PT, OT, and ST Benefits to Change for Acute Services for Texas Medicaid

Information posted November 15, 2013

Effective for dates of services on or after January 1, 2014, benefit criteria for physical (PT), occupational (OT), and speech therapy (ST) will change for acute services for Texas Medicaid.

PT, OT, and ST services, including co-therapy, will be benefits of Texas Medicaid for clients with an acute medical condition or an acute exacerbation of a chronic medical condition when all of the following criteria are met:

- Prior authorization is obtained
- Therapy is prescribed by a licensed physician
  - A prescription is considered current when it is signed and dated within 30 days before the start of therapy.
- Documentation of medical necessity indicates a condition that requires ongoing therapy or rehabilitation in the usual course, treatment, and management of the client’s condition.
- Documentation from the prescribing provider and the treating therapist shows there is or will be progress made towards goals.

Therapy is considered acute for 180 rolling days from the first date (onset) of therapy for a specific condition. If the client’s condition persists for more than 180 rolling days from the start of therapy services, the condition is considered chronic and will not be covered.

**Note:** For clients who are 20 years of age and younger and do not meet criteria through acute services, therapies may be considered through the Comprehensive Care Program (CCP). PT and OT services that are provided in the home setting may be considered as a home health services benefit.

Therapy goals for an acute condition or acute exacerbation of a chronic medical condition include, but are not limited to, improving function and restoring function.

PT, OT, and ST evaluations and treatment must be ordered or prescribed by the client’s physician and based on medical necessity.

When services are furnished based on verbal physician orders, the orders must be taken by someone who is authorized to receive them under state and federal laws and regulations, (a registered nurse (RN), physical therapist, occupational therapist, or speech language pathologist), as well as under a therapy provider's internal policies.

Verbal orders must be reduced to writing, include the date of receipt, and be signed and dated by the RN, or qualified physical, occupational, or speech therapist responsible for furnishing or supervising the ordered services. The orders must be transcribed to the plan of care (POC), and must be maintained in the client's medical record and made available upon request.

When a revision or extension of PT, OT, or ST services is based on verbal physician orders, the verbal order may be taken and documented by either the RN or qualified
physical, occupational, or speech therapist responsible for furnishing or supervising the ordered services.

Verbal physician orders must be countersigned by the client's physician within the time frame required by the therapy provider's internal policies.

Therapy and swallowing function evaluations are a benefit once per 180 rolling days, any provider. Therapy and swallowing function re-evaluations are a benefit when documentation supports a change in the client's status or with a request for extension of services. Additional therapy evaluations or re-evaluations and swallowing function evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change-of-provider letter that is signed and dated by the client or responsible adult and documents all of the following:
  - The date that the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation of why providers were changed

**Note:** Providers who terminate services must give reasonable notice to the client and must maintain documentation of the reason in the client's medical record.

An evaluation or re-evaluation performed on the same date of service as an evaluation or re-evaluation from a different therapy discipline must be performed at distinctly separate times to be considered for reimbursement. Concurrent evaluations or re-evaluations performed by two disciplines will not be reimbursed.

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

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

Texas Medicaid reimburses physicians and licensed therapists who are authorized by the state licensing boards (i.e., licensed physical therapists, licensed occupational therapists, and licensed speech language pathologists) to provide therapy services. Therapy services may also be provided by licensed physical therapy assistants, licensed occupational therapy assistants, and licensed speech-language pathology assistants under the supervision of a licensed physical therapist, licensed occupational therapist, or licensed speech-language pathologist. Claims for services that are provided by a licensed assistant are submitted by the licensed therapist.
Services that are performed by students who are enrolled in an accredited therapy program are not reimbursed under Texas Medicaid, because the students are not licensed health-care providers. Therapy services provided to a client that are performed by a therapy student in which a licensed therapist is not directly, hands-on, involved with the therapy provided to the client will not be reimbursed under Texas Medicaid; however, a service that is provided by a licensed health-care provider while a student is present may be reimbursed.

