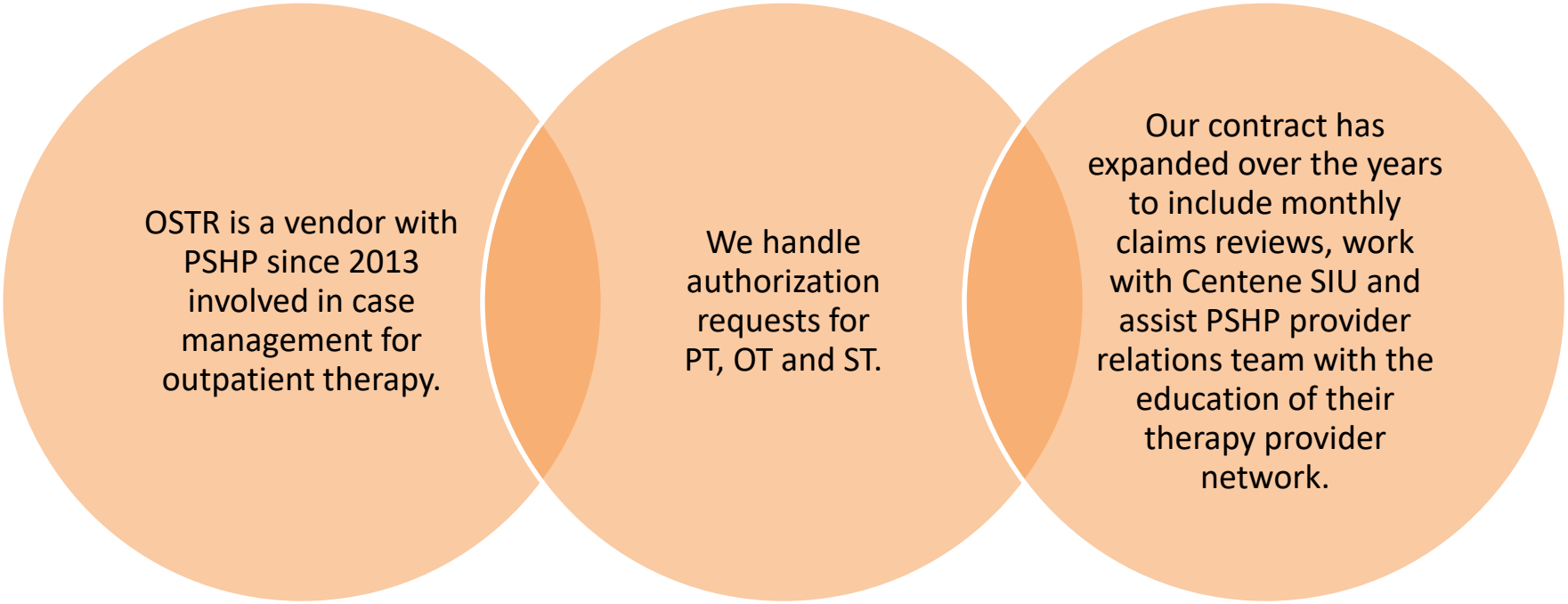
peach state health plan™

Therapy Services

Provider Training

May 31, 2023

Therapy Services Provider Training



Purpose of this Training

To assist providers in understanding what is required of PSHP therapy providers, and the rules and regulations providers are expected to follow for PSHP therapy authorizations.

OSTR reports denial rates to PSHP monthly and PSHP has started to put into place corrective action plans (CAP) for providers with high denial rates.

OSTR also refers providers to SIU for repeatedly not adhering to rules and regulations and for behaviors that raise “red flags”.

This training will provide specific education to providers on the authorization process, including the rules and regulations that govern the process, that should reduce denials and any issues with the authorization process.

Authorizations

General Information

Providers should be using the GAMMIS portal for therapy authorization requests, especially for CIS members.

All required clinical documentation and any additional information requested on a re-authorization should be attached at the time of the request entry.

