CookChildren's Health Plan

Therapy Services Handbook

Physical Therapy | Occupational Therapy | Speech Therapy

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TSH0821

To ensure better health outcomes

for our Members, Cook Children's Health Plan has developed this Comprehensive Therapy Program Handbook for your reference.

Our objective is to communicate our policies, protocols and criteria to help ensure that ordering Providers, therapists and therapy agencies are able to maintain their focus on providing quality treatment services to our Members.

We value your participation in our network.

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Therapy overview

Comprehensive therapy program guidelines

It is **Cook Children's Health Plan's** policy to authorize all medically necessary and appropriate therapy (Physical Therapy, Occupational Therapy and Speech Therapy). A diagnosis alone is not sufficient documentation to support medical necessity for therapy.

Therapy services must be provided in the appropriate setting, consistent with accepted practice and the Member's diagnosis, and should provide a proper balance of safety, effectiveness and efficiency. Therapy setting should not be provided primarily for the convenience of the Member or the Provider.

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, home, other) must be medically necessary and appropriate.

Medically necessary therapy services

Physical, Occupational and Speech Therapy services must be medically necessary to the treatment of the individual's chronic or acute need. A diagnosis alone is not sufficient documentation to support medical necessity for therapy.

To be considered medically necessary, all of the following conditions must be met:

- The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the Member's condition.
- The services requested must be of a level of complexity or the Member's condition must be such that the services required can only be effectively performed by or under the supervision of a licensed Occupational Therapist, Physical Therapist or Speech-Language Pathologist and requires the skills and judgment of the licensed therapist to perform education and training.
- Functional goals refer to a series of behaviors or skills that allow the Member to achieve an outcome relevant to his/her health, safety or independence within the context of everyday environments. Functional goals must be specific to the Member, objectively measurable within a specified time frame, attainable in relation to the Member's prognosis or developmental delay, relevant to Member and family and based on a medical need.
- For Members who are 20 years of age and younger, the following conditions must be met:
    - The goals of the requested services to be provided are directed at improving, adapting, restoring or maintaining functions which have been lost or impaired due to a recent illness, injury, loss of body part or congenital abnormality or as a result of developmental delay or the presence of a chronic medical condition.
    - Testing must establish a Member with developmental delays meets the medical necessity criteria as defined in subsection 5.3, "Developmental Delay Criteria" in this handbook for chronic therapy services.
- For Members who are 21 years of age and older, the following conditions must be met:
    - The goals of the requested services to be provided are directed at improving, adapting or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part and restore Member's function to within normal activities of daily living (ADL).
    - There must be reasonable expectation that therapy will result in a meaningful or practical improvement in the Member's ability to function within a reasonable and predictable time period.

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. When applying criteria to each individual, consider at least the following characteristics:

- Age
- Comorbidities
- Complications
- Progress in treatment
- Psychosocial situation
- Home Environment, when applicable

The therapy service must be related to the Member's medical condition, rather than primarily for the convenience of the Member or Provider.

Frequency must always be commensurate with the Member's medical and skilled therapy needs, level of disability (for Members who are 20 years of age and younger) and standards of practice; it is not for the convenience of the Member or the responsible caregivers.

The following apply:

- Treatment plans and plans of care developed must include not only the initial frequency (high, moderate or low) but the expected changes of frequency throughout the duration period requested based on the Member's anticipated therapy treatment needs.
- An example of a tapered down frequency request initiated with a high frequency is: 3 times a week for two weeks, two times a week for two weeks, one time a week for two weeks, 1 time every other week.

Therapy services are limited to one evaluation, re-evaluation or treatment up to the limits outlined in this handbook for each therapy discipline per date of service.

Physical Therapy (PT)

The practice of Physical Therapy includes:

- Evaluation and treatment of deficits involving the musculoskeletal and/or neurological systems.
- Rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, surgery or birth defect through the application of goal-directed functional activities.
- Utilization of the following services to reduce the incidence or severity of disability and/or pain to enable, train or retrain a person to perform independent skills and activities of daily living (ADL):
    - Treatment
    - Consultation
    - Caregiver/Member education

Texas Medicaid limits Physical Therapy to the skilled treatment of Members who have an acute disorder, acute exacerbation of a chronic disorder or chronic medical condition of the musculoskeletal and/or neuromuscular systems. A Physical Therapist or Physical Therapist Assistant within their licensed scope of practice may provide Physical Therapy. A physician can request, provide and bill for therapy services (physical, occupational and speech therapy). However, a physician may not misrepresent themselves as a therapist.

Occupational Therapy (OT)

The practice of Occupational Therapy includes:

- Evaluation and treatment of a person whose ability to perform the tasks of living is threatened or impaired by developmental deficits, sensory impairment, physical injury, surgery or illness.

- "Occupational Therapy evaluations include an occupational profile, medical and therapy history, relevant assessments and development of a plan of care, which reflects the therapist's clinical reasoning and interpretation of the data." CPT 2017, p. 664
- Using therapeutic goal-directed activities to:
- Evaluate, prevent or correct physical dysfunction
    - Maximize function in a person's life
    - Applying therapeutic goal-directed activities in treating Members on an individual basis, in groups, or through social systems, by means of direct or monitored treatment or consultation.
    - Occupational Therapy uses purposeful activities to obtain or regain skills needed for ADLs and/or functional skills needed for daily life lost through an acute medical condition, acute exacerbation of a medical condition or a chronic medical condition related to injury, disease, surgical intervention or other medical causes. ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming and mobility.

Texas Medicaid limits Occupational Therapy to the skilled treatment of Members whose ability to function in life roles is impaired. An Occupational Therapist or Occupational Therapist assistant within their licensed scope of practice may provide Occupational Therapy. A physician can request, provide and bill for therapy services (physical, occupational and speech therapy). However, a physician may not misrepresent themselves as a therapist.

Speech Therapy (ST)

The practice of Speech Therapy includes:

- Evaluation and treatment of speech sound and motor speech disorders, stuttering, voice disorders, aphasia and other language impairments, cognitive disorders, social communication disorders and feeding and swallowing (dysphagia) deficits.
- Speech Therapy is designed to ameliorate, restore or rehabilitate speech-language, communication and swallowing disorders that have been lost or damaged as a result of chronic, acute or acute exacerbation of a medical condition due to a recent injury, disease or other medical conditions, or congenital anomalies or injuries.

Types of disorders treated by Speech-Language Pathologists:

- Language Disorders – Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology and syntax), content and meaning of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one or all of the above components.
- Speech Production Disorders – Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production Disorders may involve one, all, or a combination of these components of the speech production system. An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal and/or apraxia, dysarthria.

- Oral-Motor/Swallowing/Feeding Disorders – Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

A Speech-Language Pathologist or assistant in Speech Therapy within their licensed scope of practice may provide Speech Therapy. A physician can request, provide and bill for therapy services (physical, occupational and speech therapy). However, a physician may not misrepresent themselves as a therapist.

