

## Policy and Procedure

<b>DEPARTMENT:</b> Medical Management	<b>DOCUMENT NAME:</b> Physical, Occupational & Speech Therapy Services
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<b>PRODUCT TYPE:</b> STAR+PLUS, STAR, STAR Health, MRSA, CHIP, CHIP-RSA	<b>REFERENCE NUMBER:</b> TX.UM.10.49

### SCOPE:

Centene Company of Texas, LP (CCTX) – A Texas licensed Utilization Review Agent (URA), contracted with Superior HealthPlan to perform utilization review for members enrolled in Superior HealthPlan programs.

### IMPORTANT REMINDER:

This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough review and consideration of generally accepted standards of medical practice, peer-reviewed medical literature, government agency/program approval status, and other indicia of medical necessity.

Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits (“Benefit Plan Contract”) and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. TX.UM.10.49 is not intended to dictate to providers how to practice within their discipline, nor does it constitute a contract or guarantee regarding results. It is expected that providers will exercise professional clinical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. Additionally, providers will be expected to abide by standard clinical practice and documentation standards as directed by the national therapy associations (AOTA, APTA and ASHA).

### PURPOSE:

To provide guidelines for the authorization of home health and outpatient speech therapy, occupational therapy, and/or physical therapy evaluation and treatment services. All therapy requests pre or post discharge from an inpatient hospitalization will be reviewed per TX.UM.02.10 Discharge Planning and are not included in this policy.

### DESCRIPTION:

Physical and occupational therapy are defined as therapeutic interventions and services that are designed to improve, develop, ameliorate, rehabilitate, or prevent the worsening of physical functions and functions that affect activities of daily living (ADLs) that have been lost, impaired, or reduced as a result of an acute or chronic medical condition, congenital anomaly, or injury. Various types of interventions and techniques are used to focus on the treatment of dysfunctions involving neuromuscular, musculoskeletal, or integumentary systems to optimize functioning levels and improve quality of life.

Speech therapy is defined as services that are necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a

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communication disability. Speech therapy is designed to ameliorate, restore, or rehabilitate speech/language communication and swallowing disorders that have been lost or damaged as a result of chronic medical conditions, congenital anomalies, or injuries.

“Medically necessary services” refers to services or treatments which are ordered by an examining Physician and which (pursuant to the EPSDT Program) diagnose, correct, or significantly ameliorate deficits, physical and mental illnesses, and health conditions. “Correct” or “ameliorate” means to optimize a member’s health condition, to compensate for a health problem, to prevent a serious medical deterioration, or to prevent the development of additional health problems.

For the purpose of medical necessity review of therapy documentation, it is expected that each request will include all required elements as set forth in this policy, document the safety of the treatment to be delivered, and meet best practice standards of the therapy national associations (AOTA, APTA and ASHA) and State of Texas licensure laws.

### **POLICY CRITERIA:**

Initiation and continuation of therapy services require the following:

1. Patient must be clinically stable.
2. There must be a reasonable expectation for meaningful functional improvement, prevention, or delay of further decline.
3. Treatment program must be individualized and measured by member’s progress in achieving anticipated goals and desired outcomes.
4. Member and caregiver must be committed to program participation.
5. Therapy services must be rendered by a qualified, licensed speech, physical, or occupational therapist or by a licensed speech, physical, or occupational therapy assistant under the supervision of an appropriately licensed therapist.
6. A formal evaluation may be conducted and a treatment plan developed by the PCP or specialist for physical therapy service requests. Requests of this type must meet all medical necessity criteria as outlined in this policy.
7. Services are provided within the provider’s scope of practice, as defined by state law.

