THERAPY GUIDE **Revised: 6/25/2020**

As part of our ongoing mission to ensure better health outcomes for our members, Driscoll Health Plan is making 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 membership.

Requests for initial evaluations and re-evaluations must originate directly from the PCP (or a specialist, neurologist, orthopedic physician or rehabilitation physician) by fax, phone or web. Requests will not be accepted from mid-level providers unless they have been classified as a primary care physician by DHP. Requests for initial evaluations and re-evaluations originating from therapy providers will be returned as "incomplete".

Requests for therapy visits may be submitted directly by the therapy providers. The referring PCP/approved Specialist must have a copy of the recent therapy evaluation/re-evaluation/progress summary and plan of care on file for the member.

- If submitted by the therapy provider via the DHP Provider Portal, the request must be accompanied by the appropriate clinical notes and either:
  - *Texas Standard Prior Authorization Request Form for Health Care Services (TARF)* signed by the referring/ordering physician OR,
  - An order signed by the referring/ordering physician and the *Therapy Referral Review by Ordering Physician Attestation Form.* This document is available on the DHP Provider Portal and is completed and signed by the therapy provider.
- If submitted by the therapy provider via fax, the request must be accompanied by a TARF signed by the referring/ordering physician.

All requests for evaluations, re-evaluations, and therapy will be reviewed for medical necessity.

Requests for prior authorization of therapy services can be made by web at www.driscollhealthplan.com or by 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.

As we are unable to provide authorization for retroactive dates of service, please ensure that prior authorization requests are submitted no later than the day the requested service is to begin. Optimally, we recommend submitting requests five business days prior to the desired start date in order to allow time for processing.

For Initial Evaluation Requests: An evaluation order specifying the discipline(s) to be evaluated and signed by the PCP (or a neurologist, orthopedic physician or rehabilitation physician) must be submitted ***directly*** by the referring provider along with:

- A copy of the visit note and/or the current THSteps Exam / Well Child Exam and developmental screening (as determined by the periodicity schedule) that identified a need for evaluation.

- For speech therapy evaluation requests for articulation, language, and stuttering, documentation of normal hearing in one ear by an objective method (Pure-tone, Otoacoustic Emissions Test, or Auditory Brainstem Response) will be requested from the referring provider. Authorization of the initial speech evaluation will not be delayed due to a lack of objective hearing testing at the time of the request. The expectation is that objective hearing testing will be completed within concurrent timeline of the evaluation[1].

For Re-evaluation Requests: An evaluation order specifying the discipline(s) to be evaluated and signed by the PCP (or a neurologist, orthopedic physician or rehabilitation physician) must be submitted ***directly*** by the referring provider along with:

- A copy of the visit note and / or the current THSteps Exam / Well Child Exam and developmental screening (as determined by the periodicity schedule) that documents the continued need for therapy services.
- Requests for re-evaluation should be submitted no more than 60 days prior to the expiration of the existing treatment authorization; requests submitted more frequently will be reviewed on a case-by case basis.
- If the member has received an 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. Evaluations are limited to once every 180 rolling days. Re-evaluations ***may be*** reimbursed when documentation supports a change in the client's status, a request for extension of services, or a change of provider.
- In cases where a member receiving therapy services transitions to coverage by DHP, the first request for re-evaluation must be submitted with a copy of all information required from the PCP for initial evaluation requests, as well as a copy of the initial evaluation and treatment plan including documentation of progress in treatment.
- Formal assessment of hearing by an audiologist or Ear, Nose and Throat (ENT) specialist may be requested based on lack of progress in therapy, history of previous hearing loss and / or medical diagnoses which are prone to hearing loss.

For Treatment Requests: Requests for therapy visits may be submitted directly by the therapy providers. The referring PCP/approved Specialist must have a copy of the recent therapy evaluation/re-evaluation/progress summary and plan of care on file for the member.

- If submitted by the therapy provider via the DHP Provider Portal, the request must be accompanied by the appropriate clinical notes and either:
    - *Texas Standard Prior Authorization Request Form for Health Care Services (TARF)* signed by the referring/ordering physician OR,
    - An order signed by the referring/ordering physician and the *Therapy Referral Review by Ordering Physician Attestation Form.* This document is available on the DHP Provider Portal and is completed and signed by the therapy provider.
- If submitted by the therapy provider via fax, the request must be accompanied by a TARF signed by the referring/ordering physician.

Requests should be submitted along with:

- A copy of the visit note and/or the current THSteps Exam/ Well Child Exam documenting the need for continuation of services is required. Additional clinical documentation may be requested.

