Physical, Occupational, and Speech Therapy Benefits to Change for Acute Services for Texas Medicaid

Information posted November 7, 2008

Effective for dates of service on or after January 1, 2009, the benefit criteria for physical, occupational, and speech therapy will change for acute services for Texas Medicaid.

Physical, occupational, and speech therapy are benefits of Texas Medicaid for acute conditions, as follows:

- Treatments are expected significantly to improve the patient’s condition in a reasonable and generally predictable period of time, based on the physician’s assessment of the patient’s restorative potential.
- Treatments are directed towards restoration of or compensation for lost function.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider’s scope of practice, as defined by state law.

The physician must maintain in the client’s medical record documentation of medical necessity, including the treatment plan and therapy evaluation or re-evaluation. The requesting provider may be asked for additional information to clarify or complete a request for therapy. The date, time, and time-length of services provided must be documented and maintained in the client’s medical record. The physician must keep all signed, original documents in the physician’s medical record for the client.

Occupational and speech therapy, including functional evaluations, must be provided according to the current (within 60 days) written orders of a physician and based on medical necessity. The occupational or speech therapy may be performed by auxiliary personnel under the direct supervision of the physician.

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, occupational, and speech therapy are not covered for clients who are 21 years of age or older unless ordered by a physician for an acute condition or an exacerbation of a chronic condition and billed by one of the following:

- A physician in an outpatient setting.
- A hospital in an inpatient or outpatient setting.
- A home health agency as a home health service.

**Note:** Speech therapy is not reimbursable in the home.

During an inpatient admission for acute care episodes, physical, occupational, and speech therapy services are reimbursed as part of the inpatient hospital reimbursement methodology (Diagnosis Related Group or Tax Equity Fiscal Responsibility Act), and are not reimbursed separately to the individual therapist.

The following services are not considered medically necessary for an occupational therapy request:

- Training in nonessential tasks (e.g., homemaking, gardening, recreational activities, cooking, driving, assistance with finances, and scheduling).
• Maintenance therapy, including passive range of motion and exercises, which are not directed towards restoration of a specific loss of function.

• Instruction of other agency or professional personnel in the patient's occupational therapy program.

• Emotional support, adjustment to extended hospitalization, or disability behavioral readjustment.

Occupational therapy prescribed primarily as an adjunct to psychotherapy is not a benefit.

Prior authorization is not required for acute therapy that does not exceed 180 days from the date of the initiation of treatment except in the following circumstances:

• The therapy is provided through Title XIX Home Health Services.

• The therapy is provided through a comprehensive outpatient rehabilitation facility (CORF) or an outpatient rehabilitation facility (ORF).

Providers should submit the date of initiation of therapy as the onset date.

Claims for physical, occupational, and speech therapy services must include the applicable modifier (GP, GO, or GN) to be considered for reimbursement. Modifier AT must be submitted with all physical, occupational, and speech therapy procedure codes for acute conditions or the claim will be denied. Evaluation and re-evaluation procedure codes 1-92506, 1-92610, 1-97001, 1-97002, 1-97003, 1-97004, and 1-S9152 do not require the use of the above modifiers.

The following table shows the modifiers and their descriptions:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
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<tbody>
<tr>
<td>AT</td>
<td>Treatment provided for an acute condition or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy</td>
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<tr>
<td>GP</td>
<td>Required for all physical therapy claims</td>
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<tr>
<td>GO</td>
<td>Required for all occupational therapy claims</td>
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<tr>
<td>GN</td>
<td>Required for all speech therapy claims.</td>
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</tbody>
</table>

Therapy should be completed within the 180 calendar days from the first date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic and treatment is no longer considered “acute.”

Therapy that exceeds 180 days is not a benefit for clients who are 21 years of age or older.

Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

**Note:** Therapy that exceeds 180 days may be considered for prior authorization for clients who are 20 years of age or younger through the Comprehensive Care Program.

A client may receive therapy in more than one distinct therapy type (physical, occupational, or speech) in one day when:

• Therapy is rendered at different times.
• Reimbursement in any one distinct therapy type does not exceed one evaluation or one re-evaluation or four units (one hour) of therapy with a maximum of eight units (two hours) of combined therapy.

Procedure codes 1-92506, 1-92507, 1-92508, 1-92526, and 1-92610 may be reimbursed to audiologists in the office and outpatient setting. Audiologist can bill only for clients who are birth through 20 years of age.

Procedure codes 1-92507, 1-92508, and 1-92526 may be reimbursed in 15-minute increments for a combined maximum of four units (one hour) per day.

Electrical stimulation therapy (procedure code 1-97032) may be considered with documentation of medical necessity for clients receiving speech therapy.

Evaluations (procedure codes 1-97001 and 1-97003) may be reimbursed once per 180 days for the same provider.

Re-evaluations (procedure codes 1-97002 and 1-97004) may be reimbursed once per 30 days for the same provider.

Procedure code 1-97150 will be denied if billed on the same date of service by the same provider as procedure code 1-97750.

Procedure codes 1-97012, 1-97016, 1-97018, 1-97022, 1-97024, 1-97026, 1-97028, and 1-97150 are limited to one per day.

If a therapy evaluation or re-evaluation (procedure codes 1-97001, 1-97002, 1-97003, or 1-97004) is billed for the same date of service as one of the therapy codes in the following table for the same therapy type by any provider, the evaluation or re-evaluation will be denied.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>1-97012</td>
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<td>1-97026</td>
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<td>1-97150</td>
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<td>1-97750</td>
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Procedure codes 1-97535, 1-97537, and 1-97542 may be reimbursed only for clients who are birth through 20 years of age in an outpatient rehabilitation setting or through CCP.

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