Therapy Provider Training

Revised: 070722

Cook Children's Health Plan

Our Promise

Knowing that every child's life is sacred, it is the promise of Cook Children's to improve the health of every child through the prevention and treatment of illness, disease and injury.

Cook Children's Health Plan

Agenda

- Our Promise
- Provider Support Services
- Benefits, Limitations and Exclusions
- Prior Authorization Timelines
- Signature Requirements
- Clinical Requirements
- Re-Evaluations
- Authorization Duration
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- Therapy Rendering Provider
- Telehealth Services
- Reimbursement
- Occupational and Physical Therapy Reminders
- Speech Therapy Reminders
- Therapy Information

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Provider Support Services

888-243-3312

A representative is available Monday – Friday, 8am-5pm, excluding State holidays.

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Benefits, Limitations and Exclusions

Providers should verify benefits, limitations and exclusions located in the Texas Medicaid Provider Procedures Manual at tmhp.com prior to rendering services. Always refer to the most recent publication.

When submitting services for reimbursement Providers should refer to the most recent publications of the:

- Texas Medicaid Provider Procedures Manual located at tmhp.com
- Cook Children's Health Plan Provider Manuals located on cookchp.org
- Electronic Data Interchange Requirements located on tmhp.com and cookchp.org
- CPT, ICD-10, HCPC coding books
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Medicaid National Correct Coding edits located on CMS.gov and Medicaid.gov

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Prior Authorization Timelines

Retro Authorizations

- Start dates more than thirty (30) days from the date received by Cook Children's Health Plan will be amended
- Retro dating applies to the date the latest information necessary for review was received
  - The health plan will retroactively date authorization requests up to thirty (30) days from the date it was received
- Visit/unit counts will be amended to match the requested frequency for the new allowable date of service

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Signature Requirements

Signature Requirements

- The Referring Provider and Rendering Provider signatures must be dated within sixty (60) days of the date the prior authorization request is received
- The Referring Provider is expected to respond to the Rendering Provider within two (2) weeks

Note: You may reach out to Provider Relations for assistance by emailing CCHPProviderRelations@cookchildrens.org if you have not received a response within three to four (3-4) weeks.

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Electronic Signature Requirements

"All signatures must be electronic, digital or handwritten. An electronic or digital signature must be derived using software that creates a digital signature logo with a system-generated date and time stamp or includes the logo of the digital software used. Photocopy or ink stamp of a handwritten signature or a typed signature without a digital stamp are not permitted. Texas Medicaid Healthcare Partnership (TMHP) will not authorize any dates of services on the request earlier than the date of the Provider's signature. The prior authorization request that contains the original signature must be kept in the client's medical record for future access and possible retrospective review. These documentation requirements also apply to telephone authorizations. To avoid delays, Providers are encouraged to have all clinical documentation at the time of the initial telephone authorization request."

Resource: Please refer to the Texas Medicaid Provider Procedure Manual Volume 1, Section 5 Fee for Services Prior Authorizations.

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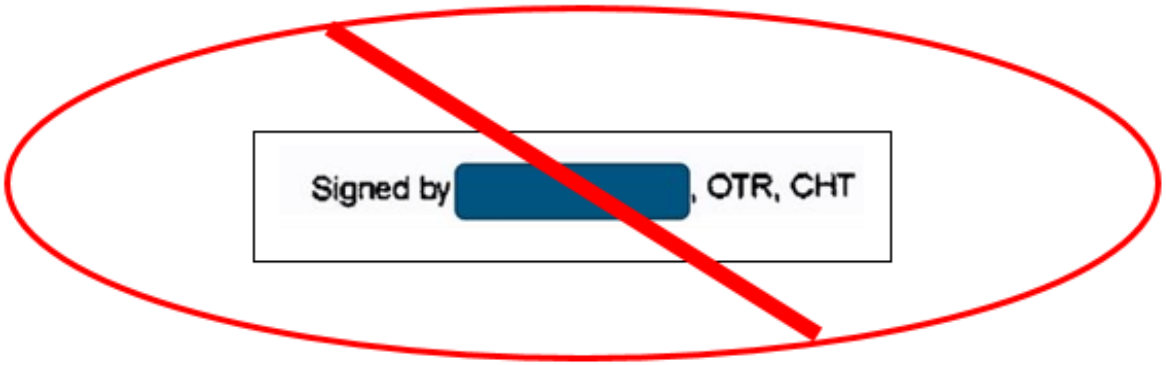
Electronic Signature Requirements

Does not meet criteria per Texas Medicaid Provider Procedures Manual.