Outpatient speech therapy, occupational therapy, and/or physical therapy evaluation and treatment services are considered medically necessary when all the following criteria are met:

1. The member exhibits signs and symptoms of physical deterioration or impairment in one or more of the following areas:
  - a. Sensory/motor ability
  - b. Functional status– as evidenced by an inability to perform basic activities of daily living (ADLs)
  - c. Cognitive/psychological ability
  - d. Cardiopulmonary status
  - e. Speech/language/swallowing ability

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- f. Integumentary deficits
  - g. Wound Care
2. The treatment is ordered by the member's PCP or appropriate specialist and formal evaluation is conducted by a licensed speech, occupational, or physical therapist.
  - a. Please refer to TX.UM.26 Electronic and Verbal Signature Policy for other acceptable alternative orders.
  - b. For members under 21 years of age therapy orders may be signed by an advanced practitioner such as a physician's assistant or a nurse practitioner.
3. There is an expectation that the treatment will produce clinically significant and measurable improvement in the member's level of functioning within a reasonable and medically predictable period of time.
4. If treatment is part of a medically necessary program to maintain function or prevent significant functional regression it must meet both of the following criteria:
  - a. Must be a skilled service that could not reasonably be carried out by a lay person.
  - b. Have short and long term goals which are clearly stated as maintenance goals.
5. The treatment requires the judgment, knowledge, and skills of a licensed/registered speech, occupational or physical therapist or therapy assistant (SLPA, COTA or PTA).
6. In determining whether a service requires the skill of a licensed physical, occupational, or speech therapist, consideration must be given to the inherent complexity of the service, the condition of the member, and the accepted standards of medical and therapy practice guidelines. A service would be considered not a skilled service if:
  - a. The service could be performed by the average, non-medical person. The absence of a skilled person to perform the service does not cause it to become a skilled service.
  - b. The service is such that it can safely and effectively be performed by the average non-medical person without the direct supervision of a licensed therapist.
7. The treatment cannot be reasonably learned and implemented by non-professional or lay caregivers.
8. The member's function would not be expected to improve as the member gradually resumes normal activities.
9. The ordered treatment meets accepted standards of discipline-specific clinical practice and is targeted and effective in the treatment of the member's diagnosed impairment or condition.
10. The treatment does not duplicate services provided by other types of therapy or services provided in multiple settings (see sections regarding ECI and school based therapy).
11. The treatment conforms to a treatment plan specific to the member's diagnosed impairment or condition.

### Additional Notes:

1. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** Members who are receiving EPSDT services may continue to receive demonstrated medically necessary therapies where loss or regression of present level of function is likely within a

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reasonable and medically predictable period of time. **Treatment plan and goals must be reflective of this.**

2. For CHIP products only: Provision of rehabilitative services or therapies that are medically necessary in the opinion of a physician may not be denied, limited, or terminated if the services or therapy meet or exceed treatment goals for the member. For a member with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration (TIC Section 1271.156). **The treatment plan and goals must be reflective of this.**
3. Procedures when requested as speech, occupational, or physical therapy evaluations or visits that are not performed by or under the direct supervision of a licensed speech, occupational, or physical therapist are subject to secondary medical director review.
4. Aquatic Therapy procedures, when performed under the direction of a licensed physical or occupational therapist, may be considered medically necessary as a part of the member's plan of care. Any other aquatic procedures done by any licensed professional must be billed under the appropriate professional benefit plan.
5. 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. The therapy service must be related to the member's medical condition, rather than primarily for the convenience of the member or provider.

### **DOCUMENTATION REQUIREMENTS:**

#### **Initial Evaluation Authorization**

Requests for initial evaluation must originate directly from the office of the member's PCP or other appropriate physician and should include:

1. An evaluation order signed and dated within the last 30 days by the member's PCP or other appropriate specialist involved in the member's care. The evaluation order must specify the discipline(s) to be evaluated.
2. For members 18 and under, a copy of the most recent TH-Steps Periodicity exam or office exam note. If the referral is being made by a specialist, the specialist's office exam note must be included. For members of all ages where a developmental screen is not required, the exam notes or physician order must document the medical necessity for the service being requested.
3. For members under age 6, evidence of a developmental screen performed by the PCP within the last 90 days, demonstrating significant concerns in the area to be evaluated (speech, gross motor, fine motor, etc.). The ASQ or the PEDS are recommended as they are the screening tools required at the TH-Steps periodicity visits. Screening outcome must be clearly documented.
4. A developmental screen will not be required for members presenting with a non-developmental diagnosis, such as, but not limited to, feeding issues or acute orthopedic injury. However, the member's condition to be evaluated should be included in the TH-Steps note, office visit note, or specialist note submitted.

