PT and OT Benefits to Change for Home Health for Texas Medicaid

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Effective for dates of services on or after January 1, 2014, benefit criteria for physical therapy (PT) and occupational therapy (OT) will change for home health services.

PT and OT services, including co-therapy, are benefits of Texas Medicaid Title XIX Home Health Services for clients with an acute medical condition or an acute exacerbation of a 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.

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 and will not be covered.

**Note:** For clients who are 20 years of age and younger and do not meet criteria outlined in this article, therapies may be considered through the Comprehensive Care Program (CCP).

Providers must maintain a completed Texas Medicaid Home Health Services 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 medical condition or an acute exacerbation of a chronic medical condition include, but are not limited to, improving function and restoring function.

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

When services are furnished based on verbal physician orders, the orders must be taken by licensed home health agency staff 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 by a home health agency's internal policies. The RN is responsible for initiating the POC, and is responsible for obtaining and documenting the verbal physician order for the initial POC.

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 home health agency 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 home health agency's internal policies.

Therapy 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 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 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 to provide therapy services (i.e., licensed physical therapists or licensed occupational therapists). Therapy services may also be provided by licensed physical therapy assistants or licensed occupational therapy assistants under the supervision of a licensed physical therapist or licensed occupational therapist. 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 they are not licensed healthcare 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 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 through a home health agency may be a benefit when rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and performed by one of the following:

- The therapy is performed by a licensed physical therapist
- The therapy is performed by a licensed physical therapy assistant under the supervision of a licensed physical therapist

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.

**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 an acute 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 through a home health agency may be a benefit when rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners and performed by one of the following:

- The therapy is performed by a licensed occupational therapist
- The therapy is performed by 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) may also be submitted with modifier U1 for a wheeled mobility system seating assessment that is performed by a licensed occupational therapist.

**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.

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 or licensed occupational therapist), 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 or OT).

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**

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.

Home health therapy services must be provided in the client's home. PT and OT in the home will not be prior authorized for the convenience of the client or responsible adult. 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

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

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

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.

A new prior authorization request form, the Request for Outpatient Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, will be required when requesting prior authorization for physical or occupational 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 in the client’s medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request for therapy.

**Initial Prior Authorization Requests**

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.

- The frequency of visits requested must be supported by documentation that supports the medical necessity. The following factors may be taken into consideration when determining frequency of visits requested:
  
  - Client's age
  - Diagnoses
  - Prognosis
  - Expected outcomes
  - Client's developmental or life stage and how this affects the client's ability for skill acquisition
  - How frequently or what level of clinical decision making and problem solving is required by the licensed therapist to progress the client
The level of support available in assisting the client to reach his/her goals. This may include, but is not limited to, the client's ability to attend visits, comply with therapy, or the client's or responsible adult's motivation to participate in therapy.

- 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 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

**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 60 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, 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 that 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 documenting the client's age at the time of the evaluation or re-evaluation.
A therapy evaluation or re-evaluation is current when performed within 30 days before the request for subsequent services.

- An updated client-specific comprehensive treatment plan established by the ordering physician or therapist to be followed during treatment in the home 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

**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 that 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 the client ended therapy (effective date of change) with the previous provider, the names of the previous and new providers, and an explanation 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 identified provider will be updated with the new provider's information, while maintaining the original authorized period.

**Frequency Levels**

PT and OT 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 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 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 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 medical condition.
  o 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:
  • Supervised exercise for weight loss
  • Therapy services provided in daycare and public recreational facilities
• PT and OT equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided.

• 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:
  o Unlicensed physical therapy aides, interns, orderlies, students, or technicians
  o Unlicensed occupational therapy aides, interns, 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:
  o Biological, adoptive, or foster parents
  o Guardians
  o Court-appointed managing conservators
  o Other family members by birth or marriage

• Procedure code 97755

• The following services are considered investigational and experimental:
  o Procedure codes 97533, S8940, and S9476
  o Anodyne therapy
  o 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-propiroceptive input
  o Craniosacral therapy

• The following services are considered investigational and are not supported by evidence-based studies:
  o Interactive metronome therapy for the treatment of attention deficit hyperactivity disorder (ADHD)
  o Cranial electrotherapy stimulation (CES) (low electrical voltages delivered to a client) to influence neurotransmitter activity and production of serotonin and dopamine for ADHD
  o 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
  o 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
  o Lycra splints and suits used to improve proximal stability and function in clients with cerebral palsy
  o 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.

- Separate reimbursement for VitalStim therapy for dysphagia

For more information, call the TMHP Contact Center at 1-800-925-9125.