NURSING AND THERAPY SERVICES HANDBOOK

Table of Contents

1 General Information .................................................. 5
2 Certified Respiratory Care Practitioner (CRCP) Services ...................... 5
  2.1 Enrollment ......................................................... 5
  2.2 Services, Benefits, Limitations, and Prior Authorization ..................... 6
    2.2.1 Prior Authorization ............................................. 6
  2.3 Documentation Requirements ....................................... 7
  2.4 Claims Filing and Reimbursement ..................................... 7
    2.4.1 Claims Information ............................................... 7
    2.4.2 Reimbursement .................................................... 7
3 Home Health Nursing and Therapy Services .................................... 8
  3.1 Enrollment ......................................................... 8
    3.1.1 Change of Address and Telephone Number ......................... 9
    3.1.2 Pending Agency Certification .................................... 9
    3.1.3 Home Health Skilled Nursing and Home Health Aide (HHA) Services
          Provider Responsibilities ........................................ 9
  3.2 Services, Benefits, Limitations, and Prior Authorization ................. 10
    3.2.1 Home Health .................................................... 10
      3.2.1.1 Client Eligibility ............................................. 10
      3.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility
                      ......................................................... 10
      3.2.1.3 Client Evaluation ............................................ 11
    3.2.2 Benefits ....................................................... 11
    3.2.3 Home Health Skilled Nursing Services ................................ 12
      3.2.3.1 SN Visits ..................................................... 13
        3.2.3.1.1 SN Care .................................................. 13
        3.2.3.1.2 Professional Nursing ................................... 14
        3.2.3.1.3 Vocational Nursing ..................................... 14
    3.2.4 Home Health Aide Services ...................................... 15
      3.2.4.1 HHA Visits ................................................... 15
      3.2.4.2 Supervision of HHA .......................................... 16
    3.2.5 DME and Medical Supplies Submitted with a Plan of Care (POC) ........ 16
    3.2.6 Medication Administration Limitations ................................ 17
    3.2.7 Occupational Therapy (OT) Services ................................ 17
    3.2.8 Physical Therapy (PT) Services .................................. 18
    3.2.9 Occupational Group Therapy and Physical Group Therapy ............... 18
      3.2.9.1 Group Therapy Guidelines .................................... 18
      3.2.9.2 Group Therapy Documentation Requirements .................... 19
    3.2.10 Prior Authorization ............................................. 19
      3.2.10.1 Home Health SN and HHA Services Prior Authorization Requirements
                    ......................................................... 20
        3.2.10.1.1 Routine Laboratory Specimens ............................ 22
        3.2.10.1.2 Home Phototherapy ..................................... 22
        3.2.10.1.3 Prothrombin Time/Internationalized Normalized Ration (TP/INR)
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Contact TMHP</td>
<td>51</td>
</tr>
<tr>
<td>7</td>
<td>Forms</td>
<td>51</td>
</tr>
<tr>
<td>8</td>
<td>Claim Form Examples</td>
<td>52</td>
</tr>
</tbody>
</table>
1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, “Carve-Out Services” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

The information in this handbook is intended for nursing and therapy services. Nursing services include home health skilled nursing visits and home health aide services. Therapy services include occupational therapy (OT), physical therapy (PT), speech therapy (ST), and certified respiratory care practitioners (CRCP) services. The Handbook provides information about Texas Medicaid’s benefits, policies, and procedures applicable to these therapies.

This section does not apply to Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehabilitation Facility (ORF), or Inpatient Rehabilitation Facility (Freestanding) services provided through the Comprehensive Care Program (CCP).

Refer to: Subsection 2.5, “Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information.

Subsection 2.16, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information.

Important: All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.14, “Therapy Services (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about providing OT, PT, and ST services.

2 Certified Respiratory Care Practitioner (CRCP) Services

2.1 Enrollment

To enroll in Texas Medicaid, a CRCP must be certified by the Department of State Health Services (DSHS) to practice under the Texas Occupations Code, Chapter 604. For CRCPs, Medicare certification is not a prerequisite for Medicaid enrollment. A provider cannot be enrolled if his license is due to expire within 30 days; a current license must be submitted. CRCPs must enroll as individual providers and comply with all applicable federal, state, and local laws and regulations.
2.2 Services, Benefits, Limitations, and Prior Authorization

Respiratory therapy services provided by a Texas Medicaid provider enrolled as a CRCP may be reimbursed when services are reasonable, medically necessary, and prescribed by the client’s physician. These services are for all age groups and do not require the client to be homebound.

CRCP services are a benefit of Texas Medicaid with prior authorization when provided in the home setting for ventilator-dependent clients. Providers must use procedure code 99504 when billing for in-home respiratory services.

Benefits include, but are not limited to, the following:

- Respiratory therapy services and treatments prescribed by a physician who is familiar with the client’s medical history and care, and who has medically determined that in-home care is safe and feasible for the client.
- Education of the client, the appropriate family members, and support people about the in-home respiratory care (must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation).

2.2.1 Prior Authorization

Prior authorization is required for in-home CRCP services (procedure code 99504).

To avoid unnecessary denials, the provider must submit correct and complete information including documentation of medical necessity for the service requested. The prescribing physician and provider must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the service.

Prior authorization requests for traditional Medicaid clients must be submitted by the physician or the CRCP to the Special Medical Prior Authorization (SMPA) Department by approved electronic method using the SMPA Request Form.

When required, the requests must include the physician’s original signature and the date signed. Stamped or computerized signatures and dates are not accepted. Without this information, requests will be considered incomplete.

The SMPA Request Form must be submitted with the following documentation supporting medical necessity for the requested procedure:

- The client is on a ventilator at least six hours per day.
- The client has been ventilator-dependent for at least 30 consecutive days or more as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF).
- The respiratory therapy services are in lieu of respiratory services requiring the client to remain in an inpatient care setting.
- Identification of the adequate support services in place that allow the client to be cared for at home.
- The respiratory services and goals for the services that will be provided by the CRCP.
- The frequency and number of home visits requested by the CRCP.
- The client’s wish to be cared for at home.
• Documentation supporting why the respiratory therapy visits included in the Home Health durable medical equipment (DME) rental of a ventilator, or the monthly respiratory therapy visit included in the Ventilator Service Agreement authorized to a Home Health DME provider would not meet the client's medical needs.

**Note:** For clients who are birth through 20 years of age, CRCP services that do not meet the criteria above, may be considered through the Comprehensive Care Program (CCP) when prior authorized and billed with procedure code 99503.

The prior authorization request may be authorized for up to a 12-month period. Prior authorization requests for more than 24 visits in a 12-month period will be referred for the medical director to review and a determination will be based on the individual client’s medical needs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim for procedure codes 99503 or 99504.

**Refer to:** Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

### 2.3 Documentation Requirements

All supporting documentation must be included with the request for prior authorization. Providers should send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-A Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

### 2.4 Claims Filing and Reimbursement

#### 2.4.1 Claims Information

CRCP services must be submitted to the Texas Medicaid & Healthcare Partnership (TMHP) in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Electronic billers must submit the prior authorization number (PAN) on the electronic claim form. Providers should consult the software vendor for the location of this field in the software.

#### 2.4.2 Reimbursement

Respiratory therapy services provided by a participating CRCP are reimbursed the lesser of the provider’s billed charges or the rate calculated in accordance with 1 TAC §355.8089.
Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

The professional service may be billed by the CRCP for services provided in the client’s home (procedure code 99504). The professional service will be allowed once per day up to a limit of 24 visits per year. The recommended frequency for CRCP services is as follows: 7 visits during the first week, a total of 6 visits during the second through fourth weeks, and 11 monthly visits for the second through the 12th month.

Providers will not be reimbursed for procedure codes 99503 and 99504 on the same date of service, any provider.

Disposable respiratory supplies and respiratory equipment rental or purchase are a home health services benefit and are not reimbursed to the certified respiratory therapist.

Refer to: Subsection 2.2, “Services, Benefits, Limitations and Prior Authorization” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME or medical supplies prior authorization information.

3 Home Health Nursing and Therapy Services

3.1 Enrollment

To enroll in Texas Medicaid as a provider of home health services, Home Health Services and Home and Community Support Services Agency (HCSA) providers must complete the Texas Medicaid Provider Enrollment Application. Medicare certification is required for providers that are licensed as a Licensed and Certified Home Health Agency. Providers that are licensed as a Licensed Home Health Agency are not required to enroll in Medicare as a prerequisite to enrollment with Texas Medicaid.

Licensed and Certified Home Health agencies that are enrolled as Medicaid providers can provide personal care services (PCS) using their existing provider identifier. PCS for clients who are 20 years of age and younger will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: Subsection 2.11, “Personal Care Services (PCS) (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

To provide CCP services, HCSA providers must follow the enrollment procedures in subsection 5.2, “Enrollment” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126.

Providers may also obtain the application by writing to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214
Providers may request prior authorization for home-health services by contacting:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977
1-800-925-8957
Fax: 1-512-514-4209

3.1.1 Change of Address and Telephone Number
A current physical and mailing address and telephone number must be on file for the agency/company to receive reimbursement checks, Medicaid provider procedures manuals, and all other TMHP correspondence. Promptly send all address and telephone number changes to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

3.1.2 Pending Agency Certification
Home health agencies submitting claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is when all Texas Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Texas Medicaid enrollment, the agency must contact the TMHP Home Health Services Prior Authorization Department before serving a Texas Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Texas Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

3.1.3 Home Health Skilled Nursing and Home Health Aide (HHA) Services Provider Responsibilities
Providers must be licensed home health agencies, enrolled in Texas Medicaid, and must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid policies and procedures. All providers must maintain written policies and procedures:

- That meet the standards of the Texas Family Code, Chapter 32 for obtaining consent for the medical treatment of clients in the absence of the primary caregiver.
- For obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

Providers must only accept clients on the basis of a reasonable expectation that the client’s needs can be adequately met in the place of service (POS). The essential elements of safe and effective home health SN or HHA services include a trained parent, guardian, or caregiver, a primary physician, competent providers, and an environment that supports the client’s health and safety needs.
Necessary primary and back-up utility, communication, and fire safety systems must be available.

