POLICY & PROCEDURE

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SCOPE: STRS Utilization Management Department
This policy apples to Cenpatico Behavioral Health's Specialty Therapy & Rehabilitation Services (STRS) department operations ("Company").

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 indication 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 speech therapy, occupational therapy, and/or physical therapy evaluation and treatment services.

Applicability
These guidelines and policy apply to markets and populations delegated to STRS by the health plan unless a market specific policy has been developed. (See Attachment C for applicable markets and delegated populations)

Description
Physical and occupational therapy are therapeutic interventions and services that are medically prescribed and require the knowledge and skills of physical or occupational therapist to develop, improve, restore, or prevent the worsening of physical functions, functions that affect activities of daily living (ADLs), and other functional skills needed for daily life. These skills may have been lost, impaired or reduced as a result of an acute or chronic medical condition, congenital anomaly, developmental delay, disease, or injury. Various types of interventions and techniques are used to focus on the treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular, pulmonary or the integumentary systems to optimize functioning levels and improve quality of life.

Speech therapy consists of interventions that require the knowledge and skills of a speech language pathologist and are medically prescribed for the diagnosis and treatment of speech and language disorders that result in communication disabilities and/or for the diagnosis and treatment of swallowing (dysphagia) and feeding disorders. Speech/language pathologists use a variety of modalities in the treatment of communication deficits and dysphagia, allowing for successful treatment outcomes. Speech therapy is designed to develop, improve, or restore speech/language communication and feeding/swallowing disorders that have developed as a result of acute or chronic medical condition, congenital anomalies, developmental delay, disease, or injuries.

Policy/Criteria:

A. Medical Necessity Definitions:

1. Adults age 21 and over:

   Physical, Occupational and Speech Therapy evaluation and treatment services are considered medically necessary when the services, or interventions that a therapist, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, condition, or its symptoms in a manner that is:

   a. in accordance with generally accepted standards of medical practice for therapy services;

   b. clinically appropriate in terms of type, frequency, extent, site and duration

   c. considered effective for the current illness, injury, disease or condition;

   d. are not primarily for the convenience of the member or provider;

   e. and the treatment techniques and activities require the knowledge and skills of a therapist

2. Children under age 21 / EPSDT related services (problems/delays identified during periodic wellness screenings):

   Physical, Occupational and Speech Therapy evaluation and treatment services may be considered medically necessary when the service, or intervention that a therapy provider, exercising prudent clinical judgment, would provide to a member for the purpose of:

   a. Correcting or ameliorating a physical condition

   b. Helping the member attain, maintain, or regain functional capacity

   c. Achieving age appropriate growth and development; and

   The service;

   d. Is not contraindicated;

   e. Is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results (i.e. cannot be carried out by non-skilled personnel);

   f. Is not investigational or experimental;

   g. Is an accepted medical practice for the discipline providing the service;

   h. And requires the knowledge and skills of a therapist for the interventions and activities used in treatment

B. Criteria

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

1. The member exhibits signs and symptoms of physical delay, deterioration or impairment that impact functional status as evidenced by inability to perform basic activities of daily living (ADLs) (for example, functional mobility, feeding, dressing, bathing, or toileting) or instrumental, activities of daily living (IADLs) (for example, making a bed), or usual daily activities.

2. The member exhibits signs and symptoms of physical delay, deterioration or impairment in one or more of the following areas:

   a. Sensory and/or motor ability - problems with sensory integration, cranial and peripheral nerve integrity, ergonomics and body mechanics, joint integrity and mobility, motor function, muscle performance, neuromotor development, posture, range of motion, sensory integrity, swallowing, or feeding.

   b. Cognitive/psychological ability - problems with orientation, concentration (attention loss), comprehension, organization of thought, problem-solving, or memory.

   c. Cardiopulmonary status – impairments in aerobic capacity, aerobic endurance, ventilation, or respiration

   d. Communications – impairments in voice, speech production, language, fluency, or pragmatics.

   e. Skin and Circulation - integumentary integrity or circulation

3. Treatment requires the judgment, knowledge, and skills of a Licensed/Registered Speech, Occupational or Physical Therapist and cannot be reasonably learned and implemented by non-professional or lay caregivers.

