UnitedHealthcare Community Plan

Prior Authorization Policy Change for Speech, Occupational and Physical Therapy Services

As part of our commitment to the Triple Aim of better quality, improved health outcomes and better cost for our members, we regularly evaluate our policies using objective, evidence-based criteria to guide coverage decisions and support patient care.

Effective Nov. 1, 2019, UnitedHealthcare Community Plan of Texas is changing our prior authorization process for speech, occupational, and physical therapy services. These requirements will apply whether a member is new to therapy or currently receiving therapy. As with all notification/prior authorization requirements, if prior authorization is not on file before therapy is provided, it will result in a claim denial.

Requests for Initial Evaluation

Prior authorization for initial evaluations must be obtained by either the prescribing provider or therapy agency providing the service. As we are unable to provide authorization for retroactive dates of service, please ensure that prior authorization requests are submitted no later than the day the requested service is to begin. Optimally, we recommend submitting requests five business days prior to the desired start date in order to allow time for processing.

Ages 0 months to 20 years

The following documentation must be submitted:

- Signed and dated physician order, less than 60 days old, specifying the discipline(s) to be evaluated.
- Current well child visit or an exam note describing the need for the requested evaluation(s).
- For speech therapy initial evaluation requests related to language, articulation, and fluency for members less than 6 years, documentation of a hearing screening.
    - In the case of behavioral issues or the inability to participate in the hearing screen, an objective description of the behavioral issues and/or inability to participate in the hearing screen along with a statement as to why a hearing deficit is not suspected should be included.
    - In the case of suspected hearing deficit, a referral to an audiologist or physician who is experienced with the pediatric population and who offers auditory services is appropriate. Documentation of such a referral should be included in in the clinical documentation submitted.
    - ***Note***: Authorization of an initial speech evaluation will not be delayed due to a lack of objective hearing screening at the time of the request, with the expectation that objective hearing testing will be required within a reasonable timeframe.

Ages 21 years and older

The prescribing provider must submit all of the following documentation:

- Signed and dated physician order, less than 60 days old, specifying the discipline(s) to be evaluated
- Exam note describing the need for the requested evaluation(s)

Requests for Re-evaluation

Re-evaluations will require prior authorization. Requests for re-evaluation should be submitted no more than 60 days prior to the expiration of the existing treatment authorization; requests submitted more frequently will be reviewed on a case-by case basis.

- Please submit a signed and dated physician order, less than 60 days old, specifying the discipline(s) to be evaluated.
- Current well child exam or visit note documenting suspected need for ongoing care

Requests for Initial Therapy Visits

The initial request for authorization of therapy services must include the therapy evaluation report. A copy of the therapy evaluation report must include **all** of the following:

- A statement of the member's medical history, and
- Relevant review of systems, onset date of the Illness, Injury, or exacerbation and
- Description of prior therapy treatment; and
- A comparison prior level of function to current level of function, as applicable; and
- A clear diagnosis including the appropriate ICD-10 code; the ICD-10 code listed must be consistent with the clinical documentation; and
- Baseline objective measurements based on other Standardized testing performed or other Standardized Assessment tools:
    - Tests used must be norm-referenced, standardized, and specific to the therapy provided.
    - Retesting with norm-referenced standardized test tools for re-evaluations must occur every 180 days.Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation. If reuse of the initial testing instrument is not appropriate, i.e. due to change in client status or restricted age range of the testing tool, provider should explain the reason for the change.
    - Eligibility for therapy will be based upon a score that falls 1.5 standard deviatioins (SD) or more below the mean in at least one subtest area of composite score on a norm-referenced, standardized test. Raw scores must be reported along with score reflecting SD from mean.
    - When the client's test score is less than 1.5 SD below the mean, a criterion-referenced test along with informed evidence-based clinical opinion must be included to support the medical necessity of services and will be sent to physician review to determine medical necessity.
    - If a child cannot complete norm-referenced standardized assessments, then a functional description of the child's abilities and deficits must be included. Measurable, functional short and long-term goals will be considered along with test results. Documentation of the reason a standardized test could not be used must be included in the evaluation.
    - Articulation and language screeners will not be accepted in lieu of Standardized Assessment(s). Vocabulary tests should not be used to establish eligibility for a receptive and expressive language delay;and

- A description of the member's functional impairment including its impact on their health, safety, and/or independence; and
- Reasonable prognosis, including the member's potential for meaningful and significant progress;