[1] UMCC Section 8.1.3.1

- A therapy evaluation and Plan of Care which document:
  - A brief statement of the member's medical history and any prior therapy treatment;
  - A description of the member's current level of functioning or impairment, to include current raw scores, standard scores, , and/or criterion-referenced scores as appropriate for the member's condition or impairment;
  - A clear diagnosis and reasonable prognosis;
  - A statement of the prescribed treatment modalities and their recommended frequency/duration;
  - Short and long-term treatment goals which are functional, measureable, and specific to the member's deficits as determined by the therapy evaluation.
- If the request is for **reauthorization of ongoing treatment**, new standardized testing is required once every six months. If new standardized testing has not been completed, documentation must **also** include:
  - Objective demonstration of the member's progress toward previous treatment goals;
  - An explanation of any changes to the member's plan of care, and the clinical rationale for revising the plan;
  - Attendance during the prior authorization period;
  - Documentation of parent or primary care giver participation in therapy sessions;
  - Documentation of transition to a home program and parent/primary care giver compliance with the plan.
- 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 of the delays and deficits in fine motor and self-care skills that impact completion of Activities of Daily Living (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 evaluations.

Hearing Assessment Requirements:

- If a member has not had an objective hearing screen or testing (Pure-tone, Otoacoustic Emissions Test, or Auditory Brain Stem Response) completed prior to the speech evaluation, documentation of normal hearing in one ear by objective method must be submitted with the request for therapy visits. If at the time of request for therapy a hearing evaluation has not been performed but is documented as scheduled, a short duration of therapy may be authorized.
- If the member has failed the hearing screening completed at the PCP / physician's office, an ENT specialist referral is required. Such ENT evaluation should include documentation of treatment for any hearing loss that has been identified. Any member identified with hearing deficits requires a therapy treatment plan tailored to their needs that addresses hearing loss.
- Formal assessment of hearing by an audiologist or ENT may be requested based on lack of progress in therapy, history of previous hearing loss and / or medical diagnoses which are prone to hearing loss.

In cases where an initial evaluation was not prior authorized by DHP, the initial treatment request must be submitted with a copy of all information required from the PCP for initial evaluation requests, as well as a copy of the initial evaluation and treatment plan.

A maximum of three months may be authorized for initial and second requests for acute therapy to establish compliance, attendance and achievement of short term goals. Further therapy will be considered

based on compliance with home programs, attendance and significant progress towards short-term goals. If appropriate, up to six months may be approved for chronic therapy services based on compliance, progress and severity of disorder.

Therapy Services Provided in the Home: There should be a specified medical necessity for therapy to be provided in the home. Medical necessity criteria for therapy services provided in the home must be based on the supporting documentation of the medical need and the appropriateness of the equipment, service, or supply prescribed by the prescribing provider for the treatment of the individual. Home therapy service must be related to the client's medical condition, rather than primarily for the convenience of the client or provider.

Therapy Services for Members under Age Three: HHSC requires that DHP educate providers regarding the federal laws on ECI (Early Childhood Intervention). ECI is a statewide program designated to provide services to children age's birth through 35 months of age suspected of having developmental disabilities or delays, or is at risk of delay. Referrals must be made to the designated ECI program for screening and assessment within seven business days from the day the Provider identifies the member. As such, ECI is considered to be the appropriate service delivery model for developmentally delayed members under three years of age. ECI services do not require prior authorization. ECI is a voluntary service and may be refused by the parent.

Members with the following conditions may also be considered for medical-based therapy as an alternative to or as adjunct to ECI services:

- Members with severe to profound developmental delays;
- Members with major medical diagnoses related to their therapeutic needs;
- Members with high acuity medical needs (tracheostomies, ventilator dependent, etc.)

Referring provider may be asked to attest that ECI referral has been made and submit the reasons that require medically-based therapy in addition to or instead of ECI.

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

REFERENCES:

1. Texas Health and Human Services Commission. *Chapter 3.5, Uniform Critical Elements Requirements, Version 2.0.* In Texas Medicaid and CHIP - Uniform Managed Care Manual.
2. Texas Medicaid & Healthcare Partnership (TMHP). (2019, December). Children's Services Handbook . *Texas Medicaid Provider Procedures Manual, 2*.
3. Texas Medicaid & Healthcare Partnership (TMHP). (2019, December) Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook. *Texas Medicaid Provider Procedures Manual, 2*. Texas Health and Human Services Commission. Texas Medicaid and CHIP – Uniformed Managed Care Contract Version 2.29 – *UMCC 8.1.3.1*