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Cook Children's Health Plan

SEPTEMBER 2015

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THERAPY GUIDE

OVERVIEW:

It is Cook Children's Health Plan's policy to authorize all medically necessary and appropriate therapy (Physical Therapy, Occupational Therapy, Speech Therapy).

At the highest level - medically necessary services are those that are necessary to correct or ameliorate a defect or physical or mental illness or condition.

It must also be provided in the appropriate setting, consistent with accepted practice, consistent with the member's diagnosis, provides a proper balance of safety, effectiveness and efficiency and not primarily for the convenience of the member or the provider. (See T.A.C. §353.2 for Medicaid and 1 T.A.C. §370.4 for CHIP.)

- Protocol and/or these authorizations are evaluated, reviewed and supported by the Medical Director and Associate Medical Director(s) that are experienced physicians with a strong understanding of patient needs and expected clinical outcomes associated with outpatient therapy.
- Determinations are based upon evidence based criteria and can change if warranted by clinical needs of Cook Children's Health Plan members.
- The location of the therapy service (outpatient or home) must be medically necessary and appropriate. Cook Children's Health Plan does not routinely authorize therapy in day care, and other similar settings.

WHO MAY SUBMIT THERAPY REFERRAL REQUESTS

THERAPY REQUESTS BEGIN WITH THE PRIMARY CARE PHYSICIAN OR ATTENDING SPECIALIST. Physicians guide requests for therapy. This includes, initial evaluations, re-evaluations, and requests for services. Requests are accepted from mid-level practitioners assigned as primary care physicians.

After the therapist's evaluation is completed, the recommended therapy treatment plan is to be reviewed by the primary care physician/attending specialist to determine appropriateness and medical necessity. The primary care physician/attending specialist signs and attests to agreement with the plan of care.

The request for therapy is then submitted with the signed Cook Children's Health Plan authorization request from the primary care physician/attending specialist. At this time, Cook Children's Health Plan does not specify whether it be faxed from the primary care physicians/specialists office or from the therapy provider

The primary care physician or attending specialist's order date must pre-date the therapy evaluation date.

All requests for services must come through the primary care physician/attending specialist. This insures that the primary care physician/attending specialist is kept in the loop as 'captain of the ship' and responsible for the total care of his/her patient.

Cook Children's Health Plan appropriately reimburses physicians for re-evaluation examinations, which guide continued therapy.

THERAPIST SERVICES AND RE-EVALUATIONS

Initial authorizations may be given for 60 days to document attendance and progress toward short term goals, a progress report documenting those items should accompany the request to extend services beyond 60 days.

Formal re-evaluation may be performed every six months. The re-evaluation should occur after a medical evaluation visit with the primary care physician or attending specialist who would then order continued services.

PHYSICAL THERAPY PROTOCOL

- Children under the age of 36 months are referred to Early Childhood Intervention – unless compelling reasons to go elsewhere. If additional services are needed Early Childhood Intervention will collaborate with Cook Children's Health Plan and primary care providers/attending specialist. Note: The parent may decline, after objective education.
- Emphasis on true rehab and instruction to the member/parent or legally authorized representative.
- No 'athletic trainer work' (strengthening and conditioning – tempering condition through continued aggravating sports actions). Lumbago, patella-femoral syndrome, sprains, strains can be addressed with visits to develop and implement home exercise program.

AUTHORIZATION SUBMISSION TIPS: (PHYSICAL THERAPY)

- **INITIAL EVALUATION** may be requested by a mid-level practitioner when the request is an outcome of a well-child examination (THSteps). Submit that assessment with the request for a therapy evaluation.
    - Important: Requests must include a copy of the prescription or order by the primary care physician/attending specialist for the evaluation dated **prior** to the therapy evaluation date.
    - **TREATMENT PLAN SIGN OFF:** All therapy treatment plans and authorization requests must be signed off by the primary care physician/attending specialist.

- Requests must have an initial evaluation that includes documentation in the medical record of the diagnosis and reason for referral (for example, injury, deficit in movement, post-op, etc.)
- For chronic conditions, a plan of care is needed which includes transition to home program/self-administered therapies. Goals should state specific therapies required to "train" home person (mom or other) and then therapy follow-up to evaluate how home person is doing (for example, 2 therapy sessions X one week to train mom, and then 1 therapy session per month to evaluate member, X 3 months.)

- Physical therapy is not needed for those injuries that heal on their own, like minor sprains.
- If therapy is related to an injury, Cook Children's Health Plan needs to know how the injury occurred, as this may be a subrogation issue (for example, if due to a car accident.)

OCCUPATIONAL THERAPY PROTOCOL

- Children <36 months are referred to Early Childhood Intervention– unless there is a compelling reasons to go elsewhere. Note: The parent may decline, after objective education.
- Functional or hard skills addressed (not splinter skills of block stacking, drawing circles – all of which can be done elsewhere and not require skilled training) – walking, zipping, tying, potty training/skills – transfers, etc...
- Not to be used as adjunct for behavioral diagnoses (ADD, etc.)

