OCCUPATIONAL THERAPY PROTOCOL

A. Occupational Therapy Assessment

1. Is the service recipient age 21 years or older?

   If **YES**, proceed to Question #2.

   If **NO**, skip to Question #9.

2. Is this a new assessment for environmental accessibility (i.e., home) modifications?

   If **YES**, skip to Question #7.

   If **NO**, proceed to Question #3.

3. Is the assessment needed in order to determine the need for treatment of a medical condition or functional deficit involving performance of activities of daily living that is related to an injury, illness, or hospitalization occurring within the past 90 days?

   If **YES**, proceed to Question #4.

   If **NO**, skip to Question #5.

4. Was a request for an Occupational Therapy assessment denied through the TennCare MCO fair hearing process and, if applicable, denied or not covered by Medicare?

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

   If **NO**, stop and deny based on the waiver being the **payor of last resort**, unless the service recipient is currently receiving waiver-funded Occupational Therapy and is requesting all of the Occupational Therapy to be provided through the waiver by the same provider. If the latter, proceed to Question #5. Otherwise, deny and include the following statement in the denial letter: "Medically necessary Occupational Therapy services to restore lost function are covered for adults age 21 and older under the TennCare Program. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

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

   If **YES**, skip to Question #7.

If **NO**, proceed to Question #6.

6. Is a new Occupational Therapy assessment needed because:

   a. The service recipient was discharged from services by an occupational therapist who discontinued being a waiver services provider; **OR**

   b. The service recipient is currently receiving waiver-funded Occupational Therapy and has now developed an acute need for additional services to restore lost function. Such additional services would normally be provided by the MCO, but to ensure coordination, all of the Occupational Therapy will be provided through the waiver by the same provider.

   If **YES**, proceed to Question #7.

   If **NO**, skip to Question #8.

7. Medical necessity review questions:

   a. Is there an order by a physician, physician assistant, or nurse practitioner for the Occupational Therapy assessment; **AND**

   b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving performance of activities of daily living; **AND**

   c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving performance of activities of daily living, the service recipient's functional and/or treatment needs cannot be adequately determined without a new Occupational Therapy assessment?

   If **YES** ***to all three*** of the criteria specified in "7.a" through "7.c" above, skip to Question #11.

   If **NO to *any*** criterion specified in "7.a" through "7.c" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "7.a" through "7.c" above and the applicable prongs)of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

   - "Not ordered by a doctor" ("7.a");
   - "Not necessary to treat" ("7.b" and "7.c");
   - "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."*) ("7.b" and "7.c"); and
   - "Not the least costly adequate alternative" ("7.b" and "7.c").

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

8. Medical necessity review questions:

   a. Is there an order by a physician, physician assistant, or nurse practitioner for the Occupational Therapy assessment; **AND**

   b. Is there sufficient information in the Individual Support Plan (ISP) to document that:

(1) The service recipient has a <u>new</u> medical diagnosis or functional deficit involving performance of activities of daily living; **OR**;

(2) The service recipient has experienced a significant exacerbation of a pre-existing medical condition or functional deficit after having been discharged from Occupational Therapy services by the occupational therapist; **AND**

c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving performance of activities of daily living, the service recipient's functional and/or treatment needs cannot be adequately determined without a new Occupational Therapy assessment?

If **YES** ***to all three*** of the criteria specified in "8.a" through "8.c" above, skip to Question #11.

If **NO to *any*** criterion specified in "8.a" through "8.c" above, stop and deny as **<u>not medically necessary</u>**. All of the unmet medical necessity criteria from "8.a" through "8.c" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not ordered by a doctor" ("8.a");
- "Not necessary to treat" ("8.b" and "8.c");
- "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."*) ("8.b" and "8.c"); and
- "Not the least costly adequate alternative" ("8.b" and "8.c").

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

9. Is this a new assessment for environmental accessibility (i.e., home) modifications?

If **YES**, proceed to Question #10.

If **NO**, stop and deny based on the waiver being the **<u>payor of last resort</u>**. Include the following statement in the denial letter: "Medically necessary Occupational Therapy Services are covered under the TennCare Program for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

10. Medical necessity review questions:

a. Is there an order by a physician, physician assistant, or nurse practitioner for the Occupational Therapy assessment; **AND**

b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving performance of activities of daily living; **AND**

c. Is there sufficient information in the Individual Support Plan (ISP) to conclude that, based on the service recipient's medical diagnosis or functional deficit involving performance of activities of daily living, the service recipient's functional and/or treatment needs (in the case of a child under age 21, the need for environmental accessibility modifications) cannot be adequately determined without a new Occupational Therapy assessment?

