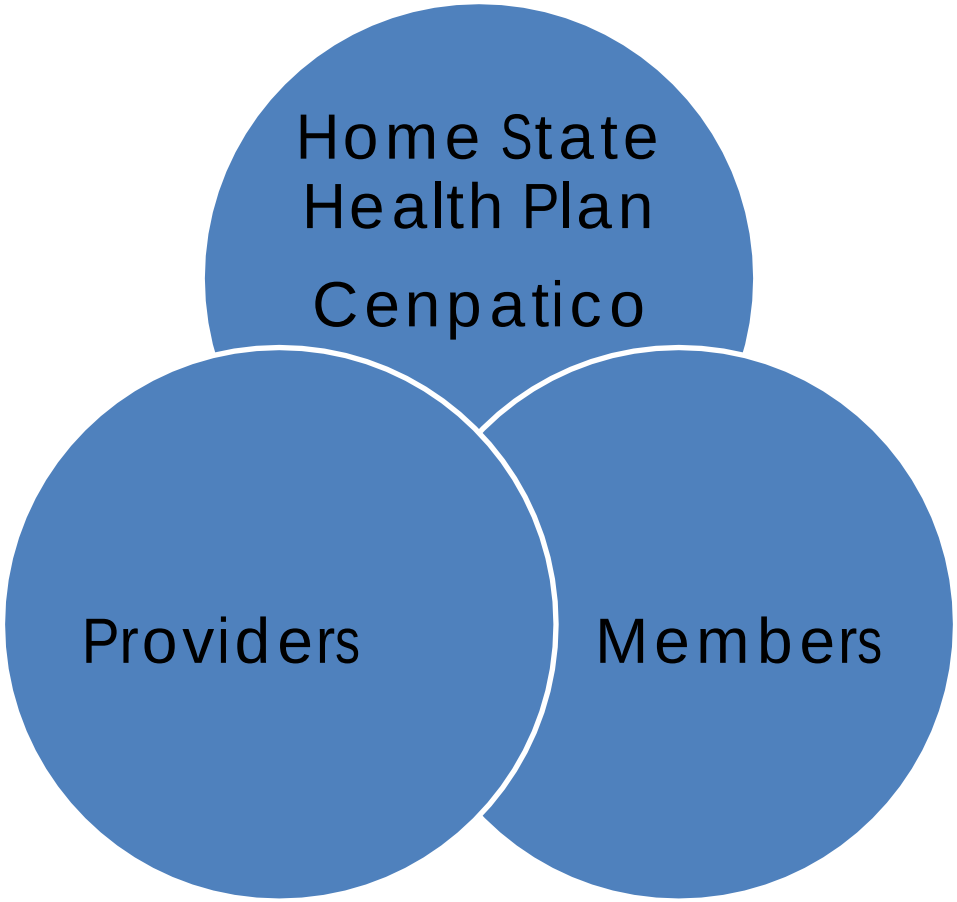
Specialty Therapy & Rehabilitative Services (STRS)

Requesting an Authorization

Partnership



STRS Clinical Services

- Utilization Management
- Clinical Provider Training
- Care Coordination

Getting Started
Prior Authorization

Prior Authorization is **required** for all Physical (PT),Occupational (OT), and Speech Therapy (ST) services

Exceptions:

- **Evaluations** - 1 initial evaluation per provider, per discipline, per calendar year without authorization for participating providers.
- **Re-evaluations** - 2 re-evaluations per provider, per discipline, per calendar year without authorization for participating providers.
- **Post-Surgical Requests** - With a verbal/written doctor's order we can approve up to 5 post-surgical visits telephonically for urgent therapy needs.