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- For speech therapy evaluation requests under age 6, documentation of a hearing screening performed within the last six months for member's birth to 3 years of age or within the last twelve months for members 3 years and 1 month to 6 years and 0 months of age. (May be performed as a component of the TH-Steps exam.) Hearing Screening is defined as a test administered with a **pass/fail result** for the purpose of rapidly identifying those persons with possible hearing impairment which has the potential of interfering with communication. If the member failed the hearing screening, results of a full audio logical assessment by an audiologist or physician who is experienced with the pediatric population and who offers auditory services must also be submitted, to include a plan and documentation of treatment for any hearing loss identified.

Note: The developmental screen may be waived when the member has a specific major diagnosis that would indicate medical necessity for a therapy evaluation.

### Re-evaluation Authorization

Request for re-evaluation may originate from the servicing provider's office and should include:

- A re-evaluation order signed and dated within the last 30 days by the PCP or other appropriate specialist involved in the member's care. Requests for re-evaluation should be submitted no more than 30 days prior to the expiration of the existing treatment authorization; requests submitted more frequently will be reviewed on a case-by-case basis and must supply a medical necessity reason for the re-evaluation.
- If the re-evaluation request is made more than 30 days from the end of an open authorization period, an explanation regarding the reason for delay in initiation of services or a medical necessity reason for the re-evaluation must be submitted.

Note: Requests for PT re-evaluation will be approved in accordance with Executive Council of Physical Therapy and Occupational Therapy Examiners (ECPTOTE) rules requiring 60 day reassessment by a **licensed physical therapist**.

### Initial Authorization Visits

Initial authorization for therapy treatment must include a treatment plan. The treatment plan must be signed and dated by the PCP or appropriate specialist. In lieu of having the treatment plan signed, the provider may submit a physician referral/order signed and dated the day of the evaluation or after specifying the frequency and duration of the requested service regardless of history. The treatment plan must also be signed and dated by the treating therapist.

The Treatment Plan must document:

- Date of evaluation
- Member's age and birthdate
- For speech therapy only - member's primary language

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4. A brief statement of the member's medical history, including onset date of the illness, injury, or exacerbation that requires the therapy services and any prior therapy treatment
5. Relevant review of systems
6. Pertinent physical assessment including a description of the member's current deficits and their severity level documented using objective data. This may include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
7. A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
8. A description of the member's functional impairment with a comparison of prior level of function to current level of function.
9. A statement of the prescribed treatment modalities and their recommended frequency/duration.
10. Proposed patient and/or caregiver education.
11. Short and long-term treatment goals which are specific to the member's diagnosed condition or impairment. Short and long-term treatment goals must be functional, measureable, attainable and time based.
12. Treatment plan may not be more than 90 days old.
13. If the treatment plan is part of a medically necessary program to maintain or prevent a significant functional regression, it must document skilled services to be provided and have goals that address maintenance.

**Additional evaluation requirements for speech therapy include:**

**Language evaluations** – should include oral-mechanism examination and objective assessment of hearing, speech production, voice, and fluency skills.

**Speech production** - should include objective assessment of language skills, hearing, voice, and fluency skills.

**Oral motor/swallowing/feeding** - if swallowing/feeding problems and/or signs of aspiration are noted as a concern, then a complete objective, clinical-bedside swallow evaluation is expected, as per ASHA standards for both pediatric and adult dysphagia. The member's language, speech, hearing, voice and fluency skills need to be addressed in the assessment via a screen or objective testing.

**Bilingual Testing** -

1. The member's dominant language must be established using objective information.
2. Bilingual and multilingual speakers are frequently misclassified as having a language delay. Equivalent proficiency in both languages should not be expected.

