Clinical Information and Documents To Support Medical Necessity

Driscoll Health Plan (DHP) may request any combination from the following list of clinical information and documents to support medical necessity of requested services.

All information and documents should be current and legible with appropriate ordering physician signature dated within the past 90 days where applicable.

Providers need to submit only the applicable documents listed below related to the requested services.

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
All Inpatient, Outpatient, and Therapy Requests for Services (in addition to items listed below)	Essential Information to initiate authorization referral request: • Member name • Member or Medicaid number • Member date of birth • Requesting provider name • Requesting provider National Provider Identifier (NPI) • Procedure codes requested • Service start and end dates • Quantity requested
Inpatient & Observation Requests	Information and documents should relate to the current admission/stay. In addition to the documents listed above: • Admission Notification and/or Face Sheet • Rendering provider/facility name • Rendering provider National Provider Identifier (NPI) • Behavioral Health Inpatient Admission Notification Form • Diagnosis • History and Physical • Progress Notes • Consult Notes and/or Reports from Specialists • Behavioral Health Inpatient Extended Stay Form • Physician Orders • Radiology/Imaging Results • Laboratory Results • Blood Glucose Testing • Vital Sign Reports

	• Medication Administration Records • Discharge Summary • Behavioral Health Discharge Summary Form
Outpatient Requests and Discharge Planning	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) • Texas Standard Prior Authorization Request Form (TARF) • Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form • Change of Provider Letter • Psychological Testing Prior Authorization Request Form • Modifiers • Diagnosis • History and Physical • Progress Notes • Consult Notes and/or Reports from Specialists • Physician Orders • Radiology/Imaging Results • Laboratory Results • Blood Glucose Testing • Vital Sign Reports • Medication Administration Records or Medication History • Developmental Screening Tool • Hearing evaluations and test results • Growth Charts • Noninvasive Prenatal Screening (NIPS) Attestation for OBGYN's Form • OB Attestation for Cystic Fibrosis Screening Form • Laparoscopic or Open Removal of Fallopian Tubes and/or Ovaries for Elective or Opportunistic Sterilization Attestation • Glucose monitors readings • How often the member requires increase in the insulin dosage • What number ultrasound is being requested

	• Change In Provider Letter/Form • Previous ultrasound reports • Flowsheets • Notes for current pregnancy • Confirmation that member has chronic incontinence with description of type of enuresis or incontinence and comorbid conditions, detail of what management/workup including specialist referral has been done and the response
Children and Pregnant Women (CPW) Case Management Services	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) • Initial Prior Auth Request for CPW Case Management Services form • Prior Auth Request for Additional Visits for CPW Case Management Services form • Progress Notes • Member Service Plan • Family Needs Assessment • Any other documents supporting need for additional visits
Occupational Therapy Requests	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) **Initial Occupational Therapy Evaluations & Re-Evaluations:** • **Initial Evaluations:** A recent clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to occupational therapy (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals) • **Re-Evaluations: If less than 6 months since the previous evaluation/re-evaluation:** A recent/updated clinical note from a physician/appropriate specialist documenting the change in medical status that makes additional formal testing medically necessary (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals) • **Re-Evaluations: If more than 6 months since the previous evaluation/re-evaluation or the member is new to DHP:** A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to occupational therapy (note should be less than twelve (12) months old for developmental delay and less than one month (1) old for orthopedic referrals) • A developmental screen that documents deficits (screen should be less than three (3) months old)

	• Date of the most recent evaluation/re-evaluation and/or therapy visit (if applicable)
	• The history of previous referrals for occupational therapy and copies of any prior evaluations, re-evaluations, and progress summaries
	• Clinical notes from an appropriate specialist (Examples: Psychology, Neurology, Orthopedics, Developmental Pediatrics, Sports Medicine) that document the specific functional deficits, diagnosis, and need for occupational therapy
	• Any radiology/imaging reports related to the current occupational therapy referral
	• Clarification to prevent duplication of services (between therapy disciplines or between different therapy providers)
	• Appropriate evaluation codes & modifiers
	• **Referrals to an out-of-network therapy provider**: An explanation of the medical necessity or reason for referral to an out-of-network provider
	• **Telehealth:** Documentation from the referring physician/appropriate specialist of the medical need for the services to be provided via telehealth and reasons why an in-person evaluation/re-evaluation is not possible/desirable
	
	<u>Occupational Therapy Treatment:</u>
	• A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to occupational therapy (note should be less than twelve (12) months old for developmental delay, less than one month (1) old for orthopedic referrals and less than three (3) months old if medical necessity is not clear based on the therapy clinical notes)
	• **If new to Driscoll Health Plan:** The history of previous referrals for occupational therapy, date of the most recent therapy visit (if applicable), and copies of any prior evaluations, re-evaluations, and progress summaries
	• Clinical notes from an appropriate specialist (Examples: Psychology, Neurology, Orthopedics, Developmental Pediatrics, Sports Medicine) that document the specific functional deficits, diagnosis, and need for occupational therapy
	• Any radiology/imaging reports related to the current occupational therapy referral
	• Clarification to prevent duplication of services (between therapy disciplines or between different therapy providers)
	• Appropriate evaluation codes & modifiers
	• **Referrals to an out-of-network therapy provider**: An explanation of the medical necessity or reason for referral to an out-of-network provider
	• **For initial requests for visits:** An occupational therapy evaluation and plan of care that includes:
	  ○ Member's medical history and history of any prior occupational therapy treatment
	  ○ Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements)