All authorizations start on the date they are reviewed, unless the provider requests a date after the review date.

All authorizations are given in visits not units.

PSHP reviewers will fax ONLY approvals or talk down approvals to providers.

All treating therapists must be credentialed with PSHP.

PSHP uses a family of codes. 97110 for PT; 97530 for OT and 92507 for ST. A provider may bill any code from the family of codes for that discipline. Refer to CIS Manual

Electronic signatures are accepted but must follow requirements set forth for electronic signatures. *(Part 1 DCH Manual)*

Medical Necessity

Medical necessity determinations for both CIS and NON-CIS requests are made using the Medicaid Medical Necessity Definition that can be found in the DCH manuals.

Determination of need is based on clinical information sent in the Evaluation as well as the Care Plan. Evidence of continued need is based on notes sent for review.

Notes must show evidence of skilled services occurring and must be services that can ONLY be delivered by a licensed, skilled service provider.

We use ASHA, AOTA and APTA practice guidelines as well as CMS guidelines to assist in medical necessity determinations.

Phone Calls from OSTR

- OSTR will use ONLY the contact information sent via the GAMMIS PAR form or fax form.
- Reviewers will call the requesting provider for any questions and/or information needed to complete the review. If the provider is not available, reviewers will leave detailed messages on secured voicemail boxes with a call back number. Again, all required documents must be attached to request at the time of submission. Reviewers may not have time to wait for a call back or for missing information to be submitted as all requests are time-sensitive (3-day TAT).
- If the voicemail is unidentified or not HIPPA compliant, we cannot leave any specific information regarding the member, but will leave the basic/general information on the case - PT, OT or ST, if it is information we need, or that the case is pended to the Medical Director for second level review and our call back information.
- If the number we are calling is not the one you want information to, please change your GAMMIS profile to where you would like us to contact you.
- OSTR cannot take or make phone calls to members or their families. We can only speak with providers. Members can call Member Services at PSHP for any issues.

“Talk Downs”

A provider can adjust a requested amount verbally and request a lesser frequency/duration to allow time for the missing information to be submitted.
This is called a “talk-down”.

“Talk downs” are given for all NON-MEDICAL NECESSITY reasons and would typically be a “technical denial” for a member under FEE FOR SERVICE MEDICAID.

A “talk-down” can be given for missing clinicals, dates of service requested beyond a care plan, a document that expires within the requested date range, or the number of visits does not match the duration requested – a case that would otherwise meet medical necessity for a full approval.