**Note:** A parent or guardian, primary caregiver, or alternate caregiver may not provide SN or HHA services to their family member even if he or she is an enrolled provider or employed by an enrolled provider.

### 3.2 Services, Benefits, Limitations, and Prior Authorization

#### 3.2.1 Home Health

Prior authorization must be obtained for all professional services (SN, HHA, OT, PT, most DME, and some medical supply services). Prior authorization requests for SN, HHA, DME and some medical supply services must be submitted within three business days of the start of care (SOC), and within five business days for PT and OT services.

The benefit period for home health professional services is up to 60 days with a current plan of care (POC). This extended prior authorization period begins on the date that clients receive their first prior authorized home health service. Texas Medicaid allows prior authorization of additional visits that have been determined to be medically necessary and have been prior authorized by TMHP Home Health Services Prior Authorization Department. These records and claims must be retained for a minimum of five years from the date of service (DOS) or until audit questions, appeals, hearings, investigations, or court cases are resolved. Use of these services is subject to retrospective review.

#### 3.2.1.1 Client Eligibility

It is the provider’s responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is eligible to receive. To verify client Medicaid eligibility and retroactive eligibility, the home health agency, DME, or medical supplier must contact the Automated Inquiry System (AIS) at 1-800-925-9126 or the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638. Home health clients do not need to be homebound to qualify for services.

The Medicaid client must be eligible on the DOS and must meet all of the following requirements to qualify for Home Health Services:

- Have a medical need for home health professional services, DME, or medical supplies that is documented in the client’s POC and considered a benefit under Home Health Services
- Receive services that meet the client’s existing medical needs and can be safely provided in the client’s home
- Receive prior authorization from TMHP for most home health professional services, DME, or medical supplies

**Refer to:** “Automated Inquiry System (AIS)” in “Preliminary Information” (Vol. 1, General Information).

**Note:** Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

#### 3.2.1.2 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client’s Medicaid coverage is before the date the client’s Medicaid eligibility is added to TMHP’s eligibility file, which is called the “add date.”

For clients with retroactive eligibility, prior authorization requests must be submitted after the client’s add date and before a claim is submitted to TMHP.
For services provided to fee-for-service Medicaid clients during the client’s retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client’s add date and before a claim for those services is submitted to TMHP. For services provided on or after the client’s add date, the provider must obtain prior authorization within 3 business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access AIS or TexMedConnect to verify eligibility frequently while providing services to the client. If services are discontinued before the client’s add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: Section 4: Client Eligibility (Vol.1, General Information).

3.2.1.3 Client Evaluation

When a home health agency receives a referral to provide home health nursing and therapy services for a client who is eligible for Texas Medicaid, the agency-employed registered nurse (RN) must evaluate the client in the home before calling TMHP for prior authorization. A home evaluation by the agency-employed RN is required for SN, HHA, OT, PT, DME, or medical supplies requested on a Home Health Services POC. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client’s physician to ensure the client’s medical record is current.

This evaluation must include assessment of the following:

- Medical necessity for Home Health Services, DME, or medical supplies requested
- Client safety
- Appropriateness of care in the home setting
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition

Following the RN’s assessment/evaluation of the client in the home setting for Home Health Services needs, the agency-employed RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the SOC.

3.2.2 Benefits

Home Health Services include SN, HHA, OT, PT, DME, and medical supplies that are provided to eligible Medicaid clients at their place of residence.

Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

Refer to: Subsection 2.14, “Therapy Services (CCP)” and subsection 2.13, “Private Duty Nursing (PDN)(CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on nursing and therapy benefits for clients who are 20 years of age and younger.

The Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks).

An SN or HHA visit may be reimbursed for up to a maximum of 2.5 hours per visit. A combined total of three SN or HHA visits may be reimbursed per date of service. When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support that the services were delivered at distinct, separate time periods. Total Home Health Services billed for all clients cannot exceed the individual provider’s total number of hours spent at the POS.
One SN visit as needed (PRN) may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been prior authorized for the particular client. For reimbursement purposes, home health SN and HHA services are always billed as POS 2 (home) regardless of the setting in which the services are actually provided. SN and HHA services provided in the day care or school setting will not be reimbursed.

OT and PT services must be billed one visit per day, per therapy.

The quantity billed must be identified and each procedure code must be listed as separate line items on the claim.

Procedural modifiers are required when billing SN, HHA, OT, and PT visits.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Visit Service Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>U2</td>
<td>SN or HHA second visit per day</td>
</tr>
<tr>
<td>U3</td>
<td>SN or HHA third visit per day</td>
</tr>
<tr>
<td>GO</td>
<td>OT</td>
</tr>
<tr>
<td>GP</td>
<td>PT</td>
</tr>
</tbody>
</table>

Note: The U2 and U3 modifiers are only required if a PRN SN visit is the second or third SN or HHA visit performed on the same date of service.

3.2.3 Home Health Skilled Nursing Services

Home health SN services are a benefit of Texas Medicaid when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. SN visits may be provided on consecutive days. SN visits are intended to provide SN care to promote independence and support the client living at home. Home Health Services must be provided by a licensed and certified home health agency enrolled in Texas Medicaid.

Note: Nursing visits for the primary purpose of assessing a client’s care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.

An acute condition is a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is an SN visit that is provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. Part-time visits are continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

SN visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments and procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death
When documentation does not support medical necessity for home health SN visits, providers may be directed to possible alternative services based on the client’s age and needs.

**Note:** For Medicaid clients who are 20 years of age or younger, home health skilled nursing services are available when the client requires nursing services for an acute condition, acute exacerbation of a chronic condition, or a chronic condition that can be treated on an intermittent or part-time basis.

### 3.2.3.1 SN Visits

SN visits (procedure code G0154) are limited to SN procedures performed by an RN or licensed vocational nurse (LVN) licensed to perform these services under the Texas Nursing Practice Act and include direct SN care, and parent or guardian, caregiver training, and education as well as SN observation, assessment, and evaluation by an RN, provided a primary physician specifically requests that a nurse visit the client for this purpose, and the physician’s order reflects the medical necessity for the visit.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

The cost of incidental medical supplies used during an SN or HHA visit may be added to the charge of the visit ($10 maximum for medical supplies is included in G0154 visit code).

#### 3.2.3.1.1 SN Care

SN care consists of those services that must, under state law, be performed by an RN or LVN, and meet the criteria for SN services specified in the Title 42 Code of Federal Regulations (CFR) §§ 409.32, 409.33, and 409.44. In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

The fact that the SN service can be, or is taught to the client or to the client’s family or friends does not negate the skilled aspect of the service when the service is performed by a nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be an SN service. If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as an SN service.

Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client’s illness or injury, would be covered on that basis. However, in some cases, the client’s condition may cause a service that would ordinarily be considered unskilled to be considered an SN service. This may occur when the client’s condition is such that the service can be safely and effectively provided only by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client’s family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

SN services must be reasonable and necessary to the diagnosis and treatment of the client’s illness or injury within the context of the client’s unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client’s illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client’s particular medical needs, and within
accepted standards of medical and nursing practice. A client’s overall medical condition is a valid factor in deciding whether skilled services are needed. A client’s diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration of the primary physician’s determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

SN care must be provided on a part-time or intermittent basis.

3.2.3.1.2 Professional Nursing

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

3.2.3.1.3 Vocational Nursing

Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual
- Participating in the planning of the nursing care needs of an individual
- Participating in the development and modification of the nursing care plan
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual

Vocational nursing also involves assisting in the evaluation of an individual’s response to a nursing intervention and the identification of an individual’s needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse’s experience, continuing education, and demonstrated competency.
3.2.4 Home Health Aide Services

HHA visits (procedure code G0156) are a benefit of Texas Medicaid when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days. HHA visits are intended to provide personal care under the supervision of an RN, occupational therapist, or physical therapist employed by the home health agency to promote independence and support the client living at home.

An acute condition is considered a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is considered an HHA visit provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is considered an HHA visit provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

HHA visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments or procedures
- Individualized, intermittent, acute skilled care
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function
  - Imminent risk to health status due to medical fragility, or risk of death
  - General supervision of nursing care provided by an HHA over whom the RN, occupational therapist, or physical therapist is administratively or professionally responsible

When documentation does not support medical necessity for HHA visits, providers may be directed to possible alternative services based on the client’s age and needs.

3.2.4.1 HHA Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (RN, occupational therapist, or physical therapist) employed by the home health agency.

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

The duties of an HHA during a visit include, but are not limited to the following:

- Ambulation
- Assistance with medication that is ordinarily self-administered
- Assisting with nutrition and fluid intake
- Completing appropriate documentation
- Exercise
- Household services essential to the client’s health care at home
- Obtaining and recording the client’s vital signs (temperature, pulse, respirations, and blood pressure)
- Observation, reporting, and documentation of the client’s status, and the care or service furnished
- Personal care (hygiene and grooming), including, but not limited to the following:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub, or bed bath
  - Nail and skin care
  - Oral hygiene
- Positioning
- Range of motion
- Reporting changes in the client’s condition and needs
- Safe transfer
- Toileting and elimination care

3.2.4.2 Supervision of HHA

Supervision, as defined by the Texas Nursing Practice Act, is the process of directing, guiding, and influencing the outcome of an individual’s performance of an activity. An RN, occupational therapist, or physical therapist must provide the HHA written instructions for all the tasks delegated to the HHA. An occupational therapist or physical therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

The requirements for HHA supervision are as follows:

- When only HHA visits are provided, an RN must make a supervisory visit to the client’s residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.

- When SN, OT, or PT visits are provided in addition to an HHA visit, an RN must make a supervisory visit to the client’s residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.

- When only OT or PT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.

- Documentation of HHA supervision must be maintained in the client’s medical record.