Speech Therapy hearing requirements

Hearing plays a critical role in the development of speech and language. Early identification and treatment of a hearing loss will help minimize the negative effects associated with hearing loss. Cook Children's Health Plan would like to ensure that each Member has adequate hearing to maximize their potential to attain speech and language and fully benefit from Speech Therapy services. Cook Children's Health Plan will not withhold what might be necessary therapy for its Members solely because of delays in the Member's ability to schedule a hearing screening. Cook Children's Health Plan does not require prior authorization for initial evaluation or re-evaluations. Initial Speech Therapy treatment requests are not denied or delayed when there is no objective hearing screen received. Cook Children's Health Plan will issue an authorization up to 180 days to allow additional time to complete an objective hearing screening.

Objective hearing screenings may include the *The Cook Children's Health Plan Hearing Loss Risk Screen* completed by the evaluating Speech-Language Pathologist or an audiometric screening. An audiometric screening is a hearing screening completed with the use of an audiometer and performed by the primary care physician office, audiologist, school nurse or Speech-Language Pathologist. Additional objective hearing measures are included in *Chart A* (page 9), "*objective auditory screenings*". *The Cook Children's Health Plan Hearing Loss Risk Screen* checklist is included as a separate attachment and is featured at the end of this handbook. The information in *The Cook Children's Health Plan Hearing Loss Risk Screen* may be included in the medical and/or hearing history of the Speech Therapy evaluation report, or the checklist attached at the end of this handbook, second to last page.

Both of these hearing screenings are administered with pass/fail results for the purpose of identifying those persons with possible hearing impairment that have the potential of interfering with communication. The Member/legally authorized representative (LAR), referring, and servicing Providers are notified via the authorization approval letter.

Additional notification of Speech Therapy authorizations to the Member/LAR and servicing Provider are communicated via the approval letter. Cook Children's Health Plan may deny subsequent Speech Therapy treatment requests if the objective hearing screening is not completed and the Member has at least two risk factors for hearing loss and/or demonstrates a lack of progress despite Speech Therapy intervention.

To that end, the following process will be followed for all children receiving Speech Therapy intervention:

Cook Children's Health Plan follows the Texas Medicaid Provider Procedures Manual (TMPPM) Children's Services Handbook guidelines for hearing screenings. The following medical and hearing history information, from Cook Children's Health Plan Hearing Loss Risk Screen, should be included on the first Speech Therapy evaluation submitted to Cook Children's Health Plan.

Children ages 3 years and younger with a failing hearing loss risk screen

If the Member's medical and hearing history identifies **two (2)** or more risk factors for hearing loss, documentation of normal hearing in at least one ear by an objective hearing screening (see *Chart A* on page 9, "*objective auditory screenings*") performed by the primary care physician office, audiologist, school nurse or Speech-Language Pathologist should be completed within the 180-day authorization period and submitted to Cook Children's Health Plan with the next request for Speech Therapy treatment.

- For children who are not able to participate in audiometric screening at their primary medical Provider's office, school or by the Speech-Language Pathologist due to developmental abnormalities, level of functioning and/or behavioral problems, a referral to a pediatric audiologist who has the necessary equipment and expertise should be made.
- If a child has attempted testing through a pediatric audiologist and is not able to participate in audiometric screening due to developmental abnormalities, level of functioning and/or behavioral problems, then the subjective hearing screening and proposed plan of care will be taken into consideration. The Speech Therapy request may be reviewed by the Cook Children's Health Plan Medical Director and may be denied.

Cook Children's Health Plan may request an objective hearing screening should there be documentation of slow or no progress in Speech Therapy without other explanation.

Children over 3 years of age, with a failed hearing loss risk screen

If the Member's medical and hearing history identifies **three (3)** or more risk factors for hearing loss, documentation of normal hearing in at least one ear by an objective hearing screening/audiometric screening (see *Chart A* on page 9, "*objective auditory screenings*") performed by the primary care physician office, audiologist, school nurse or Speech-Language Pathologist as part of the THSteps Medical Checkup Periodicity Schedule should be completed within the 180-day authorization period and submitted to Cook Children's Health Plan with the next request for Speech Therapy treatment.

- For children who are at ages that are not required to have audiometric screening on the Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children and Adolescents, an age-appropriate, objective hearing screening should be used (see *Chart A* on page 9, "*objective auditory screenings*").
- For children who are not able to participate in audiometric screening at their primary medical Provider's office, school or by the Speech-Language Pathologist due to developmental abnormalities, level of functioning and/or behavioral problems, a referral to a pediatric audiologist who has the necessary equipment and expertise should be made.
- If a child has attempted testing through a pediatric audiologist and is not able to participate in audiometric screening due to developmental abnormalities, level of functioning and/or behavioral problems, then a subjective hearing screening and proposed plan of care will be taken into consideration. The Speech Therapy request may be reviewed by the Cook Children's Health Plan Medical Director and may be approved or denied based on medical necessity.

Cook Children's Health Plan may request an objective hearing screening should there be documentation of slow or no progress in Speech Therapy without other explanation.

Children with identified hearing loss and have hearing aids/hearing implants

A current aided hearing screening, completed within the last 12 months, should be submitted with the initial Speech Therapy request or with the subsequent Speech Therapy request.

Failed objective hearing screening

If the current objective hearing screening demonstrates failing results, a 180-day approval for initial Speech Therapy requests or a 90-day approval for Speech Therapy reauthorization requests will be granted to allow time for completion of a re-screening by the referring Provider. If the Member fails a second hearing screening, medical management of the hearing loss should be initiated by the ordering Provider, which may include services of a pediatric audiologist for amplification initiation and treatment. Speech Therapy services will not be delayed; however, the Speech Therapy plan of care must take into consideration the status of the Member's hearing.

If a follow-up objective hearing screening cannot be completed prior to a request for Speech Therapy treatment, a 90-day approval will be granted to allow time for the objective hearing screening to be completed. If the objective hearing screening is not completed within the 90-day approval period, one additional 'grace period' approval for the remaining dates initially requested, up to 90 days, will be issued to provide extra time for the completion of the objective hearing screening. A 90-day progress note documenting objective progress toward short-term speech/ language goals may be requested at the discretion of Cook Children's Health Plan. Should the hearing screening not be completed within the two additional 'grace period' approvals, the next request for Speech Therapy may be reviewed by the Cook Children's Health Plan Medical Director and may be approved or denied based on medical necessity.

Chart A: objective auditory screenings

Auditory screening	Developmental age of child
Audiometric screening	4 years to adolescence
Conventional audiometry	4 years to adolescence
Otoacoustic emissions (OAE)	All ages
Visual reinforcement audiometry (VRA)	9 months to 2.5 years
Conditioned play audiometry	2.5 years to 4 years
Auditory brain stem response	All ages

Based on American Academy of Pediatrics (AAP) hearing recommendations: Buz Harlor, A.D. & Bower, C (2009).

Speech Therapy requests for feeding/swallowing (CPT 92526) are exempt from hearing screening unless the plan of care also includes speech and language goals.