	○ A description of specific functional skills and deficits observed during completion of Activities of Daily Living (ADLs) ○ A clear diagnosis and reasonable prognosis ○ The prescribed treatment modalities ○ Recommended frequency/duration of therapy ○ Mode and location of service delivery (Examples: telehealth, in-person, clinic, home) ○ Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes ○ Responsible adult's expected involvement in the member's treatment ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement, and the proposed plan of care ○ Signature of the evaluating occupational therapist and date • **Subsequent requests for ongoing occupational therapy treatment:** A therapy progress summary, re-evaluation or treatment notes along with other documents that communicate all of the following information: ○ An objective demonstration of progress toward the treatment goals from the most recent authorization period (baseline objective measure, from the beginning of the authorization period, the current level by the same objective measure and corresponding dates that data was collected) ○ Results of any standardized/formal testing completed since the beginning of the previous authorization period (updated standardized testing is required once every six (6) months) ○ A description of improvements in function observed during completion of Activities of Daily Living (ADLs) over the previous authorization period ○ A description of the continuing functional deficits and need for additional occupational therapy services ○ Updated short and long-term treatment goals which are functional, appropriately attainable, measurable, and specific to the member's functional deficits and include baselines/timeframes ○ The recommended treatment modalities ○ The recommended frequency/duration of therapy ○ Mode and location of service delivery for the previous authorization period and the planned mode and location of service delivery for the upcoming authorization period (Examples: telehealth, in-person, clinic, home) ○ Barriers to progress and changes that can be made to improve the response to treatment ○ The number of missed visits and scheduled visits during the prior authorization period, any reasons for missed visits, and any planned modifications to increase attendance if it was low ○ Documentation of parent or primary caregiver participation in therapy sessions ○ Documentation of the home program that has been established and a description of the caregiver's compliance with the plan

	○ **Telehealth:** documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on previous success with telehealth visits, patient compliance, family involvement, and the proposed plan of care ○ Signature of the licensed occupational therapist and date
Physical Therapy Requests	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) **<u>Initial Physical Therapy Evaluations & Re-Evaluations:</u>** • **Initial evaluations:** A recent clinical note from a physician/appropriate specialist that documents specific functional deficits, diagnosis, and referral to physical therapy (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals) • **Re-Evaluations: If less than 6 months since the previous evaluation/re-evaluation:** A recent/updated clinical note from a physician/appropriate specialist documenting the change in medical status that makes additional formal testing medically necessary (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals) • **Re-Evaluations: If more than 6 months since the previous evaluation/re-evaluation or the member is new to DHP:** A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to physical therapy (note should be less than twelve (12) months old for developmental delay and less than one month (1) old for orthopedic referrals) • A developmental screen that documents deficits (screen should be less than three (3) months old) • Date of the most recent evaluation/re-evaluation and/or therapy visit (if applicable) • Length of time of reported symptoms, medical management of the condition attempted prior to physical therapy referral, and the member's response to the treatment (Examples: rest period, change of exercise routine, heat/cold, anti-inflammatory/Analgesics, massage) • The history of previous referrals for physical therapy and copies of any prior evaluations, re-evaluations, and progress summaries • Clinical notes from an appropriate specialist (Examples: Neurology, Orthopedics, Developmental Pediatrician, Sports Medicine) that document the specific functional deficits, diagnosis, and need for physical therapy • Any radiology/imaging reports related to the current physical therapy referral • Clarification to prevent duplication of services (between therapy disciplines or between different therapy providers) • Appropriate evaluation codes & modifiers • **Referrals to an out-of-network therapy provider**: An explanation of the medical necessity or reason for referral to an out-of-network provider

	• **Telehealth:** documentation from the referring physician/appropriate specialist of the medical need for the services to be provided via telehealth and reasons why an in-person evaluation/re-evaluation is not possible/desirable
	
	<u>Physical Therapy Treatment:</u>
	• A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to physical therapy (note should be less than twelve (12) months old for developmental delay, less than one month (1) old for orthopedic referrals and less than three (3) months old if medical necessity is not clear based on the therapy clinical notes)
	• **If new to Driscoll Health Plan:** The history of previous referrals for physical therapy, date of the most recent therapy visit (if applicable), and copies of any prior evaluations, re-evaluations, and progress summaries
	• Clinical notes from an appropriate specialist (Examples: Neurology, Orthopedics, Developmental Pediatrician, Sports Medicine) that document the specific functional deficits, diagnosis, and need for physical therapy
	• Any radiology/imaging reports related to the current physical therapy referral
	• Clarification to prevent duplication of services (between therapy disciplines or between different therapy providers)
	• Appropriate evaluation codes & modifiers
	• **Referrals to an out-of-network therapy provider**: An explanation of the medical necessity or reason for referral to an out-of-network provider
	• **For initial requests for visits:** A physical therapy evaluation and plan of care that includes:
	  ○ Member's medical history and history of any prior physical therapy treatment
	  ○ Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements)
	  ○ A description of specific functional skills and deficits observed during completion of Activities of Daily Living (ADLs)
	  ○ A clear diagnosis and reasonable prognosis
	  ○ The prescribed treatment modalities
	  ○ Recommended frequency/duration of therapy
	  ○ Mode and location of service delivery (Examples: telehealth, in-person, clinic, home)
	  ○ Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes
	  ○ Responsible adult's expected involvement in the member's treatment
	  ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement, and the proposed plan of care
	  ○ Signature of the evaluating physical therapist and date

