

# Effective May 1, 2016, Policy to Change for Physical, Occupational, and Speech Therapy Services for Clients 21 Years of Age and Older

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**Note:** *The Health and Human Services Commission (HHSC) has requested that TMHP publish the following information:*

Effective for dates of service on or after May 1, 2016, policy for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) will change for Texas Medicaid adult clients who are 21 years of age and older.

Key policy changes for PT, OT, and ST services for clients who are 21 years of age and older, which are described in detail in this article, include the following:

- Acute therapy services require prior authorization. The authorization period for acute therapy services is for 60 days, and it is limited to 120 days total.
- A new prior authorization form for all therapy services will be available to providers for use on dates on or after May 1, 2016. The new form will be available as a fillable PDF on the TMHP website. Starting May 1, 2016, providers can submit prior authorization requests using either the three existing prior authorization forms or the new prior authorization form until the electronic prior authorization portal is available on May 27, 2016.
- Starting May 27, 2016, providers requesting therapy services will be required to use the new prior authorization form, Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form.
- All acute therapy services for clients 21 years of age or older must be submitted with the AT modifier.
- Reevaluations require authorization and are part of the authorization/recertification process for acute therapy services. Reevaluation codes and a progress note must be submitted with the recertification request.
- Co-treatment services outlined in the article must be submitted with the U3 modifier.
- All therapy services rendered by a licensed therapy assistant must be submitted with the UB modifier.

Below is a draft of the Texas Medicaid policy for physical, occupational, and speech therapy services for clients who are 21 years of age and older to be effective for dates of service on or after May 1, 2016.

**Note:** *"Days" refers to calendar days unless otherwise specified below,*

Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition for adult clients 21 years of age and older.

- Treatments are expected to significantly improve, restore or develop physical functions diminished or lost as a result of a recent trauma, illness, injury, disease, surgery, or change in medical condition, in a reasonable and generally predictable

period of time (60 days), based on the physician's and therapist's assessment of the client's restorative potential.

**Note:** *“Recent” is defined as occurring within the past 90 days of the physician's evaluation of condition.*

- Treatments are directed towards restoration of or compensation for lost function.
- Services do not duplicate those provided concurrently by any other therapy.
- Services must meet acceptable standards of medical practice and be specific and effective treatment for the client's condition.
- Services are provided within the provider's scope of practice, as defined by state law.
- “Acute” is defined as an illness or trauma with a rapid onset and short duration.

Adult therapy services are limited to a maximum of 120 days per identified acute medical condition or acute exacerbation of a chronic medical condition requiring therapy or whenever the maximum benefit from therapy has been achieved, whichever comes first.

A medical condition is considered chronic when 120 days have passed from the start of therapy or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time.

Physical and occupational therapy services for acute conditions are benefits of the Texas Medicaid program for adult clients in the office, outpatient, and home settings.

Speech therapy services for acute conditions are a benefit of Texas Medicaid for adult clients in the office and outpatient setting only.

Therapy services must be performed by one of the following: A licensed physical therapist, a licensed occupational therapist, a licensed speech-language pathologist, or a physician within their scope of practice, or one of the following under the supervision of a licensed therapist of the specific discipline:

- Licensed therapy assistant
- Licensed speech-language pathology intern (Clinical Fellow)

In determining whether a service requires the skill of a licensed therapist, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and therapy practice guidelines.

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 a skilled therapy 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 therapist, the services cannot be regarded as skilled therapy.

## **Overview of Policy**

Medical necessity criteria for therapy services provided in the home must be based on the supporting documentation of the medical need and the appropriateness of the equipment, service, or supply prescribed by the physician for the treatment of the individual.

The therapy service must be related to the client's medical condition, rather than primarily for the convenience of the client or provider.

Frequency must always be commensurate with the client's medical and skilled therapy needs and standards of practice, and it is not for the convenience of the client or the responsible care givers. Treatment plans and plans of care developed must include not only the initial frequency (high, moderate, or low), but the expected changes of frequency throughout the duration period requested based on the client's anticipated therapy treatment needs. An example of a tapered down frequency request initiated with a high frequency is: 3 times a week for 2 weeks, 2 times a week for 2 weeks, 1 time a week for 2 weeks, 1 time every other week).