Access to care for therapy services

Per the Uniformed Managed Care Contract Section 8.1.3.1, Cook Children's Health Plan requires the initial evaluation of Members to be completed within 21 calendar days from order receipt date. If a prior authorization request for therapy treatment is then submitted and approved, initiation of therapy treatment services should occur within 21 calendar days from the evaluation completion date in order to ensure that Members are receiving timely access to therapy services. If there is an interruption in service in which the therapy Provider cannot staff services for the Member during ongoing therapy services, the agency should notify Cook Children's Health Plan within five business days and provide an update as to when services will resume for the Member. The therapy Provider should notify Cook Children's Health Plan and/or Texas Health and Human Services (HHSC) that the Member is on a wait list should the therapy Provider not be able to comply with the above time frames.

In addition to reporting the above therapy wait list occurrences, Cook Children's Health Plan is required by Rider 57 to report monthly to HHSC complaints regarding:

- Providers that are not accepting new Members
- Providers terminated from the Cook Children's Health Plan's network

Cook Children's Health Plan has implemented the above requirements to provide timely reporting to HHSC. If any of these situations occur, Providers should submit notification to Cook Children's Health Plan Network Development Department. Therapy Providers no longer accepting new patients should send written confirmation of the change by email. If a therapy Provider cannot meet the service needs of the patient(s), the Provider should send a list of the Members affected by attaching the Therapy Notification to Cook Children's Health Plan document to Cook Children's Health Plan by email. This information may also be found on our website: http://www.cookchp.org/English/Providers/Pages/Therapy-Information.aspx

Services and benefits

Acute PT, OT and ST services

Acute* therapy services are benefits for the medically necessary short-term treatment of an acute* medical condition or an acute exacerbation of a chronic medical condition. Treatments are expected to significantly improve, restore or develop the physical functions diminished or lost as a result of recent** trauma, illness, injury, disease, surgery or change in medical condition, in a reasonable and generally predictable period of time (60 days) based on the prescribing Provider's and therapist's assessment of the Member's restorative potential.

**Acute is defined as an illness, surgery or trauma with a rapid onset and short duration.*

***Recent is defined as occurring within the past 90 days of the treating Provider's evaluation of the condition.*

A medical condition is considered chronic when 120 days have passed from the start of therapy or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time.

With documentation of medical needs, Physical, Occupational and Speech Therapy may continue for a maximum of 120 days for an acute medical condition or an acute exacerbation of a chronic medical condition.

Once the Member's condition is no longer considered acute, continued therapy for a chronic condition will only be considered for Members who are 20 years of age or younger.

Services do not duplicate those provided concurrently by any other therapy.

Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) services for adult Members 21 years of age and older are benefits of Texas Medicaid for the medically necessary short-term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition. Chronic services are not a covered service for adult Members ages 21 years and older.

Chronic PT, OT and ST services for birth through 20 years of age

Chronic therapy services are benefits for Members from birth through 20 years of age for the medically necessary treatment of chronic medical conditions and/or developmental delays when a medical need is established as indicated in this handbook. Services do not duplicate those provided concurrently by any other therapy.

A medical condition is considered chronic when 120 days have passed from the start of therapy or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time, or maybe expected to deteriorate through the nature of the condition.

Developmental delay criteria for PT/OT/ST

- Eligibility based on score of ≥ 1.5 standard deviations (SD) or more below the mean in one sub-test of composite score or one language index score (receptive or expressive language) on a norm referenced, standardized test.
- When SD is less than 1.5 SD below the mean, or if a child cannot complete a norm-referenced standardized assessment, a criterion-referenced test along with informed, evidence-based clinical reasoning must be included to support the medical necessity of services and may be sent to medical director to determine medical necessity.
- In cases where the Member uses an alternative and/or augmentative form of communication (e.g., picture communication, speech generating devices, etc.), an informal assessment or criterion referenced assessment of these skills should be included along with language testing. This should include the following:
    - Name/type of system used
        - Example: PECS, Proloquo2Go, Accent 1000, etc.
    - Access method
        - Example: direct selection, eye gaze, head stick, infrared pointer, scanning, etc.
    - Modifications needed
        - Example: icon size, color contrasting, keyguard, wheelchair mount, etc.
    - Length of use
    - Environment(s) system is used in
    - Member's ability to use the system
        - Attention to the device
        - Types of communication functions made (e.g., requesting, protesting, commenting, etc.)
        - Utterance length
        - Number of pictures/icons displayed
    - Level of assistance needed by adult/communication partner to access/operate the device
    - Fluency—at least one norm-referenced, standardized test with good reliability and clinical documentation of an informal assessment that supports the delay (e.g., frequency, type and duration of disfluencies; presence of secondary behaviors). A baseline measurement of percent of syllables stuttered should also be included.
    - Specific developmental delay criteria for Voice disorders and Oral-Motor/Swallowing/Feeding disorders requests:
        - **Voice disorder**: an instrumental voice evaluation, describing structure and function of vocal folds/chords performed by a physician (e.g., stroboscopy, flexible endoscopy) and/or an instrumental voice evaluation completed by a Speech-Language Pathologist (e.g., VisiPitch). Cook Children's Health Plan may request an instrumental voice evaluation performed by a physician when there is concern related to structure and function of the vocal tract.

- **Oral-Motor/Swallowing/Feeding disorders**: Cook Children's Health Plan recognizes that there are few standardized measures for feeding and swallowing applicable to pediatric populations to diagnose feeding/swallowing disorders. Cook Children's Health Plan closely follows the recommendations of The American Speech-Language Association's Practice Portal for Assessment and Treatment of Pediatric Dysphagia and The American Occupational Therapy Association's paper on the Practice of Occupational Therapy in Feeding, Eating and Swallowing. Cook Children's Health Plan requests that for Members with a dysphagia diagnosis, a comprehensive feeding history be submitted. A comprehensive food/liquid inventory should also be submitted. This inventory should include the foods and liquids the child consistently accepts, as well as foods and liquid that are difficult / non-preferred due to oral-motor deficits or sensory aversions. Please note when deficits impact growth (height and weight information) and development of the child as well as any delay in the child's ability to independently and safely consume an oral diet from the appropriate drinking devices and eating utensils in a timely manner. For Members requiring alternative or supplemental feeding methods, include the percentage and/or amount of their daily diet that is consumed orally as well as via alternative feeding methods (G tube, GJ Tube, NG tube, TPN).

  Oral-motor/feeding skills should be thoroughly evaluated. This evaluation should include an objective description of the child's feeding skills in oral, oral pharyngeal and pharyngeal phase of swallow with all applicable solid and liquid consistencies. Include strengths and weaknesses in each phase. In the event that the child will not complete an oral-motor/feeding evaluation, a written observation of the feeding/oral-sensory attempt should be documented. In addition, the caregiver's description of the child's skills/behaviors at mealtimes should be submitted with the comprehensive food/liquid inventory.

