

Cenpatico STRS

POLICIES & PROCEDURES	
Department: Clinical	Procedure Name: Physical, Occupational and Speech Therapy Services
Page 1 of 14	Replaces Document:
Approval Date: 07/11/11	Retired Date:
Effective Date: 07/11/11	Review/Revision Date: 07/11/11, 09/21/11
Policy #: CCL.49.STRS	Cross Reference:

SCOPE: STRS Clinical Department

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.

The purpose of this Clinical Policy is to provide a guide to 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. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

PURPOSE:

To provide guidelines for the authorization of outpatient Speech Therapy, Occupational Therapy, and/or Physical Therapy evaluation and treatment Services.

Description

Physical and Occupational Therapy are defined as therapeutic interventions and services that are designed to improve, develop, correct or 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 communication disability. Speech therapy is designed to correct or 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.

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Policy/Criteria:

1. Outpatient Speech Therapy, Occupational Therapy, and/or Physical Therapy evaluation and treatment services are considered medically necessary when all the following criteria are met (In South Carolina, refer to Attachment A when issuing an authorization for a hospital-based outpatient setting):
 - a. The member exhibits signs and symptoms of physical deterioration or impairment in one or more of the following areas:
 - Sensory/Motor Ability:
 - Functional Status– as evidenced by:
 - Inability to perform basic activities of daily living (ADLs):
 - Cognitive/Psychological Ability:
 - Cardiopulmonary Status
 - Speech/Language/Swallowing Ability
 - b. The treatment is ordered by an examining Physician and a formal evaluation is conducted by a Licensed/Registered Speech, Occupational or Physical Therapist;
 - The evaluation must include all of the following:
 - History of illness or disability
 - Relevant review of systems
 - Pertinent physical assessment
 - Current and previous level of functioning
 - Tests or measurements of physical function
 - Potential for improvement in the patient’s physical function
 - Recommendations for treatment and patient and/or caregiver education
 - c. The treatment requires the judgment, knowledge, and skills of a Licensed/Registered Speech, Occupational or Physical Therapist or Therapy Assistant (SLPA, COTA or PTA).

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- d. The treatment cannot be reasonably learned and implemented by Non-Professional or Lay Caregivers. Repetitive therapy drills which do not require a Licensed/Certified Professional's feedback are not covered services;
- e. 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;
- f. The treatment does not duplicate services provided by other types of Therapy, or services provided in multiple settings (See section regarding School Based Therapy);
- g. The treatment conforms to a Plan of Care specific to the Member's diagnosed impairment or condition:
 - The written plan of care must include all of the following:
 - Diagnosis with date of onset or exacerbation
 - Short and long term functional treatment goals that are specific and measurable
 - Treatment techniques and interventions to be used – amount, frequency, and duration required to achieve measurable goals
 - Education of the member and primary caregiver, if applicable
 - Summary of results achieved during previous periods of therapy, if applicable
- h. 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;
- i. The treatment is part of a medically necessary program to prevent significant functional regression and meets one of the following criteria (Refer to Attachment B, regarding Texas):
 - When a member (child or under 21) achieves a relative clinical and functional plateau, the provider adjusts the Plan of Care accordingly, and provides monthly (or as appropriate) reassessments to update and modify, as necessary, the Home Care Program. If the member's functional level is discovered to be in jeopardy or declining, the Plan of Care can be adjusted accordingly by the therapy provider.
 - **EPSDT Members:** 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 reasonable and medically predictable period of time.

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- j. Where appropriate, InterQual or Milliman Criteria will be used as a guideline in the medical necessity decision making process - (Please refer to the Outpatient Rehabilitation and Chiropractic InterQual Subsets or Recovery Facility Care or Ambulatory Care Rehabilitation Milliman Guidelines).
2. "Medically Necessary Services" refers to services or treatments which are ordered by an examining Physician and which (pursuant to the EPSDT Program) diagnose or correct or significantly ameliorate defects, 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.
 3. 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 Clinical Practice Guidelines.
 4. Treatment of the Member in the home may be medically necessary if the treatment can be safely and adequately performed in the Member's home environment, and the Member's diagnosed impairment or condition makes transportation to an Outpatient Rehab Facility impractical or medically inappropriate.