	• **Subsequent requests for ongoing physical therapy treatment:** A therapy progress summary, re-evaluation, or treatment notes along with other documents that communicate all of the following information:
	  ○ An objective demonstration of progress toward the treatment goals from the most recent authorization period (baseline objective measure from the beginning of the authorization period, the current level by the same objective measure and corresponding dates that data was collected)
	  ○ Results of any standardized/formal testing completed since the beginning of the previous authorization period (updated standardized testing is required once every six (6) months)
	  ○ A description of improvements in function observed during completion of Activities of Daily Living (ADLs) over the previous authorization period
	  ○ A description of the continuing functional deficits and need for additional physical therapy services
	  ○ Updated short and long-term treatment goals which are functional, appropriately attainable, measurable, and specific to the member's functional deficits and include baselines/timeframes
	  ○ The recommended treatment modalities
	  ○ The recommended frequency/duration of therapy
	  ○ Mode and location of service delivery for the previous authorization period and the planned mode and location of service delivery for the upcoming authorization period (Examples: telehealth, in-person, clinic, home)
	  ○ Barriers to progress and changes that can be made to improve the response to treatment
	  ○ The number of missed visits and scheduled visits during the prior authorization period, any reasons for missed visits, and any planned modifications to increase attendance if it was low
	  ○ Documentation of parent or primary caregiver participation in therapy sessions
	  ○ Documentation of the home program that has been established and a description of the caregiver's compliance with the plan
	  ○ **Telehealth:** documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on previous success with telehealth visits, patient compliance, family involvement, and the proposed plan of care
	  ○ Signature of the licensed physical therapist and date

Therapy Reviews of Orthotics/Bracing/Prosthetics Requests	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) • Proper forms (Examples: Texas Standard Prior Authorization Request Form for Health Care Services (TARF), Title XIX, Justification, Comprehensive Care Program Prior Authorization Form (CCP), police/fire/insurance report of loss) using modifiers and codes as appropriate

	• A recent clinical note from a physician/appropriate specialist (Examples: Neurology, Orthopedics, Sports Medicine) that documents the specific functional deficits, diagnosis, and need for the requested orthotic/brace/prosthetic (note should be less than three (3) months old) • Any radiology/imaging reports related to the current physical therapy referral • Orthotist, physical therapist occupational therapist clinical notes on functional status, clinical trials of equipment, and justification for equipment and accessories • Description of any underlying medical conditions, the resulting pain/impairment, prior medical management of the condition attempted prior to referral for brace/orthotic/prosthetic, and the outcome of that treatment (Examples: over-the-counter devices, stretching programs, supportive shoes) • Clear description and justification of item(s)/accessories being requested • Documentation of medical necessity that includes a description of the member's function with and without the orthotic/brace/prosthetic being requested • **For prosthetics:** Current functional level (K level 0-4) on the Medicare Functional Classification Levels scale • History and status of any previously used/trialed orthosis/brace/prosthetic and outcome of its use for custom and off-the-shelf items; including medical necessity for duplication of item(s) • Description of surgery and or injury including dates that relate to the referral • Description of the least supportive device that will meet this member's needs • Description of setting this item(s) will be used • Documentation of patient's/family's willingness to comply with requested item(s) / plan of care
Therapy Reviews of Durable Medical Equipment Requests	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) • Proper forms (Examples: Texas Standard Prior Authorization Request Form for Health Care Services (TARF), Title XIX, Justification, CCP, Seating assessment, Installer's Certificate for car seat, police/fire/insurance report of loss, home diagram) using modifiers and codes as appropriate • A recent clinical note from a physician/appropriate specialist (Examples: Neurology, Orthopedics, Sports Medicine) that documents the specific functional deficits, diagnosis, and need for the requested piece of equipment (note should be less than three (3) months old) • Member age, height, weight, and diagnoses impacting mobility-related activities of daily living, diagnoses affecting instrumental activities of daily living, current functional skill sets with and without equipment • Physical therapist or occupational therapist clinical notes on functional status, clinical trials of equipment, and justification for equipment and accessories • Durable medical supplier history of equipment purchases, quote/description/justification in detail for current equipment request, growth potential of requested equipment, home accessibility/equipment compatibility, justification for repairs/ modifications, state of the equipment

