Driscoll Health Plan

ACCREDITED Medicaid Health Plan Expires 08/01/2026

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THERAPY GUIDE

As part of our ongoing mission to ensure better health outcomes for our members, Driscoll Health Plan (DHP) has made improvements to the existing medical necessity criteria for therapy services. We value your participation in our network of therapy providers and understand that by clearly communicating our policies and criteria, we can help to ensure that therapists and therapy agencies are able to maintain their focus on providing quality treatment services to our Members.

Member referral should originate at a Texas Health Steps Exam, Well Child Exam, or other visit with the Primary Care Physician (PCP)/ or approved Specialist (Examples: Ear Nose and Throat Specialist, Developmental Pediatrician, Sports Medicine Specialist, Pulmonologist, Gastroenterologist, Cranio-facial Specialist, Neurologist, Hematologist/Oncologist, Orthopedic Physician or Rehabilitation Physician) at which time the provider documents deficits and the need for therapy referral.

Initial evaluations with in-network therapy providers do not require prior authorization; however, the clinical note from an office visit occurring in the last three to six months, with a PCP/appropriate Specialist who initiated the therapy referral, will be required if therapy visits are requested. All requests for initial evaluations referred to out-of-network therapy providers require prior authorization.

Requests for re-evaluations must originate directly from the PCP or appropriate Specialist, via fax, phone, or web. Requests for re-evaluations originating from therapy providers will be returned as "incomplete".

Requests for therapy visits may be submitted directly by the therapy providers. The referring PCP/appropriate Specialist must have a copy of the recent therapy evaluation/re-evaluation/progress summary and plan of care on file for the member.

- If submitted by the therapy provider, the request must be accompanied by the appropriate clinical notes and either:
  - A current Texas Department of Insurance *Texas Standard Prior Authorization Request Form for Health Care Services* (TARF) signed by the referring/ordering physician or physician delegated mid-level provider working in the practice; OR
  - An order or plan of care signed by the referring/ordering physician or physician delegated mid-level provider working in the practice and the *Therapy Referral Review by Ordering Physician Attestation Form.* This document is available on the DHP Provider Portal and is to be completed and signed by the therapy provider.

All requests for re-evaluations and therapy visits will be reviewed for medical necessity.

Requests for prior authorization of therapy services can be made via the DHP Provider Web Auth Portal at www.driscollhealthplan.com or via fax at:

STAR, STAR Kids, and CHIP Utilization Management Fax
1-866-741-5650

The guidelines below are provided for your assistance in requesting prior authorization for therapy services.

Driscoll Health Plan will honor the Start of Care (SOC) date when the Provider requesting the services submits the prior authorization request in a timely manner within five (5) business days of the Start of Care date, with complete clinical information and/or documents to support medical necessity and Driscoll Health Plan has determined the requested services meet medical necessity from the Start of Care date. Driscoll Health Plan will not consider service dates provided to the Member prior to the request received date if the Provider does not submit the request in a timely manner. Start date of the prior authorization request will default to the received date.

For Re-evaluation Requests: A re-evaluation order specifying the discipline(s) to be evaluated and signed by the PCP/appropriate Specialist must be submitted ***directly*** by the referring provider along with a copy of the visit note and / or the current THSteps Exam / Well Child Exam and developmental screening (as determined by the periodicity schedule and occurring in the last 12 months) that documents the continued need for therapy services.

- Requests for re-evaluation should be submitted no more than 60 days prior to the expiration of the existing treatment authorization; however, requests for continuation of therapy treatment require documentation of progress and the continuing need for therapy services which cannot be determined until closer to the expiration of the existing therapy treatment authorization. Requests submitted more frequently will be reviewed on a case-by-case basis.
- If the member has received an evaluation within the past six months, a new evaluation or re-evaluation is not required by DHP. Requests for therapy treatment may be submitted with a previous evaluation that is less than six months old. Evaluations/re-evaluations are limited to once every 180 rolling days. Evaluations/re-evaluations ***may be*** reimbursed when documentation supports a change in the client's status, a request for extension of services, or a change of provider.
- In cases where a member receiving therapy services transitions to coverage by DHP, the request for re-evaluation must also be submitted with a copy of the initial evaluation/treatment plan and any subsequent re-evaluations.
- For Speech Therapy referrals: Include the results of a recent hearing screening (see below for further detail).

For Treatment Requests: A maximum of six months of therapy visits may be authorized. Requests should be submitted along with:

- A copy of the visit note and/or the current THSteps Exam/ Well Child Exam, occurring in the last 12 months, documenting the need for therapy services is required. Additional clinical documentation may be requested if medical necessity is not clear.
- For Speech Therapy referrals: Include the results of a recent hearing screening (see below for further details).
- A therapy evaluation and Plan of Care which include:
    - A brief statement of the member's medical history and any prior therapy treatment;
    - A description of the member's current level of function or impairment, including current raw scores, standard scores, and/or criterion-referenced scores as appropriate for the member's condition or impairment as well as a description of functional impairments observed during the completion of Activities of Daily Living (ADLs);
    - A clear diagnosis and reasonable prognosis;
    - Documentation of the prescribed treatment modalities, their recommended frequency and duration, and the planned place of service/platform;

