PT, OT, and ST Benefits to Change for CCP for Texas Medicaid Effective January 1, 2014

Information posted November 15, 2013

Effective for dates of services on or after January 1, 2014, benefit criteria for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) will change for the Comprehensive Care Program (CCP).

PT, OT, and ST services, including co-therapy, will be benefits of CCP for clients who are 20 years of age and younger with an acute or chronic medical condition when all of the following criteria are met:

- 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.

Note: A nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) may sign all documentation related to the provision of PT, OT, or ST services on behalf of the client’s physician when the client's physician delegates this authority to the NP, CNS, or PA. The NP, CNS, or PA provider’s signature and license number must appear on the forms where the physician signature and license number are required.

Therapy is considered acute for 180 days from the first date (onset) of therapy for a specific condition. If the client’s condition persists for more than 180 days from the start of therapy services, the condition is considered chronic.

Providers must maintain a completed plan of care (POC) that includes documentation that supports medical necessity for therapy services and confirms that the client meets the criteria for acute services. The POC must include all of the following:

- The specific procedures and disciplines to be used
- The amount, duration, and frequency of therapy
- The therapist who participated in developing the POC
- Rehabilitation potential of the client
- Functional limitations of the client
- Date the client was last seen by the physician

Therapy goals for an acute or chronic medical condition include, but are not limited to, improving, maintaining, and slowing the deterioration of function.

PT, OT, and ST evaluations and treatment must be provided according to the current written orders of a physician and be based on medical necessity unless the provider is an Early Childhood Intervention (ECI) therapist.
Note: PT, OT, and ST evaluations and re-evaluations that are performed by ECI therapists must be performed according to the therapist’s scope of practice.

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, or occupational therapist), 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 therapist responsible for furnishing or supervising the ordered services. The orders must be transcribed to the POC, 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 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 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.

PT, OT, and ST procedure codes that are billed 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.
- Provider must attest that claims for all therapy services provided for the week in question have been submitted.
• Provider must indicate the appeal is for the units in excess of 4 per day, and that the number of units for the week has not exceeded the prior authorized number.

All documentation that is related to the therapy services that are prior authorized and provided, including medical necessity and 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 provided

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 that is provided under the orders of a client’s physician is limited to treatment of acute or chronic medical conditions 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 that is provided through a physician or outpatient hospital provider may be a benefit under any of the following situations:

• The therapy is performed by a licensed physician.
The therapy 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

Claims for a PT evaluation (procedure code 97001) may also be submitted 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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<th>Procedure Codes</th>
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**Occupational Therapy (OT)**

OT that is 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 developmental deficits, environmental deprivation, sensory impairment, or psychological or social dysfunction. OT uses therapeutic, goal-directed activities to treat clients with acute or chronic medical conditions. OT does not include diagnosis or psychological services that are typically performed by a licensed psychologist or behavioral health therapist.

OT that is provided through a physician or outpatient hospital provider may be a benefit under any of the following situations:

- The therapy is performed by a licensed physician.
- The therapy 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

A claim for 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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<th>Procedure Codes</th>
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<td>97012</td>
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Speech Therapy (ST)

ST provided under the orders of a client’s physician is limited to treatment of an acute or 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 through a physician or outpatient hospital provider may be a benefit under any of the following situations:

- The therapy is performed by a physician.
- The therapy 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

Speech therapy may be performed by a speech-language pathologist who is either on staff at a hospital or under the personal supervision of a physician. Claims for speech evaluations and therapy that are submitted directly by an independently practicing speech-language pathologist will be denied unless the speech-language pathologist is an ECI provider.

Note: Speech-language pathologists who are also ECI providers, and perform services through the ECI program should follow ECI program requirements when submitting a claim for ST services.

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 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 that supports the service as medically necessary and beneficial to the client.

Procedure code 97535 will be denied when it is submitted with the same date of service as procedure code 92507, 92508, or 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 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 submit claims for the therapy services that were 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 claims submission 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**

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

- The client has an acute or chronic medical condition resulting in a significant decrease in functional ability that will benefit from therapy services.
- 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.

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.

*Note: Services provided by an ECI therapist do not require prior authorization; however, the services must comply with the Individual Family Service Plan (IFSP.)*

An initial prior authorization may be granted for a period not to exceed 90 days, but the prior authorization period may be extended for an additional 90 days if a request is submitted with documentation that supports medical necessity. Subsequent prior authorization requests may be granted for up to 180 days when submitted with documentation of a chronic condition.
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 a total of 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.