3.2.5 DME and Medical Supplies Submitted with a Plan of Care (POC)

The cost of incidental medical supplies used during an SN or HHA visit may be added to the charge of the visit ($10 maximum for medical supplies and included in G0154 visit code). Medical supplies left at the home for the client to use must be billed with the provider identifier enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

Refer to: Subsection 2.2, “Services, Benefits, Limitations and Prior Authorization” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME or medical supplies prior authorization information.
When the Home Health Services POC is used to submit a prior authorization for DME or medical supplies that will be used in conjunction with the professional services provided by the agency, such as SN, HHA, OT, or PT, the home health agency’s DME provider identifier must be submitted on the POC, and all of the requested DME and medical supplies must be listed in the “Supplies” section of the POC. The POC does not require a physician’s signature before prior authorization of professional services, DME, or medical supplies is requested but does require the assessing RNs dated signature. The POC must be signed and dated by a primary physician familiar with the client prior to submitting a claim for services and no later than 30 days from the SOC date.

If the home health agency uses the [Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form](#), the agency must complete Section A. A primary physician familiar with the client must complete Section B, sign, and date it prior to submission to TMHP for prior authorization of the requested DME or medical supplies.

The following information is required to consider these medical supplies for prior authorization:

- Item description
- Procedure code
- Quantity of each medical supply requested
- Manufacturer’s suggested retail price (MSRP) for items that do not have a maximum fee assigned

Refer to: Subsection 2.2, “Services, Benefits, Limitations and Prior Authorization” in the [Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)](#) for DME or medical supplies prior authorization information.

### 3.2.6 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual’s illness or is not approved by the Food and Drug Administration (FDA) or is being used for indications not approved by the FDA.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, or neighbor have been taught or can be taught to administer subcutaneous (SQ/SC), intramuscular (IM), and intravenous (IV) injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

### 3.2.7 Occupational Therapy (OT) Services

As stated in 1 TAC §354.1039, to be payable as a Home Health Services benefit, OT services must be:

- Provided by an occupational therapist or an OT assistant who is currently registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners
- For the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition
• For specific goal-directed activities to achieve a functional level of mobility and communication to prevent further dysfunction within a reasonable length of time based on the therapist’s evaluation, physician’s assessment, and POC

  Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit will receive those services through CCP.

Refer to: Subsection 2.14, “Therapy Services (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for OT benefits for clients who are 20 years of age and younger and Section 4, “Therapists, Independent Practitioners, and Physicians” in this handbook for OT benefits provided by a physician.

3.2.8 Physical Therapy (PT) Services

As stated in 1 TAC §354.1039, in order to be payable as a Home Health Services benefit, PT services must be:

• Provided by a physical therapist or PT assistant who is currently licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners.

• For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.

• Expected to improve the client’s condition in a reasonable and generally predictable period of time, based on the physician’s assessment of the client’s restorative potential after any necessary consultation with the therapist.

• Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not a benefit. Additionally, services related to activities for the general good and welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

  Note: THSteps-eligible clients who qualify for medically necessary services beyond the limits of this Home Health Services benefit may receive those services through CCP.

Refer to: Subsection 2.14, “Therapy Services (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for PT benefits for clients who are 20 years of age and younger. Section 4, “Therapists, Independent Practitioners, and Physicians” in this handbook for PT benefits provided by a physician.

3.2.9 Occupational Group Therapy and Physical Group Therapy

Group therapy consists of simultaneous treatment of two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief, intermittent personal contact, or giving the same instructions to two or more clients at the same time, the treatment is recognized as group therapy. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one client contact is not required.

3.2.9.1 Group Therapy Guidelines

The following guidelines must be followed in order to meet the Texas Medicaid criteria for group therapy:

• Physician prescription for group therapy. ECI providers are excluded from this requirement.

• Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements.

• The licensed therapist involved in group therapy services must be in constant attendance (meaning in the same room) and active in the therapy.
• Each client participating in the group must have an individualized treatment plan for group treatment, including interventions, short and long-term goals, and measurable outcomes.

Texas Medicaid does not limit the number of clients who can participate in a group therapy session. Providers are subject to certification and licensure board standards regarding group therapy.

### 3.2.9.2 Group Therapy Documentation Requirements

The following documentation must be maintained in the client’s medical record:

- Physician prescription for group therapy. ECI providers are excluded from this requirement.
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals.

Documentation for each therapy session must include the following:

- Name and signature of the licensed therapist providing supervision over the group therapy session
- Treatment goal addressed in the group
- Specific treatment techniques utilized during the group therapy session
- How the treatment technique will restore function
- Start and stop times for each session
- Group therapy setting or location
- Number of clients in the group

The client’s medical record must be made available upon request.

When physical or occupational group therapy is administered, providers must bill procedure code 97150 for each member of the group.

**Note:** There is an exception to these requirements for Early Childhood Intervention (ECI) Services. The group therapy guidelines for ECI services are outlined in Section 2.7, “Early Childhood Intervention (ECI) Services” in the Children’s Services Handbook.

### 3.2.10 Prior Authorization

To initiate a new prior authorization request, or request an extension of an existing prior authorization, home health services providers are required to submit the request online using the TMHP secure provider portal or on paper by faxing or mailing TMHP the appropriate paper prior authorization form.

The following prior authorization requests can be submitted on the TMHP website at [www.tmhp.com](http://www.tmhp.com):

- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form
- Home Health Services POC

**Refer to:** Subsection 5.5.1, “Prior Authorization Requests Through the TMHP Website” in Section 5, “Prior Authorization” (Vol. 1, General Information) for more information, including mandatory documentation requirements.

Providers can still call the Home Health Inquiry and Prior Authorization telephone number to inquire about the status of home health prior authorization requests that have been initially submitted to TMHP online or by fax or mail.

The Home Health Inquiry and Prior Authorization telephone number is 1-800-925-8957.

If a client’s primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement. If the primary coverage is Medicare, Medicare approves the service, and Medicaid is secondary, prior authorization is not required. If Medicare denied the service, then Medicaid prior authorization is required. Contact TMHP within 30 days of the date of Medicare’s
final disposition. The medicare remittance advice notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request. If the service is a Medicaid-only service, prior authorization is required within three business days of the SOC date.

The provider is responsible for determining if eligibility is effective by using AIS or an electronic eligibility inquiry through the TMHP EDI gateway.

The provider must contact the TMHP Home Health Services Prior Authorization Department within three business days of the SOC for professional services or the DOS for DME or medical supplies to obtain prior authorization following the RN’s assessment/evaluation of the client in the home setting. When contacting TMHP by telephone for prior authorization, the nurse who made the initial assessment visit in the client’s home must make this call to answer questions about the client’s condition as it relates to the medical necessity.

If inadequate or incomplete information is provided or medical necessity is lacking, the provider will be requested to furnish additional documentation as required to make a decision on the request. Because it often must be obtained from the client’s primary physician, providers have two weeks to submit the requested documentation. If the additional documentation is received within the two-week period, prior authorization can be considered for the original date of contact. If the additional documentation is received more than two weeks from the request for the documentation, prior authorization is not considered before the date the additional documentation is received. It is the home health agency’s responsibility to contact the primary physician to obtain the requested additional documentation.

The Home Health Prior Authorization Checklist is a useful resource for home health agency providers completing the prior authorization process. This optional form offers the nurse a detailed account of the client’s needs when completed.

Refer to: Subsection 2.2.2, “Durable Medical Equipment (DME) and Supplies” in the Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for DME or medical supplies prior authorization.


Client eligibility for Medicaid is for one month at a time. Providers should verify eligibility every month. Prior authorization does not guarantee payment.

3.2.10.1 Home Health SN and HHA Services Prior Authorization Requirements

SN and HHA services require prior authorization. Requests must be submitted in writing, by fax or mail. Providers must obtain prior authorization within three business days of the SOC date for an initial prior authorization. For extension of the prior authorization providers must obtain prior authorization within seven business days of the new SOC date. During the prior authorization process, providers are required to deliver the requested services from the SOC date, which is the date agreed to by the primary physician, the RN, the home health agency, and the client, parent, guardian, or caregiver. The SOC date must be documented on the POC.

Prior authorization of SN or HHA visits requires that a client’s primary physician complete the following steps:

- Provide specific, written, dated orders for SN or HHA visits or recertification that identifies that the prescribed visits are medically necessary as defined in subsection 3.2.3, “Home Health Skilled Nursing Services” and subsection 3.2.4, “Home Health Aide Services” in this handbook.
- Maintain documentation in the client’s medical record that supports the medical necessity of the prescribed visits.
- Maintain documentation in the client’s medical record that demonstrates that the client’s medical condition is sufficiently stable to permit safe delivery of the prescribed visits as described in the client’s Home Health Services POC.
• Establish a medical POC that is maintained in the client’s medical record.
• Provide continuing care and medical supervision.
• Review and approve the client’s Home Health Services POC once every 60 days or more frequently if the primary physician determines it to be necessary, including but not limited to a change in the client’s condition.

Providers who request prior authorization for SN or HHA services must submit the following documentation:
• A completed client assessment
• A completed Texas Medicaid Home Health Services POC that must:
  • Be signed and dated by the assessing RN
  • Signed and dated by the primary physician or submitted with the signed and dated physician’s orders

All signatures and dates must be current, unaltered, original, and handwritten; computerized or stamped signatures or dates will not be accepted. All documentation, including all written and verbal orders, and all physician-signed POCs, must be maintained by the ordering physician. The home health agency must keep the original, signed copy of the POC in the client’s medical record.

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN and HHA visits that will safely meet the client’s needs. The amount and duration of SN and HHA visits requested will be evaluated by the claims administrator. The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician’s orders.

If a client is already receiving authorized SN visits, instructions to the client or caregiver in the self-administration of prescribed injections (IM, SQ, or IV), including, but not limited to, Factor 8 and intravenous immunoglobulin (IVIg), are considered part of the existing authorized SN home visits. Additional nursing visits for instruction and initial supervision of the client or caregiver will not be allowed.

Instruction and initial supervision must be provided by an RN who is appropriately trained in the administration of the drug or product being administered, and the client and caregiver must be involved in the decision to self-administer the medication.