    - **For Telehealth -** Documentation of how telehealth will be incorporated into the overall therapy plan and that it is appropriate based on patient compliance, family involvement, and the proposed plan of care; and
    - Short and long-term treatment goals that are functional, measurable, and specific to the member's deficits as determined by the therapy evaluation.
- If the request is for **reauthorization of ongoing treatment**, new standardized testing is required once every six months. If the previous testing is less than 6 months old, medical necessity determination will be based on any progress toward therapy goals, improvements in function during ADLs, and if there are continuing functional deficits. Clinical documentation must include:
    - Objective demonstration of the member's progress toward previous treatment goals;
    - Description of improvements in communication/fine motor skills/self-care/gross motor skills observed by the family or therapist during the completion of ADLs;
    - Updated short and long-term treatment goals that are functional, measurable, and specific to the member's deficits;
    - An explanation of any changes to the member's plan of care, and the clinical rationale for revising the plan;
    - Attendance during the prior authorization period;
    - **For Telehealth -** Documentation of how telehealth will be incorporated into the overall therapy plan and that it is appropriate based on previous success with telehealth visits, patient compliance, family involvement, and the proposed plan of care;
    - Documentation of parent or primary caregiver participation in therapy sessions; and
    - Documentation of transition to a home program and parent/primary caregiver compliance with the plan.
- Therapy attendance of less than 75% or other documentation of poor compliance may result in a reduction in therapy frequency or denial of the request.
- OT requests should include documentation of the delays and deficits in fine motor and self-care skills that impact the completion of ADLs and how they were identified. Medical necessity will be determined based on deficits in performing ADLs, functional goals, and medical need demonstrated throughout the evaluations.

For Continuation of Care Treatment Requests: Requests for continuation of therapy treatment should be submitted no more than 30 days prior to the expiration of the existing treatment authorization; Requests for continuation of therapy treatment require documentation of progress and the continuing need for therapy services which cannot be determined until near the expiration of the existing therapy treatment authorization. Requests submitted more frequently will be reviewed on a case-by-case basis.

Hearing Assessment Requirements:

- Documentation of normal hearing in one ear by an objective method must be submitted with the request for Speech re-evaluation and therapy visits. If at the time of request a hearing evaluation has not been performed but is documented as scheduled, the re-evaluation or a short duration of therapy may be authorized.
- If the member has failed the hearing screening completed at the PCP / physician's office, an Ear Nose and Throat (ENT) Specialist referral is required. ENT evaluation should include documentation of treatment for any hearing loss that has been identified. Any member identified with hearing deficits requires a therapy treatment plan tailored to their needs that addresses hearing loss.

- Formal assessment of hearing by an audiologist or ENT may be requested at any point during an episode of speech therapy based on lack of progress, history of previous hearing loss, and / or medical diagnoses which are prone to hearing loss.

Therapy Services Provided in the Home: There should be a specified medical necessity for therapy to be provided in the home. Medical necessity criteria for therapy services provided in the home must be based on the supporting documentation of the medical need and the appropriateness of the equipment, service, or supply prescribed by the prescribing provider for the treatment of the individual. Home therapy service must be related to the client's medical condition, rather than primarily for the convenience of the client or provider.

Telehealth: The use of telehealth to provide therapy services should be related to the member's medical condition, based on best practice for the treatment of the member's specific deficits/diagnosis, and not primarily for the convenience of the member or provider. If it is not clear that Telehealth services are appropriate, the requesting PCP/appropriate Specialist may be asked to submit documentation of the medical need for telehealth and reasons why face-to-face services are not possible/desirable. Evaluations and re-evaluations should preferentially be done face-to-face unless the member is unable to physically access specialized services or the referring physician/specialist deems it medically necessary that the services be performed via telehealth. Refer to the *DHP Telehealth Guideline* for specific criteria related to telehealth therapy.

Therapy Services for Members under Age Three: HHSC requires that DHP educate providers regarding the federal laws on ECI (Early Childhood Intervention). ECI is a statewide program designated to provide services to children ages birth through 35 months of age suspected of having developmental disabilities or delays or being at risk of delay. Referrals must be made to the designated ECI program for screening and assessment within seven business days from the day the Provider identifies the member. As such, ECI is considered to be the appropriate service delivery model for developmentally delayed members under three years of age. ECI services do not require prior authorization. ECI is a voluntary service and may be refused by the parent.
Members with the following conditions may also be considered for medical-based therapy as an alternative to or as an adjunct to ECI services:

- Members with severe to profound developmental delays;
- Members with major medical diagnoses related to their therapeutic needs;
- Members with high acuity medical needs (tracheostomies, ventilator dependent, etc.)

Questions can be directed to DHP at:
STAR, STAR Kids, or CHIP Utilization Management: 1-877-455-1053

REFERENCES:

1. Texas Health and Human Services Commission. *Chapter 3.5, Uniform Critical Elements Requirements, Version 2.0.* In Texas Medicaid and CHIP - Uniform Managed Care Manual.
2. Texas Medicaid & Healthcare Partnership (TMHP). Children's Services Handbook. *Texas Medicaid Provider Procedures Manual, 2*.
3. Texas Medicaid & Healthcare Partnership (TMHP). Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook. *Texas Medicaid Provider Procedures Manual, 2*.
4. Texas Health and Human Services Commission. Texas Medicaid and CHIP – Uniformed Managed Care Contract *UMCC 8.1.3.1*