	• Description of whether item(s) is for purchase or rental and duration of need • Description of medical necessity for all accessory components and modifiers • Description of skin integrity, sensation, and pain perception including how it is impacted by current and requested equipment
Speech Therapy Requests	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) **Initial Speech Therapy Evaluations & Re-Evaluations:** • **Initial evaluations:** A recent clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to speech therapy (note should be less than three (3) months old) • **Re-Evaluations: If less than 6 months since the previous evaluation/re-evaluation:** A recent/updated clinical note from a physician/appropriate specialist documenting the change in medical status that makes additional formal testing medically necessary (note should be less than three (3) months old) • **Re-Evaluations: If more than 6 months since the previous evaluation/re-evaluation or the member is new to DHP:** A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to speech therapy (note should be less than twelve (12) months old) • A developmental screen that documents deficits (screen should be less than three (3) months old) • Date of the most recent evaluation/re-evaluation and/or therapy visit (if applicable) • The history of previous referrals for speech therapy and copies of any prior evaluations, re-evaluations, and progress summaries • Clinical notes from an appropriate specialist (Examples: Psychology, Neurology, Pulmonology, Otolaryngology, Developmental Pediatrics) that document the specific functional deficits, diagnosis, and need for speech therapy • Hearing testing: ○ **Initial evaluations:** Recent documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), or a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech. No delay should occur in the authorization of the initial speech evaluation due to lack of objective hearing testing, with the expectation that completion of objective hearing testing is within a concurrent timeline with the evaluation. (note should be less than twelve (12) months old) ○ **Re-Evaluations:** Recent documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), or a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech, or the date of any future appointment for hearing testing. (note should be less than twelve (12) months old)

	○ **If the member has a diagnosed hearing loss or failed a hearing screening:** A recent clinical note from an Ear, Nose, Throat specialist and/or Audiologist documenting an examination, treatment plan and/or outcome of a hearing aid/cochlear implant follow up visit for aided hearing testing and to determine if devices are working properly. (note should be less than three (3) months old) • Clarification to prevent duplication of services (between therapy disciplines or between different therapy providers) • Appropriate evaluation codes & modifiers • **Feeding/swallowing evaluations**: Growth charts and/or the results of any instrumental evaluations of swallowing that have been completed • **Referrals to an out-of-network therapy provider**: An explanation of the medical necessity for or reason for referral to an out-of-network provider • **Telehealth:** Documentation from the referring physician/appropriate specialist of the medical need for the services to be provided via telehealth and reasons why an in-person evaluation/re-evaluation is not possible/desirable **<u>Speech Therapy Treatment:</u>** • A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis, and referral to speech therapy (note should be less than three (3) months old if medical necessity is not clear based on the therapy clinical notes and less than twelve (12) months old for continuation of care ongoing therapy requests) • **If new to Driscoll Health Plan:** The history of previous referrals for speech therapy, date of the most recent therapy visit (if applicable), and copies of any prior evaluations, re-evaluations, and progress summaries • Clinical notes from an appropriate specialist (Examples: Psychology, Neurology, Pulmonology, Otolaryngology, Developmental Pediatrician) that document the specific functional deficits, diagnosis, and need for speech therapy • Clarification to prevent duplication of services (between therapy disciplines or between different therapy providers) • Hearing testing: ○ **If hearing testing has not yet been submitted to DHP or has a medical diagnosis that is prone to hearing loss:** Documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech, or the date of any future appointment for hearing testing. (note should be less than twelve (12) months old) ○ **If the member has a diagnosed hearing loss or failed a hearing screening:** A recent clinical note from an Ear, Nose, Throat specialist and/or Audiologist documenting an examination, treatment plan and/or outcome of a hearing aid/cochlear implant follow up visit for aided hearing testing and to determine if devices are working properly. (note should be less than three (3) months old)

	• **Feeding/swallowing therapy visits**: Growth charts and/or the results of any instrumental evaluations of swallowing that have been completed
	• Appropriate therapy codes & modifiers
	• **Referrals to an out-of-network therapy provider**: An explanation of the medical necessity or reason for referral to an out-of-network provider
	• **For initial requests for visits:** A speech therapy evaluation and Plan of Care that includes:
	  ○ Member's medical history and history of any prior therapy treatment
	  ○ **Bilingual:** The language exposure in the home, educational setting, and community. Language used for formal testing, the amount of translation required if a bilingual assessment was used, and planned language for therapy; if exposed to multiple languages, testing in both languages or use of a bilingual test (Example: Preschool Language Scale -5 Spanish) is required
	  ○ **For Speech/Language/Stuttering:** Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements)
	  ○ **For Speech/Language/Stuttering:** A description of specific functional communication skills and deficits observed during completion of Activities of Daily Living (ADLs)
	  ○ **For Feeding/Swallowing:** A detailed description of the level of feeding/swallowing proficiency and deficits related to feeding/swallowing observed
	  ○ A clear diagnosis and reasonable prognosis
	  ○ The recommended treatment modalities
	  ○ The recommended frequency/duration of therapy
	  ○ Mode and location of service delivery (Examples: telehealth, in-person, clinic, home)
	  ○ Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes
	  ○ Responsible adult's expected involvement in the member's treatment
	  ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement, and the proposed plan of care
	  ○ Signature of the evaluating speech pathologist and date
	• **Subsequent requests for ongoing speech therapy treatment:** A therapy progress summary, re-evaluation or treatment notes along with other documents that communicate all of the following information:
	  ○ An objective demonstration of progress toward the treatment goals from the most recent authorization period (baseline objective measure, from the beginning of the authorization period, the current level by the same objective measure and corresponding dates that data was collected)
	  ○ Results of any standardized/formal testing completed since the beginning of the previous authorization period (updated standardized testing is required once every six (6) months)
	  ○ **For Speech/Language/Stuttering:** A description of improvements in functional communication observed during completion of Activities of Daily Living (ADLs) over the previous authorization period

