Physical, Occupational, and Speech Therapy - Children (Acute and Chronic)

Information posted May 6, 2016

**Note:** This article applies to claims submitted to TMHP for processing. For claims processed by a Medicaid managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, prior authorization, and reimbursement.

The updates to the Texas Medicaid Physical, Occupational, and Speech Therapy policy benefit for children who are 20 years of age and younger are effective May 1, 2016.

The Health and Human Services Commission (HHSC) is releasing the updated benefit policy to assist providers with the new Texas Medicaid Physical, Occupational, and Speech Therapy benefits and authorization requirements. This notification is a re-release of the February 2, 2016 notification, and all subsequent updates made in March and April have been incorporated. The June 15, 2016 release of the *Texas Medicaid Provider Procedures Manual* (TMPPM) will include this benefit policy, and it will replace all benefit criteria and authorization requirements currently stated in the TMPPM.

HHSC is also re-releasing clarifications on how to report standardized test results for developmental delay (previously released March 31, 2016) and the procedures required for re-evaluations and re-certifications (previously released April 29, 2016).

**Refer to:** The article titled “Changes to CCP Physical, Occupational, and Speech Therapy Policy for Clients Who Are Birth through 20 Years of Age,” which was posted to this website on March 31, 2016, and the article titled “Clarification Regarding How to Obtain Authorization for Physical, Occupational, and Speech Therapy Re-evaluation Procedure Codes,” which was posted on this website on April 29, 2016.

The benefits are effective May 1, 2015.

**Reminders and Clarifications Originally Published March 31, 2016, and April 29, 2016**

**Developmental Delay Criteria (Information Posted March 31, 2016)**

Policy states that when reporting test results for developmental delay:

Eligibility for therapy will be based upon a score that falls 1.5 standard deviations (SD) or more below the mean in at least one subtest area of composite score on a norm-referenced, standardized test.

HHSC reminds providers that age equivalents, percent delay, or scaled scores will not be accepted as a measure of developmental delay, though providers may include this information in their evaluation summaries. Raw scores must be included in the evaluation summary, but are not sufficient to communicate the measure of standard deviation from the mean on the assessment tool.

It is necessary to submit test results to communicate the score on a norm-referenced, standardized test in the form of standard deviation, z-scores, t-scores, standard scores with the mean (M) and SD of that standard score specified, or percentile rank. A test or subtest score with an SD of 1.5 or more below the mean may be communicated as:

- Z-score of -1.50 or lower
• T-score (M=50, SD=10) of 35 or lower
• Standard scores (M=100, SD=15) of 78 or lower
• Percentile rank of 7 or lower

Reevaluation Authorization and Reimbursement (Information Posted on April 29, 2016)

• A provider must state the date the re-evaluation was performed on the PA form.
• The re-evaluation procedure code must be submitted on the PA form when submitted with a request for recertification.
• When submitting claims for re-evaluations, providers should use the authorization number as referenced on the authorization letter.
• Reimbursement for the re-evaluation is not tied to continuation of services. If a therapy provider performs a re-evaluation of a client, and the therapy provider determines services are no longer necessary, a provider may state that they intend to discharge the client. The intent to discharge should be stated on the PA form in the "projected tapered-down frequency" section.

To summarize the process for obtaining authorization for a re-evaluation, HHSC expects providers to:

• Obtain an order for reevaluation from the client’s prescribing provider before performing a reevaluation
• Perform a reevaluation within 30 days of the signed and dated order
• Submit PA form with recommended frequency and duration to continue services to prescribing provider. Or follow written or verbal order procedure as specified in policy.
• Submit to TMHP no earlier than 30 days before the current authorization period expires:
  o The request for recertification with all elements required for recertification, including the plan of care (see requirements for initial authorization and recertification outlined below)
  o The PA form, or electronic equivalent, signed and dated by the therapist. The prescribing provider must sign the PA form or therapist must follow written/verbal order per policy.
  o Include the appropriate reevaluation code, and date reevaluation performed, on the PA form so that the submitted claim associated with the reevaluation procedure can be considered for reimbursement.

The following is the benefit policy which was released on February 2, 2016, all updates made in March and April have been incorporated. This benefit policy will replace all benefit criteria and authorization requirements currently stated in the TMPPM.
Physical, Occupational, and Speech Therapy - Children (Acute and Chronic) Statement of Benefits

This medical policy addresses acute and chronic physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services for clients who are birth through 20 years of age. This policy does not address freestanding inpatient rehabilitation services.