In order to support medical necessity for oral-motor/swallowing/feeding therapy, Cook Children's Health Plan may request the most recent instrumental swallow study/test be submitted for review. If there is not a completed instrumental swallow study/test within the last 6-12 months, then a current swallow study/test may be requested. The testing would be requested if any of the following are noted during the child's feeding history or feeding evaluation:

- A change in medical status due to illness, accident, surgery
- A history of recurrent lower respiratory infections (e.g., bronchitis, pneumonia)
- Signs of symptoms of aspiration or laryngeal penetration:
  - Coughing during or after eating/drinking
  - Choking during or after eating/drinking
  - Change of face/lip color - paleness, dusky or blue after swallowing (especially in infant population)
  - Wet vocal quality after swallowing
  - Increase in congestion as the feeding progresses and/or is noted directly with feeding

For Members with diagnosed or suspected oropharyngeal or pharyngeal dysphagia, include clearly stated impressions of the Member's oropharyngeal skills and plan to address the complex needs regarding dysphagia. Include safe diet recommendations, referrals (GI, pulmonology, ENT, etc), collaboration with other Providers, as well as caregiver education and training.

The treatment plan should include goals that address the impact of growth and development as well as motor delays and feeding deficits as determined by the oral-motor / feeding evaluation. If oral-motor treatment is recommended, the treatment should not include goals that would put the child at significant risk for aspiration or injury.

NPO/Saliva management

A child that has been identified by his or her medical specialist as high risk for aspiration and is NPO (no food or liquid by mouth) and demonstrates a significant risk for aspiration due to difficulty managing their saliva, may benefit from oral-motor/swallowing therapy. Modalities for this therapy may include, but are not limited to oral stimulation (thermal, tastes, vibration etc.) with or without neuromuscular electrical stimulation (NMES). Beneficial documentation would include if swallows are observed, timeliness of swallows and number of swallows needed to clear the bolus. Close physician guidance and monitoring is recommended for this population.

Speech Therapy testing for Members who are exposed to multiple languages

Cook Children's Health Plan closely follows the American Speech-Language-Hearing Association's "Bilingual Service Delivery" when determining if there is an accurate differential diagnosis between a communication disorder and normal linguistic variations (including bilingual/multilingual backgrounds). Cook Children's Health Plan requests that for bilingual Members, a thorough language history should be obtained and included in the ST Evaluation report along with dual-language testing to confirm the need for Speech Therapy services. A thorough language history includes:

- Age of acquisition of each language(s)
- Estimated percentage of language(s) exposed to at home and at school
- Estimated percentage of language(s) exposed to within the family
- Length of exposure to each language
- Language of choice with peers and family

Per Texas Medicaid Provider Procedures Manual (TMPPM), when possible, use culturally and linguistically adapted test equivalents in both languages to compare potential deficits in each language and include in the documentation. Criterion-referenced assessment tools can be used to identify and evaluate a Member's strengths and weaknesses, as opposed to norm-referenced testing, which assesses an individual relative to a group.

Standardized assessments in English that are translated into another language will not be accepted if there is an available normed-reference assessment in the other language.

Cook Children's Health Plan also recognizes dual-language testing may not be necessary in certain situation such as:

- Member performed within normal limits in one language
- Member has been using one language for three or more years and at least 80% of their home and school exposure is in that same language
- Member has just started to learn a second language within the last year and at least 80% of their exposure is in the first language

If standardized testing in one of the languages is not available, then the therapist must provide the following:

- Normed referenced assessment of English skills (if appropriate)
- Contrastive analysis of speech sounds and language skills of English and the other language which should include abilities and deficits in both languages
- Patterns of native language influence observed

Speech Therapy to teach English as a second language is not considered medically necessary.

In the event a translator is used, the translator should not be a Member of the child's family or friend of the family. Cook Children's Health Plan provides translators for our Members with advanced notice. The therapy Provider may contact Cook Children's Health Plan Member Services for assistance to schedule a translator.

Cook Children's Health Plan Member Services may be reached at:

Toll Free: 1-800-964-2247
Local TTY/TDD: 682-885-2138
Toll Free TTY/TDD: 1-844-644-4137

Telehealth services

Cook Children's Health Plan will accept OT/PT/ST services via telehealth and reimburse according to the Texas Medicaid fee schedule for the approved Telehealth procedure codes. Documentation for a telehealth service must be the same as a comparable in-person service.

Evaluations via Telehealth

Evaluations provided via Telehealth will be accepted, however, Providers should document clearly what was conducted and the methods used to collect assessment data and remain consistent with discipline practice guidelines and standards for evaluations. While it is recognized that some components on standardized testing cannot be conducted via Telehealth, the therapist should gain information from subtests which are appropriate as well as criterion-referenced checklist and other appropriate means. Per Health and Human Services (HHSC), "clinical evaluations required for the provision of new complex rehabilitation technology, such as power mobility and adaptive seating systems or augmentative communication devices, require the physical presence of the Speech-Language Pathologist, Occupational Therapist or Physical Therapist and should not be delivered via Telehealth unless exceptional medical circumstances exist."

Method for Telehealth delivery

Cook Children's Health Plan does not allow the use of telephone-only delivery of PT, OT or ST. Texas licensure rules for each discipline addresses the provision of Telehealth via two-way audio/video platforms. Although there are variations between the disciplines' rules, each requires the therapy service to meet an equivalent standard of care to in-person delivery.

Consent and provision of Telehealth therapy

Providers should obtain consent from the Member or responsible adult to perform therapy via Telehealth. If written consent is not possible, the Provider should document verbal consent in the Member's medical record. Cook Children's Health Plan requires that a responsible adult participate in the therapy session for Members under 13 years of age or in cases where the Member cannot participate without assistance. Documentation should include medical or other need for telehealth services and reason why in-person therapy services are not possible/desirable. The location(s) of service, the level of assistance provided and by whom should also be included within the clinical documentation. If the Member is not able to participate in Telehealth or if it cannot be delivered to an equivalent standard of care as face-to-face interaction, therapists are encouraged to notify the health plan by email at cchppriorauthorizations@cookchildrens.org. The therapist may also contact the Member's Service Coordinator to develop a plan of care and alternatives as needed to ensure the health and safety of the Member.

Claims for Telehealth therapy

Providers are reminded to use the required modifiers on all claims: GP for PT, GO for OT and GN for ST treatment as well as modifiers U5 for therapist or UB for therapy assistant and other modifiers as applicable. Providers should use the 95 modifier to indicate remote delivery. When submitting claims with more than one modifier, append modifier 95 in the last position.

*In order to provide Telehealth services, Providers should refer to the Telecommunication Services Handbook located in the TMPPM; Texas OT/PT/ST Practice Rules and Texas Administrative Codes and National Therapy Practice Guidelines (American Occupational Therapy Association, American Physical Therapy Association and American Speech and Hearing Association).