	○ **For Feeding/Swallowing:** A description of improvements in functional feeding/swallowing skills observed over the previous authorization period ○ A description of the continuing functional deficits and need for additional speech therapy services ○ Updated short and long-term treatment goals that are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes ○ The recommended treatment modalities ○ The recommended frequency/duration of therapy ○ Mode and location of service delivery for the previous authorization period and the planned mode and location of service delivery for the upcoming authorization period (Examples: telehealth, in-person, clinic, home) ○ Barriers to progress and changes that can be made to improve the response to treatment ○ The number of missed visits and scheduled visits during the prior authorization period, any reasons for missed visits, and any planned modifications to increase attendance if it was low ○ Documentation of parent or primary caregiver participation in therapy sessions ○ Documentation of the home program that has been established and a description of the caregiver's compliance with the plan ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on previous success with telehealth visits, patient compliance, family involvement, and the proposed plan of care ○ Signature of the licensed speech pathologist and date
Therapy Reviews of Augmentative Communication Device Requests	Information and documents should relate to the current request for services. In addition to the applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) • Proper forms (Examples: Texas Standard Prior Authorization Request Form for Health Care Services (TARF), Title XIX, police/fire/insurance report of loss) using modifiers and codes as appropriate • A recent clinical note from a physician/appropriate specialist that documents the specific functional deficits and diagnosis (note should be less than three (3) months old) • Description of any underlying medical conditions and prognosis for the development of verbal speech • Description of whether the item(s) is for rental or purchase (initial or replacement) • History of any previous augmentative communication devices (ACDs) purchased, date of previous purchase, type of device previously purchased, why a new device is needed • Hearing testing: ○ **If hearing testing has not yet been submitted to DHP or has a medical diagnosis that is prone to hearing loss:** Documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), a clinical note from an Ear,

	Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech (note should be less than twelve (12) months old) ○ **If the member has a diagnosed hearing loss or failed a hearing screening:** A recent clinical note from an Ear, Nose, Throat specialist and/or Audiologist documenting an examination, treatment plan and/or outcome of a hearing aid/cochlear implant follow up visit for aided hearing testing and to determine if devices are working properly. (note should be less than three (3) months old) • An assistive/augmentative communication evaluation performed by a licensed speech-language pathologist (SLP) and signed by the referring physician. If the signed evaluations is greater than one (1) year old when requesting the purchase of a device, justification for the delay should be provided. *Note: The licensed SLP completing the evaluation must not be employed by or similarly affiliated with the device manufacturer or vendor.* The evaluation must include: ○ Diagnosis and medical history that impact speech and language development ○ Complete description of the Augmentative Communicative Device (ACD) system with all accessories, components, mounting devices, or modifications necessary for client use (must include the manufacturer's name, model number, and retail price) ○ History of previous speech therapy, with a description of the response to traditional therapy approaches versus treatment focusing on augmentative communication ○ **Bilingual:** The language exposure in the home, educational setting, and community. Language used for formal testing, the amount of translation required if a bilingual assessment was used, and planned language for therapy; if exposed to multiple languages, testing in both languages, or use of a bilingual test (Example: Preschool Language Scale -5 Spanish), is required ○ Member-specific objective data and subjective information establishing the member's functional status without using the device in the following areas: ▪ Cognitive skills (including, but not limited to, attention, memory, and problem solving) ▪ Language abilities - Formal (Examples: raw scores, standard scores, criterion-referenced scores, measurements) and informal assessment, including, but not limited to identification of objects, following directions, understanding of cause and effect, sequencing, coding, symbol recognition, expressive vocabulary size, and pragmatic language skills ▪ Verbal speech/articulation skills – subjective intelligibility and results of formal speech sound testing. ▪ Sensory-perceptual skills (including, but not limited to, sensorimotor, visual acuity, hearing acuity, and tactile sensation) ▪ Literacy level ○ Prognosis for the development of functional verbal communication ○ Documentation of the member's interactional/behavioral abilities, social abilities, and motivation to communicate

