Aetna Better Health of Texas Clinical Information and Documents

Aetna Better Health of Texas may request any combination from the following list of clinical information and documents to support medical necessity of requested services.

Providers need to submit the applicable documents listed below related to the requested services.

Authorization Request and Referral Types	Clinical Information and Documents to Support Medical Necessity
All 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) • Rendering provider name • Rendering provider National Provider Identifier (NPI) • Rendering provider Tax Identification Number (TIN) • Procedure codes requested • Service start and end dates • Quantity requested
Inpatient & Observation Requests	Information and documents should relate to current admission/continued stay. • Member name • Member or Medicaid number • Member date of birth • Requesting provider name • Requesting provider National Provider Identifier (NPI) • Admission Notification and/or Face Sheet • Behavioral Health Inpatient Admission Notification Form • Diagnosis • History and Physical

	• Progress Notes • Consult Notes and/or Reports from 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

Outpatient Requests and Discharge Planning	Information and documents should relate to current request for services. In addition to applicable documents listed above: • Texas Standard Prior Authorization Request Form • Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form • Psychological Testing Prior Authorization Request Form • Modifiers • Diagnosis • History and Physical • Progress Notes • Consult Notes and/or Reports from Specialists • Physician Orders • Radiology/Imaging Results • Laboratory Results • Blood Glucose Testing • Vital Sign Reports • Medication Administration Records or Medication History • Developmental Screening Tool • Hearing evaluations and test results • Growth Charts • Noninvasive Prenatal Screening (NIPS) Attestation for OBGYN's Form • OB Attestation for Cystic Fibrosis Screening Form • Glucose monitor readings • How often the member requires increase in the insulin dosage • What number ultrasound is being requested • Previous ultrasound reports • Flowsheets • Notes for current pregnancy • Confirmation that member has chronic incontinence with description of type of enuresis or incontinence and comorbid conditions, detail of what management/workup including specialist referral has been done and the response

Occupational TherapyRequests	Information and documents should relate to current request for services. In addition to applicable documents listed above: **Initial Occupational Therapy Evaluations & Re-Evaluations:** If In-Network, Therapy Evals do not require prior authorization • **Initial Evaluations:** A recent clinical note from a physician/appropriate specialist that documents the specific functional deficits, diagnosis and referral to occupational therapy (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals). • **Re-Evaluations: If less than 6 months since the previous evaluation/re-evaluation:** A recent/updated clinical note from a physician/appropriate specialist documenting the change in medical status that makes additional formal testing medically necessary (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals) • **Re-Evaluations: If more than 6 months since the previous evaluation/re-evaluation or the member is new to DHP:** 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 and less than one month (1) old for orthopedic referrals) • A developmental screen that documents deficits (screen should be less than three (3) months old) • Date of the most recent evaluation/re-evaluation and/or therapy visit (if applicable) • The history of previous referrals for occupational therapy 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 • **Telehealth:** Documentation from the referring physician/appropriate specialist of the medical need for the services to be provided via telehealth and reasons why an in-person evaluation/re-evaluation is not possible/desirable

	Occupational Therapy Treatment Requests:
	• 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 requests for visits:** An occupational therapy evaluation and plan of care that includes:
	  • 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)
	  • 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/timeframes
	• Responsible adult's expected involvement in the member's treatment
	• **Telehealth:** Documentation of how telehealth will be incorporated into the overall therapy planand how it is appropriate based on patient compliance, family involvement and the proposed plan of care
	• Signature of the evaluating occupational therapist and date
	• Signature of ordering provider, NPI 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 of the following information: o 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) o 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) o A description of improvements in function observed during completion of Activities of Daily Living (ADLs) over the previous authorization period o A description of the continuing functional deficits and need for additional occupational therapy services o 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 o The recommended treatment modalities o The recommended frequency/duration of therapy o 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) o Barriers to progress and changes that can be made to improve the response to treatment o 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 o Documentation of parent or primary care giver participation in therapy sessions o Documentation of the home program that has been established and a description of the caregiver's compliance with the plan o **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 compliance, family involvement and the proposed plan of care o Signature of the licensed occupational therapist and date o Signature of ordering provider, NPI and date