AUTHORIZATION SUBMISSION TIPS (OCCUPATIONAL THERAPY)

- **INITIAL EVALUATION** may be requested by a mid-level practitioner when the request is an outcome of a well-child examination (THSteps). Submit that assessment with the request for a therapy evaluation.
- Important: Requests must include a copy of the prescription or order by the primary care physician/attending specialist for the evaluation dated **prior** to the therapy evaluation date.
- **TREATMENT PLAN SIGN OFF:** All therapy treatment plans and authorization requests must be signed off by the primary care physician/attending specialist.
- Occupational therapy authorization requests must have an initial evaluation completed and results submitted for review by Cook Children's Health Plan that includes:
- Results of standardized testing – Peabody, etc.
- Medical Diagnosis.
- Evaluation must state specific developmental appropriate ADL's that are lacking.
- Medical necessity criteria does not include Behavioral diagnoses -these are addressed through our contracted Behavioral Health Organization (Beacon.)
- Goals should be directed to activities of daily living (ADL's.)

Goals must state how patient will be improved in 3 months

SPEECH THERAPY PROTOCOL

- Children <36 months are referred to Early Childhood Intervention – unless compelling reasons to go elsewhere. Note: The parent may decline, after objective education.
- Hearing documented by Pure Tone Audiometry, or audiogram.
- Standardized testing of language, PLS-5, GFTA.
- Estimate of Intelligibility
- Full medical diagnoses (more than developmental delay – autism, Down's syndrome, PDD, preemie, etc.)
- Total length of time in therapy, and by whom.
- Copy of the prescription or order by the primary care physician for the evaluation (this is important) dated prior to the evaluation.
- Therapy referrals for developmental delay should originate at a well-child or THSteps Exam.
- Assessment/goals should include their ability to communicate their basic needs and wants.
- Requested services should not be educational, cognitive or behavioral in nature.
- Should this be done in school environment? If child does NOT qualify for school services – why not – how one functions in school (adaptability) is a fair measure of performance in ADLs.
- Articulation – not dialectic/accent – common substitutions of ch/sh or h/j for example.
- Member must be evaluated in their primary language or bilingual. Therapy will be provided in the dominant language. Speech therapy to teach English as a second language is not medically necessary.

AUTHORIZATION SUBMISSION TIPS (SPEECH THERAPY)

- **INITIAL EVALUATION** may be requested by a mid-level practitioner when the request is an outcome of a well-child examination (THSteps). Submit that assessment with the request for a therapy evaluation.
    - Important: Requests must include a copy of the prescription or order by the primary care physician/attending specialist for the evaluation dated **prior** to the therapy evaluation date.
- **TREATMENT PLAN SIGN OFF**: All therapy treatment plans and authorization requests must be signed off by the primary care physician/attending specialist.
- Speech therapy requests must have an initial evaluation completed and results submitted for Cook Children's Health Plan review that includes:
    - Results of standardized testing – PLS-5, GFTA or for under six year old – CELF, TOLD
    - Diagnosis that includes any medical diagnosis such as – Down's syndrome, CP, Autism, Microcephaly, etc.

REQUESTS FOR ADDITIONAL SPEECH THERAPY MUST INCLUDE, IN ADDITION TO ABOVE:

- Any previous therapies provided and progress towards goals from previous therapies.
- Hearing status, to include results of hearing tests, or statement from primary care physician that hearing is within normal limits.
- Current and updated statement regarding communication skills, and an estimate of intelligibility.
- Note from primary care physician that he/she has seen this child at some point over the past six months, and that has personally requested the service.

CORF SERVICES (COMPREHENSIVE OUTPATIENT REHAB FACILITY)

- At times, a more intensive type of comprehensive intense outpatient therapy will be needed for conditions such as acute injuries or illnesses.

Those patients meeting medical necessity and thereby qualify for this acute rehab designation will be identified as such and receive intense services as requested

NEW SERVICE AUTHORIZATION REQUEST FORM & NEW SERVICE AUTHORIZATION THERAPY REQUEST FORM

Cook Children's Health Plans new Service Authorization Request Form is the same format as the new Texas Department of Insurance form which became effective 09/01/2015. This form is two pages long and includes the instruction page.

Please note one Cook Children's Health Plan addition to the form on Section VI. When requesting authorization for Medicaid members, please be sure to put the service billing provider's group or individual (per your contract with Cook Children's Health Plan) Texas Provider Identification "TPI" number in this section."

Providers may elect to use the New *Service Authorization Request Form* and the New *Service Authorization Therapy Request Form* immediately. These new forms will become our standard authorization request forms effective 10/05/2015.

ON and AFTER 10/5/2015, as is Care Management's standard practice when Cook Children's Health Plan changes a form, we will send the new form to any provider who does not submit the new form. We will not hold up the authorization request submitted on the old form.

EXAMPLES OF THE FORMS MAY BE REVIEWED BELOW AND CAN BE FOUND ON OUR WEBSITE AT:

http://www.cookchp.org/English/Providers/Pages/Forms.aspx

If you have any questions please call 1-800-964-2247 Monday through Friday from 8:00am to 5:00pm CST (Central Standard Time)

CookChildren's
Health Plan

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0115

Texas Department of Insurance

Please read all instructions below before completing this form.
*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: When an issuer requires prior authorization of a health care service, use this form to request authorization **by fax or mail**. An issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, via the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I. An issuer may have already entered this information on the copy of this form posted on its website.