	○ Member-specific documentation of the functional communications needs, encompassing anticipated expressive language capacity and specifying his/her level of vocabulary requirements (core vs. fringe vocabulary needs) ○ The rationale for the selection of the requested device and each accessory, to include objective documentation regarding any other devices that were considered and ruled out, with evidence of the insufficiency of the non-selected devices ○ The ACD is a dedicated device that is adequate, and the least expensive alternative to enable the member to meet daily functional communication needs ○ Member-specific documentation demonstrating the member's cognitive, physical, and behavioral capacity to use the features/vocabulary available on the requested device ○ Member-specific objective data showing the current ability to utilize the requested device for functional communication during Activities of Daily Living (ADLs). (Examples - vocabulary size, list of words/phrases, phrase length, number of visible icons, message types produced, number of hits used to find a word, and the type and amount of cuing needed) ○ Objective documentation of the outcome of the in-home device trial (greater than or equal to 90 days), including baseline ability to use the device, current ability to use the device in therapy and repeatedly and consistently within ADLs, comparison of communication using the device versus verbal alone, and description of caregiver participation outside of therapy ○ Documentation of the ability to use the device with multiple individuals in multiple settings ○ Data showing progress with goals that indicate good prognosis for continued communicative growth ○ Documentation of the caregiver training that has occurred and identification of any additional educational/training needs related to the use of the device ○ A treatment plan to include SMART (specific, measurable, attainable, realistic, and time-based) goals related to use of the device during ADL's and documenting the intervention required to meet the goals ○ Documentation of any mobility limitations that would impact the member's ability to access the features of the device and recommendations as to the most appropriate access method or methods for the member ○ Description of the anticipated changes, modifications, or upgrades with projected time frames of the ACD system necessary to meet the client's short- and long-term speech-language needs
Applied Behavior Analysis (ABA) Requests	Information and documents should relate to current request for services. In addition to applicable documents listed above: • Rendering provider name • Rendering provider National Provider Identifier (NPI) **Initial ABA Evaluation**: • A recent diagnostic evaluation. See section below titled "Diagnostic Evaluation" for details of required information

	• A recent completed Comprehensive Care Program (CCP) Prior Authorization Request Form signed and dated by a prescribing provider
	• When requesting a change in providers please also submit:
	  ○ Change of therapy provider letter signed by the responsible adult that documents the date that the client ended therapy (effective date of change) with the previous provider, or last date of service
	  ○ Documentation including the names of new and previous provider
	
	Initial Request for 90-day ABA Treatment:
	• A recent diagnostic evaluation. See section below titled "Diagnostic Evaluation" for details of required information
	• Completed ABA evaluation with the signature of the LBA and date the evaluation was completed. The ABA evaluation must include all information listed in the section below titled "ABA Evaluation"
	• Treatment plan with signature of LBA and date the treatment plan was completed. The treatment plan must include all information listed in the section below titled "ABA Treatment Plan"
	• Completed current CCP Prior Authorization Request form signed and dated by a prescribing provider, including the requested procedure codes and maximum units requested
	• Requests for initial 90-day ABA treatment submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation date will require a progress summary signed and dated by the LBA
	
	90-day Extension of Initial ABA Authorization:
	• An attendance log for child/youth, and an attendance log for parent/caregiver, that both include the percentage of scheduled sessions that were successfully completed
	• Attendance that is less than 85% of approved hours will need documentation to substantiate the need for ABA services at the previously approved level and explanation why attendance was low
	• Progress summary for child/youth and for parent/caregiver signed by LBA and parent/caregiver. Progress summary includes, but is not limited to, the following examples:
	  ○ Thorough and objective description of goal progress
	  ○ Description of functional gains
	• Current and completed CCP Prior Authorization Request form, signed and dated by a prescribing provider
	
	ABA Re-Evaluation:
	• Completed ABA evaluation with the signature of the LBA and date the evaluation was completed. The ABA evaluation must include all information listed in the section below titled "ABA Evaluation"

	• Updated documentation of modifications to the child/youths treatment plan and protocol with signature of LBA and date the treatment plan was completed. Treatment plan is to include all information listed in the section below titled "ABA Treatment Plan"
	• Documentation attesting that the family/ caregiver has agreed to the treatment plan, including:
	  ○ Frequency of services
	  ○ Location of all services
	  ○ Treatment plan goals
	  ○ Provider has access to sufficient staff to deliver the treatment plan frequency in all locations
	• Code 97151 should be listed on the CCP Prior Authorization Request form with date span to include dates the evaluation was performed
	
	ABA 180 Day Recertification:
	• A recent comprehensive diagnostic evaluation. See section below titled "Diagnostic Evaluation" for details of required information
	• An attendance log for child/youth and for parent/caregiver that includes the percentage of scheduled sessions successfully completed
	• Attendance that is less than 85% of approved hours will need documentation to substantiate the need for ABA services at the previously approved level and explanation why attendance was low
	• Progress summary for child/youth and for parent/caregiver signed by LBA and parent/caregiver. Progress summary includes, but is not limited to, the following examples:
	  ○ Thorough and objective description of goal progress
	  ○ Description of functional gains
	• Completed current ABA evaluation with the signature of Licensed Behavior Analyst (LBA) and date the evaluation was with all information listed in the section below titled "ABA Evaluation"
	• Updated documentation of modifications to the child/youth's treatment plan and treatment protocol, with signature of LBA and date the treatment plan was completed with all information listed below in the section titled "ABA Treatment Plan"
	• CCP Prior Authorization Request Form, signed and dated by a prescribing provider, including the requested procedure codes and maximum number of units
	• Requests submitted 60 days after the completed ABA evaluation date within 180 days after evaluation, will require a review of current progress summary signed and dated by the LBA
	• A new re-evaluation must be completed when the request is submitted more than 180 days after the re-evaluation date