Plan of Care

The initial request for authorization of therapy services must also include a plan of care (POC). The POC must be signed and dated by the referring provider (PCP) (MD, DO, PA or NP) or appropriate specialist. Providers must develop a member's POC based on the results of the evaluation. The POC must include **all** the following:

- Functional limitations
- Short and long-term functional goals should be: :
  - Specific to the client
  - Objectively measurable within a specified time frame
  - Attainable in relation to the client's prognosis or developmental delay
  - Relevant to client and family
  - Based on a medical need
- Treatment frequency, duration, and anticipated length of treatment session(s)
- Therapeutic methods and monitoring criteria

Bilingual and Multilingual Speakers

Bilingual and multilingual speakers are frequently misclassified as developmentally delayed. Equivalent proficiency in both languages should not be expected. For speech therapy requests, members with exposure to more than 1 language must receive culturally and linguistically adapted norm referenced standardized testing in all languages the child is exposed to in order to compare potential deficits. For speech and language therapy services to be Medically Necessary for a member who is a minority language speaker, **all** of the following criteria must be met:

- All speech deficits must be present in the language in which the members has the highest proficiency
- All language deficits must be present in the language in which the member has the highest proficiency
- Delivery of services must be in the language in which the member has the highest receptive language proficiency

Feeding and Swallowing Disorders

For feeding and swallowing evaluations, all of the following must be submitted:

- Interview/case history
- Medical/clinical records including the potential impact of medications, if any
- Physical examination
- Previous screening and assessments
- Collaboration with physicians and other caregivers
  - During assessment, Speech-Language Pathologist's determine whether the member is an appropriate candidate for treatment and/or management; this determination is based on findings that include medical stability, cognitive status, nutritional status, and psychosocial, environmental, and behavioral factors
- Assessment must result in one or more of the following outcomes:

- Description of the characteristics of swallowing function, including any breakdowns in swallow physiology
- Diagnosis of a Swallowing Disorder
- Determination of the safest and most efficient route (oral vs. non-oral) of nutrition and hydration intake
- Identification of the effectiveness of intervention and support
- Recommendations for intervention and support for oral, pharyngeal, and/or laryngeal disorders
- Prognosis for improvement and identification of relevant factors
- Referral for other services or professionals
- Counseling, education, and training to the member, health care providers, and caregivers

Requests for Continuation of Therapy Visits

Progress Reports (Summary of Progress)

Intermittent progress reports must demonstrate that the member is making functional progress to reflect that continued services are Medically Necessary. Progress reports must include:

- Start of care date
- Time period covered by the report
- Communication/swallowing diagnosis
- Member's functional communication/swallowing at the beginning of the progress report period
- Member's current status as compared to evaluation baseline data and the prior progress reports, including objective measures of member communication/swallowing performance in functional terms that relate to the treatment goals
- Changes in prognosis and why
- Changes in POC and why
- Changes in goals and why
- Consultations with other professionals or coordination of services, if applicable
- Signature and date of licensed professional responsible for the therapy services
- Signature and date of prescribing physician

Re-evaluations

Re-evaluations must be completed at least once every six (6) months to support the need for on-going services. Re-evaluations performed more often than once every 6 months should only be completed when the member experiences a significant change in functional level in their condition or functional status. The documentation must be reflective of this change. Re-evaluations must include current standardized assessment scores, age equivalents, percentage of functional delay, criterion referenced scores or other objective information as appropriate for the member's condition or impairment. The therapy re-evaluation report must include **all** of the following:

- Date of last therapy evaluation; and
- Number of therapy visits authorized and number of therapy visits attended; and
- Compliance to home program;
- A statement of the member's medical history, and
- Relevant review of systems, onset date of the Illness, Injury, or exacerbation and
- Description of prior therapy treatment; and
- A comparison prior level of function to current level of function, as applicable

