PROTOCOL FOR ORIENTATION AND MOBILITY SERVICES (ORIENTATION AND MOBILITY TRAINING; ORIENTATION AND MOBILITY SERVICES FOR IMPAIRED VISION)

A. Assessment

1. Is the request for an initial assessment after enrollment in the waiver or after an interval of *at least* 12 months since the last assessment?

   If **YES**, skip to Question #3.

   If **NO**, proceed to Question #2.

2. Is a new assessment needed because the service recipient was discharged from services by a provider who withdrew from participation as a waiver services provider?

   If **YES**, proceed to Question #3.

   If **NO**, skip to Question #4.

3. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient is legally blind or severely visually impaired and needs training in order to move more independently, safely, and purposefully in the home and community environment?

   If **YES**, skip to Question #5.

   If **NO**, stop and deny as **not medically necessary**. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

   - "Not necessary to treat;"
   - "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
   - "Not the least costly adequate alternative."

   NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

4. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient is legally blind or severely visually impaired and that:

a. The service recipient is legally blind or severely visually impaired and has recently developed a new medical diagnosis or functional deficit involving orientation and mobility for which the service recipient needs training in order to move more independently, safely, and purposefully in the home and community environment; **OR**

b. The service recipient is legally blind or severely visually impaired and has experienced a significant exacerbation of the functional deficit involving orientation and mobility, after having been discharged from services by the Certified Orientation and Mobility Specialist; **OR**

c. The service recipient has relocated to a different place of residence or has changed the place of employment and, as a result, needs reassessment and additional training in order to move independently, safely, and purposefully in the new environment?

If **YES** to any of the criteria specified in "4.a" through "4.c" above, proceed to Question #5.

If **NO** to all three of the criteria specified in "4.a" through "4.c" above, stop and deny as **not medically necessary**. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

5. Has the waiver limit of three (3) assessments per waiver program year per provider been exceeded for the current program year?

If **YES**, stop and deny as a **non-covered service** based on the waiver service limit of three (3) assessments per service recipient per provider per program year.

If **NO**, stop and approve the assessment.

B. *Initial* Services (excluding assessment)

NOTE: This section applies to service recipients who are **not** currently approved for Orientation and Mobility Training or Orientation and Mobility Services for Impaired Vision through the waiver.

1. Medical necessity review questions:

a. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient is legally blind or severely visually impaired and needs training in order to move more independently, safely, and purposefully in the home and community environment; **AND**

b. Is there sufficient information in the ISP and/or supporting documentation to conclude that the service recipient's functional limitations in orientation and mobility cannot be adequately met unless services are provided by a Certified Orientation and Mobility Specialist who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals; **AND**

c. Is there sufficient documentation in the ISP and/or supporting documentation to conclude that the provision of services can be reasonably expected to result in measurable and sustained functional gains for the service recipient; **AND**

d. Are there clearly defined measurable goals in the ISP and/or supporting documentation which are reasonable and appropriate given the person's current age and health status?

If **YES** ***to all four*** of the criteria specified in "1.a" through "1.d" above, proceed to Question #2.

If **NO** **to** ***any*** criterion specified in "1.a" through "1.d" above, stop and deny as **not medically necessary**. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

In addition, deny as a **non-covered service** any portion of the requested number of days of services requested which *exceeds* the waiver service limit of 52 hours per service recipient per program year.

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

2. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of services requested *consistent with* and not *in excess of* the amount of services needed to achieve measurable and sustained functional gains as specified in "1.c" above?

NOTE: To the maximum extent possible and appropriate, services by a Certified Orientation and Mobility Specialist should be utilized to develop a treatment plan that can be implemented by caregivers (including, but not limited to family members, paid personal assistants, and residential services staff), across activities and settings in order to achieve the maximum therapeutic benefit. Periodic services by the Certified Orientation and Mobility Specialist should be authorized *only* as necessary to support the ongoing implementation of the treatment plan, or to modify the treatment plan in response to the changing needs of the service recipient.

If **YES**, stop and approve the amount of services requested (subject to the waiver service limit of 52 hours per service recipient per program year).

If **NO**, approve that portion of the total amount of services requested that is *consistent with* the amount of services needed to achieve measurable and sustained functional gains as specified in "1.c" above. Deny as **not medically necessary** that portion of the total amount of services requested that is *in excess of* the amount of services needed to achieve measurable and sustained functional gains; as specified in "1.c" above. The unmet medical necessity criteria and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not necessary to treat;"
- "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
- "Not the least costly adequate alternative."

If services are approved for lesser duration of service than requested, include the following in the denial letter: "Based on the medical records we have now, we can only tell that you need this care for ___ days. We must see if the care we have approved helps you before we can decide if you need more care. What if you think you will need this care for *more* than ___ days? Before the ___ days are over, your doctor can ask for more care. OR, if you think your *current* medical records

already show that you will need the care for *more* than ___ days, you can appeal.