Authorization Protocols

A. Initial Authorization -

1. Initial Evaluations: Please refer to your individual state benefits for guidance (Refer to state attachments).
2. Initial authorization for Treatment, following evaluation:
 - Members with clearly diagnosed impairments or conditions may receive an initial Authorization for a specified number of Visits.
 - The Plan of Care signed by the therapist must document the following (Refer to state attachments):
 - A brief history of treatment provided to the Member by the current or most recent Provider;
 - A description of the Member's current level of functioning or impairment, and identification of any known primary or secondary health conditions which could impede the Member's ability to benefit from treatment.
 - a. Providers must include the Member's most recent Standardized Evaluation scores, with documentation of age equivalency, percent

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of functional delay, or Standard Deviation (SD) score when appropriate for the Members' diagnosis/disability.

- b. Providers should also include any meaningful clinical observations, summary of a Member's response to the evaluation process, and a brief prognosis statement.
 - A clear diagnosis specific to the reason for receiving therapy;
 - Planned treatment modalities, their anticipated frequency and duration;
 - Short and long-term Treatment Goals which are functional, specific to the Member's diagnosed condition or impairment, and measurable relative to the Member's anticipated treatment progress.
- Utilization Review Personnel must document the following information in the Notes Section of the Authorization:
 - Diagnosis and type of service being rendered
 - Number of visits authorized
 - If the clinical information submitted by the requesting Provider is insufficient to make a determination, the Utilization Review Personnel shall contact the Provider and request that the required information be sent.
 - If there is a question as to whether the submitted information warrants additional therapeutic intervention, the Utilization Review Personnel shall refer the Request to the Medical Director or physician designee for final review and determination. The Medical Director or physician designee is the only Reviewer permitted to make an Adverse Determination due to failure to meet Medical Necessity Criteria.
3. If Services are approved, a communication will be sent to the Provider indicating Approval. Up to (6) months of treatment may be requested and authorized, when determined medically necessary and the medical prognosis clinically supports the need for up to (6) months of treatment.
4. If Services are denied, the Utilization Review Personnel shall follow the established Denial Process and Guidelines.

B. Continued Authorization -

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1. Treatment progress must be clearly documented in an updated Plan of Care/current progress summary signed by the therapist, as submitted by the requesting Provider at the end of each authorization period and/or when additional Visits are being requested.
 - a. Documentation must include the following:
 - The Member's updated Standardized Evaluation scores, with documentation of age equivalency, percent of functional delay, or Standard Deviation (SD) score, if applicable
 - Objective measures of the Member's functional progress relative to each Treatment Goal, and a comparison to the previous Progress Report
 - Summary of Member's response to Therapy, with documentation of any issues which have limited progress
 - Documentation of Member's participation in treatment as well as Member/Caregiver participation or adherence with a Home Exercise Program (HEP)
 - Brief prognosis statement with clearly established discharge criteria
 - An explanation of any significant changes to the Member's Plan of Care, and the clinical rationale for revising the Plan
 - Prescribed treatment modalities, their anticipated frequency and duration

2. Updated clinical information must be received from the Provider prior to authorization of additional Visits, and should be attached in the Notes Section of the Authorization.
 - a. The following information should also be documented in the Notes Section of the Authorization: additional number of Visits and type of Therapy authorized (i.e., Approved an additional 9 Visits of Speech Therapy).