If **YES** ***to all three*** of the criteria specified in "10.a" through "10.c" above, proceed to Question #11.

If **NO** **to** ***any*** criterion specified in "10.a" through "10.c" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "10.a" through "10.c" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

- "Not ordered by a doctor" ("10.a");
- "Not necessary to treat" ("10.b" and "10.c");
- "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."*) ("10.b" and "10.c"); and
- "Not the least costly adequate alternative" ("10.b" and "10.c").

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

11. Has the waiver limit of three (3) Occupational Therapy 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* Occupational Therapy Services (excluding assessment)

(NOTE: This section applies to service recipients who are **not** currently approved for Occupational Therapy services through the waiver.)

1. Is the service recipient age 21 years or older?

If **YES**, proceed to Question #2.

If **NO**, stop and deny based on the waiver being the **payor of last resort**. Include the following statement in the denial letter: "Medically necessary Occupational Therapy Services are covered under the TennCare Program for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

2. Is Occupational Therapy needed in order to restore lost function due to a medical condition or functional deficit involving performance of activities of daily living that is related to an injury, illness, or hospitalization occurring within the past 90 days?

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

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

3. Was a request for Occupational Therapy denied through the TennCare MCO fair hearing process and, if applicable, denied or not covered by Medicare?

If **YES**, proceed to Question #4.

If **NO**, stop and deny based on the waiver being the **payor of last resort**. Include the following statement in the denial letter: "Medically necessary Occupational Therapy services to restore lost function are covered for adults age 21 and older under the TennCare

Program. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

4. Medical necessity review questions:

   a. Is there an order by a physician, physician assistant, or nurse practitioner for the Occupational Therapy, **AND**

   b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient has a medical diagnosis or functional deficit involving performance of activities of daily living; **AND**

   c. Is there sufficient information in the ISP and/or supporting documentation (e.g., the therapy plan of care) to conclude that the service recipient's functional and/or treatment needs involving performance of activities of daily living cannot be adequately met unless Occupational Therapy is provided by a licensed occupational therapist or occupational therapy assistant working under the supervision of a licensed occupational therapist (i.e., paid and unpaid caregivers would not otherwise be able to adequately meet the specified functional or treatment needs); **AND**

   d. Is there sufficient documentation in the ISP and/or supporting documentation to conclude that the provision of Occupational Therapy services can be reasonably expected to 1) achieve measurable and sustained functional gains for the service recipient; 2) maintain current functional abilities that would be lost without the provision of Occupational Therapy Services; or 3) prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems); **AND**

   e. Are there clearly defined measurable Occupational Therapy 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 five*** of the criteria specified in "4.a" through "4.e" above, proceed to Question #5.

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

   - "Not ordered by a doctor" ("4.a");
   - "Not necessary to treat" ("4.b" through "4.e");
   - "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."*) ("4.b" through "4.e"); and
   - "Not the least costly adequate alternative" ("4.b" through "4.e").

5. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of Occupational Therapy Services requested *consistent with* and not *in excess of* the amount of services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "4.d" above?

   NOTE: To the maximum extent possible and appropriate, Occupational Therapy Services by a licensed occupational therapist or licensed occupational therapy assistant working under the supervision of a licensed occupational therapist 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 licensed occupational therapist or licensed occupational therapy assistant working under the

supervision of a licensed occupational therapist 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 Occupational Therapy Services requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Occupational Therapy Services continue to be medically necessary. Such determination shall be based on current medical records provided by the licensed professional and/or physician, physician assistant, or nurse practitioner in response to the request for concurrent review.

If **NO**, approve that portion of the total amount of Occupational Therapy Services requested that is *consistent with* the amount of Occupational Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "4.d" above. Deny as **not medically necessary** that portion of the total amount of Occupational Therapy Services requested that is *in excess of* the amount of services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "4.d" 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 Occupational Therapy Services are 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.

C. *Continuation* of Occupational Therapy Services (excluding assessment)

(NOTE: This section applies to service recipients who are *currently* approved for Occupational Therapy (OT) through the waiver and who request *continuation* of OT or an *increase* in OT.)

(NOTE: To ensure coordination of ongoing services, if a service recipient age 21 and older is already receiving waiver-funded OT Services and also develops an acute need for additional OT Services in order to restore lost function that would otherwise be provided by the MCO, the additional OT Services may be approved through the waiver if medically justified, so that all of the OT Services would be provided through the waiver by the same provider.)