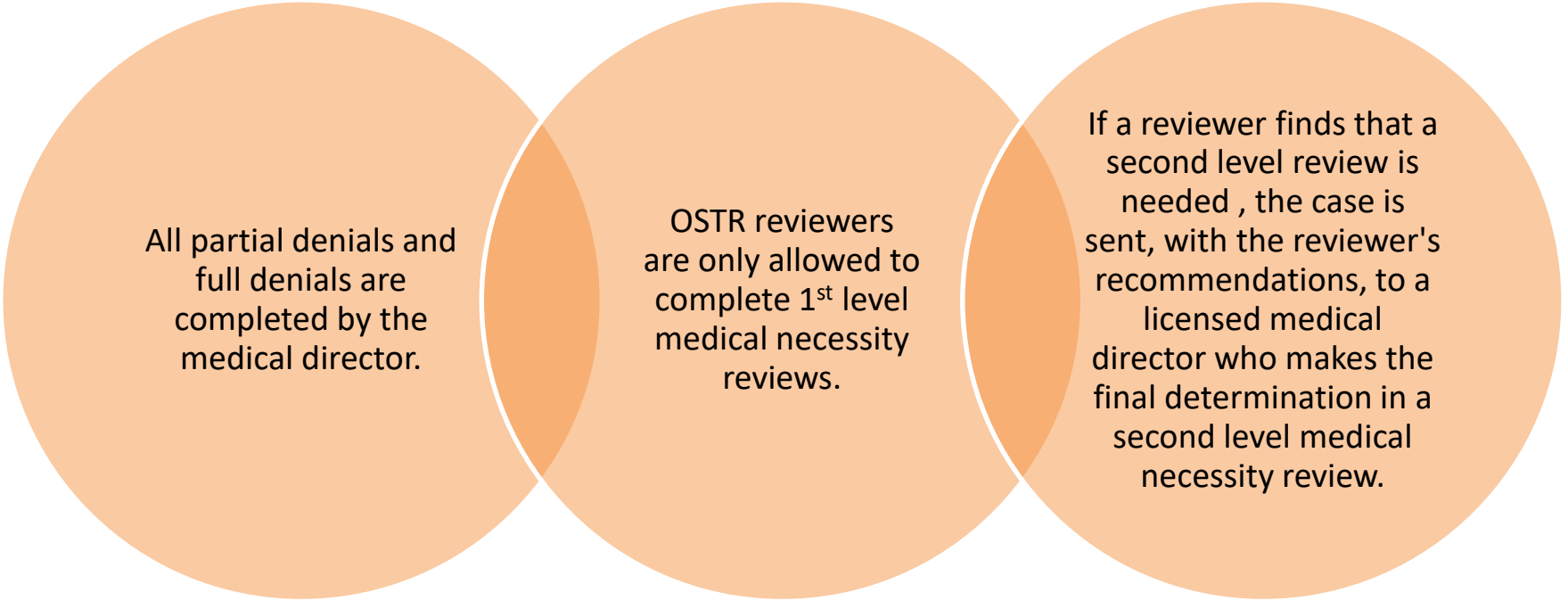
A “talk-down” does not go the Medical Director for a second level review AND the member, referring MD and provider will NOT receive a denial notification from PSHP.

continued

“Talk Downs” continued

- Talk Down cases are counted in a provider’s denial percentage provided to PSHP.
- Most requests that have incomplete/missing information will be given a “talk-down” if the provider can be reached and AGREES to the shortened authorization to allow time for that information to be submitted.
- Providers should submit for this reduced amount when all required clinicals are not available.
    - Missing treatment notes, school status → 1 month allowed
    - Missing hearing screen → 3 months allowed
    - Missing SPOC → 1 month allowed if there is an Rx or a previous SPOC on file
    - Missing Rx → 1 month allowed for initial requests if there is a SPOC