Unless otherwise specified, "days" refers to calendar days.

PT, OT, and ST are benefits of Texas Medicaid in Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs) only for clients aged birth through 20 years.

Services provided to a client on school premises are only permitted when delivered before or after school hours. The only PT, OT, and ST services that can be delivered during school hours are therapy services provided by school districts as School Health and Related Services (SHARS).

Clients who are eligible for PT, OT, and ST through the public school system (SHARS), may only receive additional therapy through Medicaid if medical necessity criteria is met as outlined in this policy.

For specific guidelines related to therapy services provided through Early Childhood Intervention, refer to the Early Childhood Intervention (ECI) Services - CCP policy.

Therapy services must be performed by one of the following: a licensed physical therapist, licensed occupational therapist, licensed speech-language pathologist, 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)

Note: An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of therapy services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.

PT/OT/ST services are provided in one of the following places of service by setting and provider:

- Outpatient
  - Comprehensive outpatient rehabilitation facility (CORF)/ Outpatient rehabilitation facility (ORF)
  - Independently enrolled therapists
  - Physical Therapy Group
  - Hospitals
- Office
  - Physician
  - Physical Therapy Group
  - Independently enrolled therapists
- Home
In determining whether a service requires the skill of a licensed physical and occupational therapist or speech language pathologist, 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 (such as a family member or medical assistant) 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.

**Acute Services**

Acute PT, OT, and 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.

- 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 prescribing provider's and therapist's assessment of the client's restorative potential.

**Note:** Recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.

- Treatments are directed toward 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.

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.

With documentation of medical need, PT, OT and ST may continue for a maximum of 120 days for an acute medical condition or an acute exacerbation of a chronic medical condition.
Once the client’s condition is no longer considered acute, continued therapy for a chronic condition will only be considered for clients who are birth through 20 years of age.

**Chronic Services**

Chronic physical, occupational, and speech therapy services are benefits of Texas Medicaid for the medically necessary treatment of chronic medical conditions and developmental delay when a medical need is established for the developmental delay as indicated in this policy. All eligible clients who are birth through 20 years of age may continue to receive all medically necessary therapy services, with documentation proving medical necessity.

The goals of the services provided are directed at maintaining, improving, adapting, or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part, congenital abnormality, degenerative disease, or developmental delay.

- 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.

Treatment for chronic medical conditions and developmental delay will only be considered for clients who are birth through 20 years of age.

**Policy Overview/Scope**

Physical, occupational and speech therapy services must be medically necessary to the treatment of the individual's chronic or 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 a specific and effective treatment 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, restoring, or maintaining functions which have been lost or impaired due to a recent illness, injury, loss of body part or congenital abnormality or as a result of developmental delay or the presence of a chronic medical condition.
- Functional goals refer to a series of behaviors or skills that allow the client to achieve an outcome relevant to his/her safety and independence within context of everyday environments. Functional goals must be specific to the client, objectively measurable within a specified time frame, attainable in relation to the client's prognosis or developmental delay, relevant to client and family, and based on a medical need.
Testing must establish a client with developmental delays meets the medical necessity criteria as defined in this policy, see Developmental Delay Criteria section in this 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 prescribing provider 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, level of disability, and standards of practice; it is not for the convenience of the client or the responsible caregivers.

- 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 for frequency, see the Frequency and Duration Criteria for PT/OT/ST section under the Authorization section in this policy.

**Physical Therapy**

The practice of physical therapy includes: (1) measurement or testing of the function of the musculoskeletal, or neurological, system; (2) rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect; (3) 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 or chronic medical condition 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**

The practice of occupational therapy includes: (1) evaluation and 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, (2) using therapeutic goal-directed activities to: (A) evaluate, prevent, or correct physical dysfunction; or (B) maximize function in a person's life; or (3) applying 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 skills needed for activities of daily living (ADL) and/or functional skills needed for daily life lost through acute medical condition, acute exacerbation of a medical condition or chronic 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**

Speech therapy is a benefit of Texas Medicaid for the treatment of chronic, 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 licensed 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 speech/language communication and swallowing disorders that have been lost or damaged as a result of a chronic, 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.

- This disorder 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.

**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 policy for each therapy discipline, and rendered in accordance with the Executive Council of 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 prescribing provider.

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 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, defined as at least two therapy disciplines (physical, occupational, or speech therapy) during the same therapy session.

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.

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

- Prescribing provider's 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:

- Prescribing provider’s 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.

