Prior Authorization Requirements

Utilization Management Program

Dell Children's Health Plan Utilization Management (UM) Program is designed to manage the use of health care resources and to maximize the effectiveness and quality of the care provided to its members. It is designed to promote appropriate, safe and consistent utilization management decision-making. The program includes pre-service, concurrent and post-service review components. Program activities are completed in a manner that is consistent with the applicable policies, procedures, and standards of the state and federal regulatory agencies. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization.

Dell Children's Health Plan will ensure that services for members are sufficient in the amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The health plan will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member (42 CFR §438.210 (a) (ii)).

Dell Children's Health Plan has appropriate personnel available at a toll free telephone line to provide determinations at a minimum from 8:00 a.m. to 5:00 p.m. of each normal business day in each time zone where Dell Children's Health Plan conducts at least two percent of its review activities.

Dell Children's Health Plan has the capability of accepting or recording incoming inquiries from providers and members during the business day and after business hours. Dell Children's Health Plan responds to communications within one (1) business days after receiving the communication and conducts its outgoing communications related to utilization management during providers' reasonable and normal business hours, unless otherwise mutually agreed. TDD/TTY services and language assistance services are available for members as needed, free of charge.

For questions about the UM process, including requesting a free copy of our UM criteria/guidelines, call Provider Services at 1-844-781-2343.

Submission Timelines

Initial requests
Prior authorization with all supporting documentation is recommended to be submitted a minimum of three business days prior to the start of care. Failure to comply with notification rules may result in an administrative denial. Additional information is available in the Administrative Denials section of this document.

The start of care (SOC) date is the date agreed to by the physician, the private duty nursing (PDN) provider, and the member or responsible adult and is indicated on the submitted plan of care (POC) as the SOC date. SOC date may include prior authorization requests for home health skilled nursing and aide services, PDN, physical therapy, occupational therapy, and speech therapy services. These services may require that the provider assess the member and initiate care prior to submitting a prior authorization request within three business days of the SOC date for initial or new PDN services. During the prior authorization process, providers are required to deliver the requested services from the SOC date. Exceptions to the start of care date may include requests for home health skilled nursing, aide services, private duty nursing, physical therapy, occupational therapy, and speech therapy services. Additional information regarding exceptions is discussed below.

Exceptions:

- **Therapy (PT/OT/ST) Services:** Initial prior authorization requests must be received no later than five business days from the date therapy treatments are initiated. Requests received after the five business day period will be denied for dates of service that occurred before the date that the prior authorization request was received.
- **Home Health Skilled Nursing:** Following the RN's initial assessment or evaluation of the client in the home setting for home health service needs, the agency-employed RN who completed the home evaluation must contact Dell Children's Health Plan for prior authorization within three (3) business days of the start of care (SOC).
- **Private Duty Nursing:**
    - Initial requests must be submitted within three business days of the SOC date.
    - Initial requests may be prior authorized for a maximum of 90 days.
    - Completed initial requests must be received and dated by the Dell Children's Health Plan Prior Authorization department within three business days of the SOC. The request must be received by the Dell Children's Health Plan Prior Authorization department no later than 5 p.m., Central time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 PM, Central time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Prior authorization recertification process
A physician or health care provider can submit a medical prior authorization recertification request at least 60 calendar days prior to the expiration of the current authorization of service(s) on file.

Exceptions:

Dell Children's Health Plan requires the following prior authorization recertification requests be received up to 30 calendar days before the expiration of the current authorized service(s)

- **Physical, Occupational and Speech Therapy:** A complete recertification request must be received no earlier than 30 calendar days before the current authorization period expires. Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.
- **Private Duty Nursing (PDN)/Prescribed Pediatric Extended Care Centers (PPECC):**
    - A recertification request must be submitted at least seven calendar days before, but no more than 30 calendar days before a current authorization period will expire**.**
    - All authorization timelines apply to recertifications.
    - Completed extension requests must be received and dated by the Dell Children's Health Plan Prior Authorization department at least seven (7) calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by the Prior Authorization department no later than 5 p.m., Central time, on the seventh day, to be considered received within seven (7) calendar days. If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m., Central time, on the seven day, authorization is given for dates of service beginning no sooner than seven (7) calendar days after the receipt of the completed request by the Prior Authorization department.

Clinical Information and Documents to Support Medical Necessity

Dell Children's Health Plan may request any combination from the following list of clinical information and documents to support medical necessity of requested services. All information and documents should be current and legible with appropriate ordering physician signature dated within the past 90 days where applicable. Providers need to submit only the applicable documents listed below related to the requested services.

