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Objective:

To ensure that Pediatric OHP members of the Tuality Health Alliance (THA) receive appropriate services for Occupational Therapy, Physical Therapy, and Speech Therapy. To ensure that utilization of these services are monitored for continuity, outcomes and quality care.

Definition "Development":

Children who are developmentally immature as compared to age-level peers in one or more of the following areas: gross motor, fine motor, speech/language, articulation or self-help skills are categorized in the following strata:

- Category 1: If the degree of immaturity is mild, these children may be expected to "catch-up" with time and maturation or may benefit from caregiver instruction in home programs. These children are following typical patterns of progression in skill acquisition, but simply at a slower rate.
- Category 2: Children who have never acquired the skills of age level peers (in the areas outlined above), where the development delay is felt to be a symptom of an underlying, but as yet undiagnosed, medical problem, (i.e., feeding disorder, sensory integration deficits, central auditory processing deficit). Withholding or delaying intervention for these children might result in more debilitating symptoms, such as contractures, movement disorders, aspiration pneumonia, behavior problems, etc.
- Category 3: Children who would fit in the category 2, but who have had an unstable medical condition, with frequent or prolonged hospitalization which is commonly associated with their demonstrated deficits (i.e., prematurity, or immediate post- natal injury or distress, chronic asthma, congenital heart disease, CF, etc).
- Category 4: Children who have failed to acquire age - appropriate skills due to a medical condition such as cerebral palsy, autism, cleft palate, and chronic otitis media.

Policy:

I. Healthshare/Tuality OHP infants, children and adolescent members are able to receive well-child care visits from infancy through adolescence accordingly to the periodicity schedule outlined in Bright Futures/American Academy of Pediatrics. If during one of these well-child care visits a practitioner identifies a medical diagnosis on the OHP

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Prioritized list and there is a need for a medically necessary treatment, a referral to THA RN Case Managers is initiated for approval of the treatment.

II. The severity of the condition will determine the frequency and duration of the treatment, as well as availability and appropriateness of school and community response.

III. Services must be paired with a covered diagnosis on the prioritized list of services.

IV. There must be reasonable expectation the rehab services (PT, OT, SLP) will provide significant improvement in the members' condition in a reasonable and generally predictable period of time, or are necessary to the establishment of a safe, and effective maintenance program after which supervised treatments should cease.

V. In conjunction with delivering these services, the therapist is expected to provide teaching and training to the patient and available family members and/or care givers to facilitate their participation in and/or assumption of the total therapy program. Maintenance programs must be taught before the end of the restorative program. Therapy becomes maintenance when any one of the following occurs:

A. The therapy treatment plan goals and objectives are reached

B. There is no progress toward the therapy treatment plan goals and Objectives

C. The therapy treatment plan does not require the skills of a therapist

D. The patient, family, foster parents, and/or caregiver have been taught to carry out the therapy regimen and are responsible for the maintenance therapy[1]

VI. Early Intervention and school based therapy programs should be investigated for children ages 0-5 as meeting therapy needs or as an adjunct to therapies.

VII. When medical necessity is established by documentation, referrals will be given in quantities not to exceed 6-10 visits per month during the acute therapeutic phase.

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VIII. The maximum combined total number of visits allowed per year is 30 visits when medically appropriate.

IX. Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included when the following criteria are met:

A. Therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide the therapy.
B. There is objective, measureable documentation of clinically significant progress toward the therapy plan of care goals and objectives.
C. The therapy plan of care requires the skills of a medical provider, and
D. The client and/or caregiver cannot be taught to carry out the therapy regimen independently.

X. Services related to activities for general good and welfare (general non-supervised, non-individualized programs to promote education and self-improvement, or activities to provide general motivation) do not constitute rehab services (PT, OT, SP) and are not covered.
The following services are not considered medically necessary:

A. Language therapy for young children with natural dysfluency

B. Treatment of specific developmental delays or speech and language delays unless specifically covered under the member contract; e.g., attention deficit disorders, behavior problems, conceptual handicaps, mental retardation, psychosocial speech delay.

Reference: Health Services Prioritized List Guideline 6 Rehabilitative Therapies OAR-410-129-0040
Guideline Notes for the July 1, 2016 Prioritized List of Health Services, Guideline Note 6, Rehabilitative Therapies.

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