Providers of therapy services, which include licensed therapists as well as designated associates, are allowed a maximum of 12 hours of therapy services performed per day, regardless of whether the provider of services is employed by an agency or individually enrolled in Texas Medicaid. All therapy service documentation, along with therapy notes, must include a beginning and ending time and is subject to retrospective review.

**Physical Therapy (PT)**

PT provided under the orders of a client’s physician is limited to treatment of acute medical conditions or acute exacerbations of a chronic medical condition that involve the musculoskeletal or neuromuscular systems and may include physical agents such as massage, electrical stimulation, traction, or exercise as a form of therapy. PT does not include diagnosis or psychological services that are typically performed by a licensed psychologist or behavioral health therapist.

PT provided in the office or outpatient hospital setting may be a benefit under any of the following situations:

- It is performed by a licensed physician.
- It is rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and performed by one of the following:
  - A licensed physical therapist
  - A licensed physical therapy assistant under the supervision of a licensed physical therapist

A PT evaluation (procedure code 97001) or re-evaluation (procedure code 97002) will be denied if it is submitted by any provider on the same date of service as therapy treatment procedure codes that are submitted with modifier GP.

A PT evaluation (procedure code 97001) may also be billed with modifier U1 for a wheeled mobility system seating assessment that is performed by a licensed physical therapist.

The following procedure codes will be limited to once per date of service, per distinct therapy type:

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**Occupational Therapy (OT)**
OT provided under the orders of the client's physician is limited to the evaluation and treatment of a client whose ability to function in life roles is impaired due to an acute medical condition or an acute exacerbation of a chronic medical condition. OT uses therapeutic goal-directed activities to treat clients. OT does not include diagnosis or psychological services that are typically performed by a licensed psychologist or behavioral health therapist.

OT provided in the office or outpatient hospital setting may be a benefit under any of the following situations:

- It is performed by a licensed physician.
- It is rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and performed by one of the following:
  - A licensed occupational therapist
  - A licensed occupational therapy assistant or a certified occupational therapy assistant under the supervision of a licensed occupational therapist

An OT evaluation (procedure code 97003) or re-evaluation (procedure code 97004) will be denied if it is submitted by any provider on the same date of service as therapy treatment procedure codes that are submitted with modifier GO.

An OT evaluation (procedure code 97003) may also be submitted with modifier U1 for a wheeled mobility system seating assessment that is performed by a licensed occupational therapist.

The following procedure codes will be limited to once per date of service, per distinct therapy type:

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Speech Therapy (ST)

ST provided under the orders of a client's physician is limited to treatment of an acute medical condition or an acute exacerbation of a chronic medical condition that involves the head or neck and affects speech production or swallowing function. ST does not include diagnosis or psychological services that are typically performed by a licensed psychologist or behavioral health therapist.

ST provided in the office or outpatient hospital setting may be a benefit under any of the following situations:

- It is performed by a physician.
- It is rendered in accordance with the State Board of Examiners for Speech-Language Pathology and Audiology and performed by one of the following:
  - A licensed speech-language pathologist
  - A licensed speech-language pathology assistant under the supervision of a licensed speech-language pathologist
A licensed speech-language pathology intern under the supervision of a licensed speech-language pathologist

ST evaluations or re-evaluations and swallowing function evaluations or re-evaluations may be considered for reimbursement on the same date of service.

When provided by a licensed speech-language pathologist, procedure code 97535 may be used only for additional augmentative communication device training. Procedure code 97535 must be prior authorized and be specifically requested on the prior authorization request form. The provider must submit documentation supporting the service as medically necessary and beneficial to the client.

Procedure code 97535 will be denied when submitted with the same date of service as procedure code 92506, 92610, or S9152.

Procedure codes 92506 and S9152 will be denied when submitted with the same date of service as procedure code 92526.

Co-therapy

Co-therapy is defined as two different therapy disciplines that are performed on the same client at the same time by a licensed therapist for each therapy discipline and rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners or the State Board of Examiners for Speech-Language Pathology and Audiology.