A new prior authorization request form, the Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, will replace the Request for Initial Outpatient Therapy (Form TP-1) and the Request for Extension of Outpatient Therapy (2 Pages) (Form TP-2). Providers must submit the new form when requesting prior authorization on or after January 1, 2014, for all outpatient physical, occupational, and speech therapy services. Online prior authorization through the secure TMHP provider portal will be updated to capture all information required on the new form.

**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 complete the prior authorization process by paper, the provider must submit the required 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.

To complete the prior authorization process electronically, the provider must submit the required 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.

**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 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:
  
  o Date and signature of the licensed therapist
  
  o Diagnosis(es)
  
  o Treatment goals that are related to the client's individual needs for the requested therapy discipline
  
  o A description of the specific therapy disciplines being prescribed
  
  o Duration and frequency of therapy
  
  o Date of onset of the illness, injury, or exacerbation that requires the office or outpatient services
  
  o Requested dates of service

The following additional medical necessity documentation is required for clients with developmental disability or delay (DD) or developmental cognitive disability (DCD):

- Diagnosis code that supports therapy
- Onset of the diagnosis
- Client's current functional status
- Standardized testing performed with scoring, including standard scores with standard deviations, or documentation that supports why testing could not be performed or is inappropriate
- Client's current deficits
- Purpose of therapy: attain new skill, maintain current function, or prevent deterioration
- Rehabilitation potential
- Specific and measurable goals
- Description of home exercise program
Subsequent Prior Authorization Requests

A prior authorization request for subsequent services must be received within 30 days before the current authorization expires. Requests for subsequent services that are received after the current prior 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 that supports medical necessity and includes all of the following:

- A new completed Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form that has been signed and dated by the ordering physician or electronic equivalent
  - 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 or re-evaluation for each therapy discipline that documents the client’s age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation is current when it is performed within 30 days before the request for subsequent services

- An updated, client-specific comprehensive treatment plan that was 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(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 office or outpatient hospital therapy services
  - A brief summary of the outcomes of the previous treatment as it relates to the client’s debilitating condition
  - Requested dates of service
The following additional medical necessity documentation is required for clients with DD or DCD:

- Diagnosis code that supports therapy
- Onset of the diagnosis
- Client's prior and current functional status
- Progress made toward goals with actual number of goals met
- New testing performed with scoring, including standard scores with standard deviations, or documentation supporting why testing could not be done or is inappropriate
- Client's current deficits
- Purpose of therapy: attain new skill, maintain current function, or prevent deterioration
- Rehabilitation potential
- New goals: specific and measurable (if applicable)
- Description of home exercise program
- Client and responsible adult compliance with home program
- Frequency and dates of service requested

**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 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
- A new evaluation with required documentation
- A change-of-provider letter that has been signed and dated by the client or responsible adult and that documents 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.

**Therapy Provided in the Home**

PT, OT, and ST home services must be provided in the client's home. The client's home can be a client- or family-owned dwelling or apartment, a relative's home, or other type of living arrangement. The following settings are not recognized as the client's home:
• Hospital
• Outpatient facility
• Nursing facility
• Physician office
• Any other medical setting
• Intermediate care facility for persons with mental retardation (ICF-MR)
• Daycare
• Public recreational facility
• School

Frequency Levels

PT, OT, and ST services may be provided at one of the following levels commensurate with the client's medical condition, developmental needs, 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 shows all of the following:
  o Client has a medical condition that is rapidly changing.
  o Client has a potential for rapid progress or rapid decline or loss of functional skill.
  o The client's therapy plan and home program require frequent modification by the licensed therapist.
  o The client requires a high frequency of intervention for a limited duration (60 days or fewer) to achieve an identified new skill or recover function lost due to surgery, illness, or trauma.
  o Home exercises as the only method of intervention would be ineffective.

• Moderate Frequency: Therapy provided two times a week is considered when documentation shows the following:
  o The client is making functional progress toward goals.
  o The client is in a critical period to restore function or is at risk of regression.
  o 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.
  o The client has complex needs requiring on-going education of the responsible adult.

• Low Frequency: Therapy provided one time per week or every other week is considered when the documentation shows the following:
  o 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 development or medical condition.
- The licensed therapist is required to adjust the client's therapy plan and home program weekly based on the client's progress.

- Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy. Because the therapy plan changes very slowly, the home program can be managed by the client and the responsible adult and does not require frequent changes by the licensed therapist.

- Maintenance Level/Prevent Deterioration: every other week to monthly or less often visits/sessions may be considered when the client meets one of the following criteria:
  
  - Progress has slowed or stopped, but documentation supports that ongoing therapy is required to maintain the progress made or prevent deterioration
  
  - The documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow
    - Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety)
    - Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs

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 provided by non-ECI providers in daycare, public recreational facilities, or after-school care programs
- 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, including, but not limited to, the following:
  - 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 adult that is responsible 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.