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
All Inpatient, Outpatient, and Therapy Requests for Services (in addition to items listed below)	Essential Information to initiate authorization referral request: ● Member name ● Member or Medicaid number ● Member date of birth ● Requesting provider name ● Requesting provider National Provider Identifier (NPI) ● Service requested- Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT) ● Service requested start and end date(s) ● Quantity of service units requested based on the CPT, HCPCS, or CDT requested
Inpatient and Observation Requests	Information and documents should relate to current admission/stay. In addition to documents listed above: ● Admission Notification and/or Face Sheet ● Behavioral Health Inpatient Admission Notification Form ● Diagnosis ● History and Physical ● Progress Notes ● Consult Notes and/or Reportsfrom Specialists ● Behavioral Health Inpatient Extended Stay Form ● Physician Orders ● Radiology/Imaging Results ● Laboratory Results ● Blood Glucose Testing ● Vital Sign Reports ● Medication Administration Records ● Discharge Summary ● Behavioral Health Discharge Summary Form

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Occupational Therapy Requests	The prescribing provider must certify that the Texas Health Steps (THSteps) checkup is current or that a developmental screening has been performed within the last 60 days. Signature of prescribing provider on PA form will attest that this service has been provided. If a prescribing provider provides verbal order or written order separate from PA form, staff member who conveys the verbal or written order must communicate that prescribing provider attests that THSteps checkup. Information and documents should relate to current request for services, in addition to applicable documents listed above: **Occupational Therapy Treatment:** ● A clinical note from a physician/appropriate specialist that documents the specific functional deficits,diagnosis and referral to occupational therapy (note should be less than twelve (12) months old for developmental delay, less than one month (1) old for orthopedic referrals and less than three (3) months old if medical necessity is not clear based on the therapy clinical notes) ● **If new to Dell Children's Health Plan:** The history of previous referrals for occupational therapy, date of the most recent therapy visit (if applicable) and copies of any prior evaluations, re-evaluations and progress summaries ● Clinical notes from an appropriate specialist (Examples: Psychology, Neurology, Orthopedics, Developmental Pediatrician, sports medicine) that document the specific functional deficits, diagnosis and need for occupational therapy ● Any radiology/imaging reports related to the current occupational therapy referral ● Clarification to prevent duplication of services(between therapy disciplines or between different therapy providers) ● Appropriate evaluation codes & modifiers ● **Referrals To an out of network therapy provider**: An explanation of the medical necessity or reason for referral to an out of network provider ● **For initial request for visits:** An occupational therapy evaluation and plan of care that includes: o Member's medical history and history of any prior occupational therapy treatment ○ Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements)

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Occupational Therapy Requests	○ A description of specific functional skills and deficits observed during completion of Activities of Daily Living (ADLs) ○ A clear diagnosis and reasonable prognosis ○ The prescribed treatment modalities ○ Recommended frequency/duration of therapy ○ Mode and location of service delivery (Examples: telehealth, in-person, clinic, home) ○ Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/time frames ○ Responsible adult's expected involvement in the member's treatment ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement and the proposed plan of care ○ Signature of the evaluating occupational therapist and date ● **Subsequent requests for ongoing occupational therapy treatment:** A therapy progress summary, re-evaluation or treatment notes along with other documents that communicate all the following information: ○ An objective demonstration of progress toward the treatment goals from the most recent authorization period (baseline objective measure from the beginning of the authorization period, the current level by the same objective measure and corresponding dates that data was collected) ○ Results of any standardized/formal testing completed since the beginning of the previous authorization period (updated standardized testing is required once every six (6) months) ○ A description of improvements in function observed during completion of Activities of Daily Living (ADLs) over the previous authorization period ○ A description of the continuing functional deficits and need for additional occupational therapy services

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Occupational Therapy Requests	○ Updated short and long-term treatment goals which are functional, appropriately attainable measurable, and specific to the member's functional deficits and include baselines/timeframes ○ The recommended treatment modalities ○ The recommended frequency/duration of therapy ○ Mode and location of service delivery for the previous authorization period and the planned mode and location of service delivery for the upcoming authorization period (Examples: telehealth, in-person, clinic, home) ○ Barriers to progress and changes that can be made to improve the response to treatment ○ The number of missed visits and scheduled visits during the prior authorization period, any reasons for missed visits and any planned modifications to increase attendance if it was low ○ Documentation of parent or primary caregiver participation in therapy sessions ○ Documentation of the home program that has been established and a description of the caregiver's compliance with the plan ○ **Telehealth**: Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement and the proposed plan of care ○ Signature of the licensed occupational therapist and date
Physical Therapy Requests	The prescribing provider must certify that the Texas Health Steps (THSteps) checkup is current or that a developmental screening has been performed within the last 60 days. Signature of prescribing provider on PA form will attest that this service has been provided. If a prescribing provider provides verbal order or written order separate from PA form, staff member who conveys the verbal or written order must communicate that prescribing provider attests that THSteps checkup. Information and documents should relate to current request for services, In addition to applicable documents listed above:

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Physical Therapy Requests	**Physical Therapy Treatment:** ● A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis and referral to physical therapy (note should be less than twelve (12) months old for developmental delay, less than one month (1) old for orthopedic referrals and less than three (3) months old if medical necessity is not clear based on the therapy clinical notes) ● **If new to Dell Children's Health Plan:** The history of previous referrals for physical therapy, date of the most recent therapy visit (if applicable) and copies of any prior evaluations, re-evaluations and progress summaries ● Clinical notes from an appropriate specialist (Examples: Neurology, Orthopedics, Developmental Pediatrician, Sports Medicine) that document the specific functional deficits, diagnosis and need for physical therapy ● Any radiology/imaging reports related to the current physical therapy referral ● Clarification to prevent duplication of services(between therapy disciplines or between different therapy providers) ● Appropriate evaluation codes & modifiers ● **Referrals To an out of network therapy provider**: An explanation of the medical necessity or reason for referral to an out of network provider ● **For initial request for visits:** A physical therapy evaluation and plan of care that includes: ○ Member's medical history and history of any prior physical therapy treatment ○ Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements) ○ A description of specific functional skills and deficits observed during completion of ○ Activities of Daily Living (ADLs) ○ A clear diagnosis and reasonable prognosis ○ The prescribed treatment modalities ○ Recommended frequency/duration of therapy ○ Mode and location of service delivery (Examples: telehealth, in-person, clinic, home)

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Physical Therapy Requests	○ Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes ○ Responsible adult's expected involvement in the member's treatment ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement and the proposed plan of care ○ Signature of the evaluating physical therapist and date ● **Subsequent requests for ongoing physical therapy treatment:** A therapy progress summary, re-evaluation or treatment notes along with other documents that communicate all the following information: ○ An objective demonstration of progress toward the treatment goals from the most recent authorization period (baseline objective measure from the beginning of the authorization period, the current level by the same objective measure and corresponding dates that data was collected) ○ Results of any standardized/formal testing completed since the beginning of the previous authorization period (updated standardized testing is required once every six (6) months) ○ A description of improvements in function observed during completion of Activities of Daily Living (ADLs) over the previous authorization period ○ A description of the continuing functional deficits and need for additional physical therapy services ○ Updated short and long-term treatment goals which are functional, appropriately attainable measurable, and specific to the member's functional deficits and include baselines/timeframes ○ The recommended treatment modalities ○ The recommended frequency/duration of therapy ○ Mode and location of service delivery for the previous authorization period and the planned mode and location of service delivery for the upcoming authorization period (Examples: telehealth, in-person, clinic, home)

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Physical Therapy Requests	○ Barriers to progress and changes that can be made to improve the response to treatment ○ The number of missed visits and scheduled visits during the prior authorization period, any reasons for missed visits and any planned modifications to increase attendance if it was low ○ Documentation of parent or primary caregiver participation in therapy sessions ○ Documentation of the home program that has been established and a description of the caregiver's compliance with the plan ○ **Telehealth**: Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement and the proposed plan of care ○ Signature of the licensed physical therapist and date
Therapy Reviews of Orthotics/Bracing/Prosthetics Requests	Information and documents should relate to current requests for services. In addition to applicable documents listed above: ● Proper forms (Examples: Texas Standard Prior Authorization Request Form for Health Care Services (TSPA), Title XIX, Justification, Comprehensive Care Program Prior Authorization Form (CCP), police/fire/insurance report of loss) using modifiers and codes as appropriate ● A recent clinical note from a physician/appropriate specialist (Examples: Neurology, Orthopedics, Sports Medicine) that documents the specific functional deficits, diagnosis and need for the requested orthotic/brace/prosthetic (note should be less than three (3) months old) ● Any radiology/imaging reports related to the current physical therapy referral ● Orthotist, physical therapist occupational therapist clinical notes on functional status, clinical trials of equipment, and justification for equipment and accessories ● Description of any underlying medical conditions, the resulting pain/impairment, prior medical management of the condition attempted prior to referral for brace/orthotic/prosthetic and the outcome of that treatment (Examples: over the counter devices, stretching programs, supportive shoes) ● Clear description and justification of item(s)/accessories being requested

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Therapy Reviews of Orthotics/Bracing/Prosthetics Requests	• Documentation of medical necessity that includes description of member's function with and without the orthotic/brace/prosthetic being requested • **For prosthetics:** Current functional level (K level 0-4) on the Medicare Functional Classification Levels Scale • History and status of any previously used/trialed orthosis/brace/prosthetic and outcome of its use for custom and off the shelf items; including medical necessity for duplication of item(s) • Description of surgery and or injury including dates that relates to the referral • Description of the least supportive device that will meet this member's needs • Description of setting this item(s) will be used • Documentation of patient's/family's willingness to comply with requested item(s)/plan of care
Therapy Reviews of Durable Medical Equipment Requests	Information and documents should relate to current requests for services. In addition to applicable documents listed above: • Proper forms (Examples: Texas Standard Prior Authorization Request Form for Health Care Services (TARF), Title XIX, Justification, CCP, Seating assessment, Installer's Certificate for car seat, police/fire/insurance report of loss, home diagram) using modifiers and codes as appropriate • A recent clinical note from a physician/appropriate specialist (Examples: Neurology, Orthopedics, Sports Medicine) that documents the specific functional deficits, diagnosis and need for the requested piece of equipment (note should be less than three (3) months old) • Member age, height, weight, diagnoses impacting mobility related activities of daily living, diagnoses affecting instrumental activities of daily living, current functional skill sets with and without equipment • Physical therapist or occupational therapist clinical notes on functional status, clinical trials of equipment, and justification for equipment and accessories • Durable medical supplier history of equipment purchases, quote/description/justification in detail for current equipment request, growth potential of requested equipment, home accessibility/ equipment compatibility, justification for repairs/ modifications, state of the equipment • Description of whether item(s) is for purchase or rental and duration of need • Description of medical necessity for all accessory components and modifiers