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3. When testing bilingual members for speech language impairment, age appropriate standardized testing or objective assessment must be completed in both languages and included in the documentation.
4. The best scores from each section of the tests completed must be combined and utilized in determining if a language delay exists.

### **Continued Authorization Visits**

Treatment progress must be clearly documented in an updated treatment plan/current progress summary. This documentation must be submitted by the servicing provider at the end of each authorization period or when additional visits are being requested. The treatment plan must be signed and dated by the PCP or appropriate specialist. In lieu of having the treatment plan signed, the provider may submit a physician referral/order signed and dated the day of the evaluation or after specifying the frequency and duration of the requested service regardless of history.

Documentation must include the following:

1. Number of therapy visits authorized and number of therapy visits attended.
2. A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
3. A description of the member's current deficits and their severity level documented using objective data. This may include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores, or other objective information as appropriate for the member's condition or impairment.
4. Objective demonstration of the member's progress towards each prior short and long term treatment goal. For all unmet short term and long term goals, baseline and current function must be submitted so that the member's progress towards goals may be measured. As the treating therapist has set the short and long term goals for a specified time period, it would be expected that short and long term goals would be met within the specified time frame. If the short and long term goals are unmet, it is the treating therapist's responsibility to objectively describe any barriers to progress that were encountered and appropriate modifications to the treatment plan in order to meet the member's needs.
5. If the member has not met the expected level of progress, the request must be reviewed by the medical director to determine if there is medical necessity to continue treatment.
6. An updated statement of the prescribed treatment modalities and their recommended frequency/duration.
7. A brief prognosis with clearly established discharge criteria.
8. Updated short and long-term treatment goals which are specific to the member's diagnosed condition or impairment. Short- and long-term treatment goals must be functional, measureable, attainable, and time-based.
9. Updated treatment plan/progress summary may be no older than 90 days old
10. Treatment plan must be signed and dated by the treating therapist.

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### Change of Provider

If a therapy provider discontinues services during an existing prior authorization period and the member requests service through a new provider, the new provider must submit all of the following:

1. A change-of-provider letter,
2. Signed by the member or member's caregiver
3. The letter must document the date the member ended therapy (effective date of change) with the previous provider,
4. The names of the previous and new providers, and
5. An explanation of why providers were changed

Or a member may request that the discharge summary from the previous provider be submitted with the request for therapy.

### Transfer Request

If the member will be transferred from one provider to another within the same facility a transfer request must be submitted specifying the previous provider's information, date of transfer and new provider's information. This does not require a member/caregiver signature.

### Treatment Notes

Documentation of all therapy evaluations, re-evaluations and daily notes must be kept on file by the treating provider and be available upon request. This documentation must include:

1. Member's name
2. Date of service
3. Time in and out of each therapy session
4. Objectives addressed (must coincide with treatment plan) and progress noted, if applicable
5. Description of specific therapy services provided and the activities rendered during each therapy session, along with a form of measurement
6. Member's response to treatment
7. Assessments of the member progress or lack of progress
8. Treatment notes must be legible

Therapist must sign each date of entry with full signature and credentials. Signatures of therapy assistants must be counter-signed by the appropriate licensed therapist. All documentation for evaluations, re-evaluations, progress assessment summaries, treatment



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notes, and discharge summaries must show the member's name, date of service, time in, and time out of each therapy session.