Partial and Full Denials



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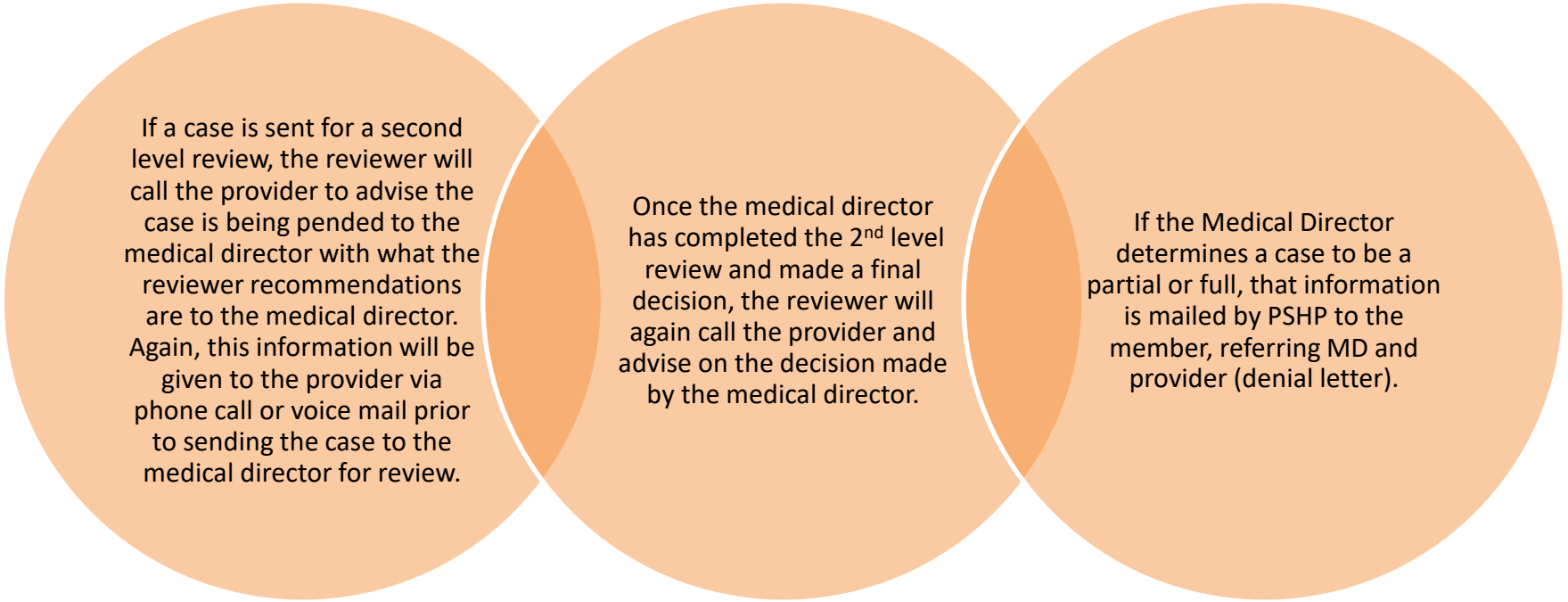
Partial and Full Denials, continued



Transition of Care

30-day transition period for new PSHP members that had an active authorization through another CMO.

Must be requested in the month the member has transitioned to PSHP.

Provider must indicate on the request that it is a transition of care case and include provider authorization details from the previous CMO.

Transition of Care cases can be backdated to include any DOS of that initial month (30 days).

Peer to Peer & Appeals

Peer to Peer requests must be received within 5 days of the medical director decision.

Peer to Peer is requested via phone call to OSTR or PSHP.

Peer to Peer is done therapist to therapist.

Peer to Peer can be requested by the provider for any case that has been denied.

continued

Peer to Peer & Appeals

Appeals can only be requested by the member only unless they assign the appeal benefit to the provider. These should only be for fully denied cases.

Appeals do NOT come to OSTR. They are handled at the plan level. OSTR cannot assist with final decisions from the health plan.

Appeal instructions are included in the denial letter package sent to the member and provider.

Change of Facility

Members that have an existing authorization with a provider and wish to change provider (different TIN) must submit a change of facility letter with the new provider request.

The change in facility letter must be initiated by the parent/caregiver (not on the provider letterhead) and signed and dated by the parent/caregiver.

The letter must include the last date of service or when service at the original provider should be terminated.

If there is no change letter, we are unable to authorize any visits to the new provider due to duplication of services.

CIS vs. Non-CIS

CIS

- Members from birth to the age of 21.
- Must have physical disability or developmental delay – chronic condition.
- Therapy course is typically greater than 90 days.
- Must be treated by a CIS provider (requested and billed under the NPI of the enrolled therapist).
- Must follow all CIS guidelines.

NON-CIS

- Any age
- Members with an acute onset of condition (less than 90 days).
- Therapy course will typically be less than 90 days.

Over 21 and Chronic

This is a PSHP PER DCH policy. It is based on CMS policies.

There is no therapy benefit for members over the age of 21 with a chronic condition.

Chronic condition is defined by PSHP as a condition with a date of onset that is over 90 days.