Physical Therapy Requests	Information and documents should relate to current request for services. In addition to applicable documents listed above: **Initial Physical Therapy Evaluations & Re-Evaluations:** *If In-Network, Therapy Evals do not require prior authorization* • **Initial evaluations:** A recent clinical note from a physician/appropriate specialist that documents specific functional deficits, diagnosis and referral to physical therapy (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals) • **Re-Evaluations: If less than 6 months since the previous evaluation/re-evaluation:** A recent/updated clinical note from a physician/appropriate specialist documenting the change in medical status that makes additional formal testing medically necessary (note should be less than three (3) months old for developmental delay and less than one (1) month old for orthopedic referrals) • **Re-Evaluations: If more than 6 months since the previous evaluation/re-evaluation or the member is new to DHP:** 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 and less than one month (1) old for orthopedic referrals) • A developmental screen that documents deficits (screen should be less than three (3) months old) • Date of the most recent evaluation/re-evaluation and/or therapy visit (if applicable) • Length of time of reported symptoms, medical management of the condition attempted prior to physical therapy referral and the member's response to the treatment (Examples: rest period, change of exercise routine, heat/cold, anti-inflammatory/Analgesics, massage) • The history of previous referrals for physical therapy 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

	• **Telehealth:** documentation from the referring physician/appropriate specialist of the medical need for the services to be provided via telehealth and reasons why an in-person evaluation/re-evaluation is not possible/desirable **Physical Therapy Treatment Requests:** • 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) • 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 requests for visits:** A physical therapy evaluation and plan of care that includes: o Member's medical history and history of any prior physical therapy treatment o Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements) o A description of specific functional skills and deficits observed during completion of Activities of Daily Living (ADLs) o A clear diagnosis and reasonable prognosis

	o The prescribed treatment modalities o Recommended frequency/duration of therapy o Mode and location of service delivery (Examples: telehealth, in-person, clinic, home) o Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes o Responsible adult's expected involvement in the member's treatment o **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 o Signature of the evaluating physical therapist and date o Signature of ordering provider, NPI and date o **Subsequent requests for ongoing physical therapy treatment:** A therapy progress summary, re- evaluation or treatment notes along with other documents that communicate all of the followinginformation: • 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 wascollected) • Results of any standardized/formal testing completed since the beginning of the previousauthorization period (updated standardized testing is required once every six (6) months) • A description of improvements in function observed during completion of Activities of DailyLiving (ADLs) over the previous authorization period • A description of the continuing functional deficits and need for additional physical therapyservices • 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 plannedmode 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 o Documentation of parent or primary care giver participation in therapy sessions o Documentation of the home program that has been established and a description of the caregiver's compliance with the plan o **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 compliance, family involvement and the proposed plan of care o Signature of the licensed physical therapist and date o Signature of ordering provider, NPI and date

Therapy Reviews of Orthotics/Bracing/Prosthetics 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 (TARF), 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 • Documentation of medical necessity that includes description of member's function with and without the orthotic/brace/prosthetic being requested • 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 request 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 • Description of skin integrity, sensation, and pain perception including how it is impacted by current and requested equipment
Speech Therapy Requests	Information and documents should relate to current request for services. In addition to applicable documents listed above: **<u>Initial Speech Therapy Evaluations & Re-Evaluations:</u>** *If In-Network, Therapy Evals do not require prior authorization* • **Initial evaluations:** A recent 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) • **Re-Evaluations: If less than 6 months since the previous evaluation/re-evaluation:** A recent/updated clinical note from a physician/appropriate specialist documenting the change in medical status that makes additional formal testing medically necessary (note should be less than three (3) months old) • **Re-Evaluations: If more than 6 months since the previous evaluation/re-evaluation or the member is new to DHP:** 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 twelve (12) months old) • A developmental screen that documents deficits (screen should be less than three (3) months old) • Date of the most recent evaluation/re-evaluation and/or therapy visit (if applicable) • The history of previous referrals for speech therapy 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 • Hearing testing: o **Initial evaluations:** Recent documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), or a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech. No delay should occur in authorization of the initial speech evaluation due to lack of objective hearing testing, with the expectation that completion of objective hearing testing is within concurrent timeline of the evaluation. (note should be less than twelve (12) months old) o **Re-Evaluations:** Recent documentation of normal hearing in at least one ear by objective screening method (Pure-tone, Otoacoustic Emissions Test (OAE), or Auditory Brainstem Response (ABR)), or a clinical note from an Ear, Nose, Throat specialist (ENT) or an audiologist documenting normal hearing adequate for speech, or the date of any future appointment for hearing testing. (note should be less than twelve (12) months old) o **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) • Clarification to prevent duplication of services (between therapy disciplines or between different therapy providers) • Appropriate evaluation codes & modifiers • **Feeding/swallowing evaluations**: Growth charts and/or the results of any instrumental evaluations of swallowing that have been completed