In order to qualify for self-administration of prescribed injections, the client must be medically stable, and the client or caregiver who is administering the injectable medication (IM, SQ, or IV) must:
• Have a history of compliance with other medications.
• Have a simple drug regimen.
• Have the ability to read and understand directions on the medication label.
• Demonstrate knowledge of the administration technique, maintenance of the required supplies and equipment, and storage requirements.

The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the primary physician, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time.

As a client’s problems are resolved and goals are met, a client’s condition is expected to become more stable, and the client’s needs for SN and HHA services may decrease.

Private duty nursing (PDN) and SN should not be routinely performed on the same date during the same time period. PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.
Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

3.2.10.1.1 Routine Laboratory Specimens
SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance.

3.2.10.1.2 Home Phototherapy
SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open prior authorization for home phototherapy. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for parent or caregiver teaching, client monitoring, and obtaining customary and routine laboratory specimens.

3.2.10.1.3 Prothrombin Time/Internationalized Normalized Ration (TP/INR) Home Testing Device
SN visits will not be authorized for setting up a TP/INR home testing device or training clients to use it.

3.2.10.1.4 Total Parenteral Nutrition (TPN)
SN visits to address TPN must:
- Be provided by an RN appropriately trained in the administration of TPN.
- Include education of the client or caregiver regarding the in-home administration of TPN before administration initially begins.
- Include the use and maintenance of required medical supplies and DME.
- Occur at least once every month to monitor the client’s status and to provide ongoing education to the client and caregiver regarding the administration of TPN.

For clients receiving PDN who also require TPN administration education, intermittent SN visits may be considered for separate prior authorization when:
- The PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation to support the medical need for an additional skilled nurse to perform TPN.

For clients receiving PDN who also require TPN administration education, the SN services may be prior authorized only for the client/caregiver training in TPN administration.

The nurse providing the intermittent SN visit for TPN services will only be reimbursed for time spent delivering client and family instruction and for direct client TPN services. The services delivered must be documented in the client’s medical record.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client’s medical record the skilled services individually provided, including, but not limited to, the following:
- The start and stop time of each nursing provider’s specialized tasks
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Up to a maximum combined total of three SN and HHA visits may be prior authorized per day.

When documentation does not support medical necessity for home health SN and HHA visits, providers may be directed to possible alternative services based on the client’s age and needs.
A prior authorization for SN and HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid.
- The client no longer meets the medical necessity criteria for SN or HHA services.
- The place of service cannot provide for the health and safety of the client.
- The client, parent, guardian, or caregiver refuses to comply with the primary physician’s plan of treatment and compliance is necessary to ensure the health and safety of the client.
- The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

An SN or HHA visit may be prior authorized to provide services to more than one client over the span of the day as long as each client’s care is based on an individualized POC and each client’s needs and POC do not overlap with another client’s needs and POC. Settings in which an SN or HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving Home Health Services, foster homes, and independent living arrangements.

Refer to: Subsection 2.13, “Private Duty Nursing (PDN)(CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for information about PDN.

3.2.10.2 Canceling a Prior Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form. The client must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change.

The client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

3.2.10.3 Home Health SN and HHA Services That Will Not Be Prior Authorized

SN visits requested primarily to provide the following will not be prior authorized:

- Respite care
- Child care
- Activities of daily living for the client
- Housekeeping services
- Routine post-operative disease, treatment, or medication teaching after a physician visit
- Routine disease, treatment, or medication teaching after a physician visit
- Individualized, comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act
- SN visits will not be approved for the sole purpose of instructing the client on the use of the subcutaneous injection port device. Any necessary instruction must be performed as part of the office visit with the primary physician.

HHA visits requested primarily to provide the following will not be prior authorized:

- Housekeeping services
- Services provided to a client residing in a hospital, SN facility, or intermediate care facility
Certain facilities are required by licensure to meet all the medical needs of the client. SN or HHA visits will not be prior authorized for clients receiving care in any of the following facilities:

- Hospitals
- SN facilities
- Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
- Special care facilities, including but not limited to, sub-acute units and facilities for the treatment of acquired immunodeficiency syndrome (AIDS)

3.2.10.4 OT and PT Prior Authorization Requirements

Additional information is available on the TMHP website at www.tmhp.com. For requests that are submitted on or after April 1, 2014, providers must follow all guidelines that became effective January 1, 2014.

Prior authorization requests for occupational or physical therapy services, provided through a home health agency for an acute condition or an exacerbation of a chronic condition, must be obtained by contacting the TMHP Home Health Department.

The date and time that therapy began and ended must be documented and maintained in the client’s medical record.

The submitted POC must include all information as shown on the Texas Medicaid Home Health POC form. The Home Health POC form is recommended but not required. The Medicare POC (485/486) will not be accepted.

Prior authorization for individual therapy services will be considered when all of the following criteria are met:

- The client has an acute condition or acute exacerbation of a chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services that can be performed in a home setting.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those that are provided concurrently by any other therapy.
- Services are within the provider’s scope of practice, as defined by state law.

A nursing POC that addresses the OT or PT services must be completed, signed, and dated by the RN who performed the client’s admission home assessment prior to the RN requesting authorization and must include:

- Diagnosis codes
- Treatment goals
- Duration of need
- Frequency
- Requested dates of service

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization requirements documentation through fax or mail. The provider must maintain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the therapy provider’s place of business.
To complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved electronic method. The provider must maintain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the therapy provider’s place of business.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the services requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

In addition to the nursing POC, home health agencies must provide the following information at the time each request for OT or PT is made:

- The requested OT or PT procedure codes with the appropriate GO or GP modifier
- OT or PT evaluation or re-evaluation results
- An initial or subsequent therapy treatment plan to include occupational or physical goals and dates of service requested

Prior authorization may be granted for a period not to exceed 60 days. A prior authorization request may be extended for an additional 60 days when requests are submitted with supporting documentation. Subsequent prior authorization requests may be granted for an additional 60 days, not to exceed a total of 180 days, when submitted with documentation.

Requests are not accepted from, nor are authorizations granted directly to the occupational therapist, physical therapist, OT assistant, or PT assistant.

If a client discontinues therapy with a provider, and a new provider begins therapy during an existing authorization period, submission of a new POC and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.

Group therapy procedures involve constant attendance of the physician, occupational therapist, or physical therapist, but by definition do not require one-on-one client contact by the physician, occupational therapist, or physical therapist. Procedure code 97150 may be submitted for each member of the group.

### 3.2.10.4.1 Initial Prior Authorization Requests

The initial request for prior authorization must be received no more than five business days from the date the therapy treatments are initiated. Initial prior authorization requests that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed Home Health Services Plan of Care (POC) form. The request form must be signed and dated by the ordering physician. If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

**Note:** A verbal order is considered current when the date received is on, or no more than, 60 rolling days before the start of therapy. A written order or prescription is considered current when it is signed and dated on, or no more than, 60 rolling days before the start of therapy. A request received without a physician’s signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.

Prior authorization requests that were submitted to the TMHP Prior Authorization
Department using the previously published Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization form will be considered on a case-by-case basis.

- A current therapy evaluation that documents the client’s age at the time of the evaluation for each therapy discipline.

  **Note:** A therapy evaluation submitted with an initial request for prior authorization is current when it is performed within 60 rolling days before the initiation of therapy services.

- A client-specific, comprehensive treatment plan that is established by the ordering physician or therapist to be followed during treatment in the home setting and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis
  - Treatment goals for the therapy discipline and associated disciplines requested that are related to the client’s individual needs
  - A description of the specific therapy disciplines being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation requiring the home health services
  - Requested dates of service

### 3.2.10.4.2 Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization requests for subsequent services may be considered for increments up to 60 days for each request with documentation that supports medical necessity and includes all of the following:

- A new, completed Home Health Plan of Care (POC) form, signed and dated by the ordering physician. If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order of prescription that is signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received.

  **Note:** A verbal order is considered current when the date received is on, or no more than, 60 rolling days before the start of therapy. A written order or prescription is considered current when it is signed and dated on, or no more than, 60 rolling days before the start of therapy. A request received without a physician’s signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.

- A current therapy evaluation or re-evaluation for each therapy discipline documenting the client’s age at the time of evaluation or re-evaluation

  **Note:** A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received.

For example:

- If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014.
- The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date TMHP receives the prior authorization request.
- If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, through July 1, 2014.
An updated client-specific comprehensive treatment plan established by the ordering physician or therapist to be followed during treatment in the home health setting must include all of the following:

- Date and signature of the licensed therapist
- Diagnosis(es)
- Updated treatment goals that are related to the client’s individual needs for the therapy discipline and associated disciplines requested
- A description of the specific therapy disciplines that are being prescribed
- Duration and frequency of therapy
- Date of onset of the illness, injury, or exacerbation that requires the home health services
- A brief summary of the outcomes of the previous treatment as it relates to the client’s debilitating condition
- Requested dates of service

3.2.10.4.3 Revisions to Existing Prior Authorization Requests

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing prior authorization must be received no later than five business days from the date that the revised therapy treatments are initiated.

Requests for revisions that are received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form
- A new evaluation with required documentation
- A change-of-provider letter signed and dated by the client or responsible adult documenting the date the client ended therapy (effective date of change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed

A change of provider during an existing authorization period will not extend the length of the original authorization with the new provider. The original authorized period will apply to services that are performed by the new provider.

