Outpatient Physical Therapy and Occupational Therapy

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16.1 Enrollment
To enroll in the CSHCN Program, outpatient therapy providers (physical therapy [PT] and occupational therapy [OT]) must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with CSHCN, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

16.2 Reimbursement
Outpatient therapy services are reimbursed according to Texas Medicaid Reimbursement Methodology. CSHCN reimburses therapists and outpatient facilities based on the procedure codes listed below. Therapy sessions include the time span the therapist is with the client: for instance, time spent preparing the client for the session, and the time spent completing documentation. Evaluation, re-evaluation, and therapy services may not be billed on the same date of service. Reimbursement of an evaluation is limited to once every six months. Reimbursement for re-evaluation is limited to one per month.

Physical and occupational therapists should use the following procedure codes for authorization or claim submission:

<table>
<thead>
<tr>
<th>Procedure Code for PT</th>
<th>Procedure Code for OT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001</td>
<td>97003</td>
<td>Evaluation</td>
</tr>
<tr>
<td>97002</td>
<td>97004</td>
<td>Re-evaluation</td>
</tr>
</tbody>
</table>

Outpatient facilities should use the following procedure codes for authorization and/or claim submission:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001</td>
<td>PT evaluation</td>
<td>97036</td>
<td>Hydrotherapy</td>
</tr>
<tr>
<td>97002</td>
<td>PT re-evaluation</td>
<td>97039</td>
<td>Physical therapy treatment</td>
</tr>
<tr>
<td>97003</td>
<td>OT evaluation</td>
<td>97110</td>
<td>Therapeutic exercises</td>
</tr>
<tr>
<td>97004</td>
<td>OT re-evaluation</td>
<td>97112</td>
<td>Neuromuscular reeducation</td>
</tr>
<tr>
<td>97012</td>
<td>Mechanical traction therapy</td>
<td>97113</td>
<td>Aquatic therapy/exercises</td>
</tr>
<tr>
<td>97014</td>
<td>Electric stimulation therapy</td>
<td>97116</td>
<td>Gait training therapy</td>
</tr>
<tr>
<td>97016</td>
<td>Vasopneumatic device therapy</td>
<td>97124</td>
<td>Massage therapy</td>
</tr>
<tr>
<td>97018</td>
<td>Paraffin bath therapy</td>
<td>97139</td>
<td>Physical medicine procedure</td>
</tr>
<tr>
<td>97020</td>
<td>Microwave therapy</td>
<td>97140</td>
<td>Manual therapy</td>
</tr>
<tr>
<td>97022</td>
<td>Whirlpool therapy</td>
<td>97150</td>
<td>Group therapeutic procedures</td>
</tr>
<tr>
<td>97024</td>
<td>Diathermy treatment</td>
<td>97504</td>
<td>Orthotic training</td>
</tr>
<tr>
<td>97026</td>
<td>Infrared therapy</td>
<td>97520</td>
<td>Prosthetic training</td>
</tr>
<tr>
<td>97028</td>
<td>Ultraviolet therapy</td>
<td>97530</td>
<td>Therapeutic activities</td>
</tr>
<tr>
<td>97032</td>
<td>Electrical stimulation</td>
<td>97542</td>
<td>Wheelchair management training</td>
</tr>
<tr>
<td>97033</td>
<td>Electrical current therapy</td>
<td>97703</td>
<td>Prosthetic checkout</td>
</tr>
<tr>
<td>97034</td>
<td>Contrast bath therapy</td>
<td>97750</td>
<td>Physical performance test</td>
</tr>
<tr>
<td>97035</td>
<td>Ultrasound therapy</td>
<td>97799</td>
<td>Physical medicine procedure</td>
</tr>
</tbody>
</table>

Procedure codes 97012 through 97530 may be paid in multiple quantities of each code if the claim states that multiple procedures were performed on different body areas, or the claim states that physical medicine treatment was performed more than once per day.
Procedure codes 97703 and 97750 are comprehensive codes and include an office visit. If the same provider bills an office visit the same day, the office visit will be denied as part of another procedure billed the same day.