Frequency and duration for PT/OT/ST services

High frequency – 3x/week

Considered for achievable goals within a short time period, (4 weeks or less) with documentation of medical necessity to achieve an identified new skill or recover of function due to surgery, illness, trauma, acute medical condition or acute exacerbation of a medical condition, with well-defined, achievable goals within the intensive period requested. High frequency at three times per week may be considered for two or more of these exceptional situations:

- Member has medical condition that is rapidly changing
- Member has potential for rapid progress (e.g., excellent prognosis for skill acquisition) or loss of functional skill (e.g., serious illness, recent surgery)
- Plan of care and home program require frequent modification by licensed therapist
- On a case-by-case basis, a high frequency requested for a short-term period (four weeks or less) which does not meet the above criteria may be considered with all of the following documentation: letter of medical need from the prescribing Provider documenting the Member's rehabilitation potential for achieving the goals identified.
- Required therapy documentation:
    - Purpose of high frequency requested
    - Identification of function or skill to be achieved with high frequency and expected date of goal to be achieved
    - Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved
    - Letter of Medical Necessity from the prescribing Provider documenting the Member's rehabilitation potential for achieving the goals identified

Moderate frequency – 2x/week

Therapy provided two times a week may be considered when documentation shows one or more of the following:

- Member making very good progress toward goals
- Member is in a critical period to gain new skills or restore function or is at risk of regression
- The licensed therapist needs to adjust the Member's therapy plan and home program weekly or more often than weekly based on the Member's progress and medical needs
- The Member has complex needs requiring ongoing education of the responsible adult

Low frequency – 1x/week

Therapy provided one time a week or every other week may be considered when documentation shows one or more of the following:

- Member is making progress toward goals, but progress has slowed or documentation shows the Member is at risk for deterioration due to the Member's development or medical condition.
- Licensed therapist needed to adjust home program weekly based on Member's progress.

Note: As the Member's medical need for therapy decreases, it is expected that the therapy frequency will decrease as well.

Maintenance level: 1x/2 weeks; 1x/month; or 1x/3 months

For Members who are 20 years of age and younger only, this frequency level (e.g., every other week, monthly, every three months) is used when the therapy plan changes very slowly, the home program is at a level that may be managed by the Member or the responsible adult, or the therapy plan requires infrequent updates by the skilled therapist. A maintenance level or preventive level of therapy services may be considered when a Member requires skilled therapy for ongoing periodic assessments and consultations and the Member meets one of the following criteria:

- Progress has slowed or stopped, but documentation supports skilled therapy needed to maintain gains prevent deterioration.
- Making limited progress, or goal attainment is extremely slow.
- Identified factors that inhibit ability to achieve goals (e.g. the client cannot participate in therapy sessions due to behavioral issues).
- Documentation shows the Member and responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the Member's needs.

Discontinuation of therapy for PT/OT/ST

Services are discontinued* when the Member demonstrates any one or more of the following scenarios during the course of therapy treatment:

- No longer shows functional impairment or has met goals in plan of care (POC)
- Has returned to baseline function
- Plateau in response to therapy/lack of progress toward therapy goals. This may be an indication for therapeutic break in treatments or, for those under age 21, transition to chronic status and maintenance therapy
- Can maintain status with home therapy program and deficits no longer require a skilled therapy intervention and, for clients who are 20 years of age and younger only, maintain status
- Has adapted to impairment with use of assistive devices
- Performs ADL with minimal to no assistance from caregiver
- Unable to participate in therapy 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 indicates Member is no longer developmentally delayed
- Noncompliance due to poor attendance or poor compliance with therapy and home program

If Cook Children's Health Plan decides a Member is a candidate for reduction of frequency of therapy and/or stopping it altogether based on documentation provided, Cook Children's Health Plan will agree to another re-evaluation after the 6-month authorization period (if requested by the ordering Provider) to assure the ordering Provider and the LAR that the Member's condition/skills have not regressed with the reduction of service frequency.

**It should be noted that a discontinuation of therapy does not imply that the discontinuation is permanent. A change in medical status, among other situations may warrant resumption of therapy in the future.*

Therapy prior authorization submissions

All therapy requests may originate from the PCP/medical home, attending specialist physician or therapy Provider by fax or online through the Cook Children's Health Plan Provider portal.

Requests for prior authorization of therapy services can be made by fax or through the Provider portal by contacting Cook Children's Health Plan at:

Fax
STAR/CHIP 682-885-8402 | 1-844-643-8402
STAR Kids 682-303-0005 | 844-843-0005

Web
cookchp.org

Cook Children's Health Plan will retro-authorize requests up to 30 days from the receipt date of the prior authorization requests and are medically necessary. Requests can be submitted up to, but not exceeding, 60 days prior to the start date in order to allow time for processing. Dates of service, frequency and duration requested on the Prior Authorization Form should match those authorized on the plan of care evaluation signed by the referring Provider and treating therapist.

The following information is required or considered "Essential" to initiate the prior authorization process.

Essential information (EI) includes:

1. Member name
2. Member ID number
3. Member date of birth
4. Requesting Provider's name
5. Requesting Provider's National Provider Identifier (NPI)
6. Rendering Provider's name
7. Rendering Provider's National Provider Identifier (NPI)
8. Rendering Provider's Tax Identification Number (TIN)
9. Service requested - Current Procedural Terminology (CPT)
10. Service requested start and end date(s)-not to exceed 120 day for acute requests & not to exceed 180 days for treatment for chronic requests
11. Quantity of service units requested based on CPT. Total number of visits/units requested (4 units=1 visit unless otherwise specified on the Prior Authorization Form).

*See Request for Information section for next steps if the Essential information is not submitted.

Note: Additional information is required to be included in the clinical documentation. See verbal and written orders, initial evaluation and therapy treatment sections for details.

Services not requiring prior authorization

For service codes for which Cook Children's Health Plan does not require prior authorization, it remains the Provider's responsibility to verify that the code is a benefit of Texas Medicaid by utilizing the TMPPM and the Medicaid Fee Schedule.

Written and verbal orders

For new authorizations and recertifications of therapies, if the submitted request form is not signed and dated by the prescribing Provider, the request must be accompanied by a verbal or written order.

The request form or written or verbal order must be signed and dated within the 60-day period before the initiation of services. A prescribing physician's order to evaluate and treat is acceptable for the evaluation or re-evaluation, but is not acceptable for the therapy treatment. The therapy treatment order must contain the prescribing Provider's ordered frequency, duration and affirmation that the client's Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.

The documentation for a verbal order must meet the following criteria:

- It must be signed and dated by the licensed professional who by state and federal law may take a verbal order.
- It must have the name and credentials of the licensed professional who took the order and who is responsible for furnishing or supervising the ordered services.
- The verbal order must include the date on which the verbal order was taken.
- The verbal order must include the services, frequency and duration that was prescribed by the ordering Provider.

Types of therapy authorization requests

Routine authorization request

Routine care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent. A non-emergent condition is a condition that is neither acute nor severe and can be diagnosed and treated as the Provider schedule allows, or that allows adequate time to schedule an office visit for a history, physical or diagnostic studies prior to diagnosis and treatment. Routine authorization requests will be processed within three working days from Cook Children's Health Plan receiving the request (see Acute and Chronic OT, PT, ST Services section to determine if the request is routine or urgent).