Electronic Signature Requirements

Meets criteria per Texas Medicaid Provider Procedures Manual.

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Clinical Requirements

Clinical Requirements

- Clinical documentation must be completed within sixty (60) days of the date the prior authorization request is received
- The dates of service requested on the prior authorization should not exceed the Therapy Plan of Care

Re-Evaluations

Re-Evaluations

- Re-evaluations must be completed every six (6) months (one hundred eighty (180) days)
- The health plan allows an additional thirty (30) day grace period to complete a re-evaluation
  - This equals two hundred ten (210) days from the last re-evaluation
    - If the end date of service exceeds two hundred ten (210) days from the last re-evaluation, it will be amended to the two hundred tenth (210^{th}) day
- The visit/unit count will be amended to match the requested frequency for the allowable date of service

Authorization Duration

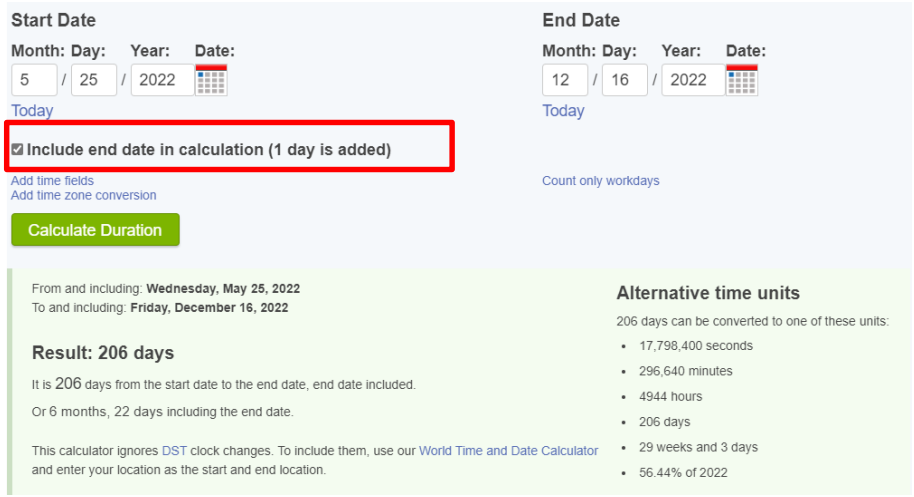
Authorization Duration

- Authorizations cannot exceed one hundred eighty (180) days in duration
- If the end date of service exceeds one hundred eighty (180) days
  - The end date will be amended to the one hundred eightieth (180th) day
- The visit/unit count will be amended to match the requested frequency for the allowable date of service

Date Calculation Tool

The Utilization Management Review Team uses the following time and date website as a tool to assist with consistently calculating these dates:

- Enter the evaluation date as the START Date
- Enter the last day of the authorization being requested as the END Date
- Check include end date in calculation
- Click Calculate Duration



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Prior Authorization Submission

Prior Authorization Submission

Providers should submit all prior authorization requests via the Secure Provider Portal.

- All supporting documentation attached should match the data entered on the prior authorization
  - This includes but is not limited to: Date of Service, Referred by and Referred to Providers, procedure codes, units/visits, etc.
- Providers must review the Texas Medicaid Provider Procedures Manual to verify benefits, limitations and exclusions
- If an authorization is required for the service you provided you must submit the claim form with the authorization number in the appropriate field.
- Only one authorization number per claim
  - If the services you are billing for have more than one authorization number you will need to split the claim or the service will deny

Prior Authorization Submission

- The requested Provider on the authorization form must match the way that the Provider is credentialed and contracted with the health plan
- Authorization dates of service, procedure codes, place of service, and modifiers must match the services as billed on the claim form

Prior Authorization Submission

If you do not have access to the Secure Provider Portal please review the Secure Provider Portal Reference Guide for instructions or email Provider Relations at CCHPProviderRelations@cookchildrens.org for enrollment assistance.

Providers pending enrollment to the Secure Provider Portal may submit a prior authorization request via fax by visiting our Prior Authorization page located on our website at cookchp.org.

- The prior authorization form must be completed in it's entirety

Note: Providers must submit a complete prior authorization request in order for authorization to be processed

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Therapy Rendering Provider

Rendering Provider NPI

- Each prior authorization request and each claim form received must include the National Provider Identifier for the Rendering Provider
- The Rendering Provider NPI must match the way the Provider is enrolled and attested with Texas Medicaid
  - Login to your profile on tmhp.com to verify your attestation
- The Rendering Provider submitted on the prior authorization request must match
  - The Rendering Provider submitted on the claim form
  - The Rendering Provider listed in the medical record documentation
- The Attending, Referring and Rendering Provider cannot be a group
- The Referring & Rendering Provider cannot be the same

Note: Inaccurate billing can lead to audits and recoupments.