Co-therapy may be considered a benefit when it is medically necessary for the client to receive therapy from two different therapy disciplines at the same time. The therapy performed must require the expertise of two different disciplines (i.e., licensed physical therapist, licensed occupational therapist, or licensed speech-language pathologist), to perform the therapy safely and effectively to reach the client’s goals as determined by the approved POC, which must be signed and dated by the client’s physician.

When performing co-therapy, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may bill for the therapy services rendered. The secondary therapist will not be reimbursed by Texas Medicaid for assisting a designated primary performing therapist with co-therapy services.

Co-therapy documentation requirements are as follows:

- Medical necessity for the individual therapy services must be justified before performing co-therapy.
- Documentation supports co-therapy goals and how co-therapy will help achieve the therapist’s goals for the client, for each therapy discipline.
- A physician order or prescription is received for co-therapy.
- An explanation of why the client requires, and will receive, multidisciplinary team care, defined as at least two therapy disciplines (PT, OT, or ST)

Retrospective review may be performed to ensure documentation supports the medical necessity of the co-therapy performed and that the billing was appropriate for the services provided by the designated primary performing therapist.

Claims for co-therapy services must be submitted with modifier U3.
Prior Authorization

PT, OT, and ST provided in the office or outpatient setting will require prior authorization. PT, OT, and ST evaluations or re-evaluations, when provided with the limits outlined in this article, will not require prior authorization.

Prior authorization may be granted for a period not to exceed 90 days per event for acute care services. A prior authorization may be extended for an additional 90 days when a request is submitted with supporting documentation. Subsequent requests for services exceeding 180 days will not be prior authorized.

**IMPORTANT:** Clients with an acute medical condition who currently receive therapy services without a prior authorization in the office or outpatient facility setting will also be subject to the prior authorization requirement effective January 1, 2014. Initial prior authorizations may be approved up to 90 days, less any days that have passed since the date of onset. If more than 90 days have passed, the prior authorization may be approved for the number of days remaining in the acute care period (180 days).

**Note:** Texas Medicaid will not authorize therapy services that duplicate services that are the legal responsibility of the school districts. The school district, through the School Health and Related Services (SHARS) program, is required to meet the therapy needs of the client while the client is at school. However, if those needs cannot be met by SHARS or the school district, documentation that supports medical necessity may be submitted for consideration of prior authorization.

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 assigned during the prior authorization period. A week includes the day of the week on which the prior authorization period begins and continues for seven days. The number of therapy services authorized for a week must be provided in that prior authorization week. Claims for services that exceed those authorized for the prior authorization week are subject to recoupment.

Providers must identify the requested PT, OT, or ST procedure code with the appropriate GP, GO, or GN modifier at the time each request for PT, OT, or ST is made:

Providers can submit the prior authorization request on paper or electronically.

- To submit the prior authorization request on paper, providers must complete the Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form. To complete the prior authorization process by paper, the provider must submit the prior authorization requirements documentation through fax or mail and must retain 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.

  **Note:** The Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form will be available on this website beginning December 2, 2013.

- To submit the prior authorization request electronically, providers can use the secure TMHP provider portal to complete the SMPA, Request for Outpatient Therapy (PT, OT, or ST). To complete the prior authorization process electronically, the provider must submit the prior authorization requirements documentation through any
approved electronic method and must retain 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 submit correct and complete information including documentation of medical necessity for the service requested. 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 physician’s original signature copy must be kept in the physician’s medical record for the client. The requesting therapy provider may be asked for additional information to clarify or complete a request for therapy.

PT, OT, and ST procedure codes that are authorized in 15-minute units will be limited to a combined maximum of 4 units (1 hour) per day, per therapy type. Additional services may be considered with prior authorization. If the claims for therapy services exceed four units a day, the claim will be denied, but providers may appeal with all of the following information:

- Provider must identify the authorization week period that includes the date of service being appealed.
- Attestation that all therapy services provided for the week in question have been billed.
- Provider must indicate they are appealing for the units in excess of four per day, but they have not exceeded their approved units for the week.

Initial Prior Authorization Requests

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.

The initial request for prior authorization must be received no later than three business days from the date therapy treatments are initiated. Requests received after the three-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 Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent. 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 later than 30 days before the start of therapy. A written order or prescription is considered current when it is signed and dated on or no later than 30 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 that documents the client's age at the time of the evaluation for each therapy discipline.