4. 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;

5. Treatment does not duplicate services provided by other types of therapy, or services provided in multiple settings (see section on habilitative services for possible exceptions)

6. Treatment is expected to produce clinically significant, measurable and sustainable improvement in the member's level of functioning within a reasonable and medically predictable period of time or;

7. The treatment is part of a medically necessary skilled program to prevent significant functional regression; maintain current capabilities and function; or for EPSDT services (Members under 21): the treatment is necessary to correct or ameliorate deficits or physical conditions; and the treatment meets the following criteria:

   a. For home program monitoring/maintenance, the provider adjusts the POC accordingly and provides monthly (or as appropriate) reassessments to update and modify the home program; or

   b. For ongoing treatment, the therapist uses interventions that require the judgment, knowledge, and skills of a Licensed/Registered Speech,

Occupational or Physical Therapist and cannot be reasonably learned and implemented by non-professional or lay caregivers; and

c. The frequency and duration of treatment is adjusted to provide only the necessary level of services to prevent regression and /or ameliorate the condition

Note: 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. They are also dependent on the stated covered benefits of the member.

The following services <u>are not considered medically necessary</u> therapy services and will not be approved:

a. Repetitive activities (exercises, skill drills) which do not require a licensed/registered professional's expertise, knowledge, clinical judgment, instruction or decision making abilities, and can be learned and implemented by the member or a caregiver.

b. Services which do not require the skills of a therapist to update the treatment interventions, plan of care, or home program

c. Activities for general fitness and flexibility, sports specific training enhancement, mental acuity training or general tutoring to improve educational performance

Therapy Documentation Standards:

A. A formal evaluation is conducted by a licensed/registered speech, occupational or physical therapist. The evaluation/re-evaluation should include all of the following:
   1. History of recent illness, injury, or disability to include diagnosis with date of onset of problem or date of exacerbation of a chronic condition.
   2. Relevant review of systems
      a. Identification of other health services concurrently being provided for this condition (e.g., physician, PT, OT, SLP, chiropractic, nurse, respiratory therapy, social services, psychology, nutritional/dietetic services, radiation therapy, chemotherapy, ABA services, etc.)
      b. Identification of durable medical equipment needed for this condition
      c. Identification of any medications that may impact the member's ability to participate in therapy
      d. If comorbidities affect treatment, describe why or how. Documentation should indicate how the current symptoms or problems are affected by the comorbidities. For example: cardiac dysrhythmia is not a condition for which a therapist would directly treat a member, but in some cases such dysrhythmias may directly and significantly affect the pace of progress in treatment, requiring a change in the frequency and duration of services in order for the member to benefit from the therapy ;
      e. Identification of underlying, treatable factors that led to the current functional impairments

3. Pertinent physical assessment and appropriate objective tests with clinical observations

4. Current and previous level of functioning, including:

    a. Standard and objective tests or measurements of physical function that include standard scores, percentage of functional delay, age equivalency, or normative data. Standard scores and percentile rankings will take precedence over age equivalencies as these have a higher statistical validity.

    b. Subjective reports of member's abilities prior to injury or exacerbation if applicable

5. A brief history of any prior treatment provided to the member for the condition and outcome of the prior treatment

6. Identification of any health or social conditions which could impede the member's ability to benefit from treatment.

B. Treatment is ordered by an appropriate health care professional either through a signed and dated order or signed plan of care (POC).

C. The POC is specific to the member's diagnosed impairment or condition. The written POC signed by the therapist must include all of the following:

1. Diagnosis with date of onset or exacerbation

2. Treatment goals that:

    a. Are specific and measurable in order to determine progress or identify the functional levels related to planned maintenance/ maximum realistic therapeutic benefit,

    b. Address deficits identified in the evaluation that are consistent with the member's diagnosed condition or impairment.

    c. Can be reasonably attained with the treatment outlined

3. Treatment techniques and interventions to be used – amount, frequency, and duration required to achieve the measurable goals

4. Discharge recommendations; including education of the member in a home program and primary caregiver education, if applicable

5. Providers should also include any meaningful clinical observations, summary of a member's response to the evaluation process, and a brief prognosis statement or potential for improvement in the member's physical function.