C. *Continuation* of Services (excluding assessment)

NOTE: This section applies to service recipients who are *currently* approved for Orientation and Mobility Training or Orientation and Mobility Services for Impaired Vision through the waiver and who request *continuation* of services or an *increase* in services.

1. Medical necessity review questions for *continuation* of the *currently* approved level of services plus any requested *increase* in such services, as applicable:

   a. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient *continues* to have functional limitations in orientation and mobility; **AND**

   b. Is there sufficient information in the ISP and/or supporting documentation to demonstrate progress toward defined treatment goals in terms of measurable and sustained functional gains for the service recipient that can be generalized to settings outside the immediate treatment environment?

   If **YES** ***to both*** criteria specified in "1.a" and "1.b" above, proceed to question 2.

   If **NO to *either*** criterion specified in "1.a" or "1.b" above:

   - If the request for services was submitted as an ISP amendment or as an annual update of the ISP, stop and **deny** as **not medically necessary**; **OR**

   - If the protocol was used for a DMRS-initiated review of an ISP and cost plan (i.e., rather than review of an ISP amendment or annual ISP update), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved services shall continue to be authorized and reimbursed pending such advance notice period.

   The service recipient may file a timely appeal regarding the reduction/termination of services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated). If an appeal is received within 20 days from the date of notice (inclusive of mail time) or *any time prior* to the effective date of the action, the service recipient may request continuation of the previously approved services pending resolution of the appeal, in which case such previously approved services (up to the waiver service limit of 52 hours per service recipient per program year) shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

   All of the unmet medical necessity criteria from "1.a" through "1.b" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

   - "Not necessary to treat;"
   - "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
   - "Not the least costly adequate alternative."

   In addition, deny as a **non-covered service** any portion of the requested number of days of services requested which *exceeds* the waiver service limit of 52 hours per service recipient per program year.

Continuation of benefits is **not available** for a non-covered service, including a request that is beyond the scope of the waiver service limit of 52 hours per service recipient per program year, and accordingly, may not be granted.

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

2. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of *continued* services requested plus any requested increase in such services, as applicable, *consistent with* and not *in excess of* the amount of services *still* needed to achieve measurable and sustained functional gains?

   To the extent that the request includes any increase in the frequency, amount, or duration of services, is there sufficient information in the ISP and/or supporting documentation to demonstrate that the service recipient's needs have changed and/or the previously approved frequency, amount, or duration of services is no longer sufficient to achieve measurable and sustained functional gains for the service recipient that can be generalized to settings outside the immediate treatment environment?

   If **YES**, stop and approve the *continuation* of services and any *increase* as requested.

   If **NO**, approve that portion of the total amount of services requested that is *consistent with* the amount of services needed to achieve measurable and sustained functional gains.

   - If the request for services was submitted as an ISP amendment or as an annual update of the ISP, **deny** as **not medically necessary** that portion of the total amount of services requested that is *in excess of* the amount of services *still* needed to achieve measurable and sustained functional gains; **OR**

   - If the protocol was used for a DMRS-initiated review of a cost plan (i.e., rather than review of an ISP amendment or annual ISP update), issue 20 days advance notice (inclusive of mail time) of reduction or termination of services, as applicable, indicating that the services will be reduced or terminated on the 21st day from the date of the notice. The previously approved services shall continue to be authorized and reimbursed pending such advance notice period.

   The service recipient may file a timely appeal regarding the reduction/termination of services within 40 days from the date of the notice (inclusive of mail time) or *any time prior* to the effective date of the action (i.e., the date the services are reduced or terminated). If an appeal is received within 20 days from the date of notice (inclusive of mail time) or *any time prior* to the effective date of the action, the service recipient may request continuation of the previously approved services pending resolution of the appeal, in which case such previously approved services (up to the waiver service limit of 52 hours per service recipient per program year) shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

   The unmet medical necessity criteria and the applicable prong) of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

   - "Not necessary to treat;"
   - "Not safe and effective" (*"The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs."*); and
   - "Not the least costly adequate alternative."

   In addition, deny as a **non-covered service** any portion of the requested number of days of services requested which *exceeds* the waiver service limit of 52 hours per service recipient per program year.

Continuation of benefits is **not available** for a non-covered service, including a request that is beyond the scope of the waiver service limit of 52 hours per service recipient per program year, and accordingly, may not be granted.

NOTE: To the extent there is a covered, medically necessary alternative, such service will be specified in the denial notice.

If *continuation* of services is approved for a lesser duration of service than requested, include the following in the denial letter: "Based on the medical records we have now, we can only tell that you need this care for ___ days. We must see if the care we have approved helps you before we can decide if you need more care. What if you think you will need this care for *more* than ___ days? Before the ___ days are over, your doctor can ask for more care. OR, if you think your *current* medical records already show that you will need the care for *more* than ___ days, you can appeal."