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Therapy Reviews of Durable Medical Equipment Requests	● Description of skin integrity, sensation, and pain perception including how it is impacted by current and requested equipment
Speech Therapy Requests	The prescribing provider must certify that the Texas Health Steps (THSteps) checkup is current or that a developmental screening has been performed within the last 60 days. Signature of prescribing provider on PA form will attest that this service has been provided. If prescribing provider provides verbal order or written order separate from PA form, staff member who conveys the verbal or written order must communicate that prescribing provider attests that THSteps checkup. Information and documents should relate to current request for services, In addition to applicable documents listed above: **Speech Therapy Treatment:** ● A clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis and referral to speech therapy (note should be less than three (3) months old if medical necessity is not clear based on the therapy clinical notes and less than twelve (12) months old for continuation of care ongoing therapy requests) ● **If new to Dell Children's Health Plan:** The history of previous referrals for speech therapy, date of the most recent therapy visit (if applicable) and copies of any prior evaluations, re-evaluations and progress summaries ● Clinical notes from an appropriate specialist (Examples: Psychology, Neurology, Pulmonology, Otolaryngology, Developmental Pediatrician) that document the specific functional deficits, diagnosis and need for speech therapy ● Clarification to prevent duplication of services(between therapy disciplines or between different therapy providers) ● Hearing testing: ○ **If hearing testing has not yet been submitted to Dell Children's Health Plan or has a medical diagnosis that is prone to hearing loss:** Documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech, or

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Speech Therapy Requests	the date of any future appointment for hearing testing. (note should be less than twelve (12) months old) ○ **If the member has a diagnosed hearing loss or failed a hearing screening:** A recent clinical note from an Ear, Nose, Throat specialist and/or Audiologist documenting an examination, treatment plan and/or outcome of a hearing aid/cochlear implant follow up visit for aided hearing testing and to determine if devices are working properly. (note should be less than three (3) months old) ● **Feeding/swallowing therapy visits**: Growth charts and/or the results of any instrumental evaluations of swallowing that have been completed ● Appropriate therapy codes & modifiers ● **Referrals to an out of network therapy provider**: An explanation of the medical necessity or reason for referral to an out of network provider ● **For initial requests for visits:** A speech therapy evaluation and Plan of Care that includes: ○ Member's medical history and history of any prior therapy treatment ○ **Bilingual:** The language exposure in the home, educational setting and community. Language used for formal testing, the amount of translation required if a bilingual assessment was used and planned language for therapy; if exposed to multiple languages, testing in both languages or use of a bilingual test (Example: Preschool Language Scale -5 Spanish) is required ○ **For Speech/Language/Stuttering:** Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements) ○ **For Speech/Language/Stuttering:** A description of specific functional communication skills and deficits observed during completion of Activities of Daily Living (ADLs) ○ **For Feeding/Swallowing:** A detailed description of the level of feeding/swallowing proficiency and deficits related to feeding/swallowing observed ○ A clear diagnosis and reasonable prognosis ○ The recommended treatment modalities ○ The recommended frequency/duration of therapy ○ Mode and location of service delivery (Examples: telehealth, in-person, clinic, home)

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Speech Therapy Requests	○ Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes ○ Responsible adult's expected involvement in the member's treatment ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on patient compliance, family involvement and the proposed plan of care ○ Signature of the evaluating speech pathologist and date ● **Subsequent requests for ongoing speech therapy treatment:** A therapy progress summary, re-evaluation or treatment notes along with other documents that communicate all the following information: ○ An objective demonstration of progress toward the treatment goals from the most recent authorization period (baseline objective measure from the beginning of the authorization period, the current level by the same objective measure and corresponding dates that data was collected) ○ Results of any standardized/formal testing completed since the beginning of the previous authorization period (updated standardized testing is required once every six (6) months) ○ **For Speech/Language/Stuttering:** A description of improvements in functional communication observed during completion of Activities of Daily Living (ADLs) over the previous authorization period ○ **For Feeding/Swallowing:** A description of improvements in functional feeding/swallowing skills observed over the previous authorization period ○ A description of the continuing functional deficits and need for additional speech therapy services ○ Updated short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes ○ The recommended treatment modalities ○ The recommended frequency/duration of therapy