**Exclusions (Non-covered Services)**

The following services are not a benefit 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. VitalStim must be a component of a comprehensive feeding treatment plan to be considered a benefit.

- 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 who are not considered medically necessary because they do not require the skills of a therapist, such as: (1) General exercises to promote overall fitness and flexibility or improve athletic performance, (2) Activities to provide diversion or general motivation and, (3) 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.
- 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, vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback, and the Wilbarger brushing protocol.
- 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.
- 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).
- 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.
  o Providers may not bill Texas Medicaid for therapy services provided solely by auxiliary personnel.
  o 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 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 may sign prior authorization forms and supporting documentation using electronic or wet signatures. For additional information about electronic signatures, please refer to the 'Electronic Signatures in Prior Authorizations' medical policy.

Therapy services performed in the acute care inpatient setting do not require prior authorization.

Initial Evaluation and Considerations for Prior Authorization for Treatment
Initial evaluations do not require prior 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 prescribing provider's order for the evaluation, support a medical need for the therapy evaluation and be available when requested.

A therapy evaluation is considered current when it is performed within 60 days before the prior authorization request is received.

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 prescribing provider must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The prescribing provider 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. PT, OT, or ST services may be prior authorized to be provided in the following locations: home of the client, home of the caregiver or guardian, client's daycare facility or the client's school.

For acute therapy services, i.e. acute services billed with an AT modifier, prior authorization requests may not exceed a 60 day period per each request. After two 60 day authorized periods, any continued requests for therapy services must be considered under the chronic sections of this policy.

For chronic therapy services, prior authorization may be granted for up to 180 days with documentation of medical necessity and additional prior authorizations.

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

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

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

- The prescribing provider must certify that the Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.
Signature of prescribing provider on PA form will attest that this service has been provided. If prescribing provider provides verbal order or written order separate from PA form, staff member who conveys the verbal or written order must communicate that prescribing provider attests that Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.

- For acute services: Documentation from the prescribing provider that a visit for the acute or acute exacerbation of the medical condition requiring therapy has occurred within the last 90 days.

- 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
  - Time in and time out
  - Baseline objective measurements based on standardized testing performed or other standard assessment tools. For chronic services, see section on Developmental Delay Criteria.
  - Safety risks
  - Client-specific, measurable short and long-term functional goals within the length of time the service is 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 the evaluation note
  - Requested dates of service for planned treatments after the completion of the evaluation
  - Responsible adult's expected involvement in client's treatment
  - History of prior therapy and referrals as applicable
  - Signature and date of treating therapist

**Additional Evaluation and Documentation Requirements for Speech Therapy**

- Additional evaluation and documentation requirements for speech therapy includes one or more of the following:
o **Language evaluations** - oral-peripheral speech mechanism examination and formal or informal assessment of hearing, articulation, voice and fluency skills;

o **Speech production (voice)** - formal screening of language skills, and formal or informal assessment of hearing, voice and fluency skills;

o **Speech production (fluency and articulation)** - formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills;

o **Oral Motor/Swallowing/Feeding** - In addition to formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills, if swallowing problems and/or signs of aspiration are noted, then a statement indicating that a referral has been made to the client's prescribing provider to consider a video fluoroscopic swallow study must be included.

**Bilingual Testing Requirements**

Bilingual and multilingual speakers are frequently misclassified as developmentally delayed. Equivalent proficiency in both languages should not be expected.

Criterion-referenced assessment tools can be used to identify and evaluate a client's strengths and weaknesses, as opposed to norm-referenced testing, which assesses an individual relative to a group. When possible, use culturally and linguistically adapted test equivalents in both languages to compare potential deficits and included in the documentation. The therapist will show the highest score of the two languages to determine whether the child qualifies and which language will be used for the child's therapy. Testing for all subsequent re-evaluations should only be conducted in the language used in therapy.

**Written and Verbal Orders**

For all therapies, when the request form submitted is not signed and dated by the prescribing provider 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 prescribing provider based on the evaluation and services requested by the therapist (the order for the evaluation may be obtained separately), and a prescribing provider's order to evaluate and treat is acceptable for the evaluation, but not acceptable for the therapy treatment. Written orders must contain the prescribing provider ordered frequency and duration and affirmation that client's Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.

- Documentation of a verbal order to include 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
  - Verbal order includes the date the verbal order was taken.
Verbal order includes the services, frequency and duration prescribed by the ordering provider.

Verbal order includes attestation from prescribing provider that client's Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.

**Requests for Recertification - Acute Therapy Services**

A recertification for prior authorization of acute therapy services may be considered up to a maximum of 60 day increments, when services continue to meet authorization criteria.