Additional Information and Considerations: Developmental Delays-Habilitative Services

1. The Individuals with Disabilities Education Act (IDEA) is a Federal mandate ensuring services to children with disabilities throughout the nation. IDEA Part B is for children 3-21 years 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 Education Plan (IEP), and the child's home school/district shall be the primary provider and payer of the required treatment services. IDEA Part C is for infants and toddlers (0-2) and their families to receive early intervention services. This program is also known as state-funded Early Childhood

Intervention (ECI) and is provided to Infants and toddlers who are identified with developmental delays that are deemed 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. In these cases, children are entitled to the protections and services identified as part of the IFSP, and the child's local area agency shall be the primary provider and payer of the required treatment services.

a. ECI is considered to be an appropriate service delivery model for developmentally delayed members less than 3 years of age. The ECI model of care offers additional services under a holistic approach to patient care, such as access to case management professionals, developmental specialists, etc.

b. In cases where there is an IFSP in place, children are entitled to the protections and services identified as part of the IFSP, and the child's local area agency shall be the primary Provider and Payer of the required treatment services. Children who may be eligible for services under an IFSP will be referred to the local area agency for assessment. Coordination of services and assistance accessing local agencies will be provided if there is no current local area agency identified.

c. In cases where there is an IEP in place, children are entitled to the protections and services identified as part of the IEP, and the child's home school/district shall be the primary provider and payer of the required treatment services. Coordination of services and assistance in accessing services through the school/district will be provided if there is no relationship already established.

d. A member who does not have an IEP in place, but whose goals are related to skills that are routinely taught as part of a school curriculum (reading, writing, grammar, English as a second language, etc.) will be deemed educationally, rather than medically necessary, and the member will be referred to the School/District to obtain services.

e. A member may receive habilitative services in both the school and outpatient settings during the same duration if the school services are not intensive enough to adequately address the member's medically necessary needs. The need for this intensity of services must be clearly documented by the provider, and documented coordination between the school and outpatient or home health provider is a requirement for approvals of these types of service.

   Note, in the state of Kansas, habilitative services outside the school setting are referred to as developmental therapy services.

f. Information about a member's established IFSP or IEP may be requested for review relative to any request for treatment, if needed, in order to identify if there are any medically necessary EPSDT services not being addressed by the school or early childhood program. Parent/caregiver to therapist report or therapist to therapist report regarding the scope of IDEA services are acceptable or a copy of the member's IEP or IFSP may be submitted for review.

2. Speech therapy for intelligibility may be approved according to member's age and intelligibility standards noted below when all other medical necessity criteria are met:

Age	Expected Intelligibility for familiar listeners	Expected intelligibility for non-familiar listeners	Clinically significant variance supporting therapeutic intervention
18 months	25%	25%	10% or less to familiar listeners
24 months	50-70%	50%	30% or less to familiar or unfamiliar listeners
36 months	75-80%	75%	50% or less to familiar or unfamiliar listeners
48 months+	90-100%	90-100%	75% or less to familiar or unfamiliar listeners

Therapy Authorization Guidelines

General Guidelines:

A. Frequency and Duration of Services:

1. 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.

2. The frequency of treatment may be approved in accordance with the following:
   a. Mild delays or minimal functional impairment = Up to 1x per week
   b. Moderate delays or moderate functional impairments = Up to 2x per week
   c. Severe delays or severe functional impairment = Up to 3x per week

3. Frequency is based on additional factors which include:
   a. Active medical diagnoses of the member
   b. The physical impairments resulting from these diagnoses
   c. The member's current ability to function
   d. Assessment of the environmental factors that allow the member to participate in his or her various societal roles.
   e. Standards of care for the condition may dictate a higher or lower frequency
   f. The frequency requested is supported by the clinical documentation
   g. Length of time the member has been receiving therapy for the stated condition

4. The duration of treatment may be approved in accordance with recognized standards of care for the condition such as InterQual or established clinical practice guidelines.

