Texas Medicaid

Provider Procedures Manual

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Provider Handbooks

Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

The information in this handbook is intended for therapy services for clients of all ages. Therapy services include occupational therapy (OT), physical therapy (PT), and speech therapy (ST). The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these therapies.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

All providers are required to report suspected child abuse and neglect, as outlined in subsection 1.7, "Provider Responsibilities" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2 Enrollment

Refer to: Subsection 1.7.18, "Physical, Occupational, and Speech Therapy Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for enrollment information.

3 Managed Care Organization (MCO) Clients Who Transition to Medicaid Fee-For-Service (FFS)

When client's transition from an MCO to FFS, providers can request previously approved authorizations be transferred from the MCO to FFS for Comprehensive Care Program (CCP) services, OT, PT, and ST.

3.1 Submission Guidelines

The following submission time frames apply for providers that request to transfer previously approved MCO authorizations for PT, OT, and ST services:

- TMHP will consider the reimbursement of claims for services that were rendered on or after the MCO's disenrollment date only when the provider submits a request to TMHP to transfer the previously approved authorization for PT, OT, and ST services.

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- The request to TMHP must be received on or before the end date of the previously approved MCO authorization. Any requests submitted after the MCO's authorization end date will have to meet the regular submission guidelines for the specific service type.

3.2 Documentation Requirements

All of the requests to transfer the authorizations from the MCO to FFS must include:

- A copy of the previously approved authorization letter.
- All of the documentation that was sent in the original authorization request, including any orders by the prescribing provider that were used to determine the start of care. TMHP will accept the prescribing provider orders as the required documentation for the requested services.
- The completed CCP prior authorization form, Special Medical Prior Authorization (SMPA) form, Home Health Plan of Care, or Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form whichever is applicable for the requested service. The form must include the dates of service and quantities that are being requested from TMHP, and they must match the dates of service and quantities that were approved in the original MCO authorization. It is not necessary to obtain signatures or dates on the forms if they are submitted to TMHP for the purpose of transferring an authorization from an MCO to FFS Medicaid.

  Note: *Authorizations for services transferred from an MCO to FFS Medicaid are subject to retrospective review.*

TMHP will verify the client's eligibility, the dates of service, and the quantities requested. TMHP will process reimbursement claims as follows:

- Claims for services that were rendered before the date on which the transfer request was received will be denied as a late submission, and the provider will be notified of their administrative appeal rights through the Health and Human Services Commission (HHSC).
- Claims for services that were rendered on or after the date of receipt use the required information from the transferred authorization and will be processed as if the request was received in a timely manner.

If a request to transfer an MCO authorization is submitted after the end date of the MCO authorization or the provider does not have an authorization letter from the MCO, TMHP will process the request to transfer the authorization based on established TMHP authorization submission guidelines for PT, OT, and ST services.

All new requests for rendered services must meet the documentation requirements.

3.3 New Services and Extension of Services

For new services that occur after the client's MCO disenrollment change date, the provider is responsible for submitting all TMHP required paperwork and meeting all established submission guidelines for prior authorization.

Requests for the extension of services that occur after the MCO disenrollment change date must include all of the paperwork that is required by TMHP and meet all established submission guidelines for prior authorization.

3.4 Loss of Eligibility

If an MCO disenrolled a client and the client also loses Medicaid eligibility, providers must anticipate, if and when Medicaid eligibility is restored, that the client will initially be considered a Medicaid FFS client and will have a retroactive eligibility period.

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All requests for services that require prior authorization and that occur during the client's retroactive eligibility period, must be submitted to TMHP following the process that is outlined in subsection 5.1.1, "Prior Authorization Requests for Clients with Retroactive Eligibility" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*).

If a client is retroactively disenrolled by an MCO, all of the services that are rendered by the provider during this retroactive disenrollment period (specifically from the date on which the client was eligible for FFS to the date of the client's MCO eligibility change) will be denied by TMHP, and the provider will be notified of their administrative appeal rights.

TMHP may consider services for the MCO transition beginning on the date of the client's MCO eligibility change date and going forward. TMHP uses the MCO transition process for the submission of paperwork and the processing of provider requests.