Re-evaluation codes (Procedure codes 97002, 97004, and S9152) require authorization for acute therapy services and must be submitted with the recertification request.

Therapy for clients who are birth through 20 years of age who do not meet the acute therapy services criteria may be considered for chronic therapy services.

Recertification for an acute or acute exacerbation of medical conditions includes a Progress Summary and a Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form.

A complete request must be received no earlier than 30 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.

Prior authorization for recertification requests may be considered for increments up to 60 days for each therapy service request, with documentation supporting the medical necessity including all of the following:

- 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 prescribing provider. When the request form is unsigned by the prescribing provider, 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 a revised treatment plan or plan of care for the recertification dates of service requested, 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 treatment program
  - New treatment plan or plan of care for the recertification dates of service requested
  - 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 POC 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 treatment program
    - Updated or new functional and measurable short and long-term treatment goals with time frames, as applicable
    - Documentation of client's 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 Recertification - Chronic Therapy Services

Re-evaluation (every 180 days)

A re-evaluation is a comprehensive evaluation and must take place every 180 days and contains all the elements of an initial evaluation. It may be used to make a determination whether or not skilled therapy is medically necessary, or when determining the effectiveness of the current plan, or when the current plan requires significant modification and revision of the interventions and goals due to changes in the client's medical status or lack of progress with the current treatment. A re-evaluation requires authorization and must be submitted with the recertification request (Procedure codes 97002, 97004, and S9152).
- Routine reassessments that occur during each treatment session or visit or for a progress report required for an extension of services or discharge summary are not considered a comprehensive re-evaluation.

- Tests used must be norm-referenced, standardized and specific to the therapy provided. See section on Developmental Delay Criteria.

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

A complete request must be received no earlier than 30 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 request is received.

A re-evaluation may occur as early as 60 days prior to the end of the current authorization period.

A therapy re-evaluation is considered current when it is performed within 60 days before the current authorization period expires.

The re-evaluation must occur within 30 days of the signed and dated order from the referring provider.

Prior authorization for recertification requests may be considered for increments up to 180 days for each request with documentation supporting the medical necessity including all of the following:

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

- A re-evaluation must include a revised treatment plan or plan of care including all of the following:
  - Date therapy services started
  - Changes in the treatment plan, the rationale, and the requested change in frequency of visits
  - Documentation of reasons continued therapy services are medically needed
  - Documentation of developmental delay. See section on Developmental Delay Criteria.
  - Documentation of client's participation in treatment, as well as client/responsible adult's participation or adherence with a home treatment program
  - New treatment plan or POC for the recertification dates of service requested
  - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable. Previous authorization period's goals and progress must be included.
  - Prognosis with clearly established discharge criteria. The discharge plan must reflect realistic expectations from the episode of therapy.
- 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 POC must be signed and dated by the therapist responsible for the therapy services.

**The Following Sections Apply to both Acute and Chronic Therapy Services**

**Requests for Revisions to Existing Prior Authorization/ Recertification- Acute and Chronic Therapy Services**

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 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 prescribing provider. When the request form is not signed and dated by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed services.

- Progress summary for acute or chronic services indicating 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, including updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable. Previous authorization period's goals and progress must be included.

- 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, and also the following:
- 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
- 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.

The authorization period will not change when the provider changes.

**Treatment Note**

The following documentation must be kept on file by the treating provider and be 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, re-evaluations, progress summaries, treatment notes, and discharge summaries must show client's name, date of service, time in and time out of 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, level of disability and standards of practice; it is not for the convenience of the client or the responsible adult.

Exceptions to therapy limitations may be covered if medically necessary criteria are met for the following: a. Presentation of new acute condition, or b. Therapist intervention is critical to the realistic habilitative/restorative goal provided documentation proving medical necessity is received.

When therapy is initiated, the therapist must provide education and training of the client and responsible caregivers, by developing and instructing them in a home treatment program to promote effective carryover of the therapy program and management of safety issues.
Providers may request high, moderate, or low frequencies on the Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form by indicating 3, 2, or 1 time per week respectively. Providers may request low or maintenance level by requesting 1, 2, or 3 times per month. Additional documentation is required when requesting a frequency of 3 times a week or more.

High Frequency (3 times per week): Can only be considered for a limited duration (approximately 4 weeks or less) or as otherwise requested by the prescribing provider with documentation of medical need to achieve an identified new skill or recover function lost due to surgery, illness, trauma, acute medical condition, or acute exacerbation of a medical condition, with well-defined specific, achievable goals within the intensive period requested.