1. Is the service recipient age 20 years or older?

   NOTE: If a service recipient is age 20 years (but not yet age 21), transition of Occupational Therapy Services to the TennCare MCO will **not** be initiated since transition back to waiver services would likely be required upon attaining 21 years of age.

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

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

2. Is the request for an *increase* in the frequency (per week, per month, etc.) or amount (# of units) of Occupational Therapy Services?

   If **YES**, **deny** the requested ***increase*** in the frequency or amount of Occupational Therapy Services based on the waiver being the **payor of last resort**. **Approve** the ***continuation*** of Occupational Therapy Services at the *current* level pending transition of medically necessary Occupational Therapy Services to the TennCare MCO. Include the following statement in the denial letter: "Medically necessary Occupational Therapy Services are covered under the TennCare Program for children under age 21. For now, we'll keep paying for the same amount of care you've been getting while we work with your MCO to take over **all** of your medically necessary Occupational Therapy Services. BUT, we can't pay for more waiver services than you've been getting. If you need more Occupational Therapy Services, you must ask your MCO to pay for them. Your MCO will pay for medically necessary Occupational Therapy Services. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

   In order to facilitate a coordinated approach to the delivery of Occupational Therapy Services, if an increase is requested and denied, initiate the process for transition of the *currently* approved level of Occupational Therapy Services to the MCO as specified below.

   If **NO**, **or upon denial of a requested *increase*** in the frequency or amount of Occupational Therapy Services as noted above, initiate the process for transition of **all** medically necessary Occupational Therapy Services to the TennCare Managed Care Organization (MCO) as follows:

   a. Approve the *continuation* of Occupational Therapy at the *current* level pending transition of medically necessary Occupational Therapy to the TennCare MCO. **No increases** in **waiver** Occupational Therapy Services should be authorized for children under age 20.

   b. Notify the service recipient's MCO regarding plans to transition Occupational Therapy Services. Include in such notification a copy of all relevant medical information, including the order by a physician, physician assistant, or nurse practitioner for the Occupational Therapy Services, a copy of the ISP, therapy assessment(s) and therapy plan(s) of care indicating the medical diagnosis or functional deficit involving performance of activities of daily living, the purpose of currently authorized Occupational Therapy Services, (e.g., 1) to achieve measurable and sustained functional gains for the service recipient; 2) to maintain current functional abilities that would be lost without the continued provision of Occupational Therapy Services; or 3) to prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems), as well as measurable Occupational Therapy goals, therapy notes and other documentation supporting the service recipient's progress in meeting these goals, and any requested *increase* in the *currently* approved level of Occupational Therapy Services.

   c. The MCO may request additional medical information as needed from the treating physician and/or licensed therapy professional, and may complete an in-home evaluation in order to make an individualized determination regarding the amount of Occupational Therapy Services that are medically necessary going forward. Accordingly and since such currently approved Occupational Therapy Services are being provided under the waiver, the MCO may take additional time to make this determination and to arrange needed care. DMRS will notify TennCare regarding any unreasonable delays by the MCO in completing transition activities.

   d. Prior authorization of any requested *increase* in the currently approved level of Occupational Therapy Services must be completed by the MCO within the

applicable prior authorization timeline (not to exceed 14 days as specified in federal regulation).

e. Coordinate with the MCO regarding the appropriate date to transition medically necessary care, as determined by the MCO. There should be **no gaps in service delivery**. The transition should not occur until a TennCare MCO provider is identified, all applicable pre-service activities are completed, and a *specific* date is determined that the provider can begin delivering medically necessary care as authorized by the MCO under the TennCare program. Such date must allow adequate time for advance notice of termination of Occupational Therapy Services under the waiver.

f. Issue *at least* 20 days advance notice (inclusive of mail time) of termination of **waiver** Occupational Therapy Services, as applicable, indicating that the services will be terminated on the 21st day from the date of the notice or upon the specific date of transition to Occupational Therapy Services by the MCO under the TennCare program, as applicable. The legal basis for such action is **payor of last resort**. Include the following statement in the denial letter: "Medically necessary Occupational Therapy Services are covered under the TennCare Program for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]." The previously approved level of **waiver** Occupational Therapy Services shall continue to be authorized and reimbursed pending such advance notice period.

The service recipient may file a timely appeal regarding the termination of **waiver** Occupational Therapy 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 that waiver Occupational Therapy Services are 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 **waiver** Occupational Therapy Services pending resolution of the appeal, in which case such previously approved **waiver** Occupational Therapy Services shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

g. If the MCO denies the request for coverage of Occupational Therapy based on medical necessity, issue a written notice of termination of Occupational Therapy which states that the waiver is the payor of last resort and that the MCO has determined that the service is not medically necessary.