Urgent authorization request*

Urgent condition means a health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within one business day by the Member's Primary Care Provider or Primary Care Provider designee to prevent serious deterioration of the Member's condition or health.

Urgent behavioral health situation means a behavioral health condition that requires attention and assessment within one business day but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment. Urgent requests will be processed within one business day.

*Please note that requests submitted that are not urgent in nature, but rather submitted as urgent based on the delay in Provider submission will be processed as routine authorization requests.

Initial therapy evaluation requests (Out-of-network (OON) Providers only)

Prior authorization is not required for an initial evaluation except in cases where the therapy Provider performing the evaluation (and possibly subsequent therapy) is OON due to limited availability of an in-network-Provider within the service area.

For consideration of therapy services for OON therapy Providers, the supporting documentation for acute and chronic therapy requests that must include:

- A signature/date on the authorization form with the following: specifying the therapy discipline to be evaluated, frequency, duration and medical Provider's signature and date within 60 days.

- Written order may be included in lieu of a signature/date on the authorization form with the following: specifying the therapy discipline to be evaluated and medical Provider's signature and date within 60 days.
- Documentation of medical necessity such as a copy of the visit note and/or current Texas Health Steps exam, which follows the periodicity schedule that identifies the medical necessity for the evaluation and/or a copy of the developmental screening (ASQ or PEDS) performed by the medical Provider following the Texas Health Steps periodicity schedule. For Members over the age covered by these screening tools, a detailed developmental screening across all areas of development (communication, fine motor, gross motor, problem solving and personal-social skills) can be included in the physician visit note. Clinical notes from a specialist that provides medical necessity for the requested service are also accepted.
- For Speech Therapy requests, please refer to the hearing and bilingual criteria sections.

Requests for therapy treatment following the initial or re-evaluation

All requests for treatment should include a completed Authorization Request form that includes all of the following:

- Applicable modifiers for Occupational Therapy (GO), Speech Therapy (GN) or Physical Therapy (GP)
- CPT codes for therapy services*
- ICD-10 code/diagnosis
- Place of service (POS)
- Dates of service (DOS) (not to exceed 180 days or the dates listed on the referring Provider order and the (re)evaluation plan of care). Dates of service must align with or be included in the dates of service listed in the evaluation or re-evaluation plan of care. Frequency and dates of service on the Prior Authorization Form cannot exceed those listed on the referring Provider order and the (re)evaluation plan of care.
- Frequency of visits/units (not to exceed the frequency listed on the referring Provider order and the (re) evaluation plan of care)
- Total number of visits/units requested
- Signature and date of treating therapist** ***
- Signature, credentials and date of medical Provider within 60 days of the request** ***

**All time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service per discipline (4 units). For ST requests, individual speech treatment is limited to one encounter per date of service per Provider including 92507 and 92526. If needed, both 92507 and 92526 should be requested to accurately reflect the services to be provided, but the rendering Provider should select the code that best reflects the totality of the session delivered when submitting the claim for the visit(s). See TMPPM for specific limitations for particular treatment codes.*

***If the prescribing medical Provider and treating/evaluating therapy Provider's signature are not present on the Prior Authorization Form, the missing Provider(s) signature and date within 60 days of the request must be present on the comprehensive plan of care OR orders, which also must include the dates of service, frequency and duration. Portal requests should include all of the above with accompanying documentation which includes signatures.*

**** Signatures from requesting Provider and therapist certify and affirm that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information, such as therapy evaluations and plan of care and that it constitutes true, correct, complete and accurate information. For this reason, signatures for recertification should not be prior to the re-evaluation or plan of care date. Official electronic signature/date from prescribing Provider or therapist are acceptable.*

Supporting documentation will be requested at the discretion of Cook Children's Health Plan if medical necessity is not established with the provided documentation for acute and chronic therapy requests and may include:

- A copy of the clinic visit note and/or current Texas Health Steps exam (which follows the periodicity schedule) of the request that identifies the medical necessity for therapy.
- A copy of the most recent developmental screening (ASQ or PEDS) performed by the medical Provider as part of the THSteps exam per the periodicity schedule, demonstrating a delay in the area of the requested evaluation (speech, gross motor, fine motor, etc.). For Members over the age covered by these screening tools, a detailed developmental screening across all areas of development (communication, fine motor, gross motor, problem solving and personal-social skills) should be included in the physician visit note.
- If referred by a specialist, detailed clinical notes indicating medical necessity are accepted in lieu of a developmental screening.
- Letters of medical necessity from the treating primary care physician, specialist, therapy Provider and/or parent.

Initial/Re-evaluation and treatment plan or plan of care from the Therapy Provider must include all of the following:

- A re-evaluation may occur as early as 60 days prior to the end of the current authorization period. A therapy re-evaluation is considered current when it is performed within 60 days before the current authorization period expires.
- Medical history and background
- All medical diagnoses related to the child's condition
- Date of onset of condition requiring therapy
- Date of evaluation
- Time in and time out
- Baseline measurements based on standardized testing (including raw scores, standard score, percentile rank and age equivalence) and other assessments that document evidence-based clinical opinion to support medical necessity. Best practice guidelines recommend using the full form of assessments, not the short forms or screening versions. The short form or screening version may not provide enough information to support medical necessity. Also, assessment(s) chosen should be related to the area(s) of deficit(s) that will be addressed through the plan of care.
- Explanation of how identified limitations impair overall function of the child
- Safety risks—this may include falling, harm to others or self, lack of safety awareness in home or community, aspiration, etc.

All long- and short-term functional goals must meet the following criteria:

- Function (see pg. 26)
- Contain objective baselines
- S.M.A.R.T. goals (Specific and not broad, Measurable, Attainable within the authorization period, Relevant to the Member and their family and based on medical need and Time based for the dates of service requested)
- For all re-evaluations and/or progress reports, specific objective progress should be clear for the items being measured whether that be assistance level, trials, etc. Narrative statements on progress and general percentages should be cautioned.

- Documentation of child's primary language
- Prognosis for improvement
- Responsible adult's expected involvement in child's treatment
- History of prior therapy and referrals as applicable and known
- Supervising/Treating therapist's signature and date (should not be therapy assistant)
- PT and OT requests should include baseline range of motion measurements when identified as a goal in the plan of care.
- OT requests should include documentation of the Member's occupational profile and how the delays were identified. The occupational profile should include a narrative summary of a Member's occupational history and experiences (ADLs, etc.), patterns of daily living, interests, values and medically necessary needs. It should present a picture of a Member's present functional status.
- Providers must describe how the responsible adult or adults will be expected to support the Member's treatment. For adult Members, Providers must describe the expectation of adherence with a home program.
- Speech Therapy requests for Members who are bilingual should include evaluation results from a standardized testing measure completed in the Member's primary language, or primary language and secondary language. Criterion referenced testing may be included to identify the Member's strengths and weaknesses. Include comparisons of potential deficits in both languages if testing both languages*.

