Health Partners Speech Therapy Utilization Management Guide

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Speech Therapy Authorization Requirements

Health Partners waives the authorization requirement for the patient's first 8 speech therapy visits of each calendar year. These 8 "waiver visits" must be medically necessary and are managed as follows:

- Health Partners will pay eligible claims for 8 visits each calendar year without authorization. Care beyond the initial 8 visits requires authorization.
- Since a patient may have been treated by another therapist during the benefit year, it is important that you verify whether the patient has already received treatment and may have used all or part of the 8 waiver visits. Contact Health Partners to see if visits have already been rendered. Keep in mind that claims data is generally at least three months delayed. If in doubt, submit a Treatment Plan to request authorization for the therapy.
- If you request authorization before the patient uses all waiver visits, any unused waiver visits are void for the remainder of the calendar year. So, once you request authorization, continue to request necessary ongoing care even if you did not bill 8 visits under the waiver program.
- There is an 8-visit waiver for physical and/or occupational therapy and a separate 8-visit waiver for speech therapy.

Following are some treatment scenarios and authorization requirement examples under the utilization management (UM) program:

- A patient who has not had any speech therapy visits in the calendar year sees you for treatment. You may render up to 8 medically necessary visits before requesting authorization.
- A patient saw you for 5 visits and returns later that calendar year with a new referral. She has seen no other speech therapist during the calendar year. You may render up to 3 additional medically necessary visits before requesting authorization. If the member had previously used the 3 visits and exhausted the waiver, you may receive a claims denial or retraction for no authorization.
- A patient saw another speech therapist and used 4 of the waiver visits. Later that calendar year the patient is referred to you. You may treat up to 4 medically necessary visits before requesting authorization. If the member had previously used the 4 visits and exhausted the waiver, you may receive a claims denial or retraction for no authorization.
- A patient saw another speech therapist and used all 8 of the waiver visits. Later that calendar year the patient is referred to you. Authorization for treatment is required after the initial evaluation.
- A patient saw a physical therapist and used all 8 of the PT/OT waiver visits. Later that calendar year the patient is referred to you. The patient has not had any speech therapy visits in the calendar year. You may treat up to 8 medically necessary visits before requesting authorization.
- You see a patient who has not had any speech therapy visits in the calendar year. You submit a Treatment Plan requesting authorization after the first visit. The remaining 7 waiver visits are void; you must continue to request authorization for ongoing care through the end of the year.

Speech Therapy Treatment Plan

Landmark's clinical peer reviewers consider requests for care based on the information you submit on a Treatment Plan form. The following versions of Landmark's Treatment Plan are available for requesting speech therapy.

- Neuro (Adults & Peds)
- Pediatric Speech & Language

- Feeding/Swallowing Evaluation (Adults & Peds)
- Voice Evaluation (Adults & Peds)

Speech Therapy Treatment Plans may be submitted via fax. Follow these steps to submit your request:

1. Determine the appropriate form for the patient's condition. You may submit a Feeding/Swallowing or Voice Evaluation on its own, or when appropriate, along with the Neuro or the Pediatric Speech & Language Treatment Plan.
2. Complete every boxed section of the Treatment Plan. If a section is not applicable to your patient, select 'N/A.' Forms with incomplete sections or references such as "See attached" in lieu of completing items on Landmark's form may be returned to your office for correction and resubmission.

   > Note: When sending a Feeding/Swallowing or Voice Evaluation along with a Treatment Plan, you only need to provide clinical information that you did not already complete on the Neuro or Pediatric Treatment Plan. You are not required to provide duplicate clinical information on both forms. However, at a minimum, please provide the member's and therapist's name and ID on all pages. Landmark will make one review determination for the combined Treatment Plan submission.

3. Attach a copy of the ordering physician's referral (required documentation).
4. Fax the completed Treatment Plan to Landmark at (888) 565-4225.

Submission Guidelines

Please follow the guidelines below when you submit your Treatment Plans to Landmark.

- Do not submit your Treatment Plan more than 7 days prior to your requested "Start Date for This Treatment Plan" (Start Date). Landmark will not accept Treatment Plans submitted more than 7 days in advance because current, updated clinical information is required for Landmark to make a review determination.
- Report updated clinical findings. If your "Date Current Objective Findings Obtained" is more than 7 days prior to your Start Date, you will likely receive a Request for Information letter back from Landmark, which will delay consideration of your request.

When to Submit the Treatment Plan

First Authorization Request

The timing of your first Treatment Plan will depend on whether you are treating the patient under the waiver program.

