THERAPY GUIDE

Revised: 07/07/2025

As part of our ongoing mission to ensure better health outcomes for our members, Driscoll Health Plan (DHP) has made improvements to the existing medical necessity criteria for therapy services. We value your participation in our network of therapy providers and understand that by clearly communicating our policies and criteria, we can help to ensure that therapists and therapy agencies are able to maintain their focus on providing quality treatment services to our Members.

Member referral should originate at a Texas Health Steps Exam, Well Child Exam, or other visit with the Primary Care Physician (PCP)/ or appropriate Specialist (Examples: Ear Nose and Throat Specialist, Developmental Pediatrician, Sports Medicine Specialist, Pulmonologist, Gastroenterologist, Cranio-facial Specialist, Neurologist, Hematologist/Oncologist, Orthopedic Physician or Rehabilitation Physician) at which time the provider documents deficits and the need for therapy referral.

To avoid unnecessary denials, the prescribing provider must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The prescribing provider must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

For all requests for therapy prior authorization:

- Faxed requests for prior authorization submitted by the referring provider must be accompanied by the appropriate clinical notes and a current Texas Department of Insurance *Texas Standard Prior Authorization Request Form for Health Care Services* (TARF) signed by the referring/ordering physician or physician-delegated mid-level provider working in the practice. If the prior authorization request is submitted by the referring physician via the DHP provider portal, appropriate clinical notes are needed, but a TARF is not required.
- If the prior authorization request is submitted by the therapy provider, the request must be accompanied by the appropriate clinical notes and either:
    - A current Texas Department of Insurance *Texas Standard Prior Authorization Request Form for Health Care Services* (TARF) signed by the referring/ordering physician or physician delegated mid-level provider working in the practice;
      OR
    - An order or plan of care signed by the referring/ordering physician or physician delegated mid-level provider working in the practice and the *Therapy Referral Review by Ordering Physician Attestation Form.* This document is available on the DHP Provider Portal and is to be completed and signed by the therapy provider.

Requests for prior authorization of therapy services can be made via the DHP Provider Web Auth Portal at www.driscollhealthplan.com or via fax at:

STAR, STAR Kids, and CHIP Utilization Management Fax
1-866-741-5650

The guidelines below are provided for your assistance in requesting prior authorization for therapy services.

Driscoll Health Plan will honor the Start of Care (SOC) date when the Provider requesting the services submits the prior authorization request in a timely manner within five (5) business days of the Start of Care date, with complete clinical information and/or documents to support medical necessity and Driscoll Health Plan has determined the requested services meet medical necessity from the Start of Care date. The start date of the prior authorization request will default to the received date if submission of the referral is more than 5 business days after the Start of Care date.

For Initial Evaluation Requests: Initial evaluations with in-network therapy providers do not require prior authorization. All requests for initial evaluations referred to out-of-network therapy providers require prior authorization and should be submitted to DHP by the referring provider. The requests should include documentation from the referring provider showing the medical necessity for an out-of-network referral.

For Re-evaluation Requests: A re-evaluation is a comprehensive, formal evaluation and must take place every 180 days. The first two (2) re-evaluations with in-network providers occurring within a rolling 12-month period do not require prior authorization. If prior authorization is required, requests for re-evaluations can be submitted by either the referring provider or the therapy provider.

- Additional re-evaluations completed within the same 12-month period or re-evaluations with out-of-network therapy providers require prior authorization. When requesting prior authorization for re-evaluations, an order or TARF signed by the referring provider must be submitted along with the date of the most recent evaluation/re-evaluation and documentation of the medical reason for additional formal testing.
- Requests for re-evaluation that exceed the limit of two (2) per rolling 12 months should be faxed to DHP. The fax cover sheet should indicate that two (2) re-evaluations have already been completed and medical review for prior authorization is needed.
- When prior authorization is required, requests for re-evaluation should be submitted no more than 60 days prior to the expiration of the existing treatment authorization. Requests for continuation of therapy treatment require documentation of progress and the continuing need for therapy services which cannot be determined until closer to the expiration of the existing therapy treatment authorization. Requests submitted more frequently will be reviewed on a case-by-case basis.
- If the member has received an evaluation/re-evaluation within the past six months, a new evaluation or re-evaluation is not required by DHP. Requests for therapy treatment may be submitted with a previous evaluation that is less than six months old.