**See Chronic PT, OT and ST Services, speech therapy testing for members who speak multiple languages.*

Therapy re-evaluation prior authorization requests

Cook Children's Health Plan does not require preauthorization for therapy re-evaluations for in-network therapy Providers completed within 60 days of the current certification period.

Requests for re-evaluations that are completed prior to 120 days from the date of the last evaluation (or 60 days in acute cases) will require prior authorization from Cook Children's Health Plan due to TMHP billing limitations. Re-evaluation requests that occur on a frequent basis (less than every 120 days) should include clinically sound objective documentation that demonstrates a medical need for the increase in frequency of the evaluation. All out-of-network re-evaluation requests will be conducted through CCHP's prior authorization process. Any re-evaluation must occur within 60 days of the signed and dated order from the referring Provider.

Requests following a re-evaluation must include:

- Re-evaluation and treatment plan or plan of care from the therapy Provider. Please see Initial therapy treatment prior authorization requests for inclusive elements in addition to a comparison of the previous evaluation results to the current evaluation results.
- Objective demonstration of the Member's specific and measurable (e.g., number of successful trials, number of repetitions, level of assistance, percentages, etc.) progress toward previous treatment goals which are specific to the Member's diagnosis. In order to fully determine goal progress, both the objective baseline (starting point of the goal for the previous plan of care) and current objective status need to be present.
- An explanation of any changes to the Member's plan of care and the clinical rationale for revising the plan. All goals from preceding evaluation should be documented including the clinical rationale for modifying or discontinuing any goals.
- Discharge criteria that must reflect realistic expectations from the episode of therapy and should simply state the broad intent of the results of therapeutic intervention.

Group therapy

Group therapy consists of simultaneous treatment to two or more Members who may or may not be doing the same activities. If the therapist is dividing attention among the Members, providing only brief, intermittent personal contact, or giving the same instructions to two or more Members at the same time, the treatment is recognized as group therapy. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one Member contact is not required.

The following requirements must be met in order to meet the Cook Children's Health Plan criteria for group therapy:

- Prior authorization requests for group therapy (97150, 92508) require specific frequency and duration for the group (in encounters) that is included on the Prior Authorization Form and/or physician referral and group-based goals should be included in the plan of care.
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements.
- Each Member participating in the group must have an individualized treatment plan for group treatment, including interventions and short- and long-term goals and measurable outcomes.

Providers are subject to certification and licensure board standards regarding group therapy.

Criteria for functional goals

Functional goals must be specific to the Member, objectively measurable within a specified time-frame, attainable in relation to the Member's prognosis or developmental delay, relevant to Member and family and based on medical need.

Functional short- and long-term goals should not exceed the length of time the therapy service is requested (e.g., long-term goals for a request for 180 days of therapy should not exceed a six-month time frame). Isolated test items or scores on an assessment tool do not meet the definition of functional goals.

However, performance on relevant clinical measures may support the medical necessity of therapy and may be described in the body of the evaluation or re-evaluation. Goals that exceed the length of the therapy authorization period requested may be included as discharge criteria.

Continuation of care requests

- In cases where a Member receiving therapy services transitions to coverage by Cook Children's Health Plan, the authorization letter from the previous payer should be submitted.
- Following the continuity of care approval, the next request needs to contain all the information required for initial/re-evaluation requests. The documentation submitted should also include a copy of the most recent evaluation. A copy of the initial evaluation or other supporting documentation may be requested.
- The documentation submitted should also include a copy of the most recent evaluation. A copy of the initial evaluation or other supporting documentation may be requested.

Change of Provider requests

If a Provider or Member discontinues therapy during an existing authorized period and the Member requests services through a new Provider outside of the current therapy group, a new authorization request should be submitted with the following:

- Initial evaluation or evidence of the new agency's acceptance of the previous agency's evaluation dated within two months of the start of the new service
- A change of therapy Provider letter, signed by the Member or responsible adult. The letter must document:
    - The date that the Member ended therapy (effective date of change) with the previous Provider, or last date of service
    - The name of the new Provider and previous Provider
- When a change of Provider within the same agency is requested, the agency will need to submit a new prior authorization that contains the signature/date of the new treating therapist; units/visits used by the previous therapist and the amount requested for the new therapist. Total units/visits should not exceed what has been authorized in the current authorization period.

Request for information (RFI)

When additional information is needed after a request is made, Cook Children's Health Plan will begin the RFI process as outlined by HHSC.

- Essential information (EI):
    - If the request is missing essential information, as outlined in section, Therapy prior authorization submissions, a determination would not be rendered. The request will be returned with explanation and include instruction for resubmission with required EI.
- Priority Authorization (PA) request is incomplete
    - If the request is missing information as outlined in section, requests for therapy treatment following

the initial or re-evaluation, notifications will be issued to the Member and Providers in writing including information needed to process the request NO LATER then three business days after date sent. If the information is not received within three days after written request is sent to the Member and Provider, then the request will be sent to physician review to determine if there is enough information to determine medical necessity. This could result in a denial of the request.

Exclusions (non-covered services)

The following services are not a benefit of Texas Medicaid/Cook Children's Health Plan:

- Therapy services that are provided after the Member has reached the maximum level of improvement or is now functioning within normal limits.
- Separate reimbursement for VitalStim or Neuromuscular Electric Stimulation (NMES) therapy for dysphagia. VitalStim/NMES must be a component of a comprehensive feeding treatment plan to be considered a benefit.
- Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee.
- Emotional support, adjustment to extended hospitalization and/or disability and behavioral readjustment.
- Therapy provided as an adjunct to psychotherapy. These are addressed through our contracted behavioral health organization, Beacon.
- Treatments that are not supported by medically peer-reviewed literature, including, but not limited to, investigational treatments such as sensory integration, vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback and the Wilbarger brushing protocol.
- Therapy not expected to result in practical functional improvements in the Member's level of functioning.
- Equipment and supplies used during therapy visits are not reimbursed separately as they are considered part of the therapy services provided.
- Chronic services for Members 21 and older.
- Therapy services related to activities for the general good and welfare of Members who are not considered medically necessary because they do not require the skills of a therapist, such as:
    - General exercises to promote overall fitness and flexibility or improve athletic performance
    - Activities to provide diversion or general motivation
    - Supervised exercise for weight loss
- Treatments that do not require the skills of a licensed therapist to perform in the absence of complicating factors (i.e., massage, general range of motion exercises, repetitive gait, activities and exercises that can be practiced by the Member on their own or with a responsible adult's assistance).
- Therapy services that focus on deficits that are traditionally considered to be purely educational in nature and, therefore, would be considered the responsibility of schools to address.

Definition of terms

Definition of terms

Hearing Screening: "A test administered with pass/fail results for the purpose of rapidly identifying those persons with possible hearing impairment which has the potential of interfering with communication" (Texas Department of Licensure, 2018).