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Speech Therapy Requests	○ Mode and location of service delivery for the previous authorization period and the planned mode and location of service delivery for the upcoming authorization period (Examples: telehealth, in-person, clinic, home) ○ Barriersto progress and changes that can be made to improve the response to treatment ○ The number of missed visits and scheduled visits during the prior authorization period, any reasons for missed visits and any planned modifications to increase attendance if it was low ○ Documentation of parent or primary caregiver participation in therapy sessions ○ Documentation of the home program that has been established and a description of the caregiver's compliance with the plan ○ **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy plan and how it is appropriate based on previous success with telehealth visits, patient c compliance, family involvement and the proposed plan of care ○ Signature of the licensed speech pathologist and date
Therapy Reviews of Speech Generating Devices Requests	Information and documents should relate to current request for services. In addition to applicable documents listed above: ● Proper forms(Examples: Texas Standard Prior Authorization Request Form for Health Care Services (TSPA), Title XIX, police/fire/insurance report of loss) using modifiers and codes as appropriate A recent clinical note from a physician/appropriate specialist that documents the specific functional deficits and diagnosis (note should be less than three (3) months old) ● Description of any underlying medical conditions and prognosis for development of verbal speech ● Description of whether item(s) is for rental or purchase (initial or replacement) ● History of any previous speech generating devices purchased, date of previous purchase, type of device previously purchased, why a new device is needed ● Hearing testing: ○ **If hearing testing has not yet been submitted to Dell Children's Health Plan or has a medical diagnosis that is prone to hearing loss:** Documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Therapy Reviews of Speech Generating Devices Requests	(OAE), or Auditory Brainstem Response (ABR)), a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech (note should be less than twelve (12) months old) ○ **If the member has a diagnosed hearing loss or failed a hearing screening:** A recent clinical note from an Ear, Nose, Throat specialist and/or Audiologist documenting an examination,treatment plan and/or outcome of a hearing aid/cochlear implant follow up visit for aided hearing testing and to determine if devices are working properly. (note should be less than three (3) months old) ● Language/Augmentative Communication Evaluation completed by a speech-language pathologist and signed by the referring physician that includes: ○ The member's medical history, including any underlying diagnosis or condition that impacts speech and language development ○ The history of any prior speech therapy treatment with a description of the response to traditional therapy approaches versus treatment focusing on augmentative communication ○ **Bilingual:** The language exposure in the home, educational setting and community. Language used for formal testing, the amount of translation required if a bilingual assessment was used and planned language for therapy; if exposed to multiple languages, testing in both languages or use of a bilingual test (Example: Preschool Language Scale -5 Spanish) is required ○ Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements) ○ A description of specific functional communication skills and deficits observed during completion of Activities of Daily Living (ADLs) both verbally and with the chosen device ○ A detailed description of communication impairment (diagnosis,severity, language skills, cognition, anticipated duration) ○ Description/comparison of other devices considered and why they would not meet the member's communication needs ○ Rationale for the specific device chosen including gross motor skills, fine motor skills and cognitive abilities that make the device appropriate

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Therapy Reviews of Speech Generating Devices Requests	● A recent clinical note from a physician/appropriate specialist that documents the specific functional deficits and diagnosis (note should be less than three (3) months old) ● Description of any underlying medical conditions and prognosis for development of verbal speech ● Description of whether item(s) is for rental or purchase (initial or replacement) ● History of any previous speech generating devices purchased, date of previous purchase, type of device previously purchased, why a new device is needed ● Hearing testing: ○ **If hearing testing has not yet been submitted to Dell Children's Health Plan or has a medical diagnosis that is prone to hearing loss:** Documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech (note should be less than twelve (12) months old) ○ **If the member has a diagnosed hearing loss or failed a hearing screening:** A recent clinical note from an Ear, Nose, Throat specialist and/or Audiologist documenting an examination, treatment plan and/or outcome of a hearing aid/cochlear implant follow up visit for aided hearing testing and to determine if devices are working properly. (note should be less than three (3) months old) ● Language/Augmentative Communication Evaluation completed by a speech-language pathologist and signed by the referring physician that includes: ○ The member's medical history, including any underlying diagnosis or condition that impacts speech and language development ○ The history of any prior speech therapy treatment with a description of the response to traditional therapy approaches versus treatment focusing on augmentative communication ○ **Bilingual:** The language exposure in the home, educational setting and community. Language used for formal testing, the amount of translation required if a bilingual assessment was used and planned language for therapy; if exposed to multiple