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Rendering Provider Taxonomy

- Each claim form received must include the taxonomy code and qualifier for the Rendering Provider
- The Rendering Provider Taxonomy code and qualifier must match the way the Provider is enrolled and attested with Texas Medicaid
  - Login to your profile on tmhp.com to verify your attestation
- The Provider taxonomy code and qualifier must match the services billed

Note: Claims submitted with incorrect, invalid or missing NPI and Taxonomy code combination will reject or deny. Authorization dates of service, procedure codes, place of service, and modifiers must match services on the claim.

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Telehealth Services

Telehealth Services

- 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
- Providers should document clearly what was conducted and the methods used to collect assessment date 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

Telehealth Services

- Per Health and Human Services, 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 therapists and should not be delivered via Telehealth unless exceptional medical circumstances exist

Note: Documentation should include medical or other need for telehealth services and reason why in-person therapy services are not possible/desirable.

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Reimbursement

Reimbursement

Cook Children's Health Plan reimburses claims per the Texas Medicaid Healthcare Partnership fee schedule.

- Providers should follow the benefit, limitations, exclusions, and claim filing instructions within the Texas Medicaid Provider Procedures Manual
- Providers should bill their usual and customary rates
  - Do not bill less than the contracted reimbursement rate
  - If a Provider bills less than the contracted rate, the claim reimburses up to the Providers billed charge
- Claims are reimbursed based on the contracted rate schedule
- Our Provider's agree to accept the reimbursement rate as payment in full for services rendered to Medicaid Members

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Occupational and Physical Therapy Reminders

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Timed Treatment Limitations

Time based treatment codes must be billed in fifteen (15) minute increments:

- These are requested as UNITS
  - PT and OT treatment codes 97034 and 97035 are limited to a combined total of two (2) units, thirty (30) minutes, per date of service per discipline
  - PT and OT treatment code 97036 is limited to a combined total of three (3) units (forty-five (45) minutes) per date of service per discipline
  - PT and OT treatment codes:
    - 97032, 97033, 97110, 97112, 97113, 97116, 97124, 97140, 97530, 97535, 97537, 97542, 97750, 97761
    - Are limited to a combined total of four (4) units, one (1) hour per date of service per discipline

Untimed Treatment Limitations

Untimed PT and OT treatment codes are limited to once per date of service per procedure code and must be delivered on the same date of service as one or more time based PT and OT procedure codes

- PT and OT untimed codes include:
  - 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028
    - These codes are requested as visits

Speech Therapy Reminders

Treatment Limitations

Individual speech treatment is limited to one encounter per date of service per Provider.

- This includes codes 92507 and 92526
  - If needed, both 92507 and 92526 should be requested to accurately reflect the services to be provided
    - The Rendering Provider should select the code that best reflects the totality of the session delivered when submitting the claim for the visit(s)

Note: Provider should follow the benefits, limitations, exclusions and claim filing instructions within the Texas Medicaid Provider Procedures Manual.

Hearing Screening Guidelines

- 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
- Initial speech therapy treatment requests are not denied or delayed when there is no objective hearing screening received
  - Will issue an authorization up to one hundred eighty (180) days to allow additional time to complete an objective hearing screening
- Objective hearing screenings may include:
  - Audiometric screening
    - Completed with use of audiometer and performed by Primary Care Physician office, Audiologist, School Nurse or Speech Language Pathologist

Objective Hearing Screening Guidelines

For children who are at ages that are not required to have audiometric screening per the Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children and Adolescents, an age-appropriate, objective hearing screening should be used.

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

Resource:

Therapy Services Handbook

Hearing Loss Risk Screening

An objective hearing screenings may include the Cook Children's Health Plan Hearing Loss Risk Screening. A printable copy is located in the Therapy Services Handbook.

- Ages birth to three (3) years
  - If two (2) or more 'yes' answers then screen considered FAIL and an objective hearing screening is needed within six (6) months
- Ages three (3) years and above
  - If three (3) or more 'yes' answers then screen considered FAIL and an objective hearing screening is needed within six (6) months

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Hearing Loss Risk Screening

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?