### Factors affecting Medical Necessity Decisions

May include, but are not limited to, the following:

1. Member has met treatment goals as evidenced by one or more of the following:
  - a. Member no longer has impairment
  - b. Member has returned to baseline function
  - c. Member will continue therapy with a home therapy exercise program
  - d. Member has adapted to impairment with assistive equipment or devices
  - e. Member is able to perform ADLs with minimal to no assistance from caregiver
2. Member has reached a functional plateau in progress or will no longer benefit from additional therapy.
3. A denial of treatment due to a member's "failure to benefit or progress" may be made in those cases when a condition or developmental deficit being treated has failed to be ameliorated or effectively treated despite the application of therapeutic interventions in accordance with the member's plan of care or if maximum medical benefit has been achieved.
4. Member is unable to participate in the treatment plan due to medical, psychological, or social complications.
5. Non-compliance with scheduled therapy appointments and/or lack of compliance with a home exercise program (HEP).
6. If therapy no longer appears to be clinically appropriate and/or beneficial to the member for any reason, including those identified above, a recommendation for discontinuation (denial) should be referred to the medical director for final review and determination.
7. If a request has been denied for lack of medical necessity, it will be denied for the entirety of the requested dates of service. During this denial period, consideration of new requests by the same servicing provider for the same service type will not be allowed. If the member has a new illness, injury or true exacerbation of their medical condition, a new request may be considered when objective documentation of the change in medical status is submitted.

### Requests for Children with Developmental Delays:

#### Early Childhood Intervention Services

Superior Health Plan Participating ECI providers do not require prior authorization for evaluations, reevaluations, or treatment. Non-participating ECI providers do require prior authorization for evaluations, re-evaluations, and treatment. However, these will be automatically authorized when a request is submitted.

Section 1905(r) (5) of the Social Security Act requires that a Medicaid recipient under the age of 21 must receive the health care services listed in the Act for which she/he has medical need (Social Security Act section 1905(r)). There is no prohibition to ECI contractors and non-ECI

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providers from providing services to the same child. If a child has Medicaid, he/she are entitled to receive all medically necessary services. The Individual Family Service Plan (IFSP) is the authorizing document for ECI services but, if the family of a child with Medicaid wants more therapy services than what the IFSP requires, the family would be able to receive the additional therapy if authorized by a physician, APRN, or PA (in accordance with HHSC medical policy). Given the MCOs' obligation to ensure that the child receives all medically necessary services, it is important that the IFSP accurately reflect the developmental needs identified by the IFSP team regardless of the service provider. Similarly, the ECI contractor is expected to keep the MCO informed with regard to needed auditory and vision evaluations. ECI contractors are expected to put forth good faith effort to obtain the necessary release of information from the parent/legal authorized representative (LAR) to allow the ECI contractor and the MCO to exchange information regarding needed evaluations. Member participation in ECI services is on a voluntary basis.

### Benefit Limitations

1. The provision of a formal and complete evaluation by a licensed/registered therapist is permissible once every (6) months; however, it is not a requirement for assessing the need for continued treatment.
2. Standardized scores greater than or equal to one-and-a-half standard deviations (SD) below the mean (except where state requirements are more stringent) may qualify as medically necessary. However, such a score may not be used as the sole criterion for determining a member's eligibility for initial or continuing treatment services if there are other objective data presented that indicate deficit.
3. Any requests for treatment for children with less than a 20% documented developmental delay or a standardized evaluation score less than one-and-a-half SD below the mean shall be referred to the medical director or physician designee for final review and determination.
4. One-and-half SD below the mean for a standardized test wherein the mean is 100 would equal a standard score of 78.
  - a. Mild: 75-78
  - b. Moderate: 70-74
  - c. Severe: 69 and below

### Adjusting Score for Children with a History of Prematurity

From birth to age 2 1/2, impairments in development must be determined based on the member's corrected age as calculated using the member's gestational age at birth and not on the member's actual age at the time of the testing. Full term is considered 40 weeks. Correct age in weeks is calculated by subtracting the number of weeks the member was premature from the number of weeks of the member's actual age. For example if a member was born at 28 weeks gestation, the member is 12 weeks (3 months) premature. If the member is now 48 weeks old (12 months old), his corrected age is 48 weeks minus 12 weeks or 36 weeks (9 months old). This member's development may be expected to be on par with a 9 month old rather than a 12 month old.