16.3 Benefits and Limitations

CSHCN may reimburse medically necessary and appropriate outpatient PT and OT for CSHCN clients. A physician or podiatrist (for conditions below the ankle) must prescribe PT and OT services that are provided through or in a rehabilitation center, a licensed hospital, a physician’s office, or the office of an enrolled PT or OT provider. CSHCN may reimburse for therapists to travel to the patient’s community, based on standard CSHCN travel reimbursement policy, when no local therapist is available or when services are provided in the client’s home. Use CSHCN local code 100PT, Transportation therapist, per mile. Only licensed therapists may provide PT and OT services.

Specific procedure or diagnosis codes related to program benefits and coverage are listed in this chapter. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, codes are added, deleted, or revised. Coverage and coding information is updated in the CSHCN Provider Bulletin. Call the TMHP-CSHCN Contact Center at 1-800-568-2413 with questions regarding covered procedure or diagnosis codes.

16.4 Authorization Requirements

Physical therapy and/or occupational therapy require authorization. Initial evaluations do not require authorization. Treatment plans, not to exceed six months, and requests for extensions require authorization. If the client is of school age, include a copy of the individual educational plan (IEP) or statement from the independent school district that the child is not eligible for the same services through the school.

Refer to:
- Authorization Request for Initial Outpatient Therapy (TP1) form on page C-38 or Authorization Request for Extension of Outpatient Therapy (TP2) form on page C-39.

Note: Fax transmittal confirmations are not accepted as proof of timely authorization submission.

Physical and/or occupational therapy may be authorized when the child meets the following criteria:

- The child is younger than 3 years of age, and measurable progress toward individual treatment goals can reasonably be expected (this may not always indicate physical improvement in the client’s condition); or

- The child is 3 years of age or older, not presently eligible for or receiving special education and/or special services during the school year, and has a disabling condition requiring therapy services where measurable progress toward individual treatment goals can reasonably be expected (this may not always indicate physical improvement in the client’s condition); and

- The child has a developmental anomaly including (but not limited to) the following: cerebral palsy, spina bifida, arthrogryposis, reduction deformities of a limb(s), hydrocephalus, Erb’s palsy (brachial plexus palsy), or encephalocele; or

- The child has an acute episode of a chronic condition that may include (but is not limited to): Juvenile rheumatoid arthritis (JRA), hemophilia, lupus erythematosus, sickle cell crisis (joint pain, swelling, and limited range of motion) or cancer; or

- The child presents a new condition that may include (but is not limited to): upper extremity trauma, median or radial nerve lesions, late effects of fractures, burns, spinal cord injury, traumatic brain injury, cerebral embolism, brain tumor, or Guillain-Barré Syndrome; or
  - • The child is seen in a specialty clinic for periodic assessment or re-evaluations; or
  - • The child needs short-term therapy related to surgery or casting; or
  - • The child requires training on the use of equipment such as: wheelchairs (powered or manual), orthotics or prosthetics, or other equipment such as ambulation aids (walkers or crutches); or
  - • Short-term assistance is required to instruct the child/family in activities of daily living specific to the home or environment (such as bathing; toileting; or making equipment assessment for braces, wheelchairs, cushions, and so on).
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PT/OT services may be authorized as follows:

• Children from birth to 3 years of age with a developmental anomaly, therapy services may be authorized up to two times a week for six months (may be extended up to school eligibility without medical review). Requests for a higher frequency of visits per week require submission of documentation of medical necessity.

• Children 3 years of age through 21 years of age with a developmental anomaly should be referred to the public school system for services unless ineligible or there is a medically related therapy issue to address.

• Presurgical therapy related to the reason for surgery may be approved up to three times a week for one month.

• Post-surgical therapy directly related to the reason for surgery or for cast removal may be authorized up to five times a week for two months; post rhizotomy—up to three times a week for one year. After these specified time periods, extensions require documentation of medical necessity.