- **Audiometer**: "An electronic device used to measure hearing thresholds for pure tones, modulated tones, speech and other acoustic stimuli" (Medical Dictionary for the Health Professions and Nursing, 2012).
- **Alternative criteria for meeting the documentation of normal hearing include:**
    - Tympanometry, with a tympanometer is defined as, "An instrument that measures movement of the tympanic membrane at various levels of air pressure, used to assess function of the middle ear" (The American Heritage Medical Dictionary, 2007).
    - Otoacoustic Emissions Testing (OAE) with a Distortion Product Otoacoustic Emissions instrument or Transient Evoked Otoacoustic Emissions instrument—OAE is defined as, A screening test for deafness that assesses the functioning of the cochlea. The test is performed by placing a probe in the external ear canal. The probe emits a series of clicks and then measures the echoes returning from the cochlea. (Medical Dictionary, 2009).
    - Speech Awareness or Speech Recognition Thresholds (SAT/SRT)—SAT is defined as, "The lowest sound intensity at which speech can be detected." Speech Awareness Threshold (Medical Dictionary for the Health Professions and Nursing, 2012). SRT is defined as "The minimum intensity in decibels at which a Member can understand 50% of spoken words; used in tests of speech audiometry. Also called speech recognition threshold." (Mosby's Medical Dictionary, 2009).
    - Auditory Brain Stem Response test (ABR)- "An automated test for hearing and brain (neurological) functioning that is performed by applying wires to the skin around the ear.
- ABR may be used in the evaluation of:
    - Hearing integrity (and neurologic normalcy) in infants and young children.
    - Neurologic integrity (and hearing) in Members who are comatose, unresponsive or impaired due to a stroke, an acoustic neuroma (tumor on the hearing nerve), Ménière's disease, etc. The ABR test involves attaching electrodes to the head to record electrical activity from the auditory nerve (the hearing nerve) and other parts of the brain. Also known as brainstem auditory evoked potentials (BAEP)" (Medicinenet.com, 2016).

Occupational Therapy (OT): "Occupational Therapy addresses the physical, cognitive, psychosocial and other aspects of performance in a variety of settings to support engagement in everyday life activities [occupations] that affect health, well-being and quality of life" (ECOTE, 2018).

Physical Therapy (PT): a service "that prevents, identifies, corrects or alleviates acute or prolonged movement dysfunction or pain of anatomic or physiologic origin" (ECPTOTE, 2017).

Speech-Language Pathology (ST): "The application of nonmedical principles, methods and procedures for measurement, testing, evaluation, prediction, counseling, habilitation, rehabilitation or instruction related to the development and disorders of communication, including speech, voice, language, oral pharyngeal function or cognitive processes, for the purpose of evaluating, preventing or modifying or offering to evaluate, prevent or modify those disorders and conditions in an individual or a group" (Texas Department of Licensure, 2018).

Telehealth: Telehealth is the use of telecommunications or information technology to provide therapy services to a Member who is physically located in a site in Texas other than the site where the therapist or therapist assistant is located.

"Claims for Telehealth Service for Occupational, Physical and Speech Therapy" last updated on 4/14/2020, TMHP.

OT/PT evaluation definitions (AMA, 2017)

Physical Therapy (PT)

Low complexity (97161): History with no personal factors or comorbidities; 1-2 elements of the following body systems: body structures/functions, activity limitations, and/or participation restrictions; stable and/or uncomplicated clinical presentation; clinical decision making of low complexity.

Moderate complexity (97162): 1-2 personal factors or comorbidities; total of three or more of the following body systems: body structures/functions, activity limitations, and/or participation restrictions; evolving or changing clinical presentation; clinical decision making of moderate complexity.

High complexity (97163): History with three or more personal factors or comorbidities; four or more elements of the following body systems: body structures/functions, activity limitations, and/or participation restrictions; unstable and unpredictable clinical presentation; clinical decision making of high complexity.

Occupational Therapy (OT)

Low complexity (97165): Includes a brief history of medical review and/or therapy records related to the presenting problem and related to 1-3 performance deficits (physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions. Member may present with comorbidities. Minimal to moderate modification of task is not needed to complete the evaluation and treatment options are limited.

Moderate complexity (97166): Includes an expanded history of medical review and/or therapy records related to the presenting problem and related to 3-5 performance deficits (physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions. Member presents with comorbidities. Minimal to moderate modification of task is needed to complete the evaluation and several treatment options are possible.

High complexity (97167): Includes an history of medical review and/or therapy records and extensive additional review of history related to current functional performance and related to five or more performance deficits (physical, cognitive or psychosocial skills) that result in activity limitations and/or participation restrictions. Member presents with comorbidities. Significant modification of task is needed to complete the evaluation and several treatment options are possible.

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The language in this handbook is gleaned from the language in the Physical Therapy, Occupational Therapy and Speech Therapy (PT/OT/ST) Services Handbook of the Texas Medicaid Provider Procedure Manual and the CPT Manual. These are publications of the Texas Medicaid and Healthcare Partnership (TMHP) and American Medical Association (AMA). The contents herein provide the essential provisions from that handbook and, in many cases, the language is identical to that in the TMHP handbook or CPT Manual. For a full text version to the TMHP manual and handbook, please go to TMHP.com and access the most current PT/OT/ST Services Handbook.

We have included some additional language pulled from other cited resources (for example national therapy organizations) that we feel would help clarify some policies surrounding therapy provided through Cook Children's Health Plan. Providers should follow Cook Children's Health Plan guidelines in instances where Cook Children's Health Plan and TMHP therapy guidelines do not align.

Hearing Loss Risk Screening

Please complete the below questionnaire for Speech Therapy requests (not required for feeding only requests):

Ages birth to three years

If 2 or more 'yes' answers then screen considered FAIL and an objective hearing screen is needed within six months.

Ages three years and above

If three or more 'yes' answers then screen considered FAIL and an objective hearing screening is needed within six months.

Cook Children's Health Plan Hearing Loss Risk Screen

yes	**no**	Are you ever concerned about your child's hearing?
yes	**no**	Is there a family history of hearing loss?
yes	**no**	Is there a history of more than three ear infections in the last 12 months?
yes	**no**	Has your child had surgery for their ears or hearing? (e.g. Ear tubes)
yes	**no**	Does your child have a history of using ototoxic medications (medications that may cause hearing loss, e.g. some antibiotics or chemotherapy)?
yes	**no**	History of illness or syndrome associated with hearing loss (e.g. Down syndrome, cleft palate, CMV, meningitis or measles)?
yes	**no**	History of premature birth (before 37 weeks gestation) or low birth weight (below: 5 pounds, 8 ounces)?

If any of the items below are checked 'yes' a hearing screen will be needed within 6 months:

yes	**no**	Has child failed a hearing screen in the last 12 months?
yes	**no**	Does child use hearing aids/cochlear implants/bone anchored hearing implant?

Based on Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs. Joint Committee on Infant Hearing. American Academy of Pediatrics.

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