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### Frequency and Duration of Services

When a member is diagnosed with a developmental impairment, treatment may be approved according to the severity of the developmental delay as demonstrated by a developmental assessment that clearly documents the member's level of deficit with objective data. The frequency of treatment may be approved in accordance with the following:

1. **Mild Developmental Delays** = Up to 1x per Week for up to 3 months duration.
  2. **Moderate Developmental Delays** = Up to 2x per Week for up to 3 months duration.
  3. **Severe Developmental Delays** = Up to 3x per Week for up to 6 months duration.
- For feeding and swallowing, therapy requests will only be authorized for a maximum duration of up to 3 months.

### Requests for Acute Injury or Illnesses:

Rehabilitative therapy services are considered benefits for the treatment of acute medical conditions or an exacerbation of a chronic medical condition following a recent trauma, illness, or change in medical condition resulting in an impairment of normal function which is expected to resolve within a short period of time.

Therapy requests for conditions which cause an interruption of a member's normal physical function and development caused by an acute or exacerbation of a chronic injury and/or medical condition will be reviewed for medical necessity using the following frequencies and durations:

**High Frequency:** Therapy provided three times a week for up to eight weeks may only be considered when documentation shows one or more of the following:

1. High frequency is required for after a recent trauma, surgery, or acute medical condition or acute exacerbation of a medical condition.
2. The member has a medical condition that is rapidly changing.
3. The member has a potential for rapid progress or rapid decline or loss of functional skill.
4. The member's therapy plan and home program require frequent modification by the licensed therapist.
5. The goals are well-defined, specific, and achievable within the intensive period requested, with an expected date of goal achievement.

**Moderate Frequency:** Therapy provided two times a week for up to eight weeks may be considered when documentation shows one or more of the following:

1. The member is making very good functional progress toward goals.
2. The member is in a critical period to restore function or is at risk of regression.
3. The licensed therapist needs to adjust the member's therapy plan and home program weekly or more often than weekly based on the member's progress and medical needs.
4. The member has complex needs requiring on-going education of the responsible adult.

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**Low Frequency:** Therapy provided one time per week for up to eight weeks may be considered when the documentation shows one or more of the following:

1. The member is making progress toward the member's goals but the progress has slowed or documentation shows that the member is at risk of deterioration due to the member's development or medical condition.
2. The licensed therapist is required to adjust the member's therapy plan and home program weekly to every other week based on the member's progress.

NOTE: As the member's medical need for therapy decreases, it is expected that the therapy frequency will be decreased as well.

When TX.UM.10.49 does not apply to a specific request, use of InterQual subsets under LOC: Home Care Adult/Pedi or LOC: Outpatient Rehabilitation & Chiropractic would be appropriate. This is the criteria subset for the screening and review of rehabilitation services following an evaluation by a licensed therapist. The subset includes criteria for the authorization period of up to four weeks. At the end of the certification period the clinician will re-evaluate and assess for functional and measurable progress or mitigating factors which hinder or limit progress. Re-evaluation must include standardized testing or other objective information as applicable.

### Benefit Limitations

Per Texas Medicaid, for members age 21 and above, coverage for speech, occupational, or physical therapy is only authorized in the following instances:

1. Objective documentation of an exacerbation of a chronic illnesses or/and injury must include documentation of onset date, mechanism of injury, and a comparison of prior level of function versus current level of function indicating a change in the member's function.
2. Treatment is not part of a maintenance program which continues the member's present level of function or prevents regression of function.
3. With documentation of a medical need therapy may continue for a maximum of 180 days from the 1<sup>st</sup> date of therapy for acute and acute exacerbation of a chronic condition.
4. A medical condition is considered chronic when 180 days have passed from the date of injury or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time.

### STAR+PLUS Waiver Members

Non-Acute ST, PT, or OT in both the home and outpatient settings can be covered under the STAR+PLUS Waiver Program if there is medical necessity to support any kind of improvement even for a chronic condition. Documentation of services must conform to the requirements outlined within this policy.

