POLICY AND PROCEDURE

POLICY NAME: LTC (Long Term Care) Skilled Therapy Criteria	**POLICY ID:** LT.UM.11
BUSINESS UNIT: Sunshine State Health Plan	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 05/01/2014	**PRODUCT(S):** Long Term Care
REVIEWED/REVISED DATE: 10/26/2014;3/2015; 3/2016; 5/2017, 3/2018, 7/2020, 10/2021, 10/2022, 10/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

POLICY STATEMENT:
Sunshine Health's skilled therapy services clinical policy supports the utilization management review process for the LTC benefits described in the Florida Agency for Health Care Administration (AHCA) contract.

PURPOSE:
To establish clinical criteria on which to review requests for skilled therapy services for Sunshine Health's Long Term Care (LTC) line of business. This applies for members residing in a home and community based environment. The goal of the skilled therapy services is to provide these services to address the member's cognitive or functional deficits which may be a result of their medical conditions. The services will assist in maintaining the member in their home and community environment, in a safe manner, to avoid the risk for nursing home placement.

SCOPE: Sunshine Health Utilization Department and the Long Term Care Case Management Department.
This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company").

POLICY:
Sunshine Health's skilled therapy services clinical policy supports the utilization management review process for the LTC benefits described in the Florida Agency for Health Care Administration (AHCA) contract.

DESCRIPTION:
The following describes the covered skilled therapy benefits:

1. Occupational Therapy – Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the member's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve a member's capability to live safely in the home setting.

2. Respiratory Therapy – Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction.

3. Physical Therapy –Physical therapy treatment is to restore, improve or maintain impaired functions by use of physical, chemical and other properties of heat, light, electricity or sound and by massage and active resistive or passive exercise. Physical Therapy treatment is to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance.

There shall be a written individual plan of care including interventions, goals, proposed frequency and duration. The outcome of therapies shall be measurable by the attending medical professional within a reasonable (and generally predictable) period of time based on assessment of restoration potential.

The treating therapist's evaluation, diagnosis, prognosis and plan of care shall include a determination that rehabilitative services are necessary to improve the member's capability to live safely in the home setting.

4. Physical Risk Reduction Services – Physical Risk Reduction Services provide assessment and provision of hands-on care and technical guidance to members and caregivers regarding specific exercises to increase physical strength capacity, dexterity, and endurance to perform activities of daily living.

5. Speech Therapy – The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that effect oral motor functions. Therapy services include the evaluation and treatment of problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve the member's capability to live safely in the home setting.

PROCEDURE:

Skilled therapy services must be authorized by Sunshine Health and be appropriate for the member. Skilled therapy services are only covered for Sunshine Health members enrolled in the LTC product and are eligible or pending eligibility on the date the service is provided.

When the member's physician identifies which skilled therapy services are appropriate for the member, the physician will follow the Sunshine Health prior authorization process to request a prior authorization as outlined in the Timeliness of UM Decisions policy FL.UM.05.00.

All requests will be prior authorized and reviewed for medical necessity as outlined in the Medical Necessity Review and Continuity of Care policy FL.UM.02.01 and FL.UM.02 Use of Clinical Criteria.

A. Identification of Member Potential Need for Skilled Nursing Services

1. Initial assessment:
The LTC Care Coordinators are responsible to develop a person-centered care plan and complete an assessment of new LTC members to determine the medical necessity of covered benefits which may meet the member's needs. Both the Department of Elder Affairs Comprehensive Assessment Form 701B and the LTC Supplemental Assessment are completed face to face at the orientation visit and following the timelines established by the Florida Agency for Health Care Administration. At the initial visit, the LTC Care Coordinator completes the 701B and LTC Supplemental Assessments and assists the member in establishing personal goals for community integration while developing the member's person centered care plan. This information is utilized to identify the specific services and amount of services which addresses the member's needs to maintain them in the least restrictive environment in a safe manner and to support their desired goals. The LTC Care Coordinator educates and assists member in obtaining the necessary prescription and medical records which are faxed directly to the Utilization Management Prior Authorization department. If the member already has the documentation to give to the LTC Care Coordinator at the time of the visit, then the LTC Care Coordinator will upload the documents into the member's electronic record (chart) and forward the request to the Utilization Management Prior Authorization department. The LTC Care Coordinator refers the request to the LTC Utilization Management (UM) team. The Utilization Management reviewers access the member record including the member's person centered care plan, the Department of Elder Affairs Comprehensive Assessment Form 701B, the LTC Supplemental Assessment, and the prescription and medical records to complete a thorough clinical review to make the appropriate determination for member's care that is in line with and supportive of the member's personal goals that are noted on the person centered care plan.

2. Ongoing assessment:
The LTC case manager reassesses the member's functional, cognitive, and social needs and informal supports at every contact. This information is used to identify changes in the member's status and if modifications to the member's goal and type of service(s) and/or amount of service(s) in place should be considered and evaluated based on medical necessity of the service(s).

3. Annual assessment:
On an annual basis the LTC Care Coordinator will complete an updated Department of Elder Affairs Comprehensive Assessment Form 701B and the LTC Supplemental Assessment on an enrolled LTC member. This information is used to identify changes in the member's goals and in the member's status and if modifications to the member's goal and type of service(s) and/or amount of service(s) in place should be considered and evaluated based on medical necessity of the service(s) and to be supportive of member's goal.

4. Physician identification:
At any time a physician or other health care professional who is treating the member may identify that the member may benefit from skilled therapy services. The treating physician or other health care professional can contact Sunshine Health to request a prior authorization of a skilled therapy service.