- Therapy provided three times a week may be considered for 2 or more of these exceptional situations:
  - The client has a medical condition that is rapidly changing.
  - The client has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery).
  - The client's therapy plan and home program require frequent modification by the licensed therapist.
- On a case-by-case basis, a high frequency requested for a short-term period (4 weeks or less) which does not meet the above criteria may be considered with all of the following documentation:
  - Letter of medical need from the prescribing provider documenting the client's rehabilitation potential for achieving the goals identified,
  - Therapy Summary documenting all of the following:
    - Purpose of the high frequency requested (e.g., close to achieving a milestone)
    - Identification of the functional skill which will be achieved with high frequency therapy
    - Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.
- A higher frequency (4 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 decrease as well.

Maintenance Level/Prevent Deterioration: This frequency level (e.g., every other week, monthly, every 3 months) is used when the therapy plan changes very slowly, the home program is at a level that may managed by the client or the responsible adult, or the therapy plan requires infrequent updates by the skilled therapist. A maintenance level or preventive level of therapy services may be considered when a client requires skilled therapy for ongoing periodic assessments and consultations and the client meets one of the following criteria:

- Progress has slowed or stopped, but documentation supports that ongoing skilled 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.

**Developmental Delay Criteria**

To establish a developmental delay, all of the following criteria must be met:

- Tests used must be norm-referenced, standardized, and specific to the therapy provided.
- Re-testing with norm-referenced standardized test tools for re-evaluations must occur every 180 days. Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation. If re-use of the initial testing instrument is not appropriate, i.e. due to change in client status or restricted age range of the testing tool, provider should explain the reason for the change.
- Eligibility for therapy will be based upon a score that falls 1.5 standard deviations (SD) or more below the mean in at least one subtest area of composite score on a norm-referenced, standardized test. Raw scores must be reported along with score reflecting SD from mean.
- When the client's test score is less than 1.5 SD below the mean, a criterion-referenced test along with informed evidenced-based clinical opinion must be included to support the medical necessity of services and may be sent to physician review to determine medical necessity.

- If a child cannot complete norm-referenced standardized assessments, then a functional description of the child's abilities and deficits must be included. Measurable functional short and long term goals will be considered along with test results. Documentation of the reason a standardized test could not be used must be included in the evaluation.

- Specific Developmental Delay Criteria Requirements for speech diagnoses:
  - Language: at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
  - Articulation: at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
  - Apraxia: at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
  - Fluency: at least one norm-referenced, standardized test with good reliability, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
  - Voice: a medical evaluation is required for eligibility and based on medical referral
  - Oral Motor/Swallowing/Feeding: an in-depth, functional profile of oral motor structures and function
  - If the client's test score is less than 1.5 SD below the mean, additional documentation supporting the client's medical need for therapy will be considered and the request will be sent to physician review to determine medical necessity.

Additional speech therapy visits or sessions may be considered for moderate speech language, articulation, voice and dysphagia developmental delays when documentation submitted supports medical necessity as delineated in the frequency criteria in this policy.

**Age Adjustment for Children Born Prematurely**

Age is adjusted for children born before 37 weeks gestation and is based on a 40-week term. The developmental age must be measured against the adjusted age rather than chronological age until the child is 24 months old. The age adjustment cannot exceed 16 weeks.

**Criteria for Discontinuation of Therapy**

Discontinuation of therapy may be considered in one or more of the following situations:
- Client no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care;
- Client has returned to baseline function;
- Client can continue therapy and maintain status with a home treatment program and deficits no longer require a skilled therapy intervention;
- Client has adapted to impairment with assistive equipment or devices
- Client is able to perform ADLs with minimal to no assistance from caregiver;
- Client has achieved maximum functional benefit from therapy in progress 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 has had instruction on the home treatment program and the skills of a therapist are not needed to provide or supervise the service;
- Testing shows client no longer has a developmental delay;
- Plateau in response to therapy/lack of progress towards therapy goals;
- Non-compliance due to poor attendance and/or client or responsible adult non-compliant with therapy and home treatment program.

The therapy requested is for general conditioning or fitness, or for educational, recreational or work-related activities which does not require the skills of a therapist.

Reimbursement/Billing Guidelines

The physical, occupational and speech therapy procedure codes billed 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 §355.8441.

Providers must use the appropriate procedure codes and modifiers for claims submitted for PT, OT, or ST services.