• Therapy addressing an acute episode of a chronic condition (seldom eligible for therapy through the school system) may be authorized up to five times a week for three months. After three months, the physician’s documentation of continued acute episode is required. After the first six months are authorized, documentation of the specific rationale of the need for continued therapy based on the client’s chronic diagnosis must be submitted.

• New conditions such as upper extremity trauma, median or radial nerve lesions, or late effects of fractures, may have therapy authorized up to five times a week for three months. Extensions after six months require additional documentation of medical necessity.

• New conditions (such as third-degree burns) may have therapy authorized up to five times a week for three months, and may be extended up to one year. After one year, documentation of the specific rationale of the need for continued therapy must be submitted.

• New conditions such as spinal cord injury, traumatic brain injury, cerebral embolism, brain tumor, or Guillain-Barré Syndrome may have therapy authorized for up to five times a week for the initial three months. This may be extended up to one year.

• Home program monitoring for clients from birth to 3 years of age with cerebral palsy, spina bifida, arthrogryposis, reduction deformities of limbs, or hydrocephalus may have home program monitoring authorized for up to two times a month for six months.

• Home program monitoring for clients from birth to 21 years of age with JRA, hemophilia, lupus erythematosus, sickle cell crisis (joint pain/swelling and limited range of motion) may have home program monitoring approved up to one time a month for six months.

• Activities of daily living instructions to teach clients, parents, and caregivers for clients 3 years of age through 21 years of age may be authorized up to three times a week for one month.

• One equipment assessment before receiving the equipment and one assessment after receiving the equipment may be authorized.

• Training for the use of manual wheelchairs may be authorized for up to five times a week for one month.

• Training for the use of powered wheelchairs may be authorized for up to five times a week for one month and then three times a week for two months.

• Training for the use of orthotics/prosthetics (braces/artificial limbs) may be authorized for up to five times a week for one month and then three times a week for two months. Additional requests for additional training require documentation of the specific rationale for the medical need. Reciprocating gait orthoses (RGOs) may be provided for children with spina bifida or similar functional disability; documentation is required including: a statement from the physician indicating the medical necessity, a coordinated physical therapy treatment plan, and documentation that the client/family is expected to comply with the treatment plan. Dynamic splints are provided on a case-by-case basis using the following criteria submitted by the physician:
  • The client’s condition to be treated with the dynamic splint.
  • The client’s current course of therapy to date for the condition to be treated.
  • The rationale for the use of the dynamic splint at this time.
  • A therapy treatment plan related to the dynamic splint.

• Training for other equipment (such as walkers or crutches) may be authorized for up to five times a week for one month.
16.5 Coordination with the Public School System

Children eligible for OT/PT services through the public school system, including extended year services, may not receive supplemental OT/PT through CSHCN. CSHCN covers medically-related therapy and cannot supplement related services provided through the public school system. The public school system is responsible for provision of therapy services related to the child’s educational needs so that the child may adequately access provided educational services/programs. A child of any age who has received special education during the school year may be eligible for summer therapy through the local school district. A child can receive therapy from both the public school system and CSHCN; however, therapy goals and services will differ because CSHCN focuses on medically-related needs while the school system focuses on the child’s educational needs. CSHCN does not pay for summer services for educational goal attainment, since school funding should be available. Children 3 years of age or older may be eligible for special education services (visually- and/or hearing-impaired children are eligible for special education services regardless of age).

To assure there is no duplication of therapy services, any child eligible for special education services must have a copy of their individual education plan (IEP) included with an authorization request in order to submit claims for reimbursement of therapy services.

16.6 Claims Information

Outpatient therapy services provided by a physical or occupational therapist or by an outpatient facility must be submitted in an approved electronic format or on a HCFA-1500 claim form. Providers may purchase HCFA-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a HCFA-1500 or HCFA-1450 (UB-92) claim form, all pertinent information must be included on the claim, since information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Instructions for proper claims completion are provided on page C-2. Blocks that are not referenced are not required for processing by TMHP and may be left blank.