B. Medical Necessity Determination

If the request for skilled therapy services has not been initiated by the member's treating physician or other health care professional and the LTC care coordinator identifies the potential need, the LTC Care Coordinator will refer the member to their physician for evaluation and recommendation. The physician will ascertain the member's need based on medical necessity. The physician will submit to Sunshine Health the request and clinical supporting information for a prior authorization review. Sunshine Health will respond to physician requests within the timelines as outlined in the policy Timeliness of UM Decisions and Notifications, FL.UM.05.00.

The review for the medical necessity of skilled therapy services will be completed following the Medical Necessity Review and Continuity of Care policy, FL.UM.02.01, and Use of Clinical Criteria Policy FL.UM.02.

The following criteria is used in the order below:

- Most recently available written/electronic version of McKesson's *InterQual* Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Long-Term Acute Care, Rehabilitation, Subacute/SNF, Home Care, and Adult and Pediatric Procedures, Outpatient Rehab
- Medical Necessity Review and Continuity of Care policy FL.UM.02.01
- Florida Medicaid Physical Therapy Services Coverage Policy Rule 59G-4.320
- Centene Clinical Policy: Physical, Occupational, and Speech Therapy Services CP.MP.49
- AHCA current contract
- Medicare National Coverage Determinations when applicable
- Department of Elder Affairs Comprehensive 701B Assessment and LTC Supplemental Assessment

To assist in determining the medical necessity of any skilled therapy services, the clinical criteria established in this policy will be applied. Any decision to deny, reduce, suspend or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Clinical Decision Criteria and Application FL.UM.02.02.

C. Referral and Authorization Process

Sunshine Health has timeframes in place for practitioners and providers to notify Sunshine Health of a service request and for Sunshine Health to make utilization management (UM) decisions and notifications to the member; the member's PCP, practitioner, and provider in a timely manner. See policy Timeliness of UM Decisions and Notifications Policy FL.UM.05.00.

The Sunshine Health UM staff will process requests for authorizations regarding skilled therapy services for LTC members and make decisions following a standardized process and time period. (See Timeliness of UM Decisions and Notifications Policy) Skilled therapy services for LTC members will be authorized for a minimum of a 6 months. All other covered services that are authorized for a duration of less than six (6) months must be for the treatment of an acute illness or a condition that will be resolved within six (6) months. The decision must be supported by the PCP's prescription of the service for a shorter duration. The person centered care plan dates shall be consistent with the service authorization(s).

> All requests for LTC skilled therapy services will be reviewed against criteria indicated in this policy. If the requested skilled therapy services meet the criteria, the services will be approved and an authorization is communicated back to the requesting provider and member. If the request does not meet the established criteria, the request will be sent to a Sunshine Health Medical Director for review. If services are reduced, denied, terminated, or suspended by the Medical Director, a communication of the denial will be sent to the requesting provider, the member, and the member's PCP. The time and date of receipt for any request for review of a service is documented in the Sunshine Health clinical management system. For fax requests, the date/time of the request field is reconciled to the date/time stamp on the fax. If the request was received via Filenet/ CDMS, the date/ time of the line item request field is reconciled to match the "Received by Centene" date/ time stamp on the document.

Coordination of Benefits

Determination of who is responsible to pay for services for a comprehensive member (which is a member enrolled in the Long Term Care (LTC) product and also in a Managed Medical Assistance (MMA) product) is made by identifying the type of service requested. For any service identified as a mixed service, the LTC product is responsible for payment of those services, regardless if the MMA plan is Sunshine Health. Mixed services include:

- Skilled nursing services- Attendant care requests are built under LTC. Private Duty Nursing requests for members under 21 years of age are built under member's MMA/CMS account
- Durable Medical Equipment (DME)
- Therapies (physical therapy, speech therapy, and occupation therapy)
- Hospice
- Transportation (only for LTC benefits)

The LTC care coordinator will coordinate all LTC covered mixed services with the applicable vendor(s) and in collaboration with the applicable MMA plan. The LTC care coordinator will follow up with member to verify that services are received and to address any issues with the delivery and or vendor.

REFERENCES:
Agency for Healthcare Administration, Standard Contract FP060
FL.UM.01 - Utilization Management Program Description
FL.UM.02.01 – Medical Necessity Reviews and Continuity of Care
FL.UM 05.00 - Timeliness of UM Decisions and Notifications
FL.UM.01.05 - Referral Process (Prior Authorization Availability)
FL.UM.02 – Use of Clinical Criteria
Florida Medicaid Physical Therapy Services Coverage Policy Rule 59G-4.320
Centene Clinical Policy: Physical, Occupational, and Speech Therapy Services CP.MP.49 and Florida Therapy Services Handbook to Florida Medicaid Physical Therapy Services Coverage Policy Rule 59G-4.32

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: Utilization Management

REGULATORY REPORTING REQUIREMENTS: State review and approval required for any substantial changes and upon request.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy	Policy Created	05/2014
Annual Review	Added Aged and Disabled Waiver and Therapy Services Provider Handbook to reference section; Added benefit criteria and limitations to services.	03/2015
Annual Review	Added respiratory therapy to clarify as a covered benefit; removed reference to waiver handbook which no longer exists	03/2016
Annual Review	Added the therapy individual plan of care includes interventions, goals, proposed frequency and duration. Updated the title of Centene Clinical Policy: Physical, Occupational, and Speech Therapy Services CP.MP.49	05/2017
Annual Review	Revised to add reference to current contract language requirements	03/2018
Annual Review	Updated policy names and numbers	07/2020
Annual Review	No changes made	10/2021
Annual Review	Added verbiage to Coordination of Benefits: "Attendant care requests are built under LTC. Private Duty Nursing requests for members under 21 years of age are built under member's MMA/CMS account"	10/2022
Annual Review	No changes needed Made minor grammatical corrections	10/2023

	Added policy ID and name to Footer	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.