B. Discontinuation of Therapy

1. It is expected that clinicians will use accepted standards of therapy practice for discharge planning. Therapy is intended to educate members and their caregivers in how to effectively recover lost function or adapt to an ongoing chronic condition.
2. Recommendations for discontinuing treatment may include, but are not limited to, the following:
   a. Member has achieved maximum functional gain as evidenced by one or more of the following:

1) No longer demonstrates functional impairment or has achieved goals set forth in the POC or has returned to their prior level of function
2) Failure to benefit or progress may be determined when a condition or developmental deficit being treated has failed to be ameliorated or effectively resolved despite the application of therapeutic interventions in accordance with the member's POC.
3) If the member has been receiving services over an extended period of time and it cannot be determined whether the member's current functional level is due to therapeutic intervention or natural development, services should be discontinued.
4) Member can continue therapy with a home program and deficits no longer require a skilled therapy intervention
5) Member has adapted to impairment with assistive equipment or devices
6) Member is able to perform ADLs, daily functional tasks, feeding, and/or communication skills independently or; with assistance from a caregiver and no further improvement in the skill is expected
7) Member has chronic functional loss and their maximal functional ability has been achieved

b. Member is unable to participate in the POC due to medical, psychological, or social complications

c. Member is non-compliant with a Home Exercise Program (HEP) and/or lacks participation in scheduled therapy appointments

3. If therapy no longer appears to be clinically appropriate and/or beneficial to the member based on the documentation received, including any of the reasons identified above, a recommendation for discontinuation of therapy services will be referred to the Medical Director or designee for final review and determination.

Clinical Practice Standards

A. Developmental delay:

1. Standardized scores greater than or equal to 1.5 SD below the mean or a 25% or greater functional deficit will be utilized as a standard to establish the presence of delay. Clinicians should document individual assessment criteria and norms to support the need for skilled intervention if the chosen test has different criteria from the standard outlined above. Scores alone will not be used as the sole criteria for determining a member's eligibility for initial or continuing treatment services. The therapist must show why skilled intervention is needed and deemed medically necessary. The therapist must also identify the underlying impairment that is being treated to remediate, ameliorate or correct the area of delay.
   In the presence of or absence of an established delay, (as indicated by standardized score(s) or functional assessment result(s); clinical observations and any informal assessment, parental questionnaires, etc. should be included in the submitted assessment documentation to support the need for skilled therapy

2. Children whose standard scores are not below 1.5 SD or show a 25% or greater functional deficit may be deemed eligible for medically necessary, skilled intervention based on supportive documentation. Clinicians can submit for consideration,

evidence of objective testing, functional impairments, clinical observations, and informal assessments to support the need for skilled intervention.

3. In some standardized tests, the prematurity of the child is taken into account when norming the test. When deciding whether or not to use the adjusted age as the comparison, the specific instructions of each standardized test should be referenced.

4. Adjusted age in premature infants rather than chronologic age should be used for developmental assessment. Term gestation is 40 weeks. Prematurity is considered to be 37 weeks or less. Adjusted age for prematurity is used until the child is 2 years old.

5. To determine the child's corrected age subtract the number of weeks the baby was born prematurely from the chronological age. For example if a baby was born at 26 weeks, the baby was born 14 weeks early. (40-26=14)
   If the baby currently has a chronologic age of 6 months (24 weeks), the baby would have an adjusted age of 10 weeks. (24-14=10)
   It would be expected that the baby have developmental milestones consistent with a10 week old.

6. To account for prematurity, growth and development monitoring should be done according to adjusted age (age in months from term due date). When delays are confirmed, infants should be referred for Early Intervention services.

7. Not all cognitive or physical skills have standardized tests. Clinical observation and documentation of current skill sets should be used in the absence of standardized tests.

B. Rehabilitative Services:

1. Rehabilitative services involve assisting the member in recovering from an acute injury or exacerbation of a chronic condition that has resulted in an acute change in function for the member. It is expected that providers will utilize appropriate tests and measures in addition to clinical observations to identify the impact of any injury or exacerbation on a member's ability to function in their usual settings.
2. Rehabilitative services should be delivered with an appropriate frequency and duration to restore lost function or to teach adaptations in function if recovery of function is not possible.