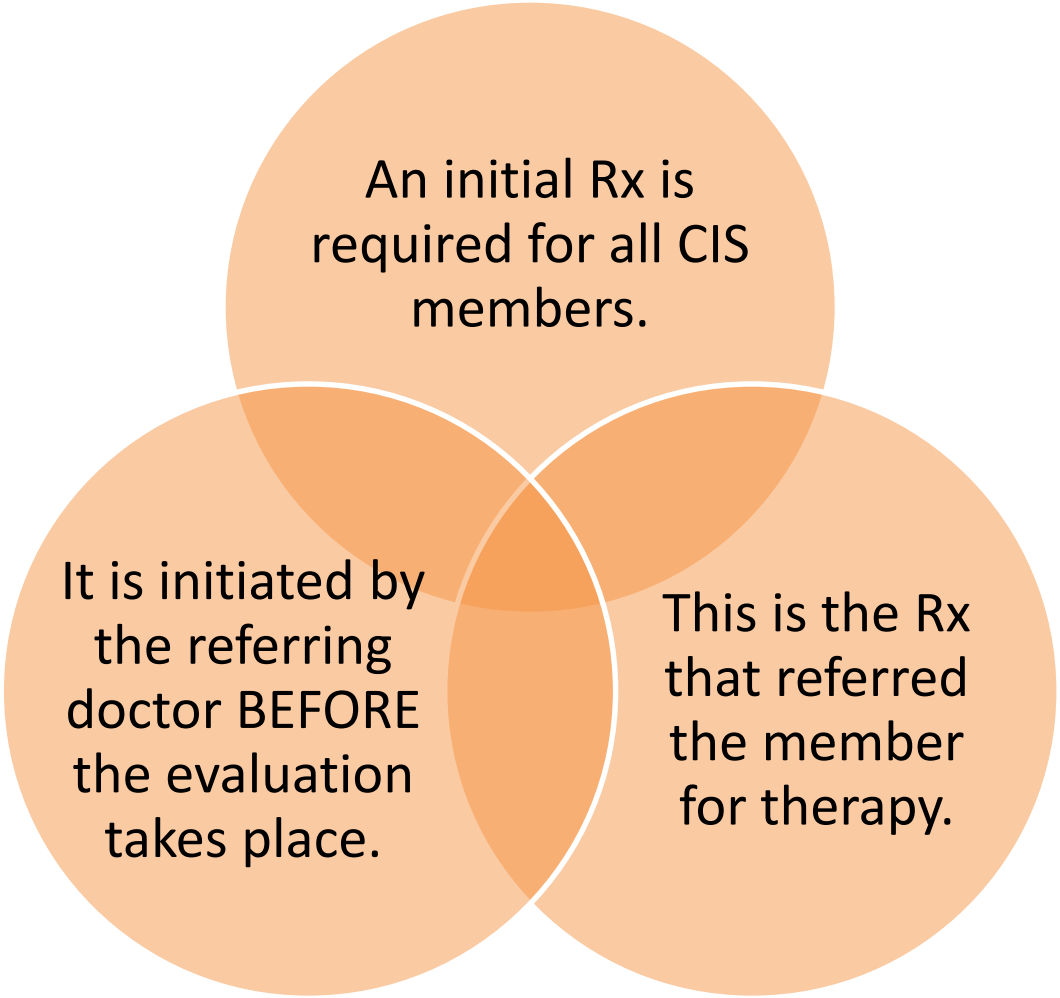
All requests must document the date of onset in evaluation.

Date of onset is the onset of symptoms - not the eval date or prescription date.

CIS Requirements

Children Intervention Services (CIS) Manual

Prescriptions



More specific information can be found in the DCH CIS Manual Chapter 700 "Children's Intervention Services are provided to Medicaid eligible members from birth to twenty-one (21) years of age with physical disabilities or a developmental delay, who have been prescribed rehabilitative or restorative intervention services by the child's primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP."

Evaluations & POC

- Must include name, DOB, diagnosis/condition, eval date, POC dates, frequency and duration of services, location of services, current level of function, patient's progress to date, functional outcomes, goals with timelines to be reached.
- An evaluation should include a full history of the member including medical history, therapy history and anything relevant or that may impact therapy.
- An evaluation/re-evaluation must include current standardized testing.
- Standardized testing is not used as the sole determinant of medical necessity. Therefore, informal assessments and a thorough description of the deficits should also be included.

