

# Therapy Evaluations

## Authorization Requirement Checklist



### Requests for Initial Evaluation

Initial evaluation requests must be submitted to Superior by the referring provider.

#### Ages: 0 months – 6 years

- ✓ Current Texas Health Steps (EPSDT) exam or exam note, based on the Texas Health Steps (EPSDT) Periodicity Table. If a specialist is making the request, submit the clinic note describing the need for evaluation.
- ✓ Current developmental screen, per the Texas Health Steps (EPSDT) Periodicity Schedule. If a developmental screen is not available or appropriate, documentation of the medical necessity for the requested evaluation is required.
- ✓ Signed and dated physician order, less than 30 days old, specifying the requested discipline (PT/OT/ST).
- ✓ For speech therapy initial evaluation requests, documentation of a hearing screening performed per the Texas Health Steps (EPSDT) Periodicity Schedule. The hearing screen may be performed by a Speech-Language Pathologist who has appropriate training.

Hearing Screening is defined as a test administered with **a pass/fail result** for the purpose of rapidly identifying those persons with possible hearing impairment which has the potential of interfering with communication. If the member failed a hearing screening, either due to behavioral issues, inability to participate in the hearing screen or due to suspected hearing deficit, the following documentation would be expected:

- In the case of behavioral issues or inability to participate in the hearing screen, an objective description of the behavioral issues and/or inability to participate in the hearing screen along with a statement as to why hearing deficit is not suspected
- In the case of a suspected hearing deficit, a referral to an audiologist or physician who is experienced with the pediatric population and who offers auditory services would be appropriate. Documentation of such a referral must be included in the clinical documentation submitted. In addition, if an auditory assessment has not occurred prior to the start of speech therapy, the speech therapy treatment plan must address the suspected hearing loss.

#### Ages: 6 – 20 years

- ✓ Current Texas Health Steps (EPSDT) exam or exam note, per the Texas Health Steps (EPSDT) Periodicity Schedule. If a specialist is making the request, submit the clinic note describing the need for evaluation.
- ✓ Signed and dated physician order, less than 30 days old, specifying the discipline to be evaluated.
- ✓ Medical necessity reason for therapy evaluation.

#### Ages: 21 years and above

- ✓ Signed and dated physician order, less than 30 days old, specifying the requested discipline (PT/OT/ST).
- ✓ Medical necessity reason for therapy evaluation.

### Requests for Re-evaluation

Re-evaluation requests can be submitted to Superior by either the referring or servicing provider.

## All Ages:

- ✓ If the request is 30 days or less from the end of an authorization period, a physician order that specifies the discipline to be evaluated that has been signed and dated no more than 30 days from when the request is submitted is required.
- ✓ If the request is more than 30 days from the end of an authorization period, an explanation regarding the reason for delay in initiation of services or a medical necessity reason along with the physician order is required.

## Initial Treatment Authorization Visits

Initial authorization for therapy treatment must include a treatment plan. The treatment plan must be signed and dated by the member's Primary Care Physician (PCP) (MD, DO, PA or NP) or appropriate specialist. If the treatment plan is not signed, the provider can submit a physician referral/order. This referral/order must be signed and dated on the day of the evaluation or after, specifying the frequency and duration of the requested service.

## The Treatment Plan Must Document:

- ✓ Date of evaluation.
- ✓ Member's age and birthdate.
- ✓ For speech therapy requests - the member's language knowledge/exposure must be established through a thorough case history and relevant caregiver interview. This must include home language(s) and (if applicable) school, daycare or community language(s) of instruction/exposure.
- ✓ A brief statement of the member's medical history, including onset date of the illness, injury, or exacerbation that requires the therapy services and any prior therapy treatment.
- ✓ Relevant review of systems.
- ✓ Pertinent physical assessment, including a description of the member's current deficits and their severity level, documented using objective data. This may include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
- ✓ A clear diagnosis and reasonable prognosis, including the member's potential for meaningful and significant progress.
- ✓ A description of the member's functional impairment with a comparison of prior level of function to current level of function.
- ✓ A statement of the prescribed treatment modalities.
- ✓ Recommended frequency/duration based on the member's anticipated response to therapy.  
*Please note: Only acute conditions qualify for 3 times a week for up to a 4-week duration.*
- ✓ Proposed patient and/or caregiver education.
- ✓ Treatment goals must be specific to the member's diagnosed condition or impairment. Treatment goals must be Specific, Measureable, Achievable, Relevant and Time Based (S.M.A.R.T.).
- ✓ Treatment goals must relate to member specific functional skills. Treatment goals written with targets set for achievements specific to standardized testing benchmarks will not be accepted.
- ✓ Treatment plan, which may not be more than 60 days old.
- ✓ The treatment plan must be signed and dated by the treating therapist.
- ✓ If the treatment plan is part of a medically necessary program to maintain or prevent a significant functional regression, it must document skilled services to be provided and have goals that address maintenance.

## Continued Treatment Authorization Visits

Treatment progress must be clearly documented in an updated treatment plan/current progress summary. This documentation must be submitted by the servicing provider at the end of each authorization period or when additional visits are being requested. The treatment plan must be signed and dated by the member's PCP (MD, DO, PA or NP) or appropriate specialist. If the treatment plan is not signed, the provider may submit a physician referral/order signed and dated on the day of the evaluation or after, specifying the frequency and duration of the requested service. In lieu of having the treatment plan signed, the provider may submit a physician referral/order signed and dated the day of the evaluation or after specifying the frequency and duration of the requested service regardless of history.

### Documentation Must Include the Following:

- ✓ Number of therapy visits authorized and number of therapy visits attended.
- ✓ A clear diagnosis and reasonable prognosis, including the member's potential for meaningful and significant progress.
- ✓ A description of the member's current deficits and their severity level documented using objective data. This can include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
- ✓ Objective demonstration of the member's progress towards each prior treatment goal.
- ✓ Treatment goals are developed by the treating therapist to be met within the timeframe specified on the treatment plan.
- ✓ If any goals are unmet, it is the treating therapist's responsibility to objectively describe specific barriers to progress that were encountered and make appropriate modifications to the treatment plan in order to meet the member's needs.
- ✓ For all unmet treatment goals, report the status of the goal at the beginning of the previous treatment period and the current status at the time of reporting, in the same terms/variables as the goal states so that a member's progress towards the goal can be measured.
- ✓ If the treatment plan was written with maintenance goals, a status statement would be expected for each maintenance goal directed at a skilled service.
- ✓ An updated statement of the prescribed treatment modalities.
- ✓ Recommended frequency/duration based on how rapidly the member is responding to therapy.  
*Please note: Only acute conditions qualify for 3 times a week for up to a 4-week duration.*
- ✓ A brief prognosis with clearly established discharge criteria.
- ✓ Updated treatment goals must be written in the S.M.A.R.T. format (Specific, Measurable, Attainable, Relevant and Time-based), and relate to member specific functional outcomes.
- ✓ Updated treatment plan/progress summary must not be older than 60 days old.
- ✓ Treatment plan must be signed and dated by the treating therapist.