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Therapy Reviews of Speech Generating Devices Requests	languages, testing in both languages or use of a bilingual test (Example: Preschool Language Scale -5 Spanish) is required ○ Objective data documenting the current level of function (Examples: raw scores,standard scores, criterion-referenced scores, measurements) ○ A description of specific functional communication skills and deficits observed during completion of Activities of Daily Living (ADLs) both verbally and with the chosen device ○ A detailed description of communication impairment (diagnosis,severity, language skills, cognition, anticipated duration) ○ Description/comparison of other devices considered and why they would not meet the member's communication needs ○ Rationale for the specific device chosen including gross motor skills, fine motor skills and cognitive abilities that make the device appropriate ○ Outcome/summary of a three (3) month trial with the chosen device including description of device use in the home during activities of daily living, and description of independent use of the device for expressive communication at the start and end of the trial ○ A description of caregiver training related to use and programming of the device ○ Treatment plan for ongoing therapy to support additional language development using the device, including frequency and duration of speech therapy services ○ Short and long-term treatment goals which are related to use of the speech generating device, functional, appropriately attainable, measurable and include baselines/timeframes ○ Responsible adult's expected involvement in the member's treatment ○ Signature of the licensed speech pathologist and date

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Applied Behavior Analysis (ABA) Requests **(Submit to Magellan)**	Information and documents should relate to current requests for services. In addition to applicable documents listed above: **Initial ABA Evaluation**: ● A recent diagnostic evaluation. See section below titled "Diagnostic Evaluation" for details of required information ● A recent completed Comprehensive Care Program (CCP) Prior Authorization Request Form signed and dated by a prescribing provider ● When requesting a change in providers please also submit: ○ Change of therapy provider letter signed by the responsible adult that documents the date that the client ended therapy (effective date of change) with the previous provider, or last date of service ○ Documentation including the names of new and previous provider **Initial Request for 90-day ABA Treatment:** ● A recent diagnostic evaluation. See section below titled "Diagnostic Evaluation" for details of required information ● Completed ABA evaluation with the signature of the LBA and date the evaluation was completed. The ABA evaluation must include all information listed in the section below titled "ABA Evaluation" ● Treatment plan with signature of LBA and date the treatment plan was completed. The treatment plan must include all information listed in the section below titled "ABA Treatment Plan" ● Completed current CCP Prior Authorization Request form signed and dated by a prescribing provider, including the requested procedure codes and maximum units requested ● Requests for initial 90-day ABA treatment submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation date will require a progress summary signed and dated by the LBA

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Applied Behavior Analysis (ABA) Requests **(Submit to Magellan)**	**90-day Extension of Initial ABA Authorization:** ● An attendance log for child/youth, and an attendance log for parent/caregiver, that both include the percentage of scheduled sessions that were successfully completed ● Attendance that is less than 85% of approved hours will need documentation to substantiate the need for ABA services at the previously approved level and explanation why attendance was low ● Progress Summary for child/youth and for parent/caregiver signed by LBA and ● parent/caregiver. Progress summary includes, but is not limited to, the following examples: ○ Thorough and objective description of goal progress ○ Description of functional gains ● Current and completed CCP Prior Authorization Request form, signed and dated by a prescribing provider **ABA Re-Evaluation:** ● Completed ABA evaluation with the signature of the LBA and date the evaluation was completed. The ABA evaluation must include all information listed in the section below titled "ABA Evaluation" ● Updated documentation of modifications to the child/youth treatment plan and protocol with signature of LBA and date the treatment plan was completed. Treatment plan is to include all information listed in the section below titled "ABA Treatment Plan" ● Documentation attesting that the family/ caregiver has agreed to the treatment plan, including: ○ Frequency of services ○ Location of all services ○ Treatment plan goals ○ Provider has access to sufficient staff to deliver the treatment plan frequency in all locations ● Code 97151 should be listed on the CCP Prior Authorization Request form with date span to include dates the evaluation was performed

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Applied Behavior Analysis (ABA) Requests **(Submit to Magellan)**	**ABA 180 Day Recertification:** ● A recent comprehensive diagnostic evaluation. See section below titled “Diagnostic Evaluation” for details of required information ● An attendance log for child/youth and for parent/caregiver that includes the percentage of scheduled sessions successfully completed ● Attendance that is less than 85% of approved hours will need documentation to substantiate the need for ABA services at the previously approved level and explanation why attendance was low ● Progress Summary for child/youth and for parent/caregiver signed by LBA and parent/caregiver. Progress summary includes, but is not limited to, the following examples: ● Thorough and objective description of goal progress ○ Description of functional gains ● Completed current ABA evaluation with the signature of Licensed Behavior Analyst (LBA) and date the evaluation was with all information listed in the section below titled “ABA Evaluation” ● Updated documentation of modifications to the child/youths treatment plan and treatment protocol, with signature of LBA and date the treatment plan was completed with all information listed below in the section titled “ABA Treatment Plan” ● CCP Prior Authorization Request Form, signed and dated by a prescribing provider, including the requested procedure codes and maximum number of units ● Requests Submitted 60 days after the completed ABA evaluation date within 180 days after evaluation, will require a review of current progress summary signed and dated by the LBA ● A new re-evaluation must be completed when the request is submitted more than 180 days after the re evaluation date ● When a gap in services is identified the provider must submit a request as an initial request and documentation related with an initial request is required ● When conducting Interdisciplinary Team Meetings and requesting additional team meetings the following should be included: ○ Documentation of the start and stop time of the meeting (30-minute minimum) ○ Documentation of the date of the most recent evaluation or re-evaluation