### STAR+PLUS Nursing Facility (NF) Add-On Services

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Nursing facility add-on services covered under this policy are physical therapy, occupational therapy, and speech therapy. These services must not be covered under the nursing facility unit rate. Medicaid nursing facility members must not be eligible for Medicare or other insurance. These services will not be processed for members that are dual eligible (have both Medicare and Medicaid) unless member is enrolled in SHP's STAR+PLUS MMP Plan.

1. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by acute illness or exacerbation of a chronic illness or condition only.
2. Rehabilitative services may be provided when there is an expectation that the member's functioning will improve measurably within 30 days.
3. The provider must ensure that rehabilitative services are provided under a written treatment plan based on the physician's diagnosis and orders and that services are documented in the member's clinical record.
4. Documentation of services must conform to the requirements outlined within this policy.

### Non-Covered Benefits

Not all treatment modalities are covered benefits. Coverage of specific modalities depends upon their proven efficacy, safety, and medical appropriateness as established by accepted and discipline-specific practice standards.

The following services are not a benefit of Superior HealthPlan:

1. Therapy services that are provided after the member has reached the maximum level of improvement.
2. Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee.
3. Therapy services related to activities for the general good and welfare of members are not considered medically necessary because they do not require the skills of a therapist, such as:
  - a. General exercises to promote overall fitness and flexibility,
  - b. Activities to provided diversion or general motivation,
  - c. Supervised exercise for weight loss,
  - d. Instruction of English as a second language,
  - e. Treatment of behavioral issues as a replacement for behavioral therapy.
4. Hippotherapy, equine therapy, and therapeutic riding are not covered benefits and may not be billed in conjunction with speech, occupational, or physical therapy services.
5. Massage therapy that is the sole therapy or is not part of a therapeutic comprehensive treatment plan to address an acute condition.
6. Separate reimbursement for VitalStimR therapy for dysphagia.
7. Treatment solely for the instruction of other agency or professional personnel in the member's PT, OT, or ST program.

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8. Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment.
9. Therapy not expected to result in practical functional improvements in the member's level of functioning.
10. Therapy equipment and supplies used during therapy visits are not reimbursed separately, these would be considered part of the therapy services provided.
11. Therapy prescribed primarily as an adjunct to psychotherapy.
12. Speech Therapy in the home for members age 21 or over is not a covered benefit with exception of STAR+PLUS Waiver members.
13. ABA therapy is not currently a coverable benefit of Texas Medicaid.
14. Treatments not supported by medically peer reviewed literature, including, but not limited to, investigational treatments such as sensory integration, vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback, and the Wilbarger brushing protocol.

### **REFERENCES:**

TIC Section 1271.156 (a) and (b)

2015 TMHP 2.4 Comprehensive Outpatient Rehabilitation Facilities (CORFs)

and Outpatient Rehabilitation Facilities (ORFs)

2016 NCQA Accreditation UM Standards

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TX.UM.05 – Timelines of UM Decisions and Notifications

TX.UM.01 - UM Program Description

TX.UM.10.35 – Physician Peer to Peer Policy

TX.UM.02.10 – Discharge Planning

TX.UM.26 Electronic and Verbal Signature Policy

The American Physical Therapy Association (APTA), Guidelines: Physical Therapy Documentation of Patient/Member Management (2014).

[http://www.apta.org/uploadedFiles/APTAorg/About\\_Us/Policies/Practice/Docum](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/Docum)

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American Occupation Therapy Association. Standards of practice for occupational therapy. The American Journal of Occupational Therapy. Nov/Dec 2010, 64:6.  
<https://www.aota.org/-/media/Corporate/Files/AboutAOTA/OfficialDocs/Standards/Standards-Practice-OT-2010.PDF>

The American Physical Therapy Association (APTA), Criteria for Standards of Practice for Physical Therapy (2014).  
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American Speech Language hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2011).  
<http://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/>

Clark GF. Guidelines for documentation of occupational therapy (2008). Am J Occupational Therapy. 2008 Nov-Dec; 62(6):684-690.

McKesson Corporation InterQual® criteria.