For Treatment Requests: All requests for therapy visits require prior authorization. Requests for therapy visits can be submitted by either the referring provider or the therapy provider. When submitted by the therapy provider, the referring PCP/ appropriate Specialist must have a copy of the recent therapy evaluation/re-evaluation/progress summary and plan of care on file for the member. A maximum of six months of therapy visits may be authorized. Requests should be submitted along with:

- A therapy evaluation/re-evaluation and Plan of Care which include:
    - A brief statement of the member's medical history and any prior therapy treatment;
    - A description of the member's current level of function or impairment, including results from the most recent formal testing (raw scores, standard scores, and/or criterion-

referenced scores as appropriate for the member's condition or impairment) as well as a description of the current functional impairments observed during the completion of Activities of Daily Living (ADLs);
    - A clear diagnosis and reasonable prognosis;
    - Documentation of the prescribed treatment modalities, their recommended frequency and duration, and the planned place of service/platform;
    - **For Telehealth -** Documentation of how telehealth will be incorporated into the overall therapy plan and that it is appropriate based on patient compliance, family involvement, and the proposed plan of care;
    - Short and long-term treatment goals that are functional, measurable, and specific to the member's deficits as determined by the therapy evaluation; and
    - Signature of a licensed therapist.
- Clinical documentation for reauthorization must also include:
    - Objective demonstration of the members' progress toward previous treatment goals;
    - Description of improvements in communication/fine motor skills/self-care/gross motor skills observed by the family or therapist during the completion of ADLs;
    - Updated short and long-term treatment goals that are functional, measurable, and specific to the members' deficits;
    - An explanation of any changes to the members' plan of care, and the clinical rationale for revising the plan;
    - Attendance during the prior authorization period;
    - Documentation of parent or primary caregiver participation in therapy sessions; and,
    - Documentation of transition to a home program and parent/primary caregiver compliance with the plan.
- If the request is for **reauthorization of ongoing treatment**, new standardized testing is required once every six months. If the previous testing is less than 6 months old, medical necessity determination will be based on any progress toward therapy goals, improvements in function during ADLs, and if there are continuing functional deficits.
- Therapy attendance of less than 75% or other documentation of poor compliance may result in a reduction in therapy frequency or denial of the request.
- OT requests should include documentation about the delays and deficits in fine motor and self-care skills that impact the completion of ADLs and how they were identified. Medical necessity will be determined based on deficits in performing ADLs, functional goals, and medical need demonstrated throughout the evaluation.
- Requests for continuation of therapy treatment should be submitted no more than 30 days prior to the expiration of the existing treatment authorization; Requests for continuation of therapy treatment require documentation of progress and the continuing need for therapy services which cannot be determined until near the expiration of the existing therapy treatment authorization. Requests submitted more frequently will be reviewed on a case-by-case basis.
- Please refer to the Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook for developmental delay criteria, guidelines for bilingual therapy, frequency and duration criteria, criteria for discontinuation, and non-covered services.

Confirmation of Normal Hearing: Hearing loss can cause delays in speech and language development and slow response to speech therapy intervention. Members should have their hearing screened at the PCP's office during their Texas Health Steps exam per the periodicity schedule. Referral for formal hearing testing with a specialist or formal hearing testing at the PCP's office is recommended if progress in speech therapy is slow, and normal hearing ability has not been confirmed by previous formal audiometric testing.

Telehealth: The use of telehealth to provide therapy services should be related to the member's medical condition, based on best practice for the treatment of the member's specific deficits/diagnosis, and not primarily for the convenience of the member or provider. If it is not clear that Telehealth services are appropriate, the requesting PCP/ appropriate Specialist may be asked to submit documentation of the medical need for telehealth and reasons why face-to-face services are not possible/desirable. Evaluations and re-evaluations should preferentially be done face-to-face unless the member is unable to physically access specialized services or the referring physician/specialist deems it medically necessary that the services be performed via telehealth. Refer to the *DHP Telehealth Guideline* for specific criteria related to telehealth therapy.

Questions can be directed to DHP at:
STAR, STAR Kids, or CHIP Utilization Management: 1-877-455-1053

REFERENCES:

1. Texas Medicaid & Healthcare Partnership (TMHP). Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook. *Texas Medicaid Provider Procedures Manual, Volume 2, Section 4, Section 5 and Section 6*.
2. Texas Medicaid & Healthcare Partnership (TMHP). Telecommunication Services Handbook. *Texas Medicaid Provider Procedures Manual, Volume 2, Section 3.3 and Section 3.5*.
3. Texas Health and Human Services Commission. *Chapter 3.22, Incomplete Prior Authorizations, Version 2.3.* In Texas Medicaid and CHIP - Uniform Managed Care Manual.
4. Bower C, Reilly BK, Richardson J, Hecht JL. Committee on Practice & Ambulatory Medicine, Section on Otolaryngology–Head and Neck Surgery. Hearing Assessment in Infants, Children, and Adolescents: Recommendations Beyond Neonatal Screening. *Pediatrics.* 2023;152(3):1-13.