- When a gap in services is identified the provider must submit a request as an initial request and documentation related with an initial request is required
- When conducting Interdisciplinary Team Meetings and requesting additional team meetings the following should be included:
    - Documentation of the start and stop time of the meeting (30-minute minimum)
    - Documentation of the date of the most recent evaluation or re-evaluation
    - Documentation of the names, disciplines, and organization affiliation of the other attendees.
    - A brief narrative of reports to parents/guardian of the child/youth with ASD
    - A summary of the decisions made
    - Documentation of any action items
    - A signature of the provider with the date

Diagnostic Evaluation Should Include:

- A Recent comprehensive diagnostic evaluation from a developmental pediatrician, neurologist, psychiatrist, licensed psychologist, or, an interdisciplinary team composed of a physician, physician assistant, or nurse practitioner, in consultation with one or more providers who are qualified as specialists and who have expertise in autism, limited to any previously mentioned provider, licensed clinical social worker, licensed professional counselor, licensed psychological associate, licensed specialist in school psychology, occupational therapist, or speech-language pathologist. The report must include:
    - Symptom severity level as per the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM),
    - Validated diagnostic assessment tool
    - Age of child/youth
    - Date of initial autism diagnosis
    - Documentation of any known co-morbid behavioral or physical health disorders
    - Documentation of trauma history
    - Comprehensive diagnostic report no more than 3 years' old

ABA Evaluation Should Include:

- Completed ABA evaluation that was conducted within 60 days prior to start of care date on the Comprehensive Care Program (CCP) Prior Authorization Request Form, with the signature of Licensed Behavior Analyst (LBA) and date the evaluation was completed. The evaluation must include:
    - A complete developmental history that includes relevant comorbidities including trauma history

	○ Vision and hearing audiologic screening or if age and clinically appropriate a passing Texas Health Steps (Results of further evaluation may be required if those screenings indicate deficits) ○ One on one observation of the child/youth including at least one natural setting ○ Documentation of interviews with parents/caregivers to include family history, primary language of family and child, identification of skills and behaviors to be addressed in treatment as well as barriers to treatment ○ Documentation of ABA history including gaps in services and how long the child/youth has been receiving ABA services, and information on responses to previous interventions if applicable ○ Prognosis based on evidence from the evaluation regarding the individual's capacity to make behavioral gains ○ A validated assessment of cognitive abilities and adaptive behaviors ○ A functional behavior assessment (FBA) related to specific behaviors of concern to be addressed in a Behavior Support Plan (BSP) as clinically indicated **ABA Treatment Plan Should Include:** • Treatment plan with signature of LBA and date the treatment plan was completed. The treatment plan must include: ○ Identification of specific treatment goals, targeted behaviors and/or skills related to the core symptoms of ASD, health, safety, or independence of the child/youth that will be addressed in treatment ○ Documentation that all goals and protocols were selected by the LBA and parents/caregivers ○ Documentation of functional goals that are specific to the child/youth, objectively measurable within a specified time frame, attainable, and socially significant to family and child/youth ○ Baseline data for all behaviors and skills identified across settings where treatment will occur ○ A BSP, that includes an operational behavioral definition of the target behavior excess, prevention and intervention strategies, schedules of reinforcement and functional alternative responses ○ Documentation of the planned frequency and duration of treatment across all settings to reflect the severity of the impairments, goals of treatment, expected response to treatment, and specific individual variables (including availability of appropriately trained and certified ABA staff) that may affect the recommended treatment dosage ○ Measurable parent/caregiver goals that pertain to learning the principles of ABA in home and community ○ Planned frequency and duration of parent/caregiver training ○ The formal design of the treatment protocol instructions to the supervised Licensed Assistant Behavior Analyst (LABA) and to the Behavior Technicians (BT) ○ A plan for maintenance and generalization of skills ○ Clearly defined, measurable, realistic discharge criteria and a transition plan across all treatment environments