- Modifier AT indicates an acute/rehabilitative service and must be billed with the appropriate physical, occupational, or speech therapy procedure codes identifying the therapy service provided is acute/rehabilitative.
- Providers must use modifier GP for PT services.
- Providers must use modifier GO for OT services.
- Providers must use modifier GN for ST services.

When physical or occupational group therapy is administered, providers should bill procedure code 97150 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 for one or more visits per week, or by month for 1, 2, or 3 visits per month.
• 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 or month must be contained in that prior authorization period.

• Services billed in excess of those authorized 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 or month for the date of service appealed.

• The appeal must include an attestation that the provider has billed all therapy services for the week or month in question.

Missed visits may be made up within the authorization period as long as total number of visits or units authorized does not exceed the amount authorized. Provider should document reason for visits outside of the weekly or monthly frequency in the client's medical record.

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

When there is a change of provider, or a change in the client's medical condition requiring therapy, a denied claim for a therapy (PT, OT, or ST) evaluation, re-evaluation or swallowing function evaluation that exceeded the limits outlined in this policy 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:
  o The date the client ended therapy (effective date of change) with the previous provider
  o The name of the new provider and previous provider

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

Modifiers GP, GO, and GN are required on all claims except when billing evaluation and re-evaluation procedure codes. 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

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

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 (4 units). Procedure codes listed in the following table must be billed in 15 minute increments:

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>TOS</th>
<th>Proc</th>
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<tbody>
<tr>
<td>1</td>
<td>92507</td>
<td>1</td>
</tr>
<tr>
<td>1/C</td>
<td>92508</td>
<td>1/C</td>
</tr>
<tr>
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<td>1</td>
</tr>
<tr>
<td>1/C</td>
<td>97032</td>
<td>1/C</td>
</tr>
<tr>
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</tr>
<tr>
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<td>97039</td>
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</tr>
<tr>
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<td>97082</td>
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<tr>
<td>1/C</td>
<td>97110</td>
<td>1/C</td>
</tr>
<tr>
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<td>97116</td>
<td>1/C</td>
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<td>97124</td>
<td>1/C</td>
</tr>
<tr>
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<td>97139</td>
<td>1/C</td>
</tr>
<tr>
<td>1/C</td>
<td>97140</td>
<td>1/C</td>
</tr>
<tr>
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<td>97530</td>
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<td>1/C</td>
<td>97537</td>
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<td>1</td>
<td>S8990</td>
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<tr>
<td>1/C</td>
<td>97976</td>
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### Table C: Therapy Treatment Codes Limited to Once per Day*

<table>
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<tr>
<th>Procedure Codes</th>
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</tr>
</thead>
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<tr>
<td>1</td>
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<tr>
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<td>97014</td>
<td>1/C</td>
</tr>
<tr>
<td>1/C</td>
<td>97016</td>
<td>1/C</td>
</tr>
<tr>
<td>1</td>
<td>97018</td>
<td>1/C</td>
</tr>
<tr>
<td>1/C</td>
<td>97022</td>
<td>1/C</td>
</tr>
<tr>
<td>1</td>
<td>97026</td>
<td>1/C</td>
</tr>
<tr>
<td>1/C</td>
<td>97028</td>
<td>1/C</td>
</tr>
<tr>
<td>1</td>
<td>97150</td>
<td>1/C</td>
</tr>
</tbody>
</table>

* For the procedure codes in tables B and C above, 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 more than one setting (outpatient, office or home setting) in one day.
If a therapy evaluation or re-evaluation procedure code and like therapy procedure code are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.

An evaluation or re-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.

For acute services, PT/OT/ST re-evaluations are reimbursed once every 60 days to any provider when a recertification of services is planned.

For chronic services, PT/OT/ST re-evaluations are reimbursed once every 180 days to any provider when a recertification of services is planned.

Additional PT, OT, or ST evaluations or re-evaluations exceeding the limits outlined in this policy may be considered for with documentation of one of the following:

- A significant change in the client’s medical condition as documented in the plan of care or treatment plan
- A change of provider has occurred and a change of provider letter is submitted with the appeal.
- The re-evaluation is required for recertification of an existing authorization.

**Therapy Assistant Modifiers**

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 in Table D to indicate the PT, OT, or ST service(s) provided by a PT, OT, or speech-language pathology 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.

<table>
<thead>
<tr>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
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**Therapy Co-Treatment**

Claims for co-treatment services must be submitted with modifier U3.
<table>
<thead>
<tr>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>U3</td>
</tr>
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</table>

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