For prior authorization criteria, see the Frequency and Duration section under the Authorization section in this article.

### **Physical Therapy (PT)**

The practice of physical therapy includes:

- Measurement or testing of the function of the musculoskeletal, or neurological, system;
- Rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect;
- Treatment, consultative, educational, or advisory services to reduce the incidence or severity of disability or pain to enable, train, or retrain a person to perform the independent skills and activities of daily living.

Texas Medicaid limits physical therapy to the skilled treatment of clients who have acute or acute exacerbation of chronic disorders of the musculoskeletal and neuromuscular systems. Physical therapy may be provided by a physician or physical therapist within their licensed scope of practice.

### **Occupational Therapy (OT)**

The practice of occupational therapy includes:

- Evaluation or treatment of a person whose ability to perform the tasks of living is threatened or impaired by developmental deficits, sensory impairment, physical injury or illness;
- Use of therapeutic goal-directed activities to:
  - Evaluate, prevent, or correct physical dysfunction; or
  - Maximize function in a person's life;
- Application of therapeutic goal-directed activities in treating patients on an individual basis, in groups, or through social systems by means of direct or monitored treatment or consultation.

Texas Medicaid limits occupational therapy to the skilled treatment of clients whose ability to function in life roles is impaired. Occupational therapy may be provided by a physician or occupational therapist within their licensed scope of practice. Occupational therapy uses purposeful activities to obtain or regain activities of daily living (ADLs) performance skills lost through acute or acute exacerbation of a medical condition

related to injury, disease or other medical causes. ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming and mobility.

## **Speech Therapy (ST)**

Speech therapy is a benefit of Texas Medicaid for the treatment of acute or acute exacerbations of pathological or traumatic conditions of the head or neck, which affect speech production, speech communication and oral motor, feeding and swallowing disorders. Speech therapy may be provided by a physician or speech-language pathologist within their scope of practice.

Speech-language pathologists treat speech sound and motor speech disorders, stuttering, voice disorders, aphasia and other language impairments, cognitive disorders, social communication disorders, and swallowing (dysphagia) deficits. Speech therapy is designed to ameliorate, restore, or rehabilitate speech/language communication and swallowing disorders that have been lost or damaged as a result of an acute or acute exacerbation of a medical condition due to a recent injury, disease, or other medical conditions, or congenital anomalies or injuries.

## **Types of Communication Disorders**

- **Language Disorders:** Impaired comprehension and/or use of spoken, written and/or other symbol systems, which may involve the following components:
  - Forms of language (phonology, morphology, syntax),
  - Content and meaning of language (pragmatics), and/or
  - The perception/processing of language.

Language disorders may involve one, all, or a combination of the above components.

- **Speech Production Disorders:** Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production Disorders may involve one, all, or a combination of these components of the speech production system. An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal and/or apraxia, dysarthria.
- **Oral Motor/Swallowing/Feeding Disorders:** Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

Physical, occupational and speech therapy services must be medically necessary to the treatment of the individual's acute need. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, all of the following conditions must be met:

- The services requested must be considered under the accepted standards of practice to be specific and effective treatments for the patient's condition.
- The services requested must be of such a level of complexity or the patient's condition must be such that the services required can only be effectively performed

by or under the supervision of a licensed occupational therapist, physical therapist, or speech-language pathologist, and requires the skills and judgment of the licensed therapist to perform education and training.

- The goals of the requested services to be provided are directed at improving, adapting or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part and restore client's function to within normal ADLs.

There must be reasonable expectation that therapy will result in a meaningful or practical improvement in the client's ability to function within a reasonable and predicable time period.

## **Co-Treatment**

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

Co-treatment may be 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 requires 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 plan of care, signed and dated by the client's physician.

When performing co-treatment, 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 for assisting a designated primary performing therapist.

The following co-treatment documentation requirements must be maintained in the client's medical records:

- Medical necessity for the individual therapy services must be justified before performing co-treatment.
- Documentation that supports co-treatment goals and how co-treatment will help the therapist achieve the therapist's goals for the client, for each therapy discipline.
- An explanation of why the client requires and will receive, multi-disciplinary team care, during the same therapy session, defined as at least two therapy disciplines (physical, occupational or speech therapy).