4 Therapy Services Overview

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 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.
- Functional goals refer to a series of behaviors or skills that allow the client to achieve an outcome relevant to his/her health, safety, or independence within the 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.
- For clients who are 20 years of age and younger, the following conditions must be met:
  - 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.
  - Testing must establish a client with developmental delays meets the medical necessity criteria as defined in subsection 5.3, "Developmental Delay Criteria" in this handbook for chronic therapy services.
  - Evidence of care coordination with the prescribed pediatric extended care center (PPECC) provider, when the client receives therapy services in a PPECC setting.
- For clients who are 21 years of age and older, the following conditions must be met:
  - 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 activities of daily living (ADL).
  - 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 predictable time period.

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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 (for clients who are 20 years of age and younger), and standards of practice; it is not for the convenience of the client or the responsible caregivers.

The following apply:

- 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).

Refer to: Subsection 4.6, "Frequency and Duration Criteria for PT, OT, and ST Services" in this handbook for the frequency prior authorization criteria.

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

4.1 Physical Therapy

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 or chronic medical condition of the musculoskeletal and neuromuscular systems. Physical therapy may be provided by a prescribing provider or physical therapist within their licensed scope of practice.

4.2 Occupational Therapy

The practice of occupational therapy includes:

- 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.
- Using therapeutic goal-directed activities to:
  - Evaluate, prevent, or correct physical dysfunction.
  - Maximize function in a person's life.
- 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 prescribing provider or occupational therapist within their licensed scope of practice.

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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.

4.3 Speech Therapy

Speech therapy is a benefit of Texas Medicaid for the treatment of chronic (for clients who are 20 years of age and younger), 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 prescribing provider 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, or rehabilitate 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.

4.3.1 Types of Communication Disorders

There are three 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, and 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.

4.4 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 handbook 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.

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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 as follows:

- 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.

4.5 Telehealth Services

Providers must defer to the needs of the person receiving services, allowing the mode of service delivery (synchronous audiovisual or in-person) to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

Evaluation, reevaluation, and treatment of some PT, OT, and ST services may be provided by synchronous audiovisual technology.

Telehealth services for OT, PT or ST by synchronous audiovisual technology are allowed for specific procedure codes if clinically appropriate as determined by the practitioner, per standard of care, safe, agreed to by the person receiving services or by the legally authorized representative (LAR), and in compliance with each discipline's rules.

The following procedure codes may be provided by synchronous audiovisual technology:

- Physical Therapy Evaluations- Low, Moderate, and High Complexity and re-evaluation (procedure codes 97161, 97162, 97163, 97164)
- Occupational Therapy Evaluation– Low, Moderate, and High Complexity and re-evaluation (procedure codes 97165, 97166, 97167, 97168)
- PT or OT Services (individual or group) (procedure codes 97110, 97112, 97116, 97150, 97530, 97535, 97750, 97537)
- Community reintegration (procedure code 97537) may be provided if the person receiving services is currently receiving other therapeutic procedure codes and may not be billed separately.
- Speech Evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, S9152)
- ST (individual or group) services (procedure codes 92507, 92508, 92526)
- The provider should obtain informed consent for treatment from the patient, patient's parent, or the patient's legal guardian prior to rendering a telehealth service. Verbal consent is permissible and should be documented in the client's medical record.
- Services delivered by synchronous audiovisual technology may require participation of a caregiver or parent to assist with the treatment.

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- Therapy assistants may deliver services and receive supervision by synchronous audiovisual technology within limits outlined in each discipline's rules. Providers should refer to state practice rules and national guidelines regarding supervision requirements for each discipline.
- Providers must use modifier 95 to indicate remote delivery. Providers are reminded to use the required modifiers GP, GO, and GN on all claims for physical, occupational, or speech therapy treatment

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth documentation requirements including requirements for informed consent.

Note: *Telehealth services must adhere to documentation, privacy and security requirements as outlined in this handbook and those in theTelecommunication Services Handbook (Vol. 2, Provider Handbooks).*

4.5.1 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 prescribing provider 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.

4.5.1.1 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.

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- Number of clients in the group.

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

4.6 Frequency and Duration Criteria for PT, OT, and ST Services

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 the medically necessary criteria are met for the following:

- Presentation of new acute condition
- Therapist intervention is critical to the realistic rehabilitative/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.