Initial Authorization Process

For initial evaluations, please refer to your individual state benefits for guidance regarding prescriptions and evaluation timeframes (refer to state attachments).

1. Initial treatment request following evaluation:

   a. The request is submitted using the approved market OTR (outpatient treatment request)

   b. The POC, as outlined above, is complete and signed by the therapist and submitted with the request

   c. OTR is complete and includes:

      1) Diagnosis (ICD-10 codes)

2) Type of service being rendered (PT/OT/ST)

3) Number of visits requested per the plan of care

4) Duration of services/dates of service

5) Provider NPI/TIN

6) member identifiers

d. Providers should also include any meaningful clinical observations, summary of a member's response to the evaluation process, and a brief prognosis statement or potential for improvement in the member's physical function.

e. If applicable, IFSP/IEP service information is attached or included

f. Referral for services by an approved health care professional is included

Note:

- If the clinical information submitted by the requesting provider is insufficient to make a determination, the utilization review personnel may contact the provider and request that the required information be sent.
- If submitted information does not meet criteria, the request is sent to the Medical Director or designee for final review and determination. The Medical Director or designee is the only reviewer permitted to make an adverse determination due to failure to meet medical necessity criteria.
- If services are approved, a communication will be provided to the provider and member, if required per market and NCQA guidelines, indicating approval.
- If Services are denied, notifications shall follow the established denial process guidelines per market contract and NCQA requirements.
- Up to six (6) months of treatment may be requested and authorized, when determined medically necessary and the information submitted clinically supports the need for up to six (6) months of skilled treatment.
- An Initial episode of care may be limited to 4-6 weeks of treatment to assess response and benefit to skilled interventions.

Continued Authorization

1. An updated POC/current progress summary, signed by the therapist and submitted by the requesting provider is required at the end of each authorization period and/or when additional visits are being requested.
2. Documentation must include the following:

a. Current and previous level of functioning, including:

1) Standard and objective tests or measurements of physical function that include standard scores, percentage of functional delay, age equivalency, or normative data as appropriate. Standard scores and percentile rankings will take precedence over age equivalencies as these have a higher statistical validity.

2) A subjective description of the member's current level of functioning or impairment,

3) Identification of any health conditions that are affecting the member's ability to benefit from treatment.

b. Objective measures of the member's functional progress relative to each treatment goal, and a comparison to the previous progress report;

c. Or if the program is maintenance to prevent regression or ameliorate a condition for EPSDT ; clear documentation of the skilled interventions used and objective details of how those interventions are preventing regression or ameliorating the condition

d. Summary of member's response to therapy, with documentation of any issues which have limited progress

e. Documentation of member's participation in treatment as well as member/caregiver participation or adherence with a home exercise program (HEP)

f. Brief prognosis statement with clearly established discharge criteria

g. An explanation of any significant changes to the member's POC, and the clinical rationale for revising the POC

h. Prescribed treatment techniques and/or modalities, their anticipated frequency and duration

i. Rationale for why ongoing care requires the skilled services of a PT/OT/ST

j. An updated referral for services if the prior referral has expired

3. If services are approved, a communication will be sent to the provider and member, if required per NCQA and contractual requirements, indicating approval.
4. If services are denied, the utilization review personnel shall follow the established denial process and guidelines.

Please note: Where appropriate, InterQual Criteria or MCG** 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).

*InterQual® criteria are proprietary and cannot be publicly published and/or distributed. On an individual member basis, the specific criteria document used to make a medical necessity determination can be made available upon request. Registered providers can obtain the appropriate InterQual® SmartSheet™ by logging in to the secure provider portal. The InterQual® SmartSheet™ can be submitted with your authorization request to help expedite the process.