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

## **Group Therapy**

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.

### **Group Therapy Requirements**

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

- 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 (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 and 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.

### **Group Therapy Documentation Requirements**

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

- Physician prescription for group therapy,
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals,
- Name and signature of licensed therapist providing supervision over the group therapy session,
- Specific treatment techniques utilized during the group therapy session and how the techniques will restore function,
- Start and stop times for each session,
- Group therapy setting or location, and
- Number of clients in the group.

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

### **Non-covered Services**

The following services are not benefits of Texas Medicaid:

- Therapy services that are provided after the client has reached the maximum level of improvement or is now functioning within normal limits.
- Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition.
- Separate reimbursement for VitalStim® therapy for dysphagia.

- Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee.
- Therapy services related to activities for the general good and welfare of clients that are not considered medically necessary, because they do not require the skills of a therapist, such as:
  - General exercises to promote overall fitness and flexibility or improve athletic performance,
  - Activities to provide diversion or general motivation and,
  - Supervised exercise for weight loss.
- Treatment solely for the instruction of other agency or professional personnel in the client's physical, occupational, or speech therapy program.
- Training in nonessential tasks (e.g. homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling).
- Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment.
- Therapy prescribed primarily as an adjunct to psychotherapy.
- Treatments not supported by medically peer reviewed literature, including but not limited to investigational treatments such as sensory integration, with the exception of cognitive rehabilitation for client's with traumatic brain injury due to illness or injury, who are able to actively participate in the treatment program, vestibular rehabilitation, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback.
- Therapy not expected to result in practical functional improvements in the client's level of functioning.
- Treatments that do not require the skills of a licensed therapist to perform in the absence of complicating factors (i.e., massage, general range of motion exercises, repetitive gait, activities and exercises that can be practiced by the client on their own or with a responsible adult's assistance).
- Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided.
- Auxiliary personnel (aide, orderly, student, or technician) may participate in physical therapy, occupational therapy, or speech therapy sessions when they are appropriately supervised according to each therapy discipline's scope of practice and provider licensure requirements.
  - Providers may not bill Texas Medicaid for therapy services provided solely by auxiliary personnel.
  - Therapy services provided by a licensed therapist who is the client's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage).

**Note:** Auxiliary personnel, a licensed therapy assistant, and a licensed speech-language pathology intern (Clinical Fellow) are not eligible to enroll as therapist providers in Texas Medicaid.

## **Authorization Requirements Outpatient and Home Health - PT/OT/ST**

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients must sign all prior authorization and authorization forms and supporting documentation.

### **Initial Evaluation and considerations for prior authorization for treatment**

Initial evaluation requests do not require authorization (Procedure codes 97001, 97003, 92521, 92522, 92523, 92524, and 92610); however, documentation kept in the client's record must include a signed and dated physician's order for the evaluation, support a medical need for the therapy evaluation, and be available when requested. 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 service(s) 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.

Therapy services, regardless of place or provider, occurring after the initial evaluation, require prior authorization. Prior authorization requests may not exceed a 60 day period.

Prior authorization (PA) requests must be received no later than five business days from the date therapy treatments following the evaluation are initiated. A completed prior authorization form, signed and dated by physician, or, if not signed by physician, the written order or prescription signed and dated by physician, or documented verbal order from the physician that includes order date, must accompany the PA request form. Requests received after the five-business-day period will be denied for dates of service that occurred before the date that the PA request is received.

All of the following documentation is required when submitting an initial request for therapy services initiated after the completion of the evaluation:

- A completed Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form signed and dated by the therapist and signed and dated by the physician is required). When the request form is unsigned by the physician, it must be accompanied by a signed and dated written order or prescription or a documented verbal order delineating the prescribed therapy services.



