

Florida Medicaid Therapy Provider Checklist

This checklist is for educational purposes only. This checklist is a tool to assist providers and is not a required form. For official policy guidance, please refer to the Therapy Services Coverage and Limitations Handbook, Provider General Handbook, and CMS-1500 Reimbursement Handbook.

Name	
Recipient ID (10 digits)	
Chronological Age (year/month)	

MEDICAL NECESSITY CRITERIA:

ARE THE SERVICES:	✓
Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (2-2)*	
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 (2-2)	
Consistent with generally accepted professional medical standards as determined by the Medicaid program, not experimental or investigational (2-2)	
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 (2-2)	
Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider (2-2)	

PRESCRIPTION/EVALUATION/PLAN OF CARE/VISIT DOCUMENTATION REQUIREMENTS:

PHYSICIAN PRESCRIPTION	✓
Recipient Diagnosis (2-3)	
The specific type of evaluation requested or the specific type of service (2-3)	
Duration and frequency of the therapy treatment period (2-3)	
The physician's MediPass authorization number, if applicable (2-3)	
Recipient's renewed plan of care reviewed every one to six months depending on the authorization period for which the services were approved (2-3)	

EVALUATION	✓
Standardized tests/professionally accepted technique (2-5)	
Plan of care written based on evaluation results (2-5)	
1 re-evaluation in 6 months (2-5)	
Reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist (2-4)	

PLAN OF CARE	✓
Initiated, developed, submitted by licensed physical, occupational and respiratory therapists or a licensed or provisionally licensed speech-language pathologist (2-6)	
All treatment services included in plan of care (2-6)	

* Numbers in parenthesis refer to the page number for this requirement in the Therapy Services Coverage and Limitations Handbook.

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Reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist (2-4)	✓
PT name, DOB, Medicaid # included (2-6)	
Achievable, measurable, time-related long and short term goals and objectives that are related to 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 (2-6)	
Medications, treatments, and equipment required(2-6)	
Description of condition, including most specific ICD-9(2-6)	
Frequency, length of each treatment and the duration of the treatment(2-6)	
Therapy methods and monitoring criteria(2-6)	
Diet as indicated(2-6)	
Methods of demonstrating and teaching, which include the family and other relevant caregivers who are involved with the recipient(2-6)	
How the treatment will be coordinated with the other service needs prescribed for the recipient(2-6)	

VISIT DOCUMENTATION	✓
Time period (2-11)	
Type of service rendered (2-11)	
Progress achieved (2-11)	
Change in recipient's status due to treatment (2-11)	