McKesson Corporation is the owner/licensor of the InterQual® Clinical Decision Support Criteria and related software. McKesson has prepared this Work for exclusive use of its licensees of software applications embodying the Clinical Content. This Work contains confidential and trade secret information of McKesson and is provided to licensees who have an existing license agreement in force only under the time-limited license as provided under that license

agreement. Licensee and any recipient thereunder shall use the Clinical Content in accordance with the terms and conditions of the license agreement.

**The MCG (formerly Milliman Care Guidelines®) guideline(s) and products are not intended to be used without the judgment of a qualified health care provider with the ability to take into account the individual circumstances of each patient's case. MCG is used in the State of Indiana.

Bibliography

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/ContentDiplay.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/ContentDispay.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

Newborn Intensive Care: What Every Parent Needs to Know, 3rd Edition (Copyright © 2009 American Academy of Pediatrics). http://www.healthychildren.org/English/ages-stages/baby/preemie/pages/Corrected-Age-For-Preemies.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token
Medicare Benefit Policy Manual: Chapter 15 – Covered Medical and Other Health Services
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

CMS Early Periodic Screening, Diagnosis and Treatment (EPSDT)
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

CMS Medicare Benefit Policy Manual- Pub. 100-2: Chapter 15, Section 220 and 230, Covered Medical and Other Health Services, Conditions of Coverage and Payment Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services.
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Policy References:
Most current NCQA Standards and Guidelines for the Accreditation of MBHO's and MCO's.

Most current market specific contracts

Current state specific definitions for medical necessity

Most current standards of practice as published by the APTA, AOTA and ASHA

Terminology:
(This information is informational only and not indicative of coverage):

Adjusted Age for Prematurity: Adjusted age is the age that a premature infant would be if he/she had born on his/her due date. To calculate adjusted age, subtract weeks born early from the chronologic age. Adjusted age is used for developmental assessment through age 2.

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.

"Correct" or "Ameliorate": Means to optimize a Member's health condition, to compensate for a health problem, to prevent serious medical deterioration (prevent from worsening), or to prevent the development of additional health problems.

EPSDT: Refers to the federal requirement for early periodic screening, diagnosis and treatment of children under 21 to correct or ameliorate conditions that are identified during screenings. The Act provides for coverage of all medically necessary services that are included within the categories of mandatory and optional services listed in section 1905(a), regardless of whether such services are covered under the State Plan.

*States are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases, but those parameters may not contradict or be more restrictive than the federal statutory requirement.

*EPSDT does not require coverage of treatments, services, or items that are experimental or investigational.

Medically Necessary Services: Services or treatments that require the skills and knowledge of a physical therapist, occupational therapist or speech pathologist and 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.

Physical, Occupational, Speech Therapy Services: are defined as skilled services offered to a member in their home (excluding inpatient, SNF, or nursing home settings, unless those services are provided on an ancillary basis), at the provider location, or in the community by a licensed therapist.

Habilitative Services: medically necessary services provided to assist the member in partially or fully attaining, learning, keeping, improving, or preventing the deterioration of developmental-age appropriate skills that were never present as a result of congenital, genetic, or early acquired health condition and required to maximize, to the extent practical, the member's ability to function within his or her environment.

Health Care Professional Signature/Prescription: 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). If the health care professional prescription is for a shorter duration and/or frequency than the plan of care, the prescription will supersede the plan of care, unless the plan of care is signed by the physician. 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.

Skilled services: Services that require the judgement and knowledge of a therapist (PT/OT/SLP) to safely and effectively carry out a therapy plan of care. A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant

under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the member, does not make it a skilled service when a therapist furnishes the service.

Standardized Testing: A test that is administered to all recipients in the same way and is scored in a standard or consistent manner which makes it possible to compare outcomes or scores among individuals or groups. The testing administered should be appropriate for the age of the member and diagnosis or functional impairment, be a test that is regularly administered, and widely accepted in the field of licensure, and also be both valid and reliable. The tests should produce an objective outcome that can be used to measure overall progress towards the stated therapeutic goals.

NOTE: DME is not covered under this policy.