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Applied Behavior Analysis (ABA) Requests **(Submit to Magellan)**	○ Documentation of the names, disciplines, and organization affiliation of the other attendees. ○ A brief narrative of reports to parents/guardian of the child/youth with ASD ○ A summary of the decisions made ○ Documentation of any actionsitems ○ A signature of the provider with the date **Diagnostic Evaluation Should Include:** ● A Recent comprehensive diagnostic evaluation from a developmental pediatrician, neurologist psychiatrist, licensed psychologist, or, an interdisciplinary team composed of a physician, physician assistant, or nurse practitioner, in consultation with one or more providers who are qualified as specialists and who have expertise in autism, limited to any previously mentioned provider, licensed clinical social worker, licensed professional counselor, licensed psychological associate, licensed specialist in school psychology, occupational therapist, or speech-language pathologist. The report must include: ○ Symptom severity level as per the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), ○ Validated diagnostic assessment tool ○ Age of child/youth ○ Date of initial autism diagnosis ○ Documentation of any known comorbid behavioral or physical health disorders ○ Documentation of trauma history ○ Comprehensive diagnostic report no more than 3 years' old **ABA Evaluation Should Include**: ● Completed ABA evaluation that was conducted within 60 days prior to start of care date on the Comprehensive Care Program (CCP) Prior Authorization Request Form, with the signature of Licensed Behavior Analyst (LBA) and date the evaluation was completed. The evaluation must include:

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Applied Behavior Analysis (ABA) Requests **(Submit to Magellan)**	○ A complete developmental history that includes relevant comorbidities including trauma history ○ Vision and hearing audiologic screening or if age and clinically appropriate a passing Texas Health Steps (Results of further evaluation may be required if those screenings indicate deficits) ○ One on one observation of the child/youth including at least one natural setting ○ Documentation of interviews with parents/caregivers to include family history, primary language of family and child, identification of skills and behaviors to be addressed in treatment as well as barriers to treatment ○ Documentation of ABA history including gaps in services and how long the child/youth has been receiving ABA services, and information on responses to previous interventions if applicable ○ Prognosis based on evidence from the evaluation regarding the individual's capacity to make behavioral gains ○ A validated assessment of cognitive abilities and adaptive behaviors ○ A functional behavior assessment (FBA) related to specific behaviors of concern to be addressed in a Behavior Support Plan (BSP) as clinically indicated **ABA Treatment Plan Should Include:** ● Treatment plan with signature of LBA and date the treatment plan was completed. The treatment plan must include: ○ Identification of specific treatment goals, targeted behaviors and/skills related to the core symptoms of ASD, health, safety, or independence of the child/youth that will be addressed in treatment ○ Documentation that all goals and protocols were selected by the LBA and parents/caregivers ○ Documentation of functional goals that are specific to the child/youth, objectively measurable within a specified time frame, attainable, and socially significant to family and child/youth

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Applied Behavior Analysis (ABA) Requests **(Submit to Magellan)**	○ Baseline data for all behaviors and skills identified across settings where treatment will occur ○ A BSP, that includes an operational behavioral definition of the target behavior excess, prevention and intervention strategies, schedules of reinforcement and functional alternative responses ○ Documentation of the planned frequency and duration of treatment across all settings to reflect the severity of the impairments, goals of treatment, expected response to treatment, and specific individual variables (including availability of appropriately trained and certified ABA staff) that may affect the recommended treatment dosage ○ Measurable parent/caregiver goals that pertain to learning the principles of ABA in home and community ○ Planned frequency and duration of parent/caregiver training ○ The formal design of the treatment protocol instructions to the supervised Licensed Assistant Behavior Analyst (LABA) and to the Behavior Technicians (BT) ○ A plan for maintenance and generalization of skills ○ Clearly defined, measurable, realistic discharge criteria and a transition plan across all treatment environments ○ Clear plan to coordinate care with providers and with schools services ○ Documentation the LBA has collaborated with the appropriate provider or licensed professional for elements of the treatment plan that are not within the LBA scope of practice or for any co-occurring conditions ○ Date of initial ABA evaluation ○ Date and time treatment plan was completed ○ Name of referring prescriber ○ Signature of LBA and parent/ caregiver with the date ● Documentation attesting that the family/ caregiver/responsible adult has agreed to the treatment plan, including: ○ The frequency of services ○ All places where service will occur ○ Treatment goals