- Documentation of the acute or acute exacerbation of the medical condition requiring therapy. Evaluation and Treatment Plan or Plan of Care (POC) with all of the following required elements:
  - Client's medical history and background
  - All medical diagnoses related to the client's condition
  - Date of onset of the client's condition requiring therapy, or exacerbation date as applicable
  - Date of evaluation
  - Baseline objective measurements documented based on any testing performed
  - Explanation of how identified limitations impair the overall function of the client
  - Safety risks
  - Client -specific, measurable short- and long-term functional goals within the length of service time requested
  - Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services
  - Therapy treatment plan/POC to include specific modalities and treatments planned
  - Documentation of client's primary language
  - Documentation of client's age and date of birth
  - Prognosis for improvement
  - Time in and time out on evaluation
  - Requested dates of service for planned treatments after the completion of the evaluation
  - Responsible adult expected involvement in client's treatment
  - Dated signature of treating therapist
- Additional requirements for speech therapy includes one or more of the following:
  - **Language evaluations:** Oral-peripheral speech mechanism examination and formal or informal assessment of hearing, articulation, voice, and fluency skills;
  - **Speech production (voice):** Formal screening of language skills, and formal or informal assessment of hearing, voice, and fluency skills;
  - **Speech production (fluency):** Formal screening of language skills, formal or informal assessment of hearing, voice, and fluency skills;
  - **Oral Motor/Swallowing/Feeding:** If swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a video fluoroscopic swallow study has been made; formal screening of language skills, formal or informal assessment of hearing, voice, and fluency skills

For all therapies, when the request form submitted is not signed and dated by the physician before the initiation of services, the request must be accompanied by one of the following:

- A signed and dated written order or prescription or documented verbal order for the therapy services (documenting the frequency ordered). The order must be dated within the 30 day period before the initiation of services and include the frequency ordered by the client's physician based on the evaluation and services requested by the therapist (the order for the evaluation may be obtained separately), and a physician's order to evaluate and treat is acceptable for the evaluation, but not acceptable for the therapy treatment. Written orders must contain the physician ordered frequency and duration, or
- A documentation of a verbal order that includes all of the following:
  - Signed and dated by the licensed professional who by state and federal law may take a verbal order
  - Name and credentials of the licensed professional taking the order who is responsible for furnishing or supervising the ordered services
  - The date the verbal order was taken and the services, frequency, and duration prescribed by the ordering physician.

### **Requests for Recertification - up to an additional 60 days for acute services**

A recertification request may be considered when services will be medically needed after the previously approved authorization period ends.

Re-evaluation codes (Procedure codes 97002, 97004, and S9152) require authorization and must be submitted with the recertification request. Required documentation for re-certifications includes a Progress Summary and Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form.

A complete request must be received at least 28 days before the current authorization period expires. Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

One recertification request may be considered for an additional 60 days for each therapy service request with documentation supporting the medical necessity including all of the following:

A Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent signed and dated by the therapist and signed and dated by the ordering physician. When the request form is unsigned by the physician, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.

- A progress summary (see progress summary documentation requirements), and
- An updated treatment plan or POC including all of the following:
  - Date therapy services started
  - Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan
  - Documentation of reasons continued therapy services are medically needed
  - Documentation of client's participation in treatment, as well as client/responsible adult's participation or adherence with a home exercise program

- Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable
- Prognosis with clearly established discharge criteria
- Documentation of consults with other professionals and services or referrals made and coordination of service when applicable (e.g., for school aged clients, documentation of the coordination of care and referrals made for school therapies)
- The updated treatment plan or plan of care must be signed and dated by the therapist responsible for the therapy services.

A Progress Summary, which may be contained in the last treatment note, must be included with the recertification request and contains all of the following:

- Date therapy started
- Date the Summary Completed
- Time period (dates of service) covered by the summary
- Client's medical and treatment diagnoses
- A summary of client's response to therapy/current treatment plan, to include:
  - Documentation of any issues limiting the client's progress
  - Documentation of objective measures of functional progress related to each treatment goal established on the initial evaluation
  - An assessment of the client's therapy prognosis and overall functional progress
  - Documentation of client's participation in treatment as well as client/responsible adult's participation or adherence with a home exercise program
  - Updated or New functional and measurable short and long-term treatment goals with time frames, as applicable
  - Documentation of client continued need for therapy
  - Clearly established discharge criteria
- Documentation of consults with other professionals and services or coordination of service when applicable.
- The Progress Summary must be signed and dated by the therapist responsible for the therapy services.