- If you are treating under the waiver and you anticipate the need for additional visits:
  - Submit a Treatment Plan before the patient’s 9th visit of the current calendar year. Remember to count visits from other therapists against the 8-visit waiver, not just your visits with the patient.
  - Select "Continuing Care" as the type of request on your Treatment Plan.
  - In the Start Date box, enter the patient’s 9th visit.
- If the waiver is not available because the patient was treated earlier in the year by you or another therapist:

- Submit a Treatment Plan after your initial evaluation.
- Select "Initial Care" as the type of request on your Treatment Plan
- In the Start Date box, enter the patient's first therapy visit for the current episode.

If your request is approved, Landmark will notify you of the approved number of visits and the Approved Time Period.

> Approved Time Period: Medical necessity authorizations are typically approved for a 30-day period. When care is approved, the Approved Time Period is the time period (duration) you have available to use approved visits. Visits must be spread throughout the authorized duration to avoid a gap in care at the end of the Approved Time Period.

Subsequent Authorization Requests

If you believe a patient will require therapy after the End Date of an Approved Time Period, submit an updated Treatment Plan to request continuing care. In order to establish the need for ongoing care, each request must include updated clinical information that documents significant lasting benefit from previous treatment.

- Submit a new Treatment Plan a few days before the first continuing care visit that will require authorization.
- Select "Continuing Care" as the type of request on your Treatment Plan.
- In the Start Date box, enter the date of the first visit you are requesting **after the end of the existing Approved Time Period**.

Retrospective Care Request

Retrospective requests are requests for treatment that has already occurred. If you do not obtain authorization after the 8-visit waiver has been used, payment will be denied. Retrospective review requests may be submitted up to 180 days from the date of service. Typically providers must have compelling reasons, such as situations where they had no control over the circumstances, before a retrospective review will be considered.

- Select "Retrospective Care" as the type of request on your Treatment Plan.
- You are required to include a copy of all evaluations, progress summaries, daily treatment notes, and any flow sheets used for the services you provided.
- Attach a copy of the ordering physician's referral (required documentation).
- Landmark will provide a review determination within the timeframe required by applicable regulations.
- Landmark will not process retrospective requests as expedited or urgent requests.

Date Extensions on Existing Authorization Periods

A date extension may be necessary due to unforeseen delays, such as your patient's inability to attend all scheduled visits. To extend the expiration date of an existing authorization, submit a Date Extension Request within 30 days after the expiration of that authorization.

- One date extension, up to 30 days beyond the authorization end date, will be allowed per authorization for patients aged 21 years and over. If additional care is required beyond the first date extension, submit a new Treatment Plan with updated clinical information.

- Two date extensions, up to 30 days each beyond the authorization end date, will be allowed per authorization for patients under the age of 21. If additional care is required beyond the second date extension, submit a new Treatment Plan with updated clinical information.

To fax a date extension request, download the Date Extension Request form from Landmark Connect and fax it to Landmark.

Resubmitted Treatment Plans

If you resubmit a modified Treatment Plan for any reason, be sure to write the word "CORRECTED" or "RESUBMITTED" across the top. And, if applicable, write the case Reference Number on the form.

Clinical Review

Review decisions and determinations are based on our Clinical Practice Guidelines, scientific evidence, literature reviews, and the reviewer's clinical experience. Accordingly, the clinical department affirms that:

- Clinical peer reviewers render decisions based on the appropriateness of care and services.
- Clinical peer reviewers are not compensated in any way for denying, limiting, or modifying care.
- No incentive is provided to the clinical peer reviewers or consulting physician reviewers to encourage modification or denial of requested care.
- Landmark prohibits making decisions regarding hiring, promoting or terminating practitioners or other individuals based on the likelihood or perceived likelihood that the individual will support or tend to support a denial of benefits.

Treatment is typically authorized in 30-day increments. Authorization in these timeframes allows the clinical peer reviewers to assess the patient’s response to treatment.

Critical data impacting the review determination made by the clinical peer reviewers include the following:

- Patient function
- Objective and subjective findings
- Special tests and measures
- Clinical diagnoses
- Date and mechanism of onset
- Co-morbidity issues and other medical complications
- Recent surgeries
- Age of the patient

Treatment Plans that present a clear clinical picture and that are accompanied by a consistent, specific diagnosis better support the medical necessity for the requested treatment. Landmark’s clinical peer reviewers use the submitted clinical information in conjunction with our proprietary Clinical Practice Guidelines to determine the number of visits to authorize for each request. Landmark’s proprietary Clinical Practice Guidelines provide decision support for peer reviewers as they make medical necessity determinations and are a reference tool for providers as they develop their treatment plans. Landmark’s Clinical Practice Guidelines are available on the Resources page on Landmark Connect.