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Applied Behavior Analysis (ABA) Requests **(Submit to Magellan)**	○ Provider has access to sufficient staff to deliver the treatment plan ○ (Group treatment) Documentation with clearly defined measurable goals for the group therapy that are specific to the individual and their targeted behaviors
Private DutyNursing (PDN) Requests	Information and documents should relate to current requests for services. In addition to any applicable documents listed above, the following is the minimal required documentation for PDN: **Initial:** ● Current (within last three (3) months) and signed Plan of Care (POC), Nursing Addendum to POC, and 24-hour schedule ● Primary Care Physician (PCP) and/or Subspecialist notes (within the last six (6) months) describing the members condition, treatment and continuous nurse need to support medical necessity for PDN services. ● Ventilator and seizure logs ● Clinical Records From acute care facilities with discharge order for PDN **Renewal:** ● All the above documentation ● At least two (2) weeks of nursing notes and allocator of services **Change in Requested Services:** ● All above documentation ● Current (within last three (3) months) PCP and/or Subspecialist clinical notes documenting the continued need or reason for change in PDN services

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Prescribed Pediatric Extended Care Centers (PPECC) Requests	Information and documents should relate to current requests for services. In addition to any applicable documents listed above, the following is the minimal required documentation for PPECC: **Initial:** ● Signed CCP Authorization Request Form ● Current (within last three (3) months) and signed Plan of Care (POC), Nursing Addendum to POC, and 24-hour schedule ● Signed consent to participate in PPECC from Member/LAR ● PCP and/or Subspecialist notes (within last six (6) months) describing the members condition, treatment and continuous nurse need to support medical necessity for PDN services ● Ventilator, suction, and seizure logs ● Clinical Records From acute care facilities with discharge orders for PDN **Renewal:** ● All the above documentation ● At least two (2) weeks of nursing notes and allocator of services **Change in Requested Services:** ● All above documentation ● Current (within last three (3) months) PCP and/or Subspecialist clinical notes documenting the continued need or reason for change in PPECC services
Personal Care Services(PCS) Requests	Information and documents should relate to current requests for services. In addition to any applicable documents listed above, the following is the minimal required documentation for PCS: ● PCS services are at the request of the Member/Legally Authorized Representative (LAR) ● Members/ LARs can contact their Service Coordinator for evaluation and review of functional necessity for PCS ● Dell Children's Health Plan will require a Physician Statement of Need (PSON) signed by the Members PCP after the Service Coordinator has performed an assessment indicating the need for PCS services.

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
Personal Care Services(PCS) Requests	• Physician can contact Dell Children's Health Plan Service Coordination toll-free at 1-844-564-5212

Community First Choice (CFC) Services Requests	Information and documents should relate to current requests for services.
	• Members/LARs can contact their Service Coordinator for review and referral for evaluation of Community First Choice Services
	• CFC Services include:
	  ○ Personal Attendant Services (PAS)
	  ○ Habilitation (HAB)
	  ○ Emergency Response System (ERS)
	• CFC institutional level of care is established by either the:
	  ○ Local Intellectual Developmental Disability Authority (LIDDA)
	  ○ Local Mental Health Authority (LMHA)
	  ○ TMHP
	• Physician can contact Dell Children's Health Plan Service Coordination at toll-free at 1-844-564-5212

Determination Timelines

Utilization review timelines standards are as follows:

Program	Authorization Type	Decision Time Frame
Medicaid	Routine/ Non-Urgent	3 Business Days
CHIP	Routine/ Non-Urgent	2 Business Days (Approval) 2 Business Days (Adverse Determination)
Medicaid and CHIP	Urgent/Expedited	3 Calendar Days
Medicaid and CHIP	Concurrent	1 Business Day
Medicaid and CHIP	Post Service	30 Days

- For STAR Members only, a written notice of final determination will be provided no later than the next business day following a prior authorization determination
- CHIP Notifications:
    - For routine and urgent approvals, written/letter notification is required no later than the second business day after the date of the request
    - For a member that is not hospitalized at the time of an adverse determination notification will be provided within three (3) business days in writing to the requesting provider and member.

Requesting a Prior Authorization

Behavioral Health Services

To request a prior authorization for all Behavioral Health services, the following may be utilized:

1. Through Magellan Health website: www.magellanhealth.com
2. Call Magellan Health at 1-800-424-1764
3. For ABA - Fax a completed Prior Authorization form to 1-888-656-0266

All other services

To request a prior authorization the following may be utilized:

1. Clinician Portal to view the status of an authorization: **https://secure.healthx.com/Provider_2022**
2. Fax a completed Prior Authorization Form to **512-324-3014** or **1-844-981-3329**
3. Call Dell Children's Health Plan at **512-324-3013** or **1-855-962-4453**
4. Email Dell Children's Health Plan at **dchp-UM@ascension.org**

For a comprehensive list of procedures with the appropriate ICD-10 or CPT codes, please refer to the most recently published PriorAuthorization Code List posted at **dellchildrenshealthplan.com**