3.2.10.4.4 Physical Therapy and Occupational Therapy Frequency Levels

Physical therapy and occupational therapy services may be provided at one of the following levels commensurate with the client’s medical condition, life stage, and therapy needs that are identified in the documentation submitted:

- **High Frequency:** Therapy provided three or more times a week may be considered when documentation supports all of the following:
  - Client has a medical condition that is rapidly changing
  - Client has a potential for rapid progress or rapid decline or loss of functional skill
• The client’s therapy plan and home program require frequent modification by the licensed therapist

• The client requires a high frequency of intervention for a limited duration (60 days or fewer) to recover function lost due to surgery, illness, or trauma

• **Moderate Frequency**: Therapy provided two times a week may be considered when documentation supports one or more of the following:
  - The client is making functional progress toward goals
  - The client is in a critical period to restore function or is at risk of regression
  - The licensed therapist needs to adjust the client’s therapy plan and home program weekly or more often than weekly, based on the client’s progress and medical needs
  - The client has complex needs requiring on-going education of the responsible adult

• **Low Frequency**: Therapy provided one time per week may be considered when the documentation supports one or more of the following:
  - The client is making progress toward the client’s goals, but the progress has slowed, or the client may be at risk of deterioration due to the client’s medical condition
  - The licensed therapist is required to adjust the client’s therapy plan and home program weekly based on the client’s progress.

As a client’s condition improves and goals are met, it is anticipated that the therapy will decrease to a lesser frequency level.

### 3.2.10.5 Medicare and Medicaid Prior Authorization

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

For eligible Medicare and Medicaid clients, Medicare is the primary insurance and providers must contact Medicare first for prior authorization and reimbursement. Home health service prior authorizations may be given for HHA services, certain medical supplies, or DME suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) does not qualify for Home Health Services under Medicare because SN care, OT, or PT are not a part of the client’s care.
- When the medical supplies and DME are not a benefit of Medicare Part B and are a home health services benefit.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client’s third party resources or other insurance.

**Note:** _If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization._

To ensure that Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of Home Health Services for clients:

- Contact TMHP for prior authorization of Medicaid services (based on medical necessity and home health services benefits) within 30 days of the date on the MRAN. Fax a copy of the original MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.
• An MRAN is not required when a client is eligible for Medicare/Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day an HHA visit is made) thereafter as long as no skilled need exists. An SN supervisory visit is reimbursable, but an SN visit made for the primary purpose of assessing a client’s nursing care is not. The SOC date will be the date of the first requested Medicare Home Health Services visit as listed on the original MRAN.

Note: Claims for State of Texas Access Reform (STAR)+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.

For Medicaid qualified Medicare beneficiary (MQMB) clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid will only consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.

• When the client is 65 years of age or older or appears otherwise eligible for Medicare (e.g., a person who is blind or disabled), but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a “pending status” for Medicare determination is 120 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.3, “Home Health Skilled Nursing Services” in this handbook.

Home health providers should follow these guidelines:

• Clients who are 64 years of age and younger without Medicare Part A or B:
  • If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of Texas Medicaid.

• Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
  • In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare’s final disposition.
  • If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days of the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: Subsection 4.12, “Third Party Liability (TPL)” in Section 4, “Client Eligibility” (Vol. 1, General Information).
3.2.10.6 Procedure Codes that Must be Included with the Prior Authorization Request

The following procedure codes are not automatically included in the prior authorization requests for PT and OT services unless requested:

| PT and OT Procedure Codes That Require Separate Prior Authorization for Home Health |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| 97012                           | 97014                           | 97016                           | 97018                           | 97022                           | 97024                           | 97026                           | 97028                           | 97032                           | 97033                           |
| 97035                           | 97150                           | 97535                           | 97537                           | 97542                           | 97799                           |

Prior authorization requests for any of the procedure codes listed above must include documentation of:

- The frequency of therapy for the procedure code
- The total amount of time in units or visits requested for the procedure code
- The therapeutic activities for which the procedure code will be used
- The specific, measurable short-term and long-term goals for the procedure code
- The appropriate modifier for the type of therapy being requested

3.2.11 Limitations and Exclusions

Payment cannot be made for any service, medical supply, or DME for which federal financial participation (FFP) is not available.

Refer to: Subsection 2.1, “CCP Overview” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) to find which of these items are a benefit for CCP clients who are 20 years of age and younger and who are eligible to receive THSteps services.

Home Health Service benefits do not include the following:

- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers
- Allergy injections
- Any services, including medical supplies or DME, furnished to a client who is a resident of a public institution or a client in a hospital, SN facility, or intermediate care facility
- Any services, including medical supplies, furnished to a client before the effective date of Medicaid eligibility as certified by HHSC or after the date of termination of Medicaid eligibility
- Any services, including medical supplies, furnished without prior authorization by TMHP, except as listed
- Application of a modality to one or more areas; hot or cold packs
- Developmental therapy
- Inpatient rehabilitation
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B12, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis
- PDN services
- Personal protective equipment (such as gloves, masks, gowns, and sharps containers) for use by a health-care provider, including but not limited to an RN, LVN, or attendant in the home setting.
- Respite care (caregiver relief)
- Services that are not medically necessary, including, but not limited to:
• Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition
• Hippotherapy
• Treatment solely for the instruction of other agency or professional personnel in the client’s physical or occupational therapy program
• Training in non-essential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling)
• Maintenance therapy, including passive range of motion and exercises, which are not directed towards restoration of a specific loss of function
• Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment
• Therapy prescribed primarily as an adjunct to psychotherapy
• ST provided in the home
• Visits made primarily for performing housekeeping services are not considered a benefit of Texas Medicaid. These requests should be referred to in-home and family support service at HHSC

Any therapy services that exceed 180 rolling days from the start of therapy are not considered to be acute and will not be covered.

Refer to: Subsection 1.11, “Texas Medicaid Limitations and Exclusions” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

3.3 Documentation Requirements
All documentation, including that which supports medical necessity, and the comprehensive treatment plan related to the therapy services that were prior authorized and provided, must be maintained in the client’s medical record and made available upon request.

For each therapy discipline provided, the documentation maintained in the client’s medical record must identify the therapy provider’s name and must include all of the following:
• Date of service
• Start time of the therapy
• Stop time of the therapy
• Total minutes of therapy
• Specific therapy performed
• Client’s response to the therapy

3.3.1 Written POC
A Home Health Services POC is required for SN, HHA, OT, or PT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be maintained by the provider and primary physician in the client’s medical record. The client’s primary physician must recommend, sign, and date a POC. The POC must be initiated by the RN in a clear and legible format.
The POC must contain the following information:

- Activities permitted
- All pertinent diagnoses
- Available caregiver
- Client’s Medicaid number
- Date the client was last seen by the primary physician. The client must be seen by a primary physician within 30 days of the initial SOC and at least once every six months thereafter unless the client’s condition changes. The primary physician visit may be waived when a diagnosis has already been established by the primary physician and the recipient is under the continuing care and medical supervision of the primary physician. Any waiver must be based on the primary physician’s written statement that an additional evaluation visit is not medically necessary. The original must be maintained by the primary physician and a copy must be maintained in the primary provider’s files
- DME or medical supplies required
- Instructions for timely discharge or referral
- List of all community or state agency services the client receives in the home (e.g., Primary Home Care (PHC), PCS, community-based alternative [CBA], Medically Dependent Children’s Program [MDCP])
- Medications including the dose, route, and frequency
- Mental status
- Nutritional requirements
- Physician’s license number
- Prior and current functional limitations
- Prognosis
- Provider Medicaid number
- Rehabilitation potential
- Safety measures to protect against injury
- SOC date for Home Health Services
- Treatments, including amount, duration, and frequency
- Types of services including amount, duration, and frequency
- Wound care orders and measurements

Primary physicians that order OT or PT services must include the ICD-10-CM diagnosis codes for an acute or exacerbated event when OT and PT is being requested and the following documentation is included with the request:

- Specific procedures and modalities to be used
- Amount, frequency, and duration of therapy needed
- Physical and occupational therapy and goals
- Name of therapist who participated in developing the POC
The primary physician and home health agency personnel (SN, HHA, OT, or PT) must review the POC as often as the severity of the client’s condition requires or at least once every 60 days. This signed and dated documentation must be maintained in the client’s medical record and must include the primary physician and requesting provider information. This applies to all written and verbal orders, and POCs.

Verbal physician orders may be given only to people authorized to receive them under state and federal law. They must be written, signed, and dated by the RN or qualified therapist who is responsible for furnishing or supervising the ordered service and placed in the client’s medical record. The physician who gave the verbal order must sign the written copy of the verbal order within two weeks or per agency policy if less than two weeks. The original verbal order (without the physician’s signature) and a copy of the verbal order that has been signed by the physician must be maintained in the client’s medical record.

The type and frequency of visits, DME, or medical supplies must appear on the POC before the primary physician signs the POC and must not be added after the primary physician has signed the POC. If any change in the POC occurs during a prior authorization period (e.g., additional visits, DME, or medical supplies), the home health agency must contact the TMHP Home Health Services Prior Authorization Department for prior authorization and maintain a completed, revised POC that has been signed and dated by the primary physician.

Coverage periods do not necessarily coincide with calendar weeks or months but instead cover a number of services to be scheduled between a start and end date that is issued for the prior authorization.

Providers may request the frequency of physical, occupational, or speech therapy services either by week or by month, but not both.

A week includes the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of therapy services authorized for a week must be provided within the prior authorized week.

A month includes the day of the month on which the prior authorization period begins and continues for 30 days. The number of therapy services authorized for a month must be provided within the prior authorized month.

Services billed in excess of those authorized for the prior authorization week or month are subject to recoupment.

Refer to: Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.

Subsection 3.2.8, “Physical Therapy (PT) Services” in this handbook.

3.3.1.1 Physician Supervision-POC
For the Home Health Services POC to be valid, the primary physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in the client’s condition.

Medicare Form 485 is not accepted as a POC. The Home Health Services POC is the only acceptable form for prior authorization through Texas Medicaid.