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C. Discontinuation of Therapy -

1. Reasons for discontinuing treatment may include, but are not limited to, the following:
 - Member has achieved Treatment Goals as evidenced by one or more of the following:
 1. Member no longer demonstrates functional impairment or has achieved goals set forth in the Plan of Care
 2. Member has returned to baseline function
 3. Member will continue therapy with a home therapy exercise program
 4. Member has adapted to impairment with assistive equipment or devices
 5. Member is able to perform ADLs with minimal to no assistance from caregiver
 - Member has reached a functional plateau in progress, or will no longer benefit from additional Therapy
 - Member is unable to participate in the Plan of Care due to medical, psychological, or social complications
 - Non-compliance with a Home Exercise Program (HEP) and/or lack of participation in scheduled Therapy appointments
2. 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 should be referred to the Medical Director or physician designee for final review and determination.

D. Children with Developmental Delays -

1. Some states have state-funded Early Intervention Programs wherein children between the ages of (0-3), who are identified with Developmental Delays, may be eligible for an Individual Family Service Plan (IFSP) in which treatment and/or family support services are provided for free or at a minimal cost. These do not require Prior Authorization.
2. In addition, there is a Federal mandate (IDEA) for children between the ages of (3-21) to be evaluated and/or treated in a school-based setting when a Developmental Delay or impairment impacts the child's ability to access the General Education Environment. In these cases, children are entitled to the protections and services identified as part of the Individual

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Education Plan (IEP), and the child's home school/district shall be the primary Provider and Payer of the required treatment services. Provider requests for treatment services which seek to supplant those services identified and/or authorized by a School/District shall not be authorized, but referred back to the School/District if they are educationally but not medically necessary.

3. When applicable, a Member's established IFSP or IEP shall be requested for review relative to any Request for Treatment. An Attestation that no IFSP or IEP exists, or that treatments are not being duplicated across multiple Providers or Settings, may also be accepted (see *Attachment 1*). Coordination of care between School and provider will be established to prevent duplication of services. Services shall not be considered duplicative if child's course of treatment will otherwise be interrupted because it is occurring during school breaks, after school hours, or during summer months. In the absence of an Attestation, a denial of requested treatments may occur when an IFSP or IEP is available but not provided. Denial of duplicative treatment may occur when documented.
4. Standardized Scores greater than or equal to (1.5) Standard Deviations (SD) below the mean (except where state requirements are more stringent) may qualify as medically necessary as defined by age equivalent/chronological age; however, such a score may not be used as the sole criteria for determining a Member's eligibility for initial or continuing treatment services.
5. Treatment may be approved according to a Member's diagnosed level of severity as long as a clearly documented prognosis is included which establishes the Member's likelihood to develop or recover the anticipated skills or functions (identified as the clinical rationale for initiating or continuing treatment) within a reasonable and medically predictable period of time. Where appropriate, InterQual or Milliman Criteria will be used as a guideline in the medical necessity decision making process. The frequency of treatment may be approved in accordance with the following:
 - Mild Developmental Delays = Up to 1x per Week
 - Moderate Developmental Delays = Up to 2x per Week
 - Severe Developmental Delays = Up to 3x per Week
6. Any Requests for treatment for Children with less than a 20% documented Developmental Delay, or a Standardized Evaluation Score less than (1.5) Standard Deviations below the mean, shall be referred to the Medical Director or physician designee for final review and determination.
7. 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

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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.

8. Treatment(s) may be re-instituted in accordance with this Policy should a documented regression occur.
9. An examining Physician's Order for treatment or physician's signature on the Plan of Care must accompany all Treatment Requests, regardless of history.

The American Physical Therapy Association (APTA), Guidelines: Physical Therapy Documentation of Patient/Client Management (2009).

<http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31688>

The American Physical Therapy Association (APTA), Criteria for Standards of Practice for Physical Therapy (2009).

<http://www.apta.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=6801>

American Speech Language hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2001).

<http://www.asha.org/uploadedFiles/practice/reimbursement/medicare/DynCorpSLPHCEC.pdf>

Clark GF. Guidelines for documentation of occupational therapy (2003). Am J Occupational Therapy. 2003 Nov-Dec;57(6):646-9.