Requesting Therapy Services
Required Documentation

A complete request includes:

1. Outpatient Treatment Request Form (OTR)
2. Physician's order/prescription

   must be physically or electronically signed by the ordering MD

3. Therapy Evaluation/ Plan of Care (POC)

Evaluation should include:

- Medical/therapy history
- Assessment of patient's abilities and deficits
- Standardized testing/clinical observations
- Current & previous level of function

Plan of Care should include:

- Short/long term goals
- Baseline function for goals
- Home exercise plan
- **Specific** frequency/duration
- Additional narrative explanation if needed for consideration

Required Documentation

Therapy Orders

Prescriptions accepted if:

- Signed by prescribing provider
  - Must be physically or electronically signed
  - Rubber stamped signatures will not be accepted
  - Verbal orders for home health have special conditions that must be met (see next slide).
- Prescribing provider is one of the following:
  - MD, DO, NP, PA
- 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 & Healthy Children and Youth (EPSDT):

- Valid for 1 year from the initial evaluation unless otherwise documented in the order

Comprehensive Day Rehab:

- Valid for 30 days months

Required Documentation

Evaluation/Assessment Key Elements

Evaluation/assessment should include, but is not limited to:

- Diagnosis with date of onset or exacerbation
- Medical/developmental history
- Current functional deficits
- Previous & current levels of function

Standardized testing/ clinical observations supporting deficits

- Report standard deviations when able
- Provide percent of delay with supporting observations
- Objective assessments preferred
- Documentation of age equivalency

- Informal assessment & narrative
- Summary of results achieved (if subsequent request)
- Specific progress for each goal (if subsequent request)

Required Documentation

Plan of Care: Objective & Measurable Goals

Objective goals are SMART, not vague

SPECIFIC goals/interventions

MEASURABE

ATTAINABLE

REALISTIC

TIMELY

Goals must address functional needs & meet medical necessity guidelines

Required Documentation

Plan of Care Elements: Benefit Limitation

Setting	Adults (21+)	Children (0-20)
Home Health	No treatment limit* Limit 2 evaluations per year per discipline	
Outpatient Therapy Location: Hospital Rehab Center & Independent Practitioner	Benefit only covers pregnant women, blind participants, and nursing facility residents. PT: any treatment diagnosis	No Limit*
	OT/ST: orthotic/ prosthetics adaptive training only	
	PT/OT/ST: orthotic/ prosthetics adaptive training only Treatment may not exceed 1 year	
Comprehensive	Pregnant women only covered population	EPSDT children only
Day Rehab	Diagnostic limitations: TBI diagnosis, excludes diagnosis of CVA, congenital deficit, and aneurysm	

*Requests must meet medical necessity guidelines

For more benefit information visit: https://manuals.momed.com/manuals/

Required Documentation

Common Errors

- Standardized developmental scores are within 1.5 standard deviations from the norm or less than 20% delay.
- Standardized evaluations utilized for inappropriate population.
- No objective measurements of deficits.
- No objective measurements of improvement.
- All objective measurements have not been administered to rule out concomitant diagnoses.

Required Documentation

Common Issues

- Clinical information or severity of deficits submitted does not support the frequency or duration of requested services.
- No updated clinical information or progress submitted to support reauthorization of services.
- Goals are written for deficits that are not documented.
- Plan of Care does not address the documented deficits.

Required Documentation

Coordination with School Services

- Services requested must be medically necessary
- IEP, IFSP, or attestation letter of non-duplication required if child is receiving school-based services.
- Unable to authorize services that are duplicative of another provider or setting.
- Failure to provide IEP, IFSP, or attestation when available may result in denial of services.

OTR Essential Elements

Member Information

Member Name

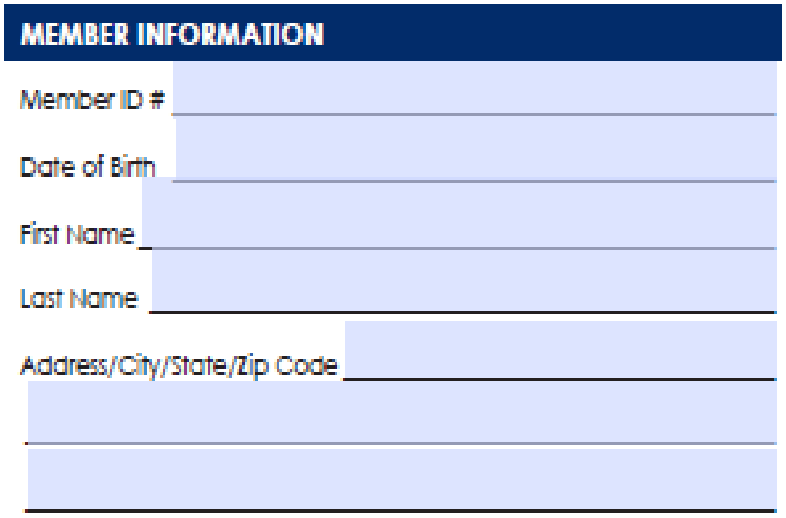
- Copy exact name as ID card
- Include hyphenated names
- Be certain the first name is not a nickname