Medical Necessity

DPW (Department of Public Welfare)

A service or benefit is medically necessary if it is compensable under the MA program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability;
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability;
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that the appropriate for members of the same age.

DOH (Department of Public Health)

- Services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:
- In accordance with generally accepted, standards of medical practice: clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Landmark clinical peer reviewers follow the guidelines below to determine "clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease":

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice and supported by evidence.

For these purposes, "accepted standards of medical practice" means standards that are based on credible scientific evidence published in the peer-reviewed literature generally recognized by the relevant healthcare community, specialty society evidence-based guidelines or recommendation, or expert clinical consensus in the relevant clinical areas.

Review Determinations

Landmark processes Treatment Plan requests and issues review determinations within the time-frames mandated by applicable state and federal regulatory requirements and NCQA and URAC timeliness standards. You may check the status of your requests and download your review determination letters anytime through Landmark Connect:

1. Login to Landmark Connect at www.LMHealthcare.com.
2. Select 'Patient Status' from the navigation bar.
3. Use the Member Search page to display a list of authorization records for your patient.
4. Click the 'View Letters' button to view or print the review determination letters from Landmark.

Landmark will also fax or mail you a copy of each review determination letter. Members are notified by a separate mailed letter.

The notification letter will indicate the number of approved visits and the Approved Time Period. When a treatment request is modified or denied, written notification will also include the following:

- Clinical rationale for the decision
- Instructions for requesting a copy of the Clinical Practice Guideline(s) used in the decision
- Instructions for peer-to-peer discussion
- Instructions for appealing a determination, including your right to submit additional information
- Time limits for submitting an appeal request

Upon receiving a review determination, provide treatment up to the number of visits authorized within the Approved Time Period. If you determine that the patient will require additional care beyond the End Date of the Approved Time Period, submit a new Treatment Plan. **The Start Date of your subsequent Treatment Plan should be after the End Date of the existing Approved Time Period**, but cannot be more than 7 days beyond the date you submit the request.

Access to Physician Peer Reviewers

Our medical director and/or physician reviewers have many years of practice experience and are available to discuss Treatment Plan determinations. Your authorization determination letter will provide instructions how to contact a Landmark medical physician reviewer. You may also call Landmark's Customer Service department to request a discussion with a medical physician reviewer. Our physician will be available to speak with you within one business day of your request.

Requests for Information

If we cannot make a decision regarding a request for treatment due to a lack of information, we will send you a "Request for Information" (RFI) letter. The letter will describe the information required, and the length of time you have to submit it. If we do not receive the requested information within the designated time period, Landmark will follow the RFI closure process applicable to the member's benefit plan and a determination will be made based on the limited clinical information originally submitted with your Treatment Plan request. If you disagree with this determination, you will be provided with instructions on how to appeal the decision.

When you submit the requested additional information, fax it to Landmark along with a copy of the RFI letter you received. If a copy of the letter is not attached, be sure that you note the following on your new documentation to avoid processing delays:

- Case Reference Number
- Patient name
- Patient date of birth
- Patient ID number
- Provider name and ID number

Requests for Care Within an Existing Approved Time Period

When you receive authorization from Landmark, visits should be spread out over the Approved Time Period. In the event you utilize the visits before the authorization expires, submit a new Treatment Plan. Indicate the first visit that exceeds the number authorized in the "Start Date for This Treatment Plan" field. If medical necessity cannot be established, Landmark will send a Request for Information (RFI) letter. Provide the requested information to describe the patient's progress since the previously submitted Treatment Plan and explain why you are requesting more visits before the authorization expiration date.

Complete Medical Records

Timely and accurate records document the treatment provided to your patients and support the reimbursement of that treatment. Good record keeping becomes especially important when establishing the medical necessity of the services you provide. Complete medical records include the following important elements:

- The writing is legible with standard abbreviations or contains a key to unique abbreviations.
- Patient name and/or identification number must be present on each page of the file.
- Demographic information, such as date of birth and gender must be present at least once.
- Complete medical history.
- Detailed description of your objective and subjective examination findings.
- Description of any diagnostic testing and the resultant findings.
- Primary diagnosis or set of diagnoses.
- Treatment Plan, including goals of treatment, objective and subjective findings, functional deficits, and the need for skilled care based on evidence-based research should be provided.
- If applicable, your referral of the patient to another practitioner and the clinical rationale for this decision.
- Signature of the therapist (not an assistant or other staff member) on all assessments, progress summaries and Treatment Plan requests.