or needs, including a description of the limits.

- 4) *Functional goals* are goals addressing ADL areas including, but not limited to mobility, gross motor, fine motor skills, self care, and home and community accessibility. Functional goals promote a maximum level of independence.

- 5) *Functional status* is objective and measurable in order to demonstrate progress attained by the patient as a result of therapy intervention in relation to ADLs and current level of function. General levels include:

Independent (I)--Child can perform the activity without assistance.

Maximum Assistance (MAX)--Child can assist in some small part of the activity, and the therapist is required to carry out most of the activity.

Moderate Assistance (MOD)--Child and therapist participate relatively equally in the activity.

Minimal Assistance (MIN)--Child can perform most of the activity, and the therapist is required to carry out only a small portion of the activity.

Contact Guard (CG)--Child is able to perform the entire activity, but requires the therapist's stand-by physical prompts.

Verbal Cueing (VC)--Child is able to perform entire activity, but requires the therapist's verbal reminders.

Dependent (DEP)--Child does not participate in the activity, and requires total assistance.

Section B: Physician Prescription

- 1) *Current prescription* is as stated in Chapter 4 (4.4.2).
- 2) The *date* the prescription is signed must be included on the prescription. The physician must *sign* the prescription in order for it to be valid and therapy services provided, or *sign* dictation that states approval of treatment plan.
- 3) The *frequency of OT sessions and the frequency of PT sessions* to meet stated goals must be specified.
- 4) The *period of time* the prescription is valid must be specified.

Section C: Current PT/OT Evaluation

A written report (MTU Summary) that includes:

- 1) Results of testing and observations.
- 2) Benefits of previous therapy. The *Therapy Improvement Scale (TIS)* can be used to document progress toward a functional goal.
 - 1 No response to treatment; no functional change noted.
 - 2 Clinical improvement noted; no measurable functional change noted.
 - 3 Minimum improvement noted; less than 50 percent of objectives met.
 - 4 Moderate improvement noted; more than 50 percent of objectives met.
 - 5 Met functional goal.
- 3) Potential for functional gain.

Section D: Current PT/OT Treatment Plan

Treatment plan must agree with the current written orders and be approved by the physician. Measurable functional goals expected to be achieved within the time frame of the prescription must be included. Treatment methods must be included as part of the plan. The goals must be based on the results of the therapy evaluation.

Section E: PT/OT Progress Notes

Progress notes (Therapy Running Notes) must be present in chart and reflect the child's present therapy status and responses to treatment.

Review of Therapy Services Delivered

Section A: Functional Goals

The goals and objectives set for a child must be based on the findings related to the MTP eligible condition, and will establish baseline criteria for the measurement of progress.

Section B: Services Provided

The services provided must relate and contribute to the child achieving stated goals.

Section C: Progress

Progress achieved toward set goals and objectives must be stated in objective terms and must relate to the therapy program established for the child.

Section D: Potential

The child's potential for improvement is based on continued progress and/or ability to continue to benefit from therapy services. Potential can be measured according to the TIS, as previously described in the UR Guidelines Review of Documentation, Section C.

Utilization Review Team Findings

The URT is to report their findings to the MTU where the child is receiving services. The findings are based on documentation in the patient chart. Additional pages may be used as necessary.

MTU Response to URT Findings

The MTU is required to respond only to deficiencies. The response must include a method and date for correction of the problem(s) as noted by the URT. If the URT does not find the MTU response acceptable, the URT is responsible for providing documentation (Step IV, Form UR-1) on the nature of the nonacceptance, and the MTU must respond (Step V, Form UR-1) to the URT. These two steps will continue until the URT accepts the response of the MTU. Additional pages may be used as necessary.

B) The URT Monthly Meeting Log (UR-2)

This form is for the exclusive use of the UR team. It is to be completed at each of the monthly meetings scheduled as a record of participants, content and the date of the meeting. Each patient chart reviewed will be logged in, and a member of the team assigned to follow up on the MTU response to URT findings (if any are required). The comments are to be narrative notes generated during

the meeting that indicate the need for change in county procedures. The assigned member is responsible for the follow through on the case or procedure when the findings are negative. The log(s) and copies of the UR checklists are to be maintained as a single file for each month. The files must be available for review during certification surveys.

C) The CCS Medical Therapy Plan/Prescription Form (UR-3)

This form is optional for use in the MTUs. If the county or MTU has already set up a system to capture all information required in Section 3 of the OPRC Certification Survey Form Worksheet, CS-1, the system in place may be used. The CCS Medical Therapy Plan/Prescription Form is designed to capture all of the necessary requirements for Section 3.

The form may be filled out by the therapist for each patient prior to being seen in MTU clinic or sent to private physicians and CCS special center physicians who are appropriate to write orders for MTP patients. One form should be completed for each discipline (service) recommended (i.e. PT, OT). The therapist may fill out the form. The physician may make any changes or additions to the form. The physician must sign and date before the form can act as physician orders (prescription). A current physician report is required.