Medicaid ID

- Copy exact number as ID card

Date of Birth/Address

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



OTR Essential Elements

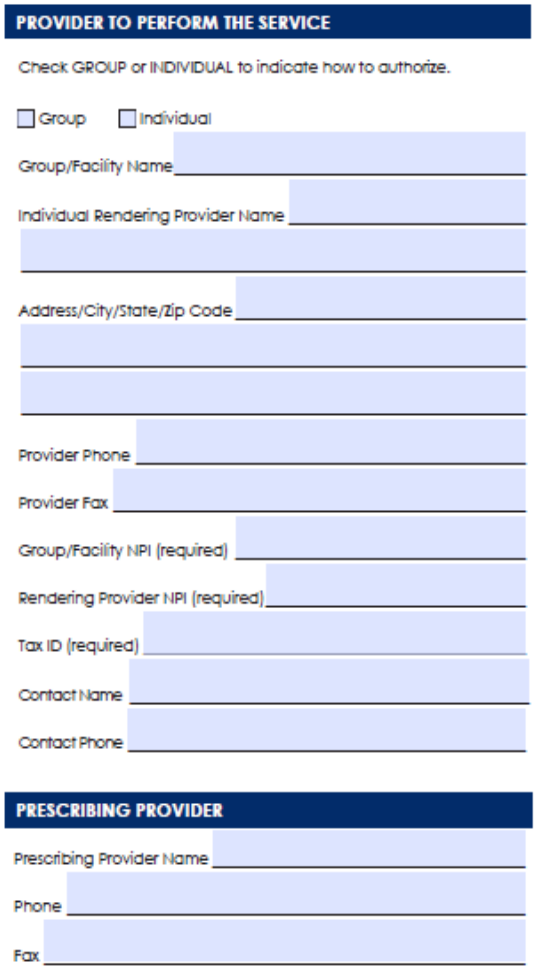
Provider Information

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

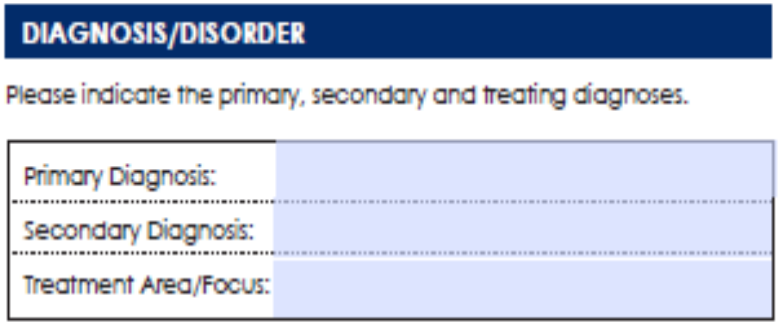


OTR Essential Elements

Diagnosis/Disorder

Primary Diagnosis

- Condition(s) referred for therapy
- Dictated by physician
- Ex: 758.0, Down's Syndrome



DIAGNOSIS/DISORDER

Please indicate the primary, secondary and treating diagnoses.