Standards of Practice, the American Occupational Therapy Association.  
<http://www.aota.org/general/docs/otsp05.pdf>

World Confederation for Physical Therapy, Position Statement: Standards of Physical Therapy Practice (Revised 2011). <https://www.aota.org/-/media/Corporate/Files/AboutAOTA/OfficialDocs/Standards/Standards-Practice-OT-2010.PDF>

**DEFINITIONS:** (Below is informational only and not indicative of coverage):

**Medically Necessary Services:** Services or treatments which are prescribed by an examining Physician, or other Licensed Practitioner, and which, pursuant to the EPSDT Program, diagnose or correct or significantly ameliorate defects, physical and mental illnesses, and health conditions, whether or not such services are in the state plan.

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**“Correct” or “Ameliorate”:** Means to optimize a Member’s health condition, to compensate for a health problem, to prevent serious medical deterioration, or to prevent the development of additional health problems.

### **Coding Implications**

Multiple codes exist for these services. If needed, exact codes should be obtained from the provider requesting the service. Refer to your State contract for exact coverage implications.

<b>REVISION</b>	<b>DATE</b>
Added detailed medical necessity guidelines for home health services. Revised guidelines for requesting initial therapy evaluations to improve clarity. Added the requirement that initial evaluation and re-evaluation requests must originate from the office of the member’s PCP or other pertinent physician.	08/13
Updated Product Type. Revised for TruCare conversion. Added authorization work process. Updated references.	10/13
Updated to add podiatrists to the list of accepted specialists ordering therapy services.	12/13
Updated Authorization Protocol and Authorization Work Process. Added Waiver approval notification work process. Updated References, Definitions and Signatories.	05/14
Moved medically necessary from criteria to description. Added the non-covered benefit criteria. Added the criteria subsets for InterQual under criteria. Revised the authorization requirement for plan of care. Updated signatories. Updated references.	08/14
Added the SC MRSA TruCare Queues under Section 3 of the policy/criteria. Added the STAR+PLUS NF add-on rehabilitative services criteria under Section 4 of the policy/criteria. Updated signatures.	02/15
Removed work process and embedded in attachment section. Added policy to reference list.	02/15
Updated References. Updated signatories. Removed work process imbedded in attachment section.	1/16
1.Added requirement for documentation of medical necessity on TH Steps or specialist note for all member's under age 21	



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<p>2. Extended age requirement for developmental screen from 30 days to 90 days.</p> <p>3. Added that developmental screen may be waived for members with a major dx that would require treatment in most instances.</p> <p>4. Change origin point for re-evaluation from ordering provider to servicing provider.</p> <p>5. Added specific requirements for Language evaluations, speech production evaluations and oral/motor/swallowing /feeding evaluations.</p> <p>5. Added specific criteria for speech therapy with bilingual members.</p> <p>6. Added specific criteria for defining progress.</p> <p>7. Added requirements for change of provider.</p> <p>8. Added requirements for transfer of provider within the same practice.</p> <p>9. Added requirements for treatment notes.</p> <p>10. Added clarifying information on ECI requests.</p> <p>11. Added clarifying information regarding standard deviation and standard score levels.</p> <p>12. Added information regarding adjustment of scores for premature children.</p> <p>13. Added information about frequency and duration for acute injury and illness.</p> <p>14. Added ABA as not a covered benefit.</p> <p>Removed</p> <p>1. Star Plus waiver language regarding S codes and work process.</p> <p>2. Removed qualification information for ECI.</p> <p>3. Removed language regarding request for IEP.</p> <p>4. Removed language about school based services.</p> <p>5. Removed language about medical home by AAP.</p> <p>6. Removed speech intelligibility information.</p>	
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### POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director of Utilization Management: \_\_\_\_\_ Date: \_\_\_\_\_

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Senior Medical Director: \_\_\_\_\_ Date: \_\_\_\_\_

Vice President of Medical Management: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Medical Officer: \_\_\_\_\_ Date: \_\_\_\_\_