The Treatment Plan

See UR Checklist (Form UR-1) Section D.

Frequency

The frequency is the number of treatments that a PT or OT (week/month/year) are required to provide in order to meet the stated goals. When a child is not receiving active treatment, frequency is to be stated in terms of monitor or consultation (month/year/PRN).

Duration of Prescription

The duration of a prescription is the period of time that the physician indicates will accurately reflect the therapy needs of the child without modification. This identifies the period of time the prescription is current. Such duration cannot exceed the currency criteria in Chapter 4.

Rehab Potential

Document "good", "fair", or "limited" as previously described in the UR Guidelines, Review of Documentation, Section A.

Benefits of Previous Therapy

Documentation of objective, functional improvements made by the child attributable to the therapy services provided.

Functional Status

Document level of assistance required for mobility, ambulation, transfers, community and home skills, feeding, dressing, toileting, and bathing as listed on Form UR-3.

Goal(s)

Functional short-term goals that reflect anticipated progress to be made by the child during the duration of the prescription.

**California Children Services
Utilization Review Checklist**

I. Patient Information Review Date _____

Child's Name _____

DOB _____ MTU _____

SSA# _____ County _____

Dates Other Therapy Services Received: PT _____ OT _____

Dates CCS Therapy Services Began: (PT) Active _____ Other _____

(OT) Active _____ Other _____

Treating Diagnosis: _____

II. Review of Documentation

ITEM	PT			OT		
	YES	NO	N/A*	YES	NO	N/A*
A) Prescribing physician's report:						
1) Report is current						
2) Information is relevant						
Documents: 3) Rehab Potential						
4) Functional Goals (ADLs)						
5) Functional Status (Progress)						
B) Physician prescription:						
1) Current						
2) Signed and dated by physician						
3) PT/OT frequency specified						
4) Duration of prescription specified						
C) Current PT/OT evaluation(s)/report present						
D) Current PT/OT treatment plan(s) present						
E) PT/OT progress (running) notes present						

III. Review of Therapy Services Delivered

ITEM	PT			OT		
	YES	NO	N/A*	YES	NO	N/A*
A) Functional goals based n PT/OT assessment(s).						
B) Services provided relate to goals.						
C) PT/OT services achieved progress toward stated goals.						
D) Evidence of continued potential for functional gains.						

IV. Utilization Review Team (URT) Findings**:

URT Representative

Date

V. MTU Response to URT Findings**:

MTU Representative

Date

**Be brief & objective. See attached for additional findings _____

MTU response reviewed by _____

Accepted ____ Nonacceptable ____ (Repeat Steps IV and V)

California Children Services
Utilization Review Team
Monthly Meeting Log

Date: ___/___/___

Team Members Present:

County: _____

Physician: _____

MTU(s): _____

PT: _____

OT: _____

Others: _____

Name(s) of Patient(s):
Reviewed:

DOB

(If necessary)
Follow-up assigned to:

<u>Name(s) of Patient(s):</u> <u>Reviewed:</u>	<u>DOB</u>	(If necessary) <u>Follow-up assigned to:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Initial Review Comments & Review of Non-Acceptable MTU Responses:

See attached for additional comments _____
UR-2 (10/94)

CCS Medical Therapy Plan/Prescription*

PT ___ OT ___

Child's Name: _____ CCS# _____ Date: _____

Child's DOB : _____ Treating Diagnosis: _____

Treatment Plan:

- | | | |
|---|--|---|
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Functional ADLs | <input type="checkbox"/> MTU Conference |
| <input type="checkbox"/> Transfer Training | <input type="checkbox"/> Community Skills | <input type="checkbox"/> Periodic Checks |
| <input type="checkbox"/> Functional Mobility | <input type="checkbox"/> Modalities | <input type="checkbox"/> Consultation (PRN) |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Splinting (UE/LE) | <input type="checkbox"/> Evaluation |
| <input type="checkbox"/> Home Skills | <input type="checkbox"/> Oral/Motor | <input type="checkbox"/> Other _____ |

Functional Status:

Mobility ___	Ambulation ___	Community Skills ___	Toileting ___
Dressing ___	Transfers ___	Home Skills ___	Bathing ___
Feeding ___	Other _____		

Goal(s):

Therapist's Name/Signature _____/_____

MTU _____ County _____

Physicians, please indicate any changes or additions to the information provided and sign below:

Frequency: _____ Duration of Prescription: _____

Rehab Potential: Good ___ Fair ___ Limited ___

Benefits of Previous Therapy: _____

Precautions: _____

Physician Signature: _____ Date: _____ (# _____)

*Physician signature required in order for therapy services to be provided.