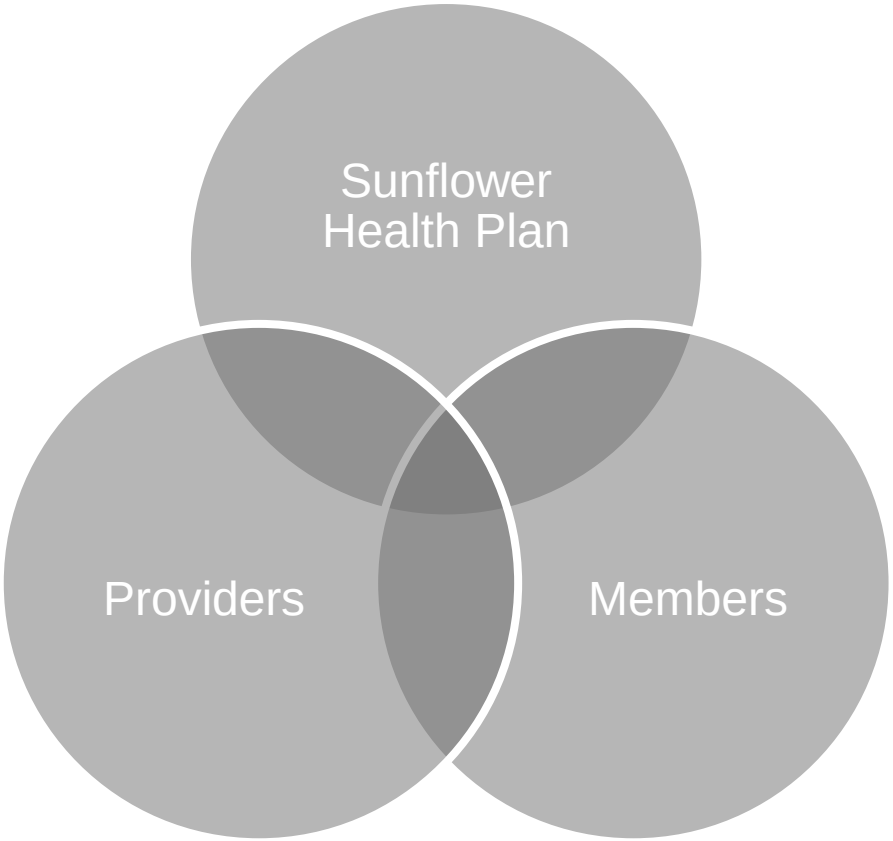
Specialty Therapy & Rehab Services (STRS)

Requesting an authorization

Partnership



STRS Clinical Services

- Utilization Management
- Clinical Provider Training
- Care Coordination

Benefits Therapy Services

Coverage of Therapy Services and Benefit Limitations:

- For enrollees 20 years of age and under:
  - ✓ There are no benefit limitations for members under 21
  - ✓ Therapy must be habilitative/rehabilitative or restorative in nature
- For enrollees 21 years of age and older:
  - ✓ Therapy services are limited to 6 months in duration from the start of therapy. A new injury, fall, clear exacerbation, or other significant change can restart the 6 months
  - ✓ Services must be rehabilitative in nature due to an acute injury/illness

Prior Authorization Par Provider

- Prior Authorization is required for all home health, treatment of autism spectrum services, and HCBS waiver therapy services
- Prior authorization is NOT needed for the following:
  - First 24 visits per discipline per member per calendar year (including evaluation)**
  - Initial evaluation; one per provider per discipline per calendar year
  - Re-evaluations: one re-evaluation per provider, per discipline, per calendar year without prior authorization for participating providers.
- Prior Authorization is required for all non-par services including evaluations