### **Requests for Revisions to Existing Prior Authorization/Recertification**

A revision to an existing authorization/recertification must be documented in the client's record when significant changes occur in the frequency or treatment plan. When the frequency is increased or services requiring separate authorization are added, a request for revision must be submitted for prior authorization.

Requests for revisions 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.

Requests for revision must be submitted with the following documentation:

- Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form including the date the revision was initiated, signed, and dated by the therapist and signed and dated by the physician. When the request form is not signed and dated by the physician, it must be accompanied by a written order or prescription or a verbal order for the prescribed services.

Progress summary including the medical rationale for the change requested, and

- Updated treatment plan or POC addressing all the elements of the previous plan and addressing all revisions to the services planned
- The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services

### **Change of Therapy Provider**

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider outside the current group or agency, they must start a new request for authorization and submit all documentation required for an initial evaluation, plus:

- A change-of- therapy provider letter signed by the client or responsible adult,
- The letter must document the date that the client ended therapy (effective date of change) with the previous provider, or last date of service, and
- The name of the new provider and previous provider.

When a provider or client discontinues therapy during an existing prior authorization period and the client requests services through a new provider located within the same enrolled group of providers or within a group of independently enrolled providers collaboratively working together, the new provider can use the same evaluation and plan of care. Therefore, the authorization period will not change.

**Treatment Note:** Documentation must be kept on file by the treating provider and available when requested:

- Client's name
- Date of service
- Time in and out of each therapy session
- Objectives addressed (should coincide with plan of care) and progress noted, if applicable
- A description of specific therapy services provided and the activities rendered during each therapy session, along with a form of measurement.
- Assessments of client's progress or lack of progress
- Treatment notes must be legible
- Therapist must sign each date of entry with full signature and credentials

All documentation for evaluations progress summaries, treatment notes and discharge summaries must show client's name, date of service, time in and time out for each therapy session.

### **Frequency and Duration Criteria for PT/OT/ST**

Frequency must always be commensurate with the client's medical and skilled therapy needs, and standards of practice; it is not for the convenience of the client or the responsible adult.

- **High Frequency** (three times per week): Can only be considered for a limited duration (approximately four weeks or less) or as otherwise requested by the ordering physician with documentation supporting all of the following:
  - High frequency is required for after a recent trauma, surgery, or acute medical condition or acute exacerbation of a medical condition, and
  - The client has a medical condition that is rapidly changing, and
  - The 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, and
  - The goals are well-defined, specific, and achievable within the intensive period requested, with an expected date of goal achievement.

**Note:** *A higher frequency (Four or more times per week) may be considered on a case-by-case basis with clinical documentation supporting why 3 times a week will not meet the client's medical needs.*

- **Moderate Frequency:** Therapy provided two times a week may be considered when documentation shows one or more of the following:
  - The client is making very good functional progress toward goals.
  - The client is in a critical period to gain new skills or 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 or every other week may be considered when the documentation shows one or more of the following:
  - The client is making progress toward the client's goals, but the progress has slowed, or documentation shows the client is 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 to every other week 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.

**Note:** *As the client's medical need for therapy decreases it is expected that the therapy frequency will be decreased as well.*

## **Discontinuation of Therapy**

Criteria for Discontinuation of Therapy are including but not limited to, the following:

- Client has achieved treatment goals as evidenced by one or more of the following:
  - No longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care;
  - Has returned to baseline function;
  - Can continue therapy with a home therapy exercise program and deficits no longer require a skilled therapy intervention;
  - Has adapted to impairment with assistive equipment or devices, is able to perform ADLs with minimal to no assistance from caregiver, or;
  - Client has achieved maximum functional benefit from therapy in progress and functioning within normal limits, or will no longer benefit from additional therapy
  - Client is unable to participate in the treatment plan or plan of care due to medical, psychological, or social complications, and responsible adult have had instruction on repetitive exercises in the home exercise program and the skills of a therapist are not needed to provide or supervise the service;
  - The therapy requested is for general conditioning or fitness, or for educational, recreational or work related activities which does not take the skills of a therapist.
  - Plateau in response to therapy/lack of progress towards therapy goals. Indication for therapeutic pause in treatments or transition to chronic status and maintenance therapy.
  - Non-compliance due to poor attendance and with responsible adult non-compliance with therapy and home program.