- A clear diagnosis including the appropriate ICD-10 code; the ICD-10 code listed must be consistent with the clinical documentation; and
- Baseline objective measurements based on other Standardized testing performed or other Standardized Assessment tools:
  - Tests used must be norm-referenced, standardized, and specific to the therapy provided.
  - Retesting with norm-referenced standardized test tools for re-evaluations must occur every 180 days.Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation. If reuse of the initial testing instrument is not appropriate, i.e. due to change in client status or restricted age range of the testing tool, provider should explain the reason for the change.
  - Eligibility for therapy will be based upon a score that falls 1.5 standard deviatioins (SD) or more below the mean in at least one subtest area of composite score on a norm-referenced, standardized test. Raw scores must be reported along with score reflecting SD from mean.
  - When the client's test score is less than 1.5 SD below the mean, a criterion-referenced test along with informed evidence-based clinical opinion must be included to support the medical necessity of services and will be sent to physician review to determine medical necessity.
  - If a child cannot complete norm-referenced standardized assessments, then a functional description of the child's abilities and deficits must be included. Measurable, functional short and long-term goals will be considered along with test results. Documentation of the reason a standardized test could not be used must be included in the evaluation.
  - Articulation and language screeners will not be accepted in lieu of Standardized Assessment(s). Vocabulary tests should not be used to establish eligibility for a receptive and expressive language delay;and
- A description of the member's functional impairment including its impact on their health, safety, and/or independence; and
- Reasonable prognosis, including the member's potential for meaningful and significant progress; and;
- An updated individualized POC must include updated measurable, functional and time based goals:
  - The updated POC/progress summary must not be older than 90 days
  - If the majority of the long and short-term goals were not achieved, the plan of care must include a description of the barriers or an explanation why the goal(s) needed to be modified or discontinued and
- A revised POC that the treating therapist has not made a meaningful update to support the need for continued services will not be accepted. In addition, the notation of the percentage accuracy towards the member's goals alone is not sufficient to establish a need for continued, Medically Necessary therapy

Treatment Session Notes

All treatment session notes must include:

- Date of treatment
- Specific treatment(s) provided that match the CPT code(s)s billed
- Start and stop time in treatment corresponding to each CPT code billed

- Total treatment time corresponding to each CPT code billed; an encounter for Speech Therapy is defined as face-to-face time with the patient and caregiver as applicable for a length of time that is consistent with nationally recognized professional speech-language pathology standards
- In exceptional cases, a shortened treatment session may be billed, provided the documentation supports the clinical reason and demonstrates the benefit to the member
- The individual's response to treatment
- Skilled ongoing reassessment of the individual's progress toward the goals
- All progress toward the goals in objective, measurable terms using consistent and comparable methods;
- Any problems or changes to the plan of care
- Member or caregiver involvement in and feedback about home program activities
- Signature and date of the treating clinician

Additional Considerations

- Speech therapy is not considered medically necessary when
  - The proposed therapy is solely education in nature such as grammar, vocabulary, or other subjects which are part of the school curriculum
  - The language delay is as a result of English being a second language
  - The proposed therapy is considered experimental or investigational

Therapy Services for Members under Age 3:

The Texas Health and Human Services (HHS) ECI program is available statewide to all children who have been determined to be eligible for ECI services by ECI contractors. To be eligible for ECI services, children must be 35 months of age and younger (i.e., before their third birthday) and have disabilities or developmental delays as defined by ECI criteria. Texas Medicaid covers the ECI claims for children who are Medicaid clients.

All health-care professionals are required by federal and state regulations to refer children who are 35 months of age and younger (i.e., before their third birthday) to the Texas HHS ECI program as soon as possible, but no longer than 7 days after identifying a disability or suspected delay in development. Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.

Criteria for Discontinuation of Services

Discontinuation of therapy may be considered in one or more of the following situations:

- Client no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care.
- Client has returned to baseline function.
- Client can continue therapy with a home treatment program and deficits no longer require a skilled therapy intervention and, for clients who are 20 years of age and younger only, maintain status.
- Client has adapted to impairment with assistive equipment or devices.
- Client is able to perform ADLs with minimal to no assistance from caregiver.
- Client has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy.

- Client is unable to participate in the treatment plan or plan of care due to medical, psychological, or social complications; and responsible adult has had instruction on the home treatment program and the skills of a therapist are not needed to provide or supervise the service.
- Testing shows client no longer has a developmental delay.
- Plateau in response to therapy/lack of progress towards therapy goals. Indication for therapeutic pause in treatments or, for those under age 21, transition to chronic status and maintenance therapy.
- Non-compliance due to poor attendance and with client or responsible adult, non-compliance with therapy and home treatment program.

If you have questions, please call us at **888-887-9003** from 8 a.m. to 6 p.m. Central Time, Monday through Friday. You can also contact your Physician Advocate directly.

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