3.3.2 Home Health SN and HHA Services Assessments and Reassessments
When a provider has received a referral and has physician orders for SN or HHA services, the provider must have an RN perform an initial client assessment in the client’s home. A client can be referred to a home health agency for SN or HHA services by the client, the client’s primary physician, or the client’s family.
The client assessment or reassessment should include, but is not limited to, the following:

- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, DME, and medical supplies required by the client
- Comprehension level of client, parent, guardian, or caregiver
- Receptivity to training and ability level of the client, parent, guardian, or caregiver
- A nursing assessment of medical necessity for the requested visits which includes:
  - Complexity and intensity of the client’s care
  - Stability and predictability of the client’s condition
  - Frequency of the client’s need for SN care
  - Identified medical needs and goals
  - Description of wounds, if present
  - Cardiac status

The initial assessment and any reassessments that are required because of changes in the client’s condition that occur during the course of the authorization period must be performed by an RN and must document medical necessity to support the requested service. If there is no change in the client’s condition, the reassessment must document medical necessity to support continued and ongoing SN or HHA visits beyond the initial 60-day prior authorization period.

**Note:** Nursing visits for the primary purpose of assessing a client’s care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.

### 3.4 Claims Filing and Reimbursement

#### 3.4.1 Claims Information

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and will result in a claim denial. Home Health Services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

**Refer to:** Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Section 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.


Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the CMS-1500 paper claim form in Block 23 and in Block 63 of
the UB-04 CMS-1450 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

### 3.4.2 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies is a statewide visit rate calculated in accordance with 1 TAC §355.8021(a).

Home health agencies are reimbursed for DME and medical supplies in accordance with 1 TAC §355.8021. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at [www.tmhp.com](http://www.tmhp.com). Providers may also request a hard copy of the fee schedule by contacting the TMHP Contact Center at 1-800-925-9126. DME and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider’s documented invoice cost.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at [www.tmhp.com/pages/topics/rates.aspx](http://www.tmhp.com/pages/topics/rates.aspx).

For reimbursement, providers should note the following:

- The client’s primary physician must request professional, SN, and HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of one-month for medical supplies according to the billing requirements.
- SN, HHA, OT, and PT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency’s provider identifier. File these services on a UB-04 CMS-1450 claim form.
- OT and PT are always billed as POS 2 (home) and may be prior authorized to be provided in the home of the client or the home of the caregiver/guardian.
- DME or medical supplies must be provided by either a Medicaid enrolled home health agency’s Medicaid/DME supply provider or an independently-enrolled Medicaid/DME supply provider. Both must enroll and bill using the provider identifier enrolled as a DME supplier. File these services on a CMS-1500 claim form.

**Note:** Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a home health services benefit. These services may be considered a benefit for clients who qualify for CCP.

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to, battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

**Refer to:** Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).
3.4.3 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies Home Health Services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that “a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for Home Health Services care services and may not establish or review a plan of treatment.”

A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency’s assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, medical supplies, DME, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or five percent of the agency’s total operating expenses, whichever is less.

When providing CCP services and general Home Health Services, the provider must file these on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number, and should send them to the appropriate address. Claims denied because of an ownership conflict will continue to be denied unless the home health agency submits documentation indicating that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with the home health agency providing services. Documentation should be sent to TMHP Provider Enrollment at the address indicated in the “Appendix A: State, Federal, and TMHP Contact Information” (Vol. 1, General Information).

3.4.4 Claims Filing for OT Services

Providers must use the codes listed under subsection 3.4.8, “OT Procedure Codes” in this handbook to submit claims for Title XIX OT services that are provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each OT procedure code. OT services must be billed on a UB-04 CMS-1450 claim form.

3.4.5 Claims Filing for PT Services

Providers must use the procedure codes listed in subsection 3.4.9, “PT Procedure Codes” in this handbook to submit claims for Title XIX PT services provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each PT procedure code. PT services must be billed on a UB-04 CMS-1450 claim form.

Refer to: Subsection 2.14, “Therapy Services (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for CCP OT and PT services.

3.4.6 OT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate OT procedure codes identifying the therapy service provided. OT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GO modifier must also be billed with all OT procedure codes except evaluation and re-evaluation procedure codes 97003 and 97004.

Providers must use procedure code 97003 when billing for OT evaluations. OT evaluations are payable once in 180 rolling days to any provider. Providers must use procedure code 97004 when billing for OT re-evaluations. OT re-evaluations are payable when documentation supports a change in the client’s status or with a request for extension of services, or with a change in provider.

An evaluation or re-evaluation performed on the same date of service as therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy discipline in one day when:

- Therapy is rendered at different times
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one re-evaluation

If a therapy evaluation or re-evaluation procedure code and therapy procedure codes for the same discipline are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. OT evaluations (procedure code 97003) or re-evaluations (procedure code 97004) will be denied as part of the following OT procedure codes billed with modifier GO.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97035</td>
</tr>
<tr>
<td>97535</td>
</tr>
</tbody>
</table>

3.4.7 PT Limitations

The AT modifier indicates an acute service and must be billed with the appropriate PT procedure codes identifying the therapy service provided. PT services billed without the AT modifier will be denied.

In addition to the AT modifier, the GP modifier must also be billed with all PT procedure codes except evaluation and re-evaluation procedure codes 97001 and 97002.

Providers must use procedure code 97001 when billing for PT evaluations. PT evaluations are payable once every 180 rolling days for any provider. Providers must use procedure code 97002 when billing for PT re-evaluations. PT re-evaluations are payable when documentation supports a change in the client’s status or with a request for extension of services, or with a change of provider.

An evaluation or re-evaluation performed on the same date of service as therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

A client may receive therapy in more than one distinct therapy discipline in one day when:

- Therapy is rendered at different times.
- Reimbursement in any one distinct therapy type does not exceed one evaluation or one re-evaluation.

If a therapy evaluation or re-evaluation procedure code and therapy procedure codes for the same discipline are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied. PT evaluations (procedure code 97001) or re-evaluations (procedure code 97002) will be denied as part of the following PT procedure codes billed with modifier GP.
3.4.8 OT Procedure Codes

OT services may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012 97014 97016 97018 97022 97024 97026 97028 97032 97033</td>
</tr>
<tr>
<td>97035 97039 97110 97112 97116 97124 97139 97140 97150 97530</td>
</tr>
<tr>
<td>97535 97537 97542 97799</td>
</tr>
</tbody>
</table>

OT services are billed one visit per day, per therapy, and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com.

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

3.4.9 PT Procedure Codes

PT services may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97003 97004 97012 97014 97016 97018 97022 97024 97026 97028</td>
</tr>
<tr>
<td>97032 97033 97035 97039 97110 97112 97116 97124 97139 97140</td>
</tr>
<tr>
<td>97150 97530 97535 97537 97542 97799</td>
</tr>
</tbody>
</table>

PT services are billed one visit per day, per therapy, and are reimbursed at the statewide visit rate available on the TMHP web site at www.tmhp.com.

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

4 Therapists, Independent Practitioners, and Physicians

4.1 Enrollment

To enroll in Texas Medicaid, licensed therapists and physicians must be enrolled in Medicare.

Refer to: Subsection 9.1.1, “Physicians and Doctors” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about physician enrollment requirements.

If providers are currently enrolled with Texas Medicaid or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in CCP is not necessary. All non-CCP therapy services must be billed with the current provider identifier.

Providers cannot be enrolled if their license is due to expire within 30 days of applying. A current license must be submitted.
4.2 Services, Benefits, Limitations, and Prior Authorization

OT, PT, and ST are benefits of Texas Medicaid for an acute condition or an exacerbation of a chronic condition when all of the following criteria are met:

- Treatments are expected to significantly improve the client’s condition in a reasonable and generally predictable period of time, based on the physician’s assessment of the client’s restorative potential.
- Treatments are directed towards restoration of or compensation for lost function.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider’s scope of practice, as defined by state law.

PT, OT, and ST services are a benefit for 180 rolling days from the first date of therapy services. If the client’s condition persists for more than 180 rolling days from the start of the therapy services, the condition is considered chronic.

Therapy may be performed by a licensed occupational therapist, physical therapist, speech therapist, or one of the following under the supervision of a licensed therapist: licensed therapy assistant or licensed speech-language pathology intern.

Services performed by an OT aide, OT orderly, OT student, OT technician, PT aide, PT orderly, PT student, PT technician, SLP aide, SLP orderly, SLP student, or SLP technician are not benefits of Texas Medicaid.

Therapy services performed by an unlicensed provider are subject to retrospective review and recoupment.

OT, PT, and ST that is not a benefit of traditional Medicaid may be covered:

- In the physician’s office, or Medicaid-enrolled private therapist’s office for a chronic condition.
- Through the SHARS program.
- In an outpatient rehabilitation or free-standing rehabilitation facility.
- In a licensed hospital.

OT, PT, and ST services that are not benefits of traditional Medicaid may be benefits under CCP.

Professional services for selective wound debridement (procedure codes 97597 and 97598) may be reimbursed to a licensed physical therapist or physical therapy group when the service is determined to be within the provider’s scope of practice and the service is prescribed by a Medicaid-enrolled supervising physician or qualified non-physician provider.

Refer to: Subsection 2.14, “Therapy Services (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for therapy benefits for clients who are 20 years of age and younger.

4.2.1 OT Services

Payment for OT is limited to the treatment of disease for individuals whose ability to function in life roles is impaired. OT can be provided by a physician or occupational therapist and may include physical agents such as massage, electricity, traction, or exercises as forms of therapy. Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions
OT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation that is performed on the same date of service as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

Claims for OT services must include modifier GO to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

Reimbursement for OT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes divided by 15 equals 4 units plus 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 units are identified in the following table:

<table>
<thead>
<tr>
<th>Units</th>
<th>Number of Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 units</td>
<td>0 minutes through 7 minutes</td>
</tr>
<tr>
<td>1 unit</td>
<td>8 minutes through 22 minutes</td>
</tr>
<tr>
<td>2 units</td>
<td>23 minutes through 37 minutes</td>
</tr>
<tr>
<td>3 units</td>
<td>38 minutes through 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes through 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes through 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes through 97 minutes</td>
</tr>
<tr>
<td>7 units</td>
<td>98 minutes through 112 minutes</td>
</tr>
<tr>
<td>8 units</td>
<td>113 minutes through 127 minutes</td>
</tr>
</tbody>
</table>

The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of four units (one hour) per day, per therapy type:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>97032</th>
<th>97033</th>
<th>97034</th>
<th>97035</th>
<th>97036</th>
<th>97039</th>
<th>97110</th>
<th>97112</th>
<th>97113</th>
<th>97116</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97124</td>
<td>97139</td>
<td>97140</td>
<td>97530</td>
<td>97750</td>
<td>97799</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the therapy services billed exceed four units a day, the claim will be denied and may be appealed. On appeal the provider must document the prior authorization period week for the date of service appealed. The appeal must include an attestation that the provider has billed all therapy services for the week in question.
Occupational group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist. When billing for occupational group therapy, procedure code 97150 must be used for each member of the group.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients who are 20 years of age and younger in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97003 is reimbursed once in 180 rolling days to any provider. Re-evaluation procedure code 97004 is payable when documentation supports a change in the client’s status, a request for extension of services, or a change of provider.

