MACOMB COUNTY COMMUNITY MENTAL HEALTH

Subject: **Utilization Management**	Procedure: **Authorizations for Occupational Therapy, Physical Therapy, and Speech, Hearing, and Language Pathology**	
Last Updated: **8/8/2024**	Owner: **Managed Care Operations**	Pages: **4**

I. PURPOSE

To provide procedural and operational guidance to directly operated and contract providers on the documentation requirements for authorizations of occupational therapy; physical therapy; and/or speech, hearing, and language therapy.

II. DEFINITIONS

Occupational Therapy (OT):
A healthcare specialty that helps individuals improve their ability to perform daily tasks in order to live as self-sufficiently as possible.

Physical Therapy (PT):
A healthcare specialty that helps individuals improve how their body performs physical movements.

Speech, Hearing, and Language Pathology (SLP):
A healthcare specialty that helps individuals improve their communication and language skills.

Medical Necessity:
Determination that a specific service is medically (clinically) appropriate; necessary to meet needs; consistent with the person's diagnosis, symptomatology, and functional impairments; is the most cost-effective option in the least restrictive environment; and is consistent with clinical standards of care. The medical necessity of a service shall be documented in the individual plan of service (IPOS).

III. PROCEDURE

A. When a person served notifies their primary clinical provider of a need for Occupational Therapy (OT); Physical Therapy (PT); and/or Speech, Hearing, and Language Pathology (SLP), the provider shall:

1. Identify if this is a treatment need for the person served, per the Michigan Medicaid Provider Manual, specific to the service and medical necessity.

    a) Therapy must be skilled (requiring the skills, knowledge, and education of a licensed therapist). Interventions that could be expected to be provided by another entity (e.g. teacher, family member, staff, or caregiver) would not be considered medically necessary for these services.

    b) It is anticipated that OT, PT, and/or SLP therapy will result in a functional improvement that is significant to the person's daily living appropriate to their chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time. Therapy to make changes in components of function that do not have an impact on the person's ability to perform age-appropriate tasks is not covered. Therapy that does not result in functional improvements that are durable and maintainable will not be covered.

    c) The treatment needs for OT, PT, and/or SLP should be acute. It is expected that the therapist will train other entities (e.g. family members, caregivers, or staff) to provide the interventions for the purpose of maintaining the achieved functional improvements. Authorizations of OT, PT, and/or SLP should not be expected to continue once the person's maximum functional potential has been realized, the person has plateaued, or the therapy has no impact on the person's ability to perform age-appropriate tasks.

    d) The treatment needs for OT, PT, and/or SLP must stem directly from the person's qualifying behavioral health diagnoses and resulting functional impairments.

    e) The person served must have active Medicaid benefits to be eligible for OT, PT, and/or SLP.

    f) Medicaid is the payor of last resort. If the person has Medicare or a private insurance policy with this benefit, then the person must pursue authorization through these insurance options.

2. The primary clinical provider will discuss the OT, PT, and/or SLP therapy needs as a part of the person-centered planning process. The case manager will assist the person in identifying a provider for this service when needed.

3. The primary clinical provider will ensure that the OT, PT, and/or SLP therapy is an identified service in the individual's person-centered treatment plan. The goal must address the medical necessity of the identified therapy.

4. The primary clinical provider will assist the person in obtaining an original physician's prescription for the requested service.

    a) The prescription must include all requirements as detailed in the Michigan Medicaid Provider Manual (MPM). It is the responsibility of the primary provider to ensure compliance with all updated standards within the MPM. These standards include the following:

        i. Person served's name;

        ii. Prescribing physician's name, address, and telephone number;

        iii. Prescribing practitioner's signature (a stamped or electronic signature is not acceptable);

        iv. The date the prescription is written;

        v. The specific service being prescribed (it must specify if for the evaluation, ongoing treatment, or both);

        vi. The expected start date of the order (if different from the prescription date); and

        vii. The length of time that the service is needed. The maximum length of time that a prescription can be valid for is one year. A new prescription is required to be obtained on an annual basis or sooner as based on the duration noted in the prescription.

5. A comprehensive evaluation by an appropriately licensed professional must be completed with detailed recommendations to support the medical necessity for all ongoing treatment. The evaluation must include the amount, scope, and duration of each service code that is recommended as medically necessary for the person served. The maximum length of time that an evaluation can be valid for is one year. A new evaluation is required to be completed on an annual basis or sooner as based on the duration noted in the evaluation.

B. The primary clinical provider submits the prior authorization request to MCCMH's Managed Care Operations (MCO) Division in the FOCUS electronic medical record (EMR).

C. MCO has fourteen (14) calendar days to make a medical necessity determination on these requests.

    1. When it is determined that the person served meets the medical necessity criteria for the authorization of OT, PT, and/or SLP, the authorization is approved in the FOCUS EMR, and an electronic notification is sent to the primary clinical provider.

2. When it is determined that the person served does not meet the medical necessity criteria for the authorization of OT, PT, and/or SLP, the authorization is denied in the FOCUS EMR, and an electronic notification is sent to the primary clinical provider. MCO sends a Notice of Adverse Benefit Determination to the person and/or their legal guardian.

IV. REFERENCES

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 2-020, "Specialized Health Care Services"

B. MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS

None.

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	8/8/2024	Creation of Procedure	MCCMH MCO Division
2	10/11/2024	Implementation of Procedure	MCCMH MCO Division