**Note:** A therapy evaluation is current when it is performed within 30 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 office or outpatient 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 office or outpatient services
- Requested dates of service

**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 three business days from the date the revised therapy treatments are initiated. Requests received after the three-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 Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent
- A new evaluation with required documentation
- A change-of-provider letter signed and dated by the client or responsible adult documenting the date that 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 original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond the limitations outlined in this article.

**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 that are identified in the documentation submitted:

- **High Frequency:** Therapy provided three or more times per 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.
  - Home exercises as the only method of intervention would be ineffective.

- **Moderate Frequency:** Therapy provided two times per week is considered when documentation supports the client meets one or more of the following criteria:
  - 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 is considered when the documentation shows all 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 the therapist will decrease to a lesser frequency level.

Discharge from therapy is expected when one of the following occurs:

- The client's goals and outcomes have been achieved.
- Therapy services no longer produce a functional or measurable outcome.
- The client or responsible adult declines to participate.
- The client is unable to progress toward anticipated goals or expected outcomes because of medical, psychological, or social factors.
- The client is no longer benefiting from therapy.

**Noncovered Services**
The following services will not be a benefit of Texas Medicaid:

- Therapy services that are provided after the client has reached the maximum level of improvement.
- Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached.
- Therapy services provided in daycare and public recreational facilities
- PT, OT, and ST equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided.
- Therapy services that are related to activities for the general good and welfare of clients but are not considered medically necessary, such as:
  - General exercises to promote overall fitness and flexibility
  - Activities to provide diversion or general motivation
  - Supervised exercise for weight loss
- Therapy that is prescribed for treatment of behavioral health diagnoses only (These are considered behavioral health conditions and not medical conditions.)
- Services that are provided by any of the following:
  - Unlicensed physical therapy aides, interns, orderlies, students, or technicians
  - Unlicensed occupational therapy aides, interns, orderlies, students, or technicians
  - Unlicensed speech-language pathology aides, orderlies, students, or technicians
- Therapy services that are provided by the responsible adult for the client. Responsible adults include, but are not limited to, the following:
  - Biological, adoptive, or foster parents
  - Guardians
  - Court-appointed managing conservators
  - Other family members by birth or marriage.
- Procedure code 97755
- The following services are considered investigational and experimental:
  - Procedure codes 97533, S8940, and S9476
  - Anodyne therapy
  - Devices (such as Therasuit) used in therapy to improve and change proprioception, reduction of client’s pathological reflexes, restoration of physiological muscle synergies for the purpose of normalization of afferent vestibulo-proprioceptive input
  - Craniosacral therapy
- The following services are considered investigational and are not supported by evidence-based studies:
• Interactive metronome therapy for the treatment of attention deficit hyperactivity disorder (ADHD)

• Cranial electrotherapy stimulation (CES) (low electrical voltages delivered to a client) to influence neurotransmitter activity and production of serotonin and dopamine for ADHD

• Low-energy neurofeedback system (LENS) with the goal of teaching a client to produce brain-wave patterns that reflect focus and enhance the brain's ability to adapt to a task for ADHD

• Working memory exercises with the goal of improving fluid intelligence quotient (IQ) and increasing the ability to solve problems or adapt to situations as they occur

• Lycra splints and suits used to improve proximal stability and function in clients with cerebral palsy

• PT or OT for the treatment of ADHD

  • Functional electrical stimulation (FES), when used to promote ambulation in other than spinal cord injury (SCI), and threshold electrical stimulation (TES) as a treatment of motor disorders, including, but not limited to, cerebral palsy or scoliosis (These are considered investigational and not medically necessary.)

  • Applied behavior analysis (ABA), also called early intensive behavioral intervention (EIBI), when performed by a physical or occupational therapist for the treatment of attention deficit disorder (ADD), ADHD, or autism spectrum disorders (ASD). These are not supported by evidence-based studies.

For more information, call TMHP Contact Center at 1-800-925-9126.