FAQs for 24 Visits without PA

- All visits are subject to a post service review audit
- Any visits over the 24 per member, per discipline for the calendar year require prior authorization
- If you have an authorization in place, all claims will be matched up with this authorization. The 24 visits without prior authorization cannot be used during any period that has an active authorization in place
- If an outpatient therapy request is sent to the STRS team, it will be reviewed for medical necessity even if the 24 visits have not been used
- If there is a denial on file, the 24 visits cannot be used during the denial timeframe

Post Service Audit

Post service audits for medical necessity review will be done on a sample portion of therapy services provided without prior authorization

- A request for therapy records, which may include the evaluation, all therapy daily notes and progress notes, will be sent to selected providers
- The request letter will provide details on how to submit records and timeframes for submission
- The audit review will be completed within 30 calendar days of receipt of all necessary information
- Providers will be given education and feedback related to medical necessity if the rendered services have not met the medical necessity criteria
- Revised prior authorization requirements may be issued to specific or all providers if 20% or more of the post service audits do not meet medical necessity or if a provider fails to submit requested records within 30 days from the request for records

Prior Authorization Par Provider

Post-Surgical Requests: We can approve up to 5 post-surgical visits telephonically for post-surgical or urgent therapy needs with a verbal/written doctor's order if requested within 7days of surgery or hospital discharge.

Requires Prior Authorization

- All **home health services**, including evaluations and re-evaluations require a prior authorization for both par and non par providers
- All HCBS waiver and therapy services related to treatment of autism require prior authorization
- Any visits over the 24 visits per member per discipline for the calendar year require prior authorization
- Prior authorization is required for all services rendered by non par providers

Authorization Extensions

- The dates of service for an authorization can be extended for missed visits if the following criteria is met:
  - The current authorization has not expired.
  - The current authorization, if extended, will not go beyond six months.
  - A date extension has not already been completed for the authorization.
- To request an extension:
  - Call Sunflower Health Plan Customer Service line at 1-877-644-4623
  - If the above criteria has been met then the authorization can be extended once for up to one month.

Required Documentation Therapy Orders

- Physician's Order/Prescription for Therapy
- Complete Therapy Evaluation: Assessment of patients abilities and deficits, current/previous level of function, medical/therapy history.
- Written Plan of Care(POC) or Rehab treatment plan
  - Short/Long Term Goals
  - Home Education Plan
  - Frequency/Duration and Dates of Service
  - Additional narrative explanation if needed for consideration
- Submit Outpatient Treatment Request Form(OTR)
- Authorization is not a guarantee of payment

Required Documentation Therapy Orders

- Prescriptions accepted if:
- Physically or electronically signed by a the ordering physician
  - Prescribing provider is one of the following:
    - ✓ MD, DPM, DDS, PA, ARNP, APRN, DC, DO
    - ✓ Rubber stamped signatures will not be accepted
    - ✓ Verbal orders for home health have special conditions that must be met
- Dates of service on prescription are current

Required Documentation Therapy Orders

- Prescription dates of service:
- Home Health:
- Verbal Orders
  - Initial Requests signed by RN from a physician
  - Subsequent requests-signed by RN acceptable if submitted along with copy of MD signed 485 from previous request
- Verbal, manuscript, or electronic prescription
  - Valid for 60 days
- Outpatient therapy:
- Valid for 1 year from the initial evaluation unless a shortened duration is indicated in the order
- Kan Be Healthy (EPSDT):

  Valid for 6 month duration

Required Documentation
Plan of Care Key Elements

- Evaluation/assessment should include, but is not limited to:
- Medical/developmental history
- Current functional deficits
- Previous & current levels of function for each goal
- Standardized testing/ clinical observations supporting deficits
  - Report standard deviations when available
  - Provide percent of delay with supporting observations
  - Objective assessments preferred
  - Documentation of age equivalency
- Informal assessment & narrative
- Summary of results achieved (if subsequent request)