Standards for Appropriateness of Physical Therapy Care Prepared by the WSPTA Delivery of Care Committee Board Approved 9/26/98; Revised and Board Approved 10/00 at

<http://www.ptwa.org/StandardsPTCare.htm>

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 (2007). <http://www.wcpt.org/node/29447>

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<p>REFERENCES: TIC Section 1271.156 (a) and (b) TX.UM.05 – Timelines of UM Decisions and Notifications TX.UM.01 - UM Program Description</p>
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<p>ATTACHMENTS: A. <i>South Carolina</i> B. <i>Texas</i> C. <i>Provider Attestation Regarding IEP/IFSP for Outpatient Therapy Services</i></p>
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<p>DEFINITIONS: (This information is informational only and not indicative of coverage):</p> <p>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.</p> <p>Physician Signature: The signature of the MD/DO or state approved designee on a Prescription or Request form must be current, on or before the first date of service and no older than the state approved timeframe (see state attachments). Stamped signatures and dates are not accepted. Signatures of Clinical Nurse Specialists or Doctors of Philosophy are not accepted on Authorization Request forms or Prescriptions.</p> <p>“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.</p> <p>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.</p>
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REVISION LOG

REVISION	DATE
New Policy Entered in Compliance 360. Replaces TX.PAR.31. New therapy policy approved by Plan Medical Directors. Added TIC language, Healthy Texas, Star+Plus, and CHIP benefits	10/05/10
Updated to add South Carolina Language	09/21/11

POLICY AND PROCEDURE APPROVAL

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Please sign and date on the lines provided (if applicable):

Electronic signature on file _____
Director, STRS Operations

09/21/11 _____
Date

Electronic signature on file _____
STRS Medical Director

09/21/11 _____
Date

Cenpatico will ensure that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations will be enforced in the application of this policy and procedure if applicable. HIPAA is a Federal regulation established to provide protections for the privacy of an individual's individually identifiable health information. Please see Cenpatico HIPAA Policy & Procedure manual for detail

Attachment A: South Carolina

In South Carolina physical, occupational, and speech therapy services in an outpatient hospital are reimbursable only under the following conditions:

- The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay, and therapy continues on an outpatient basis until that plan of treatment is concluded.
- The attending physician prescribes therapy as a direct result of outpatient surgery.
- The attending physician prescribes therapy to avoid an inpatient hospital admission.

Therefore, will only be authorized under these conditions.

Attachment B: Texas

For CHIP and RSA 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).

Initial Authorization:

- Initial Evaluations: Limited to 1 Visit - does not require prior-authorization for participating Providers; must be performed within (90) days of the examining Physician's Order. The signature of the MD, DO, APNP or PA on a Prescription or Request form must be current, on or before the start date, and no older than (3) months before the actual date of service.
- Plan of Care: MD signature must be on the plan of care or on a prescription noting the service type, frequency, and duration of treatment.

**Attachment C: Texas
Provider Attestation Regarding IEP/IFSP for Outpatient Therapy Services**

Member Name

Member ID Number

I have conducted a reasonable review of the facts regarding the therapy services recommended for the above referenced Member, including a discussion with the Parent/Guardian regarding other services that are currently provided. Based upon my review and attestation from the Parent/Guardian, the Member does not have an existing Individualized Educational Plan (IEP) or Individualized Family Service Plan (IFSP).

I understand that under my Provider Participation Agreement, Superior Health Plan, and applicable Regulators including the Centers for Medicare and Medicaid Services, and the Texas Health & Human Services Commission or their Representatives, may inspect and evaluate my records related to Members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and Federal and State Laws or Regulations.

NOTE: If Member does have an existing IEP or IFSP, it should be submitted, along with the Request for Treatment.

Provider Signature

Print Name

Title

Provider Medicaid Identification Number

Date

Contact Phone Number