## **Reimbursement/Billing Guidelines**

PT, OT, and ST procedure codes submitted by a home health agency are reimbursed at the statewide visit rate calculated in accordance with 1 TAC §355.8021(a). Therapy procedure codes billed by other therapy providers are reimbursed in accordance with 1 TAC §355.8085.

Claims submitted for physical, occupational and speech therapy for an acute medical condition or acute exacerbation of a chronic medical condition must contain the AT modifier.

The physical, occupational therapy, and speech therapy procedure codes billed by a home health agency are reimbursed at the statewide visit rate, and other therapy providers are reimbursed in 15-minute increments.

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

Coverage periods do not coincide necessarily 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.

Providers may request physical, occupational, or speech therapy services frequency by week.

- 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 in that prior authorization week.
- Services billed, in excess of those authorized for the prior authorization week, are subject to recoupment.

If the therapy services billed exceed one hour (four units a day), the claim will be denied, and may be appealed. On appeal, the provider must meet the following conditions:

- The appeal 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.

Providers must use the appropriate procedure codes and modifiers for the therapy services performed. Modifier AT indicates an acute service and must be billed with appropriate physical, occupational or speech therapy procedure codes, identifying the therapy service provided.

Therapy services are limited to one evaluation, or treatment up to the limits outlined in this article for each therapy discipline per date of service.

When there is a change of provider or change in the client's medical condition requiring therapy, a denied claim for therapy (PT, OT, or ST) evaluation and swallowing function evaluation exceeding the limits outlined in this article may be considered on appeal for reimbursement with documentation of one of the following:

- A change in the client's medical condition or new therapy-related diagnosis with date of onset documented in the plan of care or treatment plan,
- A change of provider letter signed and dated by the client or responsible adult documenting all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the new provider and previous provider

### **Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units**

Modifiers GP, GO, and GN modifiers are required on all claims except when submitting evaluation procedure codes for physical, occupational, and speech therapy. The AT modifier must be included on claims for acute therapy services.

All claims for reimbursement of procedure codes paid in 15 minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour (See Table A.).

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 zero units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 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 as follows:**

**Table A: Counting Minutes for Timed Procedure Codes in 15-Minute Units**

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

Time-based physical, occupational and speech therapy treatment procedure codes that may be billed in multiple quantities of 15 minutes each are limited to one hour per date of service per discipline (four units). Procedure codes listed in the following table must be billed in 15-minute increments:

**Table B\*: PT, OT, and ST Procedure Codes that are Billable in Units of 15 Minute Increments**

Procedure Codes					
92507	92508	92526	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97530	97535
97537	97542	97750	97799		

**Table C\*: Codes Limited to Once per Day**



Procedure Codes					
97012	97014	97016	97018	97022	97024
97026	97028	97150			

\*Home Health Agencies are reimbursed at a statewide visit rate.

A client may receive therapy in more than one discipline (physical, occupational or speech) in the outpatient, office, or home setting in one day.

If a therapy evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or will be denied.

An evaluation performed on the same day as therapy from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Physical therapy provided in the nursing home setting is limited to the nursing facility because it must be made available to nursing home residents on an “as needed” basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources. Nursing home facilities should refrain from admitting clients who need goal directed therapy if the facility is unable to provide these services.

Procedure codes for PT/OT/ST evaluations are payable once every three years to the same provider.

Additional PT, OT, or ST evaluations exceeding the limits outlined in this article may be considered for reimbursement on appeal with documentation of one of the following:

- A significant change in the client’s medical condition,
- A change of provider has occurred and a change of provider letter is submitted with the appeal.

### **Therapy Assistant Modifier**

Licensed therapists of each therapy discipline must use the therapy assistant modifier to indicate the services rendered by licensed therapy assistants while attending to Medicaid clients.

The therapist must submit on the claim the UB modifier to indicate the PT, OT, or ST service(s) provided by a PT, OT, or speech-language pathologist therapy assistant(s) in a 24-hour period to Medicaid clients.

This modifier is to be utilized as indicated with all physical, occupational, and speech therapy treatment procedure codes.

### **Therapy Co-Treatment**

Claims for co-treatment services must be submitted with modifier U3.

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