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Hearing Screening Guidelines

  - Information may be included in the medical and/or hearing history of the evaluation report
  - The checklist may be attached as a separate sheet using the checklist in the Therapy Services Handbook
- For children birth to three (3) years
  - A failing Cook Children's Health Plan hearing loss risk screening occurs when medical and hearing history identifies two (2) or more risk factors for hearing loss
- For children ages three (3) years and above
  - A failing Cook Children's Health Plan hearing loss risk screening occurs when medical and hearing history identifies three (3) or more risk factors for hearing loss
- Failed Hearing Loss Risk Screening
  - Objective audiometric hearing screening needed within six (6) months

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Hearing Screening Guidelines

- Failed objective audiometric hearing screening
  - If the current objective hearing screening demonstrates failing results, a one hundred eighty (180) day approval for initial Speech Therapy requests or a ninety (90) day approval for speech therapy re-authorization requests will be granted to allow time for completion of re-screening
  - If 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

Active Speech Therapy Authorizations

- If a Member has an active speech therapy authorization and a re-evaluation is submitted
  - Health plan will honor their previous passing hearing screenings on file
- If a Member has an active speech therapy authorization and there is not an objective hearing screening on file
  - Then an objective hearing screening should be submitted for future speech therapy requests
  - Up to one hundred eighty (180) days will be authorized to allow additional time for the objective hearing screening
  - Verbiage regarding the need for the objective hearing screening will be on the approval letter
  - Requests for speech therapy after this approval that are submitted without hearing screening results will be sent to Cook Children's Health Plan Medical Director for review

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Feeding Therapy

- Initial and Re-Evaluations:
  - Observe the Member while they are eating or drinking
  - Document skills observed while drinking and eating
  - Include skills observed during all phases of eating: oral, oro-pharyngeal, and pharyngeal phases
- Re-Evaluations:
  - Provide an updated evaluation of skills observed during eating and drinking
  - Report changes in skills
    - Increases or decreases

Bilingual Member Documentation

- Continue to include a thorough language history
- 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
- Interpreter services are available, with advance notice, for our members
- Cook Children's Health Plan recognizes dual language testing may not be necessary in certain situations such as:
  - Performed within normal limits in one (1) language
  - Member has been using one (1) language for three (3) or more years and at least eighty percent (80%) of their home and school language is in that same language
  - Member has just started to learn a second language within the last year and at least eighty percent (80%) of their exposure is in the first language

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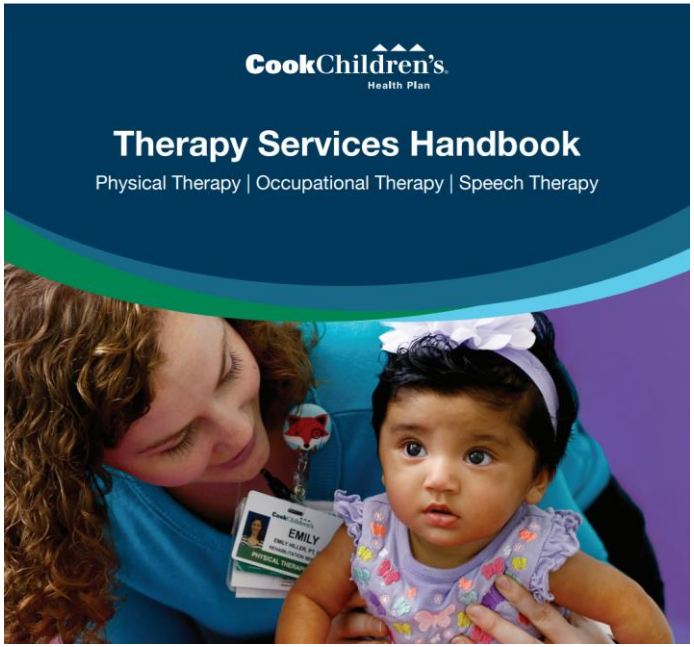
Therapy Information

Therapy Information Page

- Visit our Therapy Information page located on cookchp.org to view our Therapy Services Handbook
- Revised on October 1, 2021



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Reference Pages

Reference Page

Cook Children's Health Plan Website
cookchp.org

Secure Provider Portal
https://epiccarelink.cookchp.org/LinkHealthPlan/common/epic_login.asp

Provider Forms & Manuals
Provider Manual and Forms | Cook Children's Health Plan (cookchp.org)

TMHP Website
https://www.tmhp.com/

Education & Training
Provider Relations | Cook Children's Health Plan (cookchp.org)

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Reference Page

Therapy Information
https://cookchp.org/providers/Pages/therapy-information.aspx

Prior Authorization Search
Prior Authorization Search | Cook Children's Health Plan (cookchp.org)

Provider News
Provider News | Cook Children's Health Plan (cookchp.org)

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