Completing the Outpatient Treatment Request Form OTR

https://www.sunflowerhealthplan.com/providers/resources/forms-resources.html

Follow this link to the Sunflower Health Plan website to obtain the OTR form

OTR Essential Elements
Member Information

Member Name

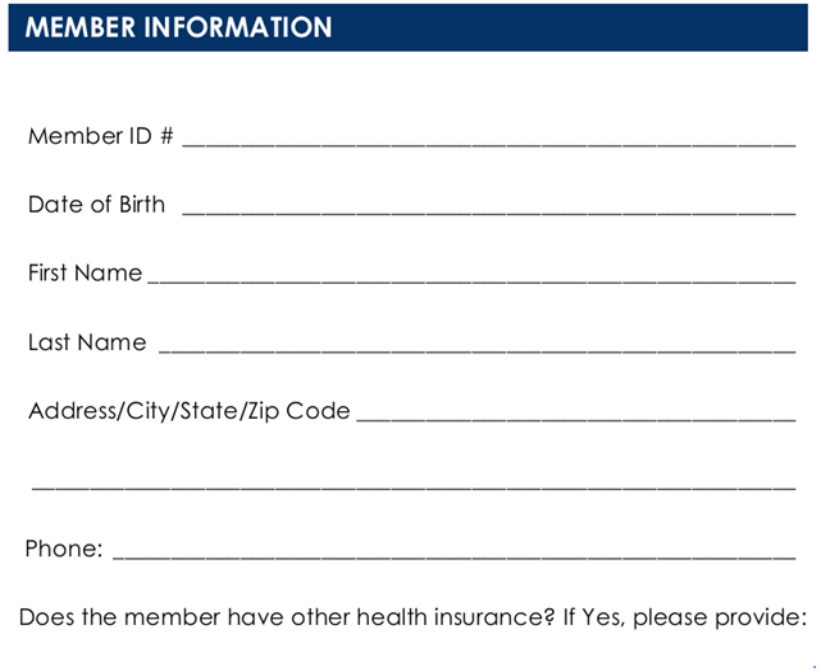
- Copy exact name as ID card
- Include hyphenated names
- Be certain the first name is not a nickname

Medicaid ID

- Copy exact number as ID card

Date of Birth/Address

- Complete member section in full to avoid delays or incomplete requests



MEMBER INFORMATION

Member ID # _____

Date of Birth _____

First Name _____

Last Name _____

Address/City/State/Zip Code _____

_____

Phone: _____

Does the member have other health insurance? If Yes, please provide:

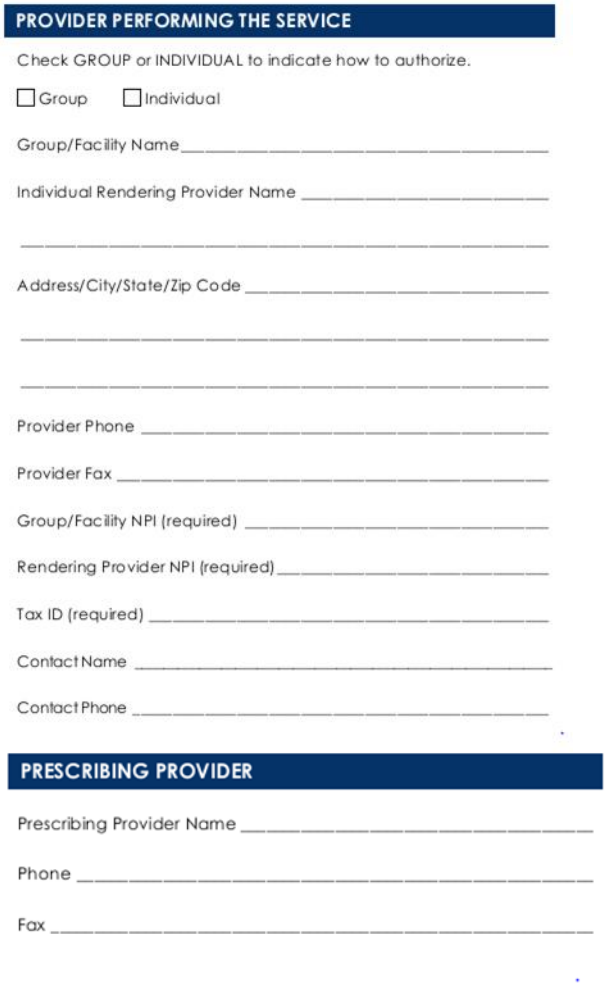
OTR Essential Elements
Provider Information