Evaluations & POC Continued

- When a child is not amenable to standardized testing, the therapist must give enough information to establish baseline abilities and deficits.
- POC completion date must be on or after the evaluation date. POC start date must be within 30 days of completion date.
- Re-eval and POC must be completed/updated every 6 months including testing.
- PSHP allows a 1-month authorization period to allow for the POC to be signed by PCP. Provider can request authorization for 1 month with a POC not signed by the PCP.
- More specific information can be found in the CIS Manual section 801.

Education Status: IEP

- All requests must have either an IFSP, IEP or Letter of Attestation form.
- More specific information can be found in the CIS Manual section 801 and 802.

IEP

- School aged children - over the age of 3
- Must submit even if there are no therapy services provided through the school.
- Must have a current date range. They are reviewed yearly.
- PSHP will allow authorization for 1 month after expiration date to allow time for the updated IEP to be received.
- If a child is school age, and clinical information shows the child would meet criteria for support within the school system but attends a private school, this information must be provided on the LOA.
- If a child is enrolled in home schooling, we will need the Ga Department of Education Intent to home school form for the current school year.

Education Status: LOA

- All requests must have either an IFSP, IEP or Letter of Attestation form.
- More specific information can be found in the CIS Manual section 801 and 802.

LOA

- If there is no IFSP or IEP, attestation form must be provided.
- The attestation form must be completed and signed by the treating therapist.
- PSHP requires an updated attestation form every 6 months.

Education Status: IFSP

- All requests must have either an IFSP, IEP or Letter of Attestation form.
- More specific information can be found in the CIS Manual section 801 and 802.

IFSP

- IFSP must be current (have a valid date range). Unable to authorize past the end date of the IFSP.
- IFSP are reviewed at a minimum of every 6 months.
- If a patient receives therapy through BCW, the provider must be listed under the Services section of the IFSP. Services can only be rendered by the provider listed in this section.
- A therapist cannot change the amount, duration and frequency.
- If a patient does NOT receive therapy through BCW, but receives other services through BCW, the therapy should be listed under "Other Services". However, this is not mandatory. In these cases, an updated IFSP will be needed 6 months from the IFSP date.

Treatment Notes

Must include member's name and DOB, Medicaid number, date of service, time of visit, duration of visit, place of service, description of services rendered and response of member, signature and title of person performing the service after EACH encounter.

Treatment notes are typically written and signed on the date of service, however, DCH will allow 3 business days for all documentation to be finalized.

Parent/Caregiver involvement and/or home exercise program must be evident.

continued

Treatment Notes continued

Therapy rendered via telehealth requires consent. Can be documented via telehealth consent form or on the treatment note for each encounter.

All treatment notes from the previous authorization period are required to be submitted with any request for continuation of therapy.

If all visits have not been used, an explanation must be provided – i.e., attendance issues, scheduling issues, medical issues, etc.

More specific information can be found in the CIS Manual section 802 and 903.

Hearing Screen

- This is a PSHP policy.
- Hearing screens are required for all speech and language therapy requests.
- PSHP will allow 3-month authorization to allow time for hearing screen to be completed or if member needs medical follow up for a failed screen.
- Newborn hearing screens are accepted until the age of 4.
- Members with IEP, the HS requirement is waived.
- Hearing tests accepted: OAE, ABR, pure tone audiometry. Hearing tests NOT accepted: Universal screeners, Music 2 My Ears.
- Accepted documentation of a hearing screen:
    1. MD note signed by the MD indicating hearing screen was passed.
    2. State of Georgia 3100 form.
    3. Therapists note/eval report must include date and test used with the hearing level and frequencies tested.