Primary Diagnosis:	
Secondary Diagnosis:	
Treatment Area/Focus:	

Treating Diagnoses:

- Condition(s) therapist is providing rehabilitation or care
- Ex: 315.8, Developmental Delay
  781.2, Abnormality of Gait

Utilize ICD-10/ ICD-9 codes

(as applicable per ICD-10 roll out)

OTR Essential Elements

Common Errors: Provider Section/Diagnosis

Provider Section

- Incorrect NPI number used for provider
- Prescription not updated
- Incorrect prescribing provider information
- Prescribing provider phone number listed inaccurately

Diagnosis

- Improper diagnosis
- Diagnosis on the OTR doesn't match the referring diagnosis
- Diagnosis changes with new request for same condition

OTR Essential Elements

Evaluations/Re-evaluations

Pre-Authorization is required for Evaluations and Re-Evaluations when:

- Provider is not participating in-network
- Provider is participating in-network, but is requesting:
  - 2nd evaluation for the same discipline/same diagnosis
  - 2nd re-evaluation in a year for the same discipline/same diagnosis

Start and End Dates:

- Authorizations will not be retroactive, with the exception of extraordinary circumstances

  Ex: inaccurate information received from Home State Health Plan or Cenpatico; technological problems with fax submission.
- Start date should be no earlier than the date faxed/submitted
- Retain a copy of fax confirmation sheet with the time/date stamp

OTR Essential Elements

Evaluation/ Re-Evaluations

Start and End Dates, Continued:

Two day look back to include retro dates can be approved when all of the following are met:

- Participating provider
- Evaluation & treatment completed on same day (initial requests only)
- Required documentation is faxed within 2 business days and the request meets medical necessity guidelines.

OTR Essential Elements

Additional Treatment Requested

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 & Healthy Children and Youth (EPSDT) Requests:
  - Updated POC required with **every** subsequent request
  - POC **cannot** exceed 6 months

OTR Essential Elements Additional Treatment Requested

Dates of Service extensions: The Dates of Services can be extended for missed visits as long as:

- Current authorization has not expired
- Script on file will include the extended dates of service
- Plan of care covers the newly requested dates of service

To request an extension:

- 1 week extension: Call Cenpatico at (855) 694-4663 to make the request
- Requesting more than a 1 week extension: Fax in a completed Outpatient Treatment Request Form (OTR) to (855) 847-1011with the new end date of services and the reason for the extension. Include a Fax Cover sheet that indicates: "Date extension requested". (additional clinical documentation may be requested to approve extensions)

OTR Essential Elements

Additional Treatment Requested: Common Errors

- Initial evaluation date listed as the date treatment started and there was no treatment completed on the same day
- Frequency documented as a range (e.g. 1-3/week)
- Frequency or duration on OTR is different than on the POC
- Frequency/duration on POC and OTR are not followed once treatment has begun
- Dates of service on OTR do not match the dates on the POC

Home State Health Plan as Secondary Coverage

- Prior Authorization **is not** required when Home State 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, Cenpatico will not coordinate with the primary payer.

Procedure for submitting for secondary coverage reimbursement:

1. Provider should submit the claim to the member's primary insurance.
2. Once the provider receives the Primary Explanation of Payment (EoP), the provider will submit that document and the Home State Health Plan claim to Home State Health Plan for consideration of payment.
3. If the Home State Health Plan claim is denied for non-administrative reasons, the provider can submit both EoPs along with the required clinical documentation (OTR, Script, Eval/Re-eval and Plan of Care) to the Cenpatico Appeals Department. The documentation will be reviewed for medical necessity and retro dates of service will be considered for approval/denial. Claims can then be reprocessed if an authorization is given.

Home State Health Plan as Secondary Coverage

Submit claim to member's primary insurance

→

Submit primary EoP & Home State Health Plan claim for consideration to Home State Health Plan

→

If Home State Health Plan claim denies, submit both EoPs & clinical documentation to Cenpatico Appeals for medical necessity review

Cenpatico Appeals Dept
12515-8 Research Blvd, Ste. 400
Austin, TX 78759

Appeals fax: 866-714-7991

Provider Communications

- **Feedback Letter:** a letter outlining what is needed with the next request to help justify medical necessity.
- **Problem Letter:** a letter communicating an outright rejection (request will not be processed) of the authorization request based on one of the following:
  - Member eligibility could not be verified
  - Provider could not be found
  - Plan of Care missing or illegible
  - Prescription/Order missing or outdated
  - Retro dates were requested (the prospective dates will be processed)
  - Medicaid is the secondary payer