Treating Provider Information

- Facility/Provider NPI
- Tax ID
- Physical address
- Contact phone number
- Fax number

Prescribing Provider

- Physician name (MD or healthcare practitioner who prescribed therapy)
- Contact phone number



PROVIDER PERFORMING THE SERVICE

Check GROUP or INDIVIDUAL to indicate how to authorize.

☐ Group ☐ Individual

Group/Facility Name _____

Individual Rendering Provider Name _____

_____

Address/City/State/Zip Code _____

_____

_____

Provider Phone _____

Provider Fax _____

Group/Facility NPI (required) _____

Rendering Provider NPI (required) _____

Tax ID (required) _____

Contact Name _____

Contact Phone _____

PRESCRIBING PROVIDER

Prescribing Provider Name _____

Phone _____

Fax _____

OTR Essential Elements Diagnosis/Disorder

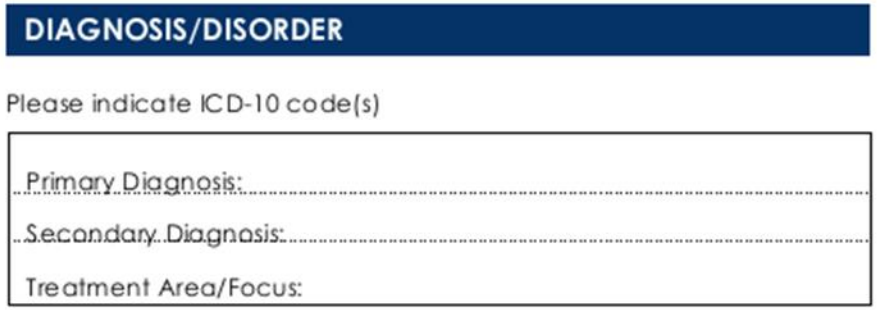
Primary Diagnosis

- Condition(s) referred for therapy
- Dictated by physician

Treating Diagnoses:

- Condition(s) therapist is providing rehabilitation or care (e.g. OT-dyspraxia, PT-back Pain, ST-dysphasia)

Utilize ICD-10 codes



OTR Essential Elements
Treatment Requested

THERAPY SERVICE AUTHORIZATION REQUESTS FOR TREATMENT

Service Location: ☐ Hospital-Outpatient ☐ Clinic/Rehab Center ☐ Office ☐ Home

Service	Date Treatment Initially Started	Frequency *(visits seen per month or week)*	Total Visits or Units Requested	Requested Start Date for Treatment ☐ use receipt date of this request	Requested End Date for Treatment ☐ use end date of the written Plan of Care
Speech Therapy		____ x ☐ week or ☐ month			
Physical Therapy		____ x ☐ week or ☐ month			
Occupational Therapy		____ x ☐ week or ☐ month			

Complete all of the fields for the discipline being requested.

OTR Essential Elements
Treatment Requested

- Date Treatment Started
  - Enter the date the member will begin therapy. This date should be after the date of the initial evaluation.
  - The therapy start date may be the same as the initial evaluation date if a treatment session was completed the same day as the initial evaluation.
- Frequency
  - Frequency can be noted in times per month or per week. It cannot be a range of frequency, i.e., 2-3 times per week for 4-6 weeks.
  - Duration and/or frequency on the OTR must match the plan of care signed by the therapist
  - Total Visits Requested
  - Indicate a total number of visits for the span of the authorization

Required Documentation
Plan of Care: Goals

- Objective Goals are SMART, not Vague
  - **S**PECIFIC Goals/Interventions
  - **M**EASURABLE
  - **A**TTAINABLE
  - **R**EALISTIC
  - **T**IMELY
- Goals must address functional needs and to meet Medical Necessity Guidelines.