Section II. Urgent reviews: Request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV.

- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI.

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before faxing or mailing your request.

If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

CookChildren's Health Plan

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
Cook Children's Health Plan	682-885-2252 Toll Free 800-862-2247	682-885-8402 Toll Free 844-643-8402	8/24/2015

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	Sex: ☐ Male ☐ Female ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name *(see instructions)*:	
Requesting Provider's Signature and Date *(if required)*:		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version__	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other:_____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency:_____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits:_____ Duration:_____ Frequency:_____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) *(Medicaid only*: Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS codes):_____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION *(SEE INSTRUCTIONS PAGE, SECTION VI)*

For Medicaid members please insert the service/billing provider's TPI here:

An issuer needing more information may call the requesting provider directly at: _____

CookChildren's Health Plan

Therapy Authorization Request Form

Member Name	Last:	First:	Middle:
ID Number		Date of Birth:	
Diagnoses Requiring Therapy:			
ICD-9/ICD-10 Diagnosis Codes:			

Therapy Discipline, Type and Requested and Place of Service – please check appropriate boxes

☐ PT ☐ OT ☐ ST Condition for Therapy ☐ Acute ☐ Chronic	**Place of Service (All Other Requested POS Must Be Medically Necessary / Appropriate and Not for Provider or Member Convenience. Attached supporting clinical information is required.)** ☐ Office (11) ☐ Outpatient Hospital (22) ☐ *Other (Specify specific place of service for therapy)_____

Are the requested therapy services provided through the following programs:	School Health and Related Services (SHARS) ☐ Yes ☐ No	Early Childhood Intervention (ECI) ☐ Yes ☐ No

Date of Therapy Evaluation or Re-evaluation	PT / /	OT / /	ST / /

Attach a copy of the therapy evaluation, re-evaluation, or most recent progress note for each therapy discipline requested.

Discipline and Modifier	Dates of Service		Procedure Code(s) Requested	Frequency per Week	Total Requested
	From	Through			☐ Units ☐ Visits
PT (GP)	/ /	/ /			
OT (GO)	/ /	/ /			
ST (GN)	/ /	/ /			

Prescribing physician signature/attestation is required on this form unless one of the following is attached to request: a legible, signed and dated prescription or written order by the attending physician for new evaluation; Prescribing physician's review and signature are required for treatment plan & any ongoing therapy authorization request.

	Printed Name	Signature & Medical Necessity Attestation	Date of Signature
Physical Therapist			/ /
Occupational Therapist			/ /
Speech Therapist			/ /
Prescribing Physician			/ /

Prescribing Physician NPI and License Number		Date Member Last Seen by Prescribing Physician: / /

Therapy Billing Provider Information

Therapist or Company Name (Service/Billing Provider):	Telephone:
Address*	Fax:
For STAR Members - TPI (Service/Billing Provider):	For CHIP Members - NPI (Service/Billing Provider):

(PLEASE DO NOT WRITE BELOW THIS LINE.)

☐Approved ☐Denied ☐Partial Denial Effective Date: From___/___/___ To___/___/___

Authorization Number:_____

Authorization is a condition of reimbursement and is not a guarantee of payment. Payment of a claim is subject to a member's eligibility at the time services are provided and to the contractual limitations, provisions, and exclusions of the member's benefit plan.

How to Contact us

Hours of Operation: Monday – Friday 8:00am – 5:00pm
You can visit our website at: www.cookchp.org

Cook Children's Health Plan

Main Number:

(682)885-2247 or (800)964-2247 Toll Free

Department	Fax Number	Service Provided
Member Services	682-885-8401 Email Address: cchpmemberservices@cookchildrens.org	Eligibility, Benefits, or General Inquiries
Care Management	682-885-8402 844-346-8402 Toll Free Fax	Pre-Authorizations, Case Management, Referrals, Disease Management
Claims Department	682-885-2148	Claims Status, Payments, Appeals or Questions
Network Development	682-885-8403 Email Address: CCHPNetworkDev@cookchildrens.org	Credentialing, Provider contracts, Name change, Address Change, NPI/TPI update, Phone & Fax update, Billing Company Change
Outreach	682-885-8436	Questions about Migrant Farm Workers, THSteps/Well Child Appointments

Department	Phone Number	Fax Number	Service Provided
National Vision Administrators (NVA)	(888)830-5630 Email Address: providers@e-nva.com	(888)830-5560	Vision Services
Beacon Health Services	(855)481-7045 Email Address: ProviderRelations@beaconhs.com	(855)371-9227	Mental Health Services

Paper Claims Address:
Cook Children's Health Plan
P.O. Box 961295
Fort Worth, TX 76161-1295

Appeals, COB, and General Mailing Address
Cook Children's Health Plan
P.O. Box 2488
Fort Worth, TX 76113-2488