Medically Necessary Services Definitions (by state):

Kansas:
The State of Kansas defines medical necessity as follows:
"Medical necessity means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

- "Authority." The health intervention is recommended by the treating physician and is determined to be necessary by the state or the state's designee.
- "Purpose." The health intervention has the purpose of treating a medical condition.
- "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
- "Evidence." The health intervention is known to be effective in improving health outcomes.
- "Value." The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity." Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the state or the state's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

Louisiana:
Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

- In order to be considered medically necessary, services must be:
    - deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and

  - Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.

- Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.
- Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Massachusetts:
Medical Necessity or Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service: (a) is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

Missouri:
Missouri Medicaid defines medically necessary services as those that are:
Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

New Hampshire:
Medically Necessary Services are defined as being:

- No more restrictive than the State Medicaid program
- Services which prevent, diagnose and treat health impairments
- Services which assist members in achieving age-appropriate growth and development
- Services which assist members in attaining, maintaining or regaining functional capacity.

Medically Necessary Services for members age 21 and older are defined as:

- Services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice
- Services that evaluate, diagnose, prevent or treat an acute or chronic illness, injury, disease, or its symptoms
- Services that are clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the member's illness, injury, disease, or its symptoms
- Services that are not primarily for the convenience of the member, or the member's caregiver, or health care provider

- Services that are no more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the member's illness, injury, disease, or its symptoms
- Services that are not experimental, investigative, cosmetic, or duplicative in nature.

Medically Necessary for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services are defined by being:

- Reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction
- Services that cannot be provided by a different and equally effective course of treatment

For LTSS Services, including CFI Waiver Necessary Services are defined as:

- Reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, cause physical deformity or malfunction
- Is essential to enable the individual to attain, maintain, or regain functional capacity and/or independence
- No other equally effective course of treatment is available or suitable for the recipient requesting a necessary long term services and supports within the limits of current waivers, statutes, administrative rules, and/or Medicaid State Plan amendments

Washington:

- Medically necessary means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.
- For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

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
Update to add Kentucky and Louisiana language.	01/18/12
Added criteria for comprehensive day rehabilitation	06/20/12
Created a combined Prescription Requirements Grid (attachment A)	06/20/12
Reviewed and approved by STRS UM Committee	06/20/12
Reviewed by a physical med rehab specialist and deemed medically appropriate based on medical literature	06/20/12
Updated to include NH and KS script and Plan of Care timeframes	12/12/12
Updated based on TX URA Requirements to use the term "enrollee"	05/17/13
Added language relative to Adjusted Age for Prematurity	09/20/13
Moved Development Delay Language to "Policy/Criteria" section	09/20/13
Added language about McKesson & MCG Guidelines	09/20/13
Update NH timeframes for scripts and Verbal Orders	09/20/13
Add NH language for Medically Necessary and IEP (Attachment E)	07/16/14

Remove redundancies within policy	07/16/14
	07/10/15
Removed CDR portion of policy to create a separate policy (CCL.50.STRS)	07/10/15
Removed Texas specific language and attachments, updated Kansas coverage of habilitation, added NH definition of necessary services, updated WA definition of medical necessity	10/28/15
Revised format of policy and edited language to align with current state practices related to EPSDT services and school based programs, updated section titles for clarity and added current references, added market population information	9/07/16
Added Attachment D per WA market request	12/07/16
Added grammatical edits per KS market request	02/15/17
Converted legacy Cenpatico policy and procedure to the new EPC template and revised policy reference number.	03/10/17

APPROVAL

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

EPC.STRS.49 - Attachment A
Prescription and Verbal Order Timeframes

Service	Script Requirements	Script Time Frame Requirement	Verbal Order Time Frame[2]
PT, OT and ST	MD, DO, ARNP or PA can prescribe therapy in an outpatient setting Exceptions listed below: • KY and KS: PT can also be prescribed by DDS, DPM, or DC • NH: DPM & DDS may also prescribe • MO: MD & DO only	1 year	N/A
PT/OT Situations when a provider can complete an initial evaluation without prescription	No script required: • LA: PT • WA[3]: Referral for initial eval can be made by an authorized health care practitioner. • MO: OT		
Home Health (HH)	MD, DO, ARNP or PA can prescribe therapy in a home health setting Exceptions listed below: • MO: MD & DO only	60 (but can extend to 62 days) Exceptions listed below: •	Signature required immediately upon receipt of verbal order. State specific exceptions time frames below: • LA – 30 days • WA – 45 days • NH – 30 days • KS - verbal order acceptable to initiate treatment. Upon subsequent request, signed orders required.
EPSDT[4]	MD, DO, APNP or PA can prescribe therapy EPSDT services	6 months •	N/A

[1]Signatures on Prescriptions or Request forms submitted must be current, on or before the start date, and occur no more than the time frame required amount before the actual date of service.