Required Documentation Coordination with Other Services

- Services requested must be medically necessary
- The therapy documentation should continue to indicate why skilled therapy is needed and how the therapy is skilled in nature
- When a member receives more than one service, documentation should include information on coordination of care between the therapists.
- If a child is receiving school based therapy or (ECI) services, the IEP/IFSP may be submitted to show the coordination of services.

Additional Treatment Requests

- Plan of Care (POC) requirements for additional visits beyond the initial therapy request (i.e., subsequent requests):
- Home Health Services: Updated POC every 60 days
- Outpatient Services & KanBeHealthy (EPSDT) Requests:
  - Updated POC required with every subsequent request
  - POC cannot exceed 6 months for EPSDT requests
  - POC cannot exceed 6 months for outpatient requests

Retro Requests

- Authorizations will not be retroactive, with the exception of extraordinary circumstances.
- Example: Inaccurate information received from Sunflower Health Plan, retro eligibility, new insurance coverage, technological problems with fax submission that can be verified with a date stamp.
  - Start date should be no earlier than the date faxed/submitted.
  - *Exception: If retro date meets the criteria for a two day look back
  - Post Surgical Request
    - ✓ Request must be received within 7 days of the surgery
  - Retain a copy of fax confirmation sheet with time/date stamp

Two Day Look Back

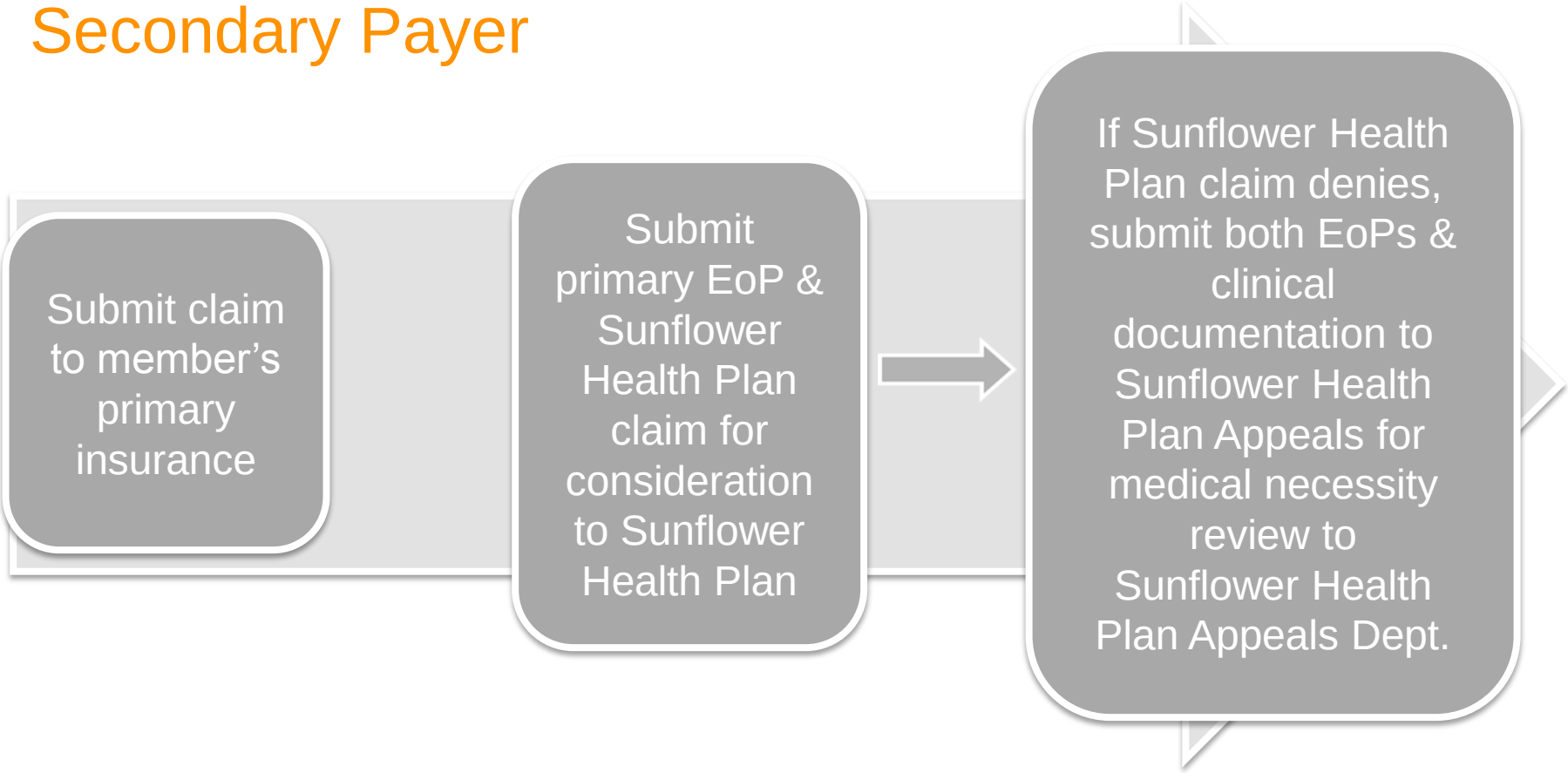
When an evaluation and treatment session are completed on the same day, the treatment date may be retro-actively approved when the following criteria are met:

- It is the initial evaluation for the member.
- Evaluation and Treatment are completed the same day.
- Required documentation is faxed within 2 business days of the initial date of service and the request meets medical necessity guidelines.
- Provider is a participating provider

Secondary Coverage Sunflower Health Plan as Secondary Payer

- Prior Authorization is not required when Sunflower Health Plan is the secondary payer.
- Member/provider is required to follow all rules of the primary payer.
- If the primary payer denied for any administrative reason, Sunflower Health Plan will not coordinate with the primary payer.

Secondary Coverage Sunflower Health Plan as Secondary Payer



Secondary Coverage Sunflower Health Plan as Secondary Payer

If a member's primary benefits are exhausted or the primary benefit does not cover therapy services then prior authorization for therapy may be requested.

- A provider may send in the entire Primary Explanation of payment (EOP documenting the exhaustion of the benefit or may write on the OTR that benefits are exhausted, along with the Outpatient Treatment Request Form, prescription, assessment and plan of care.
- The Provider must send in the EOP documentation from the primary insurance when submitting the secondary claim to Sunflower Health Plan in order for the claim to process. Prior authorization does not guarantee payment.
- If the request does not indicate a benefits exhaust situation, a problem letter will be sent to notify provider of primary insurance coverage.

Provider Communications

Problem Letter: a letter communicating an outright rejection of processing the request for authorization based on one of the following:

- Member eligibility could not be verified
- Provider could not be found
- Plan of Care missing or illegible
- Retro dates were requested (all prospective dates will be processed)
- Medicaid is the second payer

Additional Information

- Sunflower Health Plan website: https://www.sunflowerhealthplan.com
- Medical Necessity Criteria https://www.sunflowerhealthplan.com/
- Sunflower Health Plan Phone Number: 1-877-644-4623 1-888-282-6428 (TTY)
- Sunflower Health Plan Fax Number: 866-264-4452
- Claims Address: P.O. Box 4070 Farmington, MO 63640-3833