OT evaluations or re-evaluations (procedure code 97003 or 97004) will be denied when any of the procedure codes in the following table are billed with modifier GO by any provider on the same date of service:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>97012</th>
<th>97014</th>
<th>97016</th>
<th>97018</th>
<th>97022</th>
<th>97024</th>
<th>97026</th>
<th>97028</th>
<th>97032</th>
<th>97033</th>
</tr>
</thead>
<tbody>
<tr>
<td>97034</td>
<td>97035</td>
<td>97036</td>
<td>97039</td>
<td>97110</td>
<td>97112</td>
<td>97113</td>
<td>97116</td>
<td>97124</td>
<td>97139</td>
<td></td>
</tr>
<tr>
<td>97140</td>
<td>97150</td>
<td>97530</td>
<td>97750</td>
<td>97799</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

### 4.2.2 PT Services

Payment for PT is limited to acute disorders of the musculoskeletal and neuromuscular systems. PT can be provided by a physician or physical therapist and may include physical agents such as massage, electricity, traction, or exercises in the treatment of disease. Examples of what may be considered acute are as follows:

- A new injury
- Therapy before or after surgery
- Acute exacerbations of conditions
- Interventions that result in a change in a client’s condition, such as a newly implanted pump to administer an antispasmodic
- Botulinum toxin type A injections

PT is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation performed on the same date of service as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

Claims for PT services must include modifier GP to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.
Reimbursement for PT procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

Refer to: Subsection 4.2.1, “OT Services” in this handbook for an example of the 15-minute conversion table.

The following procedure codes may be reimbursed in 15-minute increments for a combined maximum of four units (one hour) per day, per therapy type:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97032 97033 97034 97035 97036 97039 97110 97112 97113 97116</td>
</tr>
<tr>
<td>97124 97139 97140 97530 97750 97799</td>
</tr>
</tbody>
</table>

If the therapy services billed exceed four units a day, the claim will be denied, and may be appealed.

On appeal, the provider must document the prior authorization period week for the date of service appealed. The appeal must also include an attestation that the provider has billed all therapy services for the week in question.

Physical group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist. When billing for physical group therapy, procedure code 97150 must be used for each member of the group.

Procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, and 97150 are limited to one per day, per therapy type.

Procedure codes 97535, 97537, and 97542 are only payable for clients who are 20 years of age and younger in an outpatient rehabilitation setting or through CCP.

Evaluation procedure code 97001 is payable once per 180 rolling days, any provider. Re-evaluation procedure code 97002 is payable when documentation supports a change in the client’s status, a request for extension of services, or a change of provider.

PT evaluations or re-evaluations (procedure code 97001 or 97002) will be denied when any of the procedure codes in the following table are billed with modifier GP by any provider on the same date of service:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012 97014 97016 97018 97022 97024 97026 97028 97032 97033</td>
</tr>
<tr>
<td>97034 97035 97036 97039 97110 97112 97113 97116 97124 97139</td>
</tr>
<tr>
<td>97140 97150 97530 97750 97799</td>
</tr>
</tbody>
</table>

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

4.2.3 ST Services

ST is limited to treatment of conditions of the head or neck which affect speech production. ST may be provided by a physician or speech-language pathologist (SLP). Examples of what may be considered acute are as follows:

- Stroke or Cerebral vascular accident (CVA)
- Neoplasms of the head or neck
• Open or closed head trauma

ST is considered acute for 180 calendar days from the first date (onset) of therapy for a specific condition. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing.

A client may receive therapy in more than one distinct therapy discipline on the same date of service when the therapy is rendered at different times.

An evaluation or re-evaluation performed on the same date as a therapy from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement.

ST evaluations are performed before the initiation of speech therapy. The speech therapy may be performed by an SLP if the SLP is on staff at the hospital or under the personal supervision of a physician.

Claims for ST services must include modifier GN to be considered for reimbursement. Modifier AT must also be submitted with all claims for therapy procedure codes for acute conditions or the claims will be denied. Modifiers are not required for evaluations or re-evaluations.

Reimbursement for ST procedure codes is based on the actual amount of billable time associated with the service. Services for which the unit of service is 15 minutes (1 unit = 15 minutes) must be rounded up or down to the nearest quarter hour. To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

Refer to: Subsection 4.2.1, “OT Services” in this handbook for an example of the 15-minute conversion table.

Procedure codes 92526 and 92610 may be reimbursed for the treatment and evaluation of swallowing dysfunctions and oral functions for feeding.

Procedure codes 92507, 92508, and 92526 may be reimbursed in 15-minute increments, and are limited to four units (one hour) per day.

Speech group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one client contact by the physician or therapist.

If reassessment is necessary within the 180-day period, payment will be considered for procedure code S9152 when documentation supports a change in the client’s status, a request for extension of services, or a change of provider.

ST evaluations or re-evaluations (procedure code 92521, 92522, 92523, 92524, or S9152) will be denied when billed on the same date of service, any provider as procedure codes 92507 and 92508 with modifier GN.

The documentation retained in the client’s file must include the billable start time, billable stop time, total billable minutes, and activity that was performed.

Refer to: Subsection 3.2.1.3, “Auditory Rehabilitation” in the Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks) for information about aural rehabilitation services.

4.2.4 Therapy in a Nursing Facility

Separate payment cannot be made to therapists, independent practitioners, or physicians who provide therapy services to a resident of a nursing facility. These services must be made available to nursing facility residents as needed and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources as part of the daily care. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.
4.2.5  **Group Therapy Definition**
Group therapy consists of simultaneous treatment to two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief, intermittent personal contact, or giving the same instructions to two or more clients at the same time, the treatment is recognized as group therapy. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one client contact is not required.

4.2.5.1  **Group Therapy Guidelines**
In order to meet Texas Medicaid criteria for group therapy, all of the following applies:

- Physician prescription for group therapy
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements
- The licensed therapist involved in group therapy services must be in constant attendance (meaning in the same room) and active in the therapy
- Each client participating in the group must have an individualized treatment plan for group treatment, including interventions, short and long-term goals, and measurable outcomes.

*Note:*  *Texas Medicaid does not limit the number of clients who can participate in a group therapy session. Providers are subject to certification and licensure board standards regarding group therapy.*

4.2.6  **Authorization Requirements**
PT, OT, and ST evaluations or re-evaluations do not require prior authorization when provided within the limits of the provider’s practice. PT, OT, and ST services performed within the office or outpatient setting do require prior authorization.

The physician must maintain documentation of medical necessity, including the treatment plan and therapy evaluation or re-evaluation, in the client’s medical record. The provider requesting the therapy may be asked for additional information to clarify or complete a request for therapy. The date, time, and duration of services provided must be documented and maintained in the client’s medical record.

Prior authorization for individual therapy services may be considered when all of the following criteria are met:

- The client has an acute condition or an acute exacerbation of a chronic medical condition resulting in a significant decrease in functional ability that will benefit from services that can be performed in the office or outpatient setting
- Documentation must support treatment goals and outcomes for specific therapy disciplines requested
- Services do not duplicate those provided concurrently by any other therapy
- Services are provided within the provider’s scope of practice, as defined by state law

Therapy procedure codes that may be authorized in 15-minute units will be limited to a combined maximum of four units (one hour) per day, per therapy type. Additional services may be considered without prior authorization.
4.2.6.1 Procedure Codes that Must be Included with the Prior Authorization Request

The following procedure codes are not included in PT, OT, and ST prior authorizations unless requested:

| PT and OT Procedure Codes That Require Separate Prior Authorization for Acute Services |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| 97012                           | 97014                           | 97016                           | 97018                           | 97022                           | 97024                           | 97026                           | 97028                           | 97033                           | 97034                           |
| 97035                           | 97799                           |

<table>
<thead>
<tr>
<th>ST Procedure Code That Requires Separate Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>97535</td>
</tr>
</tbody>
</table>

*Note: Procedure code 97535 is used for ST services for training for augmentative communication devices (ACD)*.

Prior authorization requests for any of the procedure codes listed above must include documentation of:

- The frequency of therapy for the procedure code
- The total amount of time in units or visits requested for the procedure code
- The therapeutic activities for which the procedure code will be used
- The specific, measurable short-term and long-term goals for the procedure code
- The appropriate modifier for the type of therapy being requested

4.2.6.2 Initial Prior Authorization Request for Therapy Services

The initial request for authorization must be received no later than five business days from the date the therapy treatments are initiated. Requests received after the five business-day period will be denied for dates of service that occurred before the date that the request was received.

Therapy services may be initiated upon the receipt of the physician’s order. Therapy services initiated before the date of the physician order will not be approved.

Prior authorization may be given for a service period not to exceed 90 days per event for acute care services only. An additional 90-day period may be requested with documentation submitted through prior authorization.

Subsequent prior authorizations beyond 180 days will not be authorized, as treatment for chronic conditions is not a benefit. Prior authorizations may be approved for a time period less than the established maximum.

