Texas Medicaid
Physical, Occupational, or Speech Therapy(PT, OT, ST)
Prior Authorization Form Instructions

General Instructions:

Effective May 1, 2016, all providers requesting therapy services for Fee for Service (FFS) clients must use the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form. This form is to be used for clients of all ages, for initial authorization requests, and for all subsequent recertification requests. Prior Authorization requests may be submitted by mail, fax, or on-line at www.tmhp.com.

- Providers requesting Chronic Therapy services, regardless of practice setting, for clients birth through 20 years of age, should submit prior authorization and recertification requests to the Comprehensive Care Program (CCP) at TMHP.
- Providers requesting Acute Therapy services in the home, for clients of all ages, should submit prior authorization and recertification requests to Home Health Services at TMHP, and
- Providers requesting Acute Therapy services in the outpatient setting, for clients of all ages, should submit prior authorization and recertification requests to Special Medical Prior Authorization at TMHP.

Before requesting prior authorization for PT, OT, or ST services, providers must complete all required documentation, and obtain necessary orders and signatures, as outlined in the Texas Medicaid Providers Procedures Manual (TMPPM). Initial prior authorization requests must be received by TMHP no later than five business days from the date therapy services began. All recertification requests must be received before the current authorized period expires. To reduce gaps in services, providers must submit recertification requests at least 28 calendar days prior to the end of the current authorization request.

For all initial prior authorization requests not received by TMHP within the five business-day period from the date therapy services began, dates of service prior to the date the request is received will be denied. Similarly, for recertification requests, requests not received before the current authorized period expires, the dates of service prior to the date the request is received will be denied.

Directions for completing the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form**:**

Field	Explanation
Client Name	Enter the client’s name including middle name or initial if known
Medicaid Number	Enter client’s Medicaid 9-digit identification number
Date of Birth	Enter the client’s date of birth
Condition: ☐ Acute ☐ Chronic	If requesting services for an acute condition or acute exacerbation of a chronic condition, check “Acute”. All acute therapy services must have the AT modifier on the submitted claim. If requesting services for a chronic condition, check “chronic”. **Note: For adult clients 21 years of age and older, services are limited to treatment of acute conditions or acute exacerbations of chronic conditions.**
If acute condition enter date(s) of onset:	Enter the date(s) of onset of the acute condition(s) or acute exacerbation(s) of a chronic condition if applicable.
Treatment Diagnoses:	Enter client’s ICD-10 Code(s) or diagnoses for the medical conditions that require therapy services
Other Diagnoses:	Enter client’s other relevant ICD-10 Code(s) or diagnoses
Has the client received therapy in the last year from the public school system?	Enter Yes or No. Clients who are eligible for therapy services through the public school system (SHARS) may only receive additional therapy through Texas Medicaid if medically necessary. Providers are expected to provide supporting statements and evidence in the required documentation that supports the need for further therapy services outside of the public school system.

Field	Explanation
Place of Service Requested	Home Health agency providers check the **home** box for home health services delivered in the home setting Individually or group enrolled providers check the **office** box for services provided in the office setting Outpatient facility providers (including CORF/ORF providers) check the **outpatient facility** box for services delivered in the outpatient facility setting Individually or Group enrolled providers check the **other** box for services delivered in a setting other than office. **Note: this option is only available for clients birth through 20 years of age, through CCP.**
Date of Last Therapy Evaluation or Re-evaluation (PT, OT, ST)	Enter the applicable dates for PT, OT, or ST evaluations or re-evaluations **Note: A copy of the applicable therapy evaluation or re-evaluation, for each therapy discipline requested, must be submitted with the request form.**
Discipline and Modifier Dates of Service, From, Through	On the line for each therapy discipline (PT, OT or ST) requested enter the requested service dates: The From date should be the date therapy treatment services are initiated The Through date should be the last date the therapy services are requested. **Note: For chronic conditions, under CCP only, the authorization period is 180 calendar days. For acute conditions, the authorization period is 60 calendar days.**
Projected Frequency (per week or per month) *	Enter the number of therapy sessions planned for the client each week or per month. Monthly frequencies are limited to 1, 2, or 3 times per month. Requested periods must always be noted in weeks or by the month. Refer to the TMPPM for information about additional documentation required when requesting a frequency of 3 times a week or more. If the projected frequency will be tapered down or variable, indicate the frequency plans in the space provided.
Total Number of Units Requested	Calculate and enter the total number of 15 minute units that the provider will bill for the requested authorization period. Home Health agencies calculate and enter the total home visits that the provider will bill for the requested authorization period.
Procedure Codes Requested:	Enter all relevant procedure codes the provider is requesting, including evaluation, re-evluation and/or treatment procedure codes.
Specialist, Printed Name, Signature, Date	Each therapy provider (PT, OT, or ST) who will be delivering services to the client is required to print, sign and date his/her name.
Prescribing Provider, Printed Name, Signature, Date	If the prescribing provider is signing the form, the provider must print, sign and date the form. The form may be submitted without the prescribing provider's signature and date, but the form must be accompanied by a signed and dated written order, prescription, or documented verbal order. All verbal orders must be co-signed by practitioners that include verbal orders within their scope of practice.
Prescribing Provider NPI and License No.:	Enter the prescribing provider's NPI and License Number
Date client last seen by prescribing provider:	Enter the date the client was last seen by the prescribing provider. This date will be used for reference by TMHP PA staff to determine if the acute condition or acute exacerbation of a condition is within 90 calendar days of the requested therapy services.

Field	Explanation
Therapy Billing Provider Information	This section is for the provider or agency who is billing for the therapy services
Name, Telephone, Address, Fax, TPI, NPI:	Enter the contact information for the provider or agency. The telephone and fax number will be used by TMHP for authorization approvals or to request additional information. The address should be the same as the one associated with the provider's NPI or TPI.
Taxonomy and Benefit Code	Providers need to enter taxonomy code and benefit code information if they do not enter their TPI on the form and they have multiple physical locations or program enrollments under the same NPI.