The service recipient may file a timely appeal regarding the termination of **waiver** Occupational Therapy 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 that waiver Occupational Therapy are 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 **waiver** Occupational Therapy pending resolution of the appeal, in which case such previously approved **waiver** Occupational Therapy shall continue pending notification from TennCare that the appeal has been resolved and that continuation of benefits may be stopped.

Include the following statement in the denial letter: "Medically necessary Occupational Therapy are covered under the TennCare Program for children under age 21. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]."

3. Medical necessity review questions for *continuation* of the *currently* approved level of Occupational Therapy Services for an adult service recipient age 20 or older plus any requested *increase* in such services, as applicable:

   a. Is there an order by a physician, physician assistant, or nurse practitioner for the Occupational Therapy; **AND**

   b. Is there sufficient information in the Individual Support Plan (ISP) to document that the service recipient continues to have a medical diagnosis or functional deficit involving performance of activities of daily living; **AND**

   c. Is there sufficient information in the ISP and/or supporting documentation (e.g., the therapy plan of care) to conclude that the service recipient's functional and/or treatment needs involving performance of activities of daily living *still* cannot be adequately met unless Occupational Therapy Services are provided by a licensed occupational therapist or licensed occupational therapy assistant working under the supervision of a licensed occupational therapist (i.e., paid and unpaid caregivers would *still* not otherwise be able to adequately meet the specified functional or treatment needs); **AND**

   d. Is there sufficient information in the ISP and/or supporting documentation to demonstrate:

      (1) 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; **OR**

      (2) The *continuing* medical need for Occupational Therapy Services in order to maintain current functional abilities that would be lost without the *continued* provision of Occupational Therapy Services; **OR**

      (3) The *continuing* medical need for Occupational Therapy Services in order to prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?

   e. Are clearly defined measurable Occupational Therapy Services goals as specified in the ISP and/or supporting documentation *still* reasonable and appropriate given the person's current age and health status?

   If **YES** ***to all five (5)*** criteria specified in "3.a" through "3.e" above, proceed to question 4.

   If **NO to *any*** criterion specified in "3.a" through "3.e" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria from "3.a" through "3.e" above and the applicable prongs of medical necessity must be specified in the denial letter. Applicable prongs of medical necessity may include:

   - "Not ordered by a doctor" ("3.a");
   - "Not necessary to treat" ("3.b" through "3.e");
   - "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."*) ("3.b" through "3.e"); and
   - "Not the least costly adequate alternative" ("3.b" through "3.e").

4. Is the frequency (per week, per month, etc.), amount (# of units) and duration (# of weeks or months) of *continued* Occupational Therapy 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 (1) achieve measurable and sustained functional gains; (2) maintain current

functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above?

To the extent that the request includes any increase in the frequency, amount, or duration of Occupational Therapy 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 Occupational Therapy Services is no longer sufficient to (a) achieve measurable and sustained functional gains for the service recipient that can be generalized to settings outside the immediate treatment environment; (b) maintain current functional abilities that would be lost without the continued provision of Occupational Therapy Services; or (c) prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?

NOTE: To the maximum extent possible and appropriate, Occupational Therapy Services by a licensed occupational therapist or licensed occupational therapy assistant working under the supervision of a licensed occupational therapist 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 licensed occupational therapist or licensed occupational therapy assistant working under the supervision of a licensed occupational therapist 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 *continuation* of Occupational Therapy Services and any *increase* as requested. Such approval may specify that concurrent review will be conducted after a specified period of time (see attached guidelines) to ensure that Occupational Therapy Services continue to be medically necessary. Such determination shall be based on medical records provided by the licensed professional and/or physician, physician assistant, or nurse practitioner in response to the request for concurrent review.

If **NO**, approve that portion of the total amount of Occupational Therapy Services requested that is *consistent with* the amount of Occupational Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above.

- If the request for Occupational Therapy 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 Occupational Therapy Services requested that is in excess of the amount of Occupational Therapy Services needed to (1) achieve measurable and sustained functional gains; (2) maintain current functional abilities; or (3) prevent or minimize the deterioration of a chronic condition as specified in "3.d" above; **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 Occupational Therapy 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 Occupational Therapy 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 Occupational Therapy Services pending resolution of the appeal, in which case such previously approved

Occupational Therapy Services 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 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 *continuation* of Occupational Therapy 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.