Non-Covered Services under CIS

- Services in a school setting.
- Services to children who do not have a written service plan (POC).
- Services in excess of those indicated on the IFSP or POC without prior approval.
- Inpatient services.
- Services provided by assistants (OTA, PTA, SLPA)
- Group therapy
- Co-treatment
- Billing for documentation time.
- Service of an experimental or research nature.

More specific information can be found in the CIS Manual section 904.

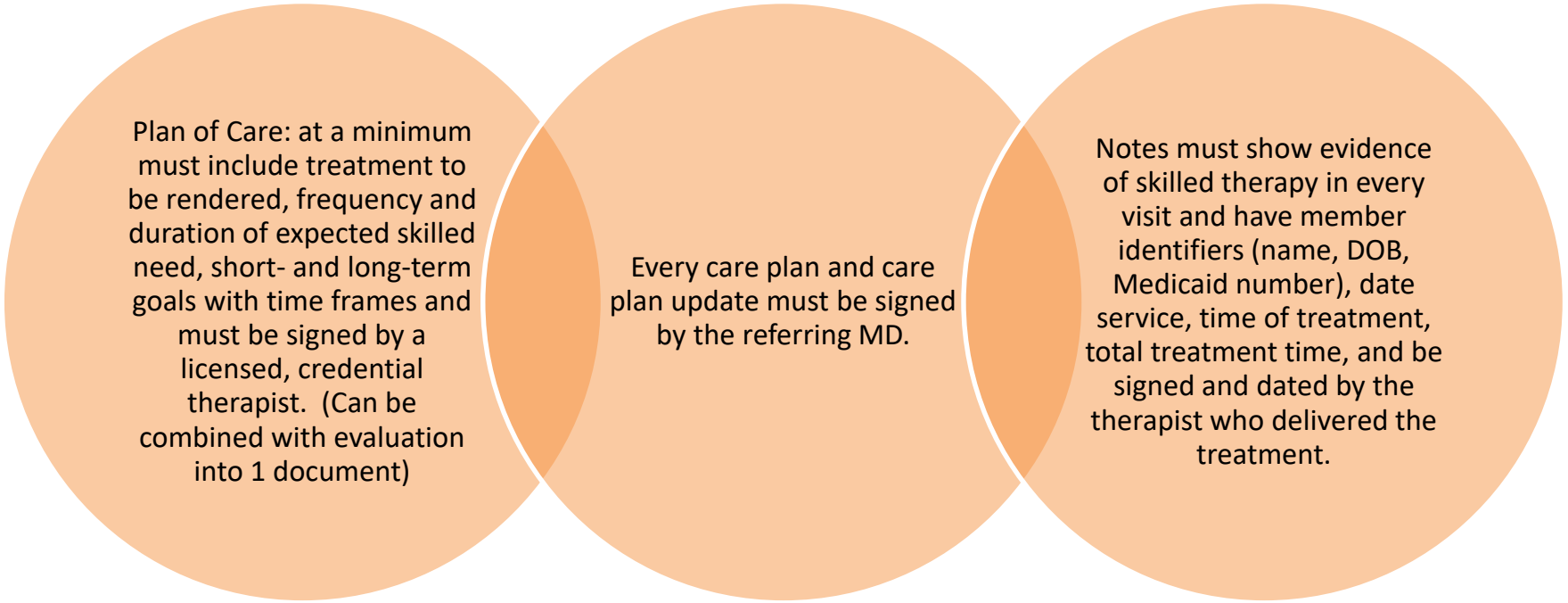
Non-CIS Requirements

We use the PSHP Policy, the DCH Hospital Services Manual, the DCH CIS Manual, National Association practice guidelines State Practice Act, or InterQual to assist with medical necessity determinations for NON-CIS members.

An initial prescription is required for all members. This is the Rx that referred the member for therapy. It is initiated by the referring doctor BEFORE the evaluation takes place. Must be signed by the referring MD.

Full evaluation: at a minimum must include onset date, full past medical history along with prior therapies and current therapies, prior and current level of function and objective information about the condition to be treated.

Non-CIS Requirements, continued



Questions