	○ Clear plan to coordinate care with providers and with school services ○ Documentation the LBA has collaborated with the appropriate provider or licensed professional for elements of the treatment plan that are not within the LBA scope of practice or for any co-occurring conditions ○ Date of initial ABA evaluation ○ Date and time treatment plan was completed ○ Name of referring prescriber ○ Signature of LBA and parent/ caregiver with the date • Documentation attesting that the family/ caregiver/ responsible adult has agreed to the treatment plan, including: ○ The frequency of services ○ All places where service will occur ○ Treatment goals ○ Provider has access to sufficient staff to deliver the treatment plan ○ (Group treatment) Documentation with clearly defined measurable goals for the group therapy that are specific to the individual and their targeted behaviors
Private Duty Nursing (PDN) Requests	Information and documents should relate to the current request for services. In addition to any applicable documents listed above, the following is the minimal required documentation for PDN: • Rendering provider name • Rendering provider National Provider Identifier (NPI) **Initial:** • Signed Comprehensive Care Program (CCP) • Current (within last three (3) months) and signed Plan of Care (POC), Nursing Addendum to POC, and 24-hour schedule • Primary Care Physician (PCP) and/or Subspecialist notes (within last six (6) months) describing the members condition, treatment and continuous nurse need to support medical necessity for PDN services. • Ventilator and seizure logs • Clinical records from acute care facilities with discharge order for PDN **Renewal:** • All of the above documentation • At least two (2) weeks of nursing notes and allocator of services **Change in Requested Services:** • All of above documentation

	• Current (within last three (3) months) PCP and/or Subspecialist clinical notes documenting the continued need or reason for change in PDN services
Prescribed Pediatric Extended Care Centers (PPECC) Requests	Information and documents should relate to the current request for services. In addition to any applicable documents listed above, the following is the minimal required documentation for PPECC: • Rendering provider name • Rendering provider National Provider Identifier (NPI) **Initial:** • Signed CCP Authorization Request Form • Current (within last three (3) months) and signed Plan of Care (POC), Nursing Addendum to POC, and 24-hour schedule • Signed consent to participate in PPECC from Member/LAR • PCP and/or Subspecialist notes (within last six (6) months) describing the members condition, treatment and continuous nurse need to support medical necessity for PDN services • Ventilator, suction, and seizure logs • Clinical records from acute care facilities with discharge orders for PDN **Renewal:** • All of the above documentation • At least two (2) weeks of nursing notes and allocator of services **Change in Requested Services:** • All of above documentation • Current (within last three (3) months) PCP and/or Subspecialist clinical notes documenting the continued need or reason for change in PPECC services. **Effective Sept. 1, 2024, PPECC Transportation:** PPECC providers must provide transportation with: 1. Documentation from the PCP that the member is stable to receive PPECC transportation service, 2. If deemed stable, the PCP must indicate whether a nurse or direct-care staff member must accompany the member on the PPECC transport vehicle to and from the PPECC, and 3. Documentation the member's parent or LAR wants the member to receive PPECC transportation services.

Personal Care Services (PCS) Requests	Information and documents should relate to the current request for services. In addition to any applicable documents listed above, the following is the minimal required documentation for PCS: • Rendering provider name • Rendering provider National Provider Identifier (NPI) • PCS services are at the request of the Member/Legally Authorized Representative (LAR) • Members/ LARs can contact their Service Coordinator for evaluation and review of functional necessity for PCS • Driscoll Health Plan (DHP) will require a Physician Statement of Need (PSON) signed by the Members PCP after the Service Coordinator has performed an assessment indicating the need for PCS services. • Physician can contact DHP Service Coordination at toll-free at 1-844-508-4673

Community First Choice (CFC) Services Requests	Information and documents should relate to the current request for services.
	• Rendering provider name
	• Rendering provider National Provider Identifier (NPI)
	• Members/LARs can contact their Service Coordinator for review and referral for evaluation of Community First Choice Services
	• CFC Services include:
	  ○ Personal Attendant Services (PAS)
	  ○ Habilitation (HAB)
	  ○ Emergency Response System (ERS)
	• CFC institutional level of care is established by either the:
	  ○ Local Intellectual Developmental Disability Authority (LIDDA)
	  ○ Local Mental Health Authority (LMHA)
	  ○ TMHP
	• Physician can contact DHP Service Coordination at toll-free at 1-844-508-4673

Day Activity and Health Service (DAHS) Requests	Information and documents should relate to the current request for services. • Rendering provider name • Rendering provider National Provider Identifier (NPI) • Members/ LARs can contact their Service Coordinator for evaluation and review of DAHS services • The potential for therapeutic benefit must be established by a physician's assessment and requires a physician's order submitted to DHP Service Coordination • A Day Activity and Health Services (DAHS) facility nurse must complete a health assessment for each STAR Kids member at the facility or the member's home

Long Term Support Services (LTSS) Requests	Information and documents should relate to the current request for services.
	• Rendering provider name
	• Rendering provider National Provider Identifier (NPI)
	• LTSS Services are for STAR Kids member on MCDP Waiver
	• LTSS Services include:
	  ○ Respite
	  ○ Flexible Family Support Services (FFS)
	  ○ Financial Management Services (FMSA)
	  ○ Minor Home Modifications (MHM)
	  ○ Transition Assistance Services (TAS)
	  ○ Employment Services (EA)
	  ○ Adaptive Aids (AA)/ Vehicle Modification (VM)
	• Member/LAR can send request to Service Coordination – Service coordinator will perform an assessment for need
	• Provider requesting Member evaluation for LTSS Service can submit their request to Population Health Medical Complex team at: Phone 1-844-376-5437 or Fax 1-844-381-5437