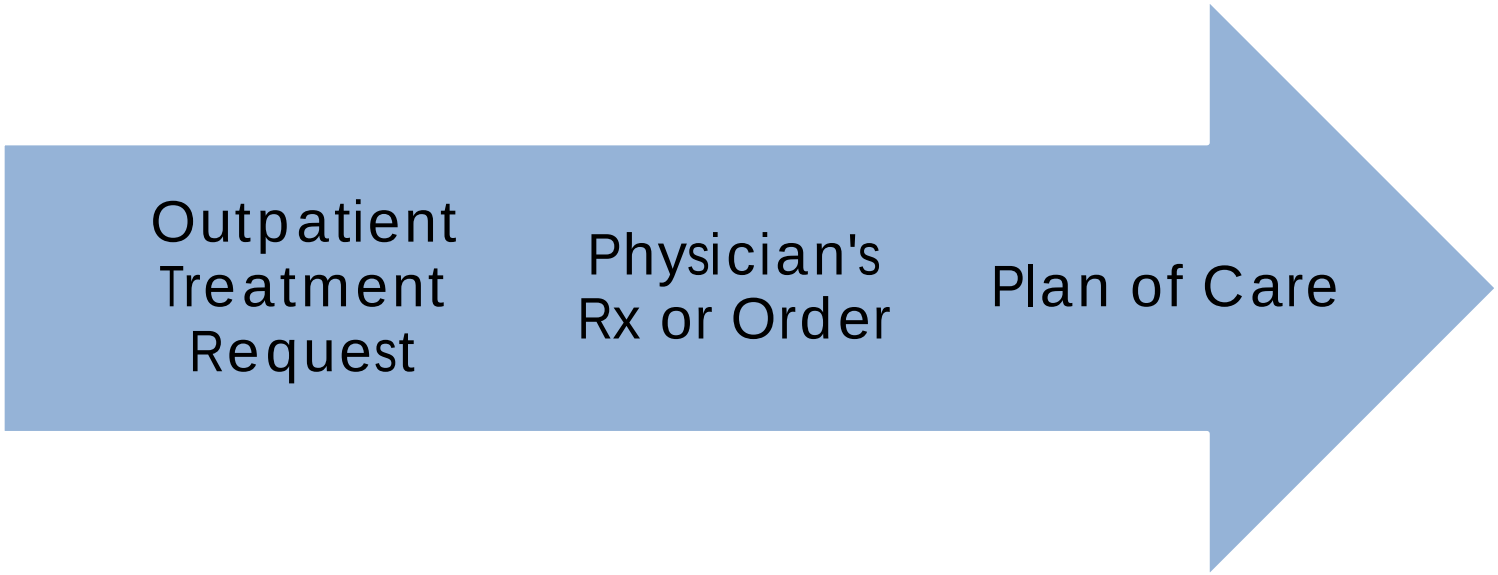
Provider Manual

Our Provider Manual offers information on our policies and procedures for serving our Members. This Manual is part of your Agreement with us and will help you ensure compliance with all regulatory authorities and program requirements. The Provider Manual covers:

- Claims Program
- Authorization Process
- Eligibility Verification
- Credentialing Policies
- Medically Necessary Criteria
- Clinical Practice Guidelines
- Appeals/Denials Process
- Utilization Management Guidelines
- Quality Improvement Guidelines
- Forms

The provider manual can be found online at
www.homestatehealth.com

Authorization Request Process



Prior Authorization

Frequently Asked Questions

Q **What?**

A OTR form, Evaluation/Plan of Care, signed prescription, and IEP/IFSP when appropriate.

Q **When?**

A After completing an initial evaluation or at end of an existing authorization period.

Q **Where?**

A Completed OTRs are faxed with supplemental clinical documentation to (855) 847-1011.

Q **How Long?**

A All requests will receive a response or phone call for additional information within one business day.

Additional Information

STRS Contacts and Resources

Home State Health Plan Website: www.homestatehealth.com

Medical Necessity Criteria: www.cenpatico.com

Home State Health Plan Phone Number: (855) 694-4663

Cenpatico Fax Number: (855) 847-1011

Claims Address: P.O. Box 6300 Farmington, MO 63640-3809

Questions?