Supporting Documentation for Initial Prior Authorization Requests

Supporting documentation must be submitted for an initial request and must include all of the following:

- A completed Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Special Medical Prior Authorization Form. The request form must be signed and dated by the ordering physician. The following also applies:
  - If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received
  - A verbal order is considered current when the verbal order is received on, or no more than, 60 rolling days before the start of therapy
• A written order or prescription is considered current when it is signed and dated on, or no more than, 60 days before the start of therapy

• A request received without a physician’s signature or documented verbal order or written prescription will not be processed and will be returned to the provider

• A current therapy evaluation for each therapy discipline documenting the client’s age at the time of the evaluation (A therapy evaluation is current when performed within 60 rolling days before the initiation of therapy services)

• A client-specific comprehensive treatment plan established by the ordering physician or therapist to be followed during treatment in the office or outpatient setting must include all of the following:
  • Date and signature of the licensed therapist
  • Diagnosis(es)
  • Treatment goals for the therapy discipline and associated disciplines requested related to the client’s individual needs
  • A description of the specific therapy disciplines being prescribed
  • Duration and frequency of therapy
  • Date of onset of the illness or injury or exacerbation requiring the office or outpatient services
  • Requested dates of service

4.2.6.3 Subsequent Prior Authorization Requests for Therapy Services

A prior authorization request for subsequent services must be received no more than 30 days before the current authorization expires. Prior authorization requests for subsequent services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization requests for subsequent services may be considered for increments up to 90 days for each request with documentation supporting medical necessity that includes all of the following:

• A new, completed Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Special Medical Prior Authorization Form. The request form must be signed and dated by the ordering physician.

• If the prior authorization form is not signed and dated by the physician, the form must be accompanied by a written order or prescription signed and dated by the physician, or a documented verbal order from the physician that includes the date the verbal order was received. A verbal order is considered current when the verbal order is received on, or no more than, 60 rolling days before the start of therapy.

• A written order or prescription is considered current when it is signed and dated on, or no more than, 60 rolling days before the start of therapy. A request received without a physician’s signature, documented verbal order, or written prescription will not be processed and will be returned to the provider.

• A current therapy evaluation or re-evaluation for each therapy discipline documenting the client’s age at the time of the evaluation or re-evaluation.

A therapy evaluation or re-evaluation for subsequent services is current when performed within 30 days before the prior authorization request is received. For example:

• If an authorization period ends on July 31, 2014, TMHP must receive the prior authorization request for subsequent services between July 1, 2014, and July 31, 2014. The therapy evaluation or re-evaluation for subsequent services can be performed up to 30 days before the date TMHP receives the prior authorization request.
• If TMHP receives the prior authorization request for subsequent services on July 1, 2014, the evaluation or re-evaluation can be performed June 1, through July 1, 2014.

• If TMHP receives the prior authorization request for subsequent services on July 31, 2014, the evaluation or re-evaluation can be performed July 1, 2014, through July 31, 2014.

Updated Treatment Plan or Prior Authorization Revisions
An updated client-specific comprehensive treatment plan established by the ordering physician or therapist to be followed during treatment in the office or outpatient setting must include all of the following:

• Date and signature of the licensed therapist
• Diagnosis(es)
• Updated treatment goals for the therapy discipline and associated disciplines requested related to the client’s individual needs
• A description of the specific therapy disciplines being prescribed
• Duration and frequency of therapy
• Date of onset of the illness, injury, or exacerbation requiring the office or outpatient hospital services
• A brief summary of the outcomes of the previous treatment relative to the client’s debilitating condition
• Requested dates of service

Requests for revisions of prior authorization must be received no later than five business days from the date the revised therapy treatments are initiated. Requests for revisions received after the five business-day period will be denied for dates of service that occurred before the date the request was received. A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Discontinuation of Therapy or Change in Provider
If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

• A new therapy request form
• A new evaluation with required documentation
• A change of provider letter signed and dated by the client or responsible adult documenting the date the client ended therapy (effective date of change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed

The change of provider letter should be submitted with the provider’s initial request for services to avoid a delay in processing the request. A change of provider during an authorization period will not extend the authorization period. Regardless of the number of provider changes, clients may not receive therapy services beyond the limitations outlined in this policy.

Speech Therapy Services Frequency Levels
PT, OT, and ST services may be provided at one of the following levels commensurate with the client’s medical condition, life stage, and therapy needs identified in the documentation submitted. As the client’s condition improves and goals are met, it is anticipated that the therapist will decrease the frequency to a lesser level.
High Frequency: Three or more times per week may be considered when documentation supports all of the following:

- The client has a medical condition that is rapidly changing.
- The client has a potential for rapid progress, rapid decline, or loss of functional skill.
- The client’s therapy plan and home program require frequent modification by the licensed therapist.
- The client requires a high frequency of intervention for a limited duration (60 days or fewer) to recover function lost due to surgery, illness, or trauma.

Moderate Frequency: Two times per week may be considered when documentation supports one or more of the following:

- The client is making functional progress toward goals.
- The client is in a critical period to restore function or is at risk of regression.
- The licensed therapist needs to adjust the client’s therapy plan and home program weekly, or more often than weekly, based on the client’s progress and medical needs.
- The client has complex medical needs requiring on-going education of the responsible adult.

Low Frequency: One time per week may be considered when the documentation supports one or more of the following:

- The client is making progress toward the client’s goals, but the progress has slowed, or the client may be at risk of deterioration due to the client’s medical condition.
- The licensed therapist is required to make weekly adjustments to the client’s therapy plan and home program based on the client’s progress.

4.2.7 Noncovered Services

The following services are not a benefit of Texas Medicaid:

- Therapy services that exceed 180 rolling days from the start of therapy are not considered to be acute and will not be covered
- Application of a modality to one or more areas; hot or cold packs
- Services that are not considered medically necessary. Examples include, but are not limited to the following:
  - Massage therapy that is the sole therapy or is not part of a therapeutic POC to address an acute condition
  - Hippotherapy
  - Treatment solely for the instruction of other agency or professional personnel in the client’s OT, PT, and ST program
  - Separate reimbursement for VitalStim therapy for dysphagia
  - Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, and scheduling)
  - Maintenance therapy, including passive range of motion and exercises that are not directed towards restoration of a specific loss of function
  - Emotional support, adjustment to extended hospitalization, or disability behavioral readjustment
- Therapy prescribed primary as an adjunct to psychotherapy

  **Note:** *Therapy that exceeds 180 days may be considered for prior authorization for clients who are birth through 20 years of age through CCP.*

### 4.2.8 Rehabilitative Services

Rehabilitative Services is a program administered by TMHP to nursing facility clients who need rehabilitation. These services must be prior authorized through TMHP before the therapy is provided and reimbursed by TMHP. Covered services include OT, PT, and ST to clients who are eligible for Texas Medicaid, with an acute onset of an illness or injury, with the expectation that function will be improved measurably. For all rehabilitative services inquiries, call Rehabilitative Services at 1-800-792-1109.

**Refer to:** Subsection 2.16, “Inpatient Rehabilitation Facility (Freestanding) (CCP)” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for more information.

### 4.3 Documentation Requirements

Therapy must be provided under the current written orders of a physician and based on medical necessity. A prescription is considered current when it is signed and dated on or no later than 60 days before the start of therapy. Therapy may be performed by auxiliary personnel under the direct supervision of the physician or the licensed, independently practicing therapist.

All documentation, including that which supports medical necessity, and a comprehensive treatment plan related to the therapy services prior authorized and provided must be maintained in the client’s medical record and made available upon request. For each therapy discipline provided, the documentation maintained in the client’s medical record must identify the therapy provider’s name and must include all of the following:

- Date of service
- Start time of the therapy
- Stop time of the therapy
- Total minutes of therapy
- Specific therapy performed
- Client’s response to therapy

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization requirements documentation through fax or mail, and must maintain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the therapy provider’s place of business.

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved electronic method, and must maintain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the therapy provider’s place of business.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the services requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

If a client discontinues therapy with a provider and a new provider begins therapy, submission of a new plan of care and documentation of the last therapy visit with the previous provider is required, along with a letter from the client, parent, or guardian stating the date therapy ended with the previous provider.
4.3.1 Group Therapy Documentation Requirements

The following documentation must be maintained in the client’s medical record:

- Physician prescription for group therapy
  
  Note: Physician prescription for group therapy is not required in the medical record of Early Childhood Intervention clients.

- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals

Documentation for each group therapy session must include the following:

- Name and signature of the licensed therapist providing supervision over the group therapy session

  - Treatment goal addressed in the group
  
  - Specific treatment techniques utilized during the group therapy session
  
  - How the treatment technique will restore function
  
  - Start and stop times for each session
  
  - Group therapy setting or location
  
  - Number of clients in the group

The client’s medical record must be made available upon request.

When physical or occupational group therapy is administered, providers must bill procedure code 97150 for each member of the group.

Note: There is an exception to these requirements for ECI services. The group therapy guidelines for ECI services are found in the current Texas Medicaid Provider Procedures Manual, Children’s Services Handbook, Subsection 2.7.2, “Services, Benefits, Limitations, and Prior Authorization”.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

The Medicaid rates for therapists, independent practitioners, and physicians are calculated in accordance with 1 TAC §355.8081 and §355.8085.

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com. Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

Subsection 2.7, “Medicare Crossover Claim Reimbursement” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for additional information about Medicare coinsurance and deductible payments.

Therapy services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number is reflected in the equivalent electronic field.
Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5 Claims Resources

Providers may refer to the following sections or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A: State, Federal, and TMHP Contact Information</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>“Appendix A: State, Federal, and TMHP Contact Information” (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Paper Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday–Friday from 7 a.m. to 7 p.m., Central Time.

7 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

- Home Health Plan of Care (POC) Instructions
- Home Health Plan of Care (POC)
- Home Health Prior Authorization Checklist
- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions
- Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form
- Special Medical Prior Authorization (SMPA) Request Form
8  Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

<table>
<thead>
<tr>
<th>Claim Form Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Respiratory Care Practitioner (CRCP)</td>
</tr>
<tr>
<td>Home Health Services Skilled Nursing Visit</td>
</tr>
<tr>
<td>Home Health Services Skilled Nursing Visit and Physical Therapy</td>
</tr>
<tr>
<td>Physical Therapist</td>
</tr>
</tbody>
</table>