	• **Referrals to an out of network therapy provider**: An explanation of the medical necessity for or reason for referral to an out of network provider • **Telehealth:** Documentation from the referring physician/appropriate specialist of the medical need for the services to be provided via telehealth and reasons why an in-person evaluation/re-evaluation is not possible/desirable **<u>Speech Therapy Treatment Requests:</u>** • 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) • 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: o **If hearing testing has not yet been submitted to ABH 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 the date of any future appointment for hearing testing. (note should be less than twelve (12) months old) o **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: o Member's medical history and history of any prior therapy treatment o **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 o **For Speech/Language/Stuttering:** Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements) o **For Speech/Language/Stuttering:** A description of specific functional communication skills and deficits observed during completion of Activities of Daily Living (ADLs) o **For Feeding/Swallowing:** A detailed description of the level of feeding/swallowing proficiency and deficits related to feeding/swallowing observed o A clear diagnosis and reasonable prognosis o The recommended treatment modalities o The recommended frequency/duration of therapy o Mode and location of service delivery (Examples: telehealth, in-person, clinic, home) o Short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes o Responsible adult's expected involvement in the member's treatment o **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 o 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 of the following information: o 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)

	o 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) o **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 o **For Feeding/Swallowing:** A description of improvements in functional feeding/swallowing skills observed over the previous authorization period o A description of the continuing functional deficits and need for additional speech therapy services o Updated short and long-term treatment goals which are functional, appropriately attainable, measurable, specific to the member's functional deficits and include baselines/timeframes o The recommended treatment modalities o The recommended frequency/duration of therapy o 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) o Barriers to progress and changes that can be made to improve the response to treatment o 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 o Documentation of parent or primary care giver participation in therapy sessions o Documentation of the home program that has been established and a description of the caregiver's compliance with the plan o **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 compliance, family involvement and the proposed plan of care o Signature of the licensed speech pathologist and date o Signature of ordering provider, NPI 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 (TARF), 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 ABH 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 normalhearing 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: o The member's medical history, including any underlying diagnosis or condition that impacts speech and language development o The history of any prior speech therapy treatment with a description of the response to traditional therapy approaches versus treatment focusing on augmentative communication o **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 o Objective data documenting the current level of function (Examples: raw scores, standard scores, criterion-referenced scores, measurements) o 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 o A detailed description of communication impairment (diagnosis, severity, language skills, cognition, anticipated duration) o Description/comparison of other devices considered and why they would not meet the member's communication needs o Rationale for the specific device chosen including gross motor skills, fine motor skills and cognitive abilities that make the device appropriate o 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 o A description of caregiver training related to use and programming of the device o Treatment plan for ongoing therapy to support additional language development using the device, including frequency and duration of speech therapy services o Short and long-term treatment goals which are related to use of the speech generating device, functional, appropriately attainable, measurable and include baselines/timeframes o Responsible adult's expected involvement in the member's treatment o Signature of the licensed speech pathologist and date o Signature of ordering provider, NPI and date

Private Duty Nursing (PDN)	Information and documents should relate to current request for services. The following is the minimal required documentation for PDN. **INITIAL:** • Signed Comprehensive Care Program (CCP)/CCP 6 months *form*, if applicable • 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 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 of the above documentation • At least two (2) weeks of nursing notes and allocator of services **CHANGE IN REQUESTED PDN:** • All of 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

Clinical Information and Documents Needed To Support Medical Necessity

Prescribed Pediatric Extended Care Centers (PPECC)	Information and documents should relate to current request for services. The following is the minimal required documentation for PPECC. **INITIAL:** • Signed CCP Authorization Request Form/CCP 6 months *form*, if applicable • 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 of the above documentation • At least two (2) weeks of nursing notes and allocator of services **CHANGE IN REQUESTED PDN:** • All of 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)	Information and documents should relate to current request for services. • 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 • ABH will require a*n annual* Physician Statement of Need (PSON) signed by the Members PCP after the Service Coordinator has performed an assessment indicating the need for PCS services.
Community First Choice (CFC) Services	Information and documents should relate to current request 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
Day Activity and Health Service (DAHS)	Information and documents should relate to current request for services. • Members/ LARs can contact their Service Coordinator for evaluation and review of DAHS services • The potential for therapeutic benefit must be established by a physician's assessment and requires a physician's order submitted to ABH Service Coordination • A Day Activity and Health Services (DAHS) facility nurse must complete a health assessment for each STAR Kids member at the facility or the member's home
MDCP Waiver Services	Information and documents should relate to current request for services. • Member/LAR can send request to Service Coordination – Service coordinator will perform an assessment for need *regarding services below* • *MDCP Waiver* Services include: ○ Respite ○ Flexible Family Support Services (FFS) ○ Financial Management Services (FMSA) ○ Minor Home Modifications (MHM) ○ Transition Assistance Services (TAS) ○ Employment Services (EA) ○ Adaptive Aids (AA)/ Vehicle Modification (VM)