[2]Verbal Orders for Home Health: In some states, the provider can treat under a physician's verbal order. If the request is received within the verbal order time frame, the request must include documentation of the verbal order to include physician name, date of order, and therapies ordered. After the verbal order time frame has been exhausted, the provider must submit a signed prescription with their request for authorization. NOTE: Services provided before the physician signs the plan of care are considered to be provided under a plan established and approved by the physician if there is a verbal order for the care and the request is received within the state specified timeframe.

Note: N/A means there is no special provision for verbal orders.

[3]PT referral: Direct referral of a patient can be made by an authorized health care practitioner by telephone, letter, or in person. If the instructions are oral, the physical therapist may administer treatment accordingly, but must make a notation for his/her record describing the nature of the treatment, the date administered, the name of the person receiving treatment, and the name of the referring authorized health care practitioner. "Authorized health care practitioner" means and includes licensed physicians, osteopathic physicians, chiropractors, naturopaths, podiatric physicians and surgeons, dentists, and advanced registered nurse practitioners.

[4]EPSDT: The plan of care needs to be updated every six (6) months to address the changing needs of the child. EPSDT has varying names in each state and may be called something other than "EPSDT"; however, the rules and regulations are the same.

Attachment B: New Hampshire Specifics: IEP

Individualized Education Plan (IEP)

A member's established IFSP or IEP may be requested for review relative to any request for treatment; however, it shall not be required as a prerequisite to determine if a child is eligible for services that are not being provided as a part of a child's IEP

Attachment C: Market Populations served and general benefit limits

This table provides a general overview of the members served by STRS. It is not all inclusive and is subject to contractual changes.

Market	Delegated Services-Medicaid	Benefit Limits
Kansas	Home Health and Outpatient therapy services for members 21 and over, All members 0-20 are considered EPSDT •There are no benefit limitations for members under 21,medical necessity must be met for all members	• Therapy services are limited to 6 months in duration per injury from the start of therapy. A new injury, fall, clear exacerbation, or other significant change in status can restart the 6 month timeframe. • Only services rehabilitative in nature (due to an acute injury/illness) are covered for members over 21
Louisiana	Home health and outpatient services for adults and children based on medical necessity	• PT/OT/ST services are not a covered benefit for members 21 and over in a stand alone outpatient clinic setting. It is a benefit in the outpatient hospital and Home Health settings.
Massachusetts	Members age 21-64 for outpatient or home health therapy,	• No Limits, requests must meet MNC
Missouri	**Home Health** •unlimited for medically necessary services for all age groups **Outpatient** •Unlimited medically necessary benefits for children under age 21 **Outpatient Setting** **Adults (21+) (Limited to the following situations)** Hospital: Pregnant women, blind participants,& nursing facility residents only- PT: any diagnosis	• No Limits, requests must meet MNC

	OT/ST: orthotic and prosthetics adaptive training only Rehab Center and Independent Practitioner: Pregnant women, blind participants, & nursing facility residents only PT/OT/ST: orthotic and prosthetics adaptive training only	
New Hampshire	Outpatient and Home health for adults and children based on medical necessity	• No Limits, requests must meet MNC
Washington	Outpatient and home health services for adults and children based on medical necessity	• Pulmonary rehab is **NOT** a covered benefit

Attachment D: Washington Specifics: IEP

Individualized Education Plan (IEP)

A member's established IFSP or IEP may be requested for review relative to any request for treatment; however, it shall not be required as a prerequisite to determine if a child is eligible for services that are not being provided as a part of a child's IEP