> ***Note:*** *The reference to "maintenance" in the above statement is applicable to clients who are 20 years of age and younger.*

4.6.1 High Frequency

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.

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4.6.2 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 ongoing education of the responsible adult.

4.6.3 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.*

4.6.4 Maintenance Level/Prevent Deterioration

For clients who are 20 years of age and younger only, 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 be 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 submitted documentation shows that the client may be making limited progress toward goals or that 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.

4.6.5 Requesting Therapy Services

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.

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- 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.

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.

4.7 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 with a home treatment program and deficits no longer require a skilled therapy intervention and, for clients who are 20 years of age and younger only, maintain status.
- 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. Indication for therapeutic pause in treatments or, for those under age 21, transition to chronic status and maintenance therapy.
- Non-compliance due to poor attendance and with client or responsible adult, non-compliance with therapy and home treatment program.

4.8 Exclusions (Non-covered Services)

The following services are not a benefit of Texas Medicaid:

- Speech therapy provided in the home to adult clients who are 21 years of age and older
- 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:
    - General exercises to promote overall fitness and flexibility or improve athletic performance

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  - Activities to provide diversion or general motivation
  - 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)
- The therapy requested is for general conditioning or fitness, or for educational, recreational or work-related activities that do not require the skills of a therapist
- 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. Providers may not bill Texas Medicaid for therapy services provided solely by auxiliary personnel

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.

4.8.1 Telehealth Exclusions

Texas Medicaid does not reimburse for PT, OT, or ST delivered through synchronous telephone (audio-only) technology. Certain procedure codes are not reimbursable for any telehealth service delivery. The following procedure codes must be provided in-person:

Procedure codes									
97012	97014	97016	97018	97022	97024	97026	97028	97032	97033
97034	97035	97036	97113	97124	97140	97542	97760	97761	97763
97799									

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5 Children's Therapy Services Clients birth through 20 years of age

5.1 Services, Benefits, and Limitations

This section addresses acute and chronic physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services for clients who are 20 years of age or younger. This section 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) for clients who are 20 years of age or younger.

Note: *CORF and ORF services provided at schools, homes, daycare facilities, or any other non-Medicare approved ORF or CORF facility is not a covered Comprehensive Care Program (CCP) benefit.*

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 handbook.

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for the specific guidelines for therapy services that are provided through Early Childhood Intervention (ECI).

Section 2.1.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about therapy services provided through SHARS.

Therapy services must be performed by one of the following: a licensed physical therapist, licensed occupational therapist, licensed speech-language pathologist, a prescribing provider 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 prescribing provider when the prescribing provider delegates this authority to the APRN or PA.*

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

Place of Service	Provider Types
Office	Physician, physical/occupational therapy group, independently enrolled therapist, podiatrist, SHARS and ECI
Home	Home health agency, independently enrolled therapist, physical/occupational therapy group, ECI, SHARS
Outpatient	Physician: podiatrist, outpatient hospital/clinic, outpatient rehabilitation center (includes comprehensive outpatient rehabilitation facility [CORF]/outpatient rehabilitation facility [ORF]) PPECC: home health agency, independently enrolled therapist, physical/occupational therapy group, ECI
Other	ECI, SHARS, independently enrolled therapist, home health agency, and physical/occupational therapy group

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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, the accepted standards of medical and therapy practice guidelines, with consideration of the following:

- 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 be safely and effectively performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy.

Refer to: Subsection 2.1, "CCP Overview" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about CCP.

5.1.1 Acute PT, OT, and ST 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 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.

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 physical, occupational, and speech therapy 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 20 years of age or younger.

5.1.2 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 handbook. 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.

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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.

5.2 Authorization Requirements for PT, OT, and ST Services

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.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Providers must list all relevant procedure codes on the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form when requesting prior authorization for therapy services.

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

Coverage periods do not coincide necessarily with calendar weeks or months, but cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period.

5.2.1 Initial Evaluation and Considerations for Prior Authorization for Treatment

Initial evaluations do not require prior authorization (procedure codes 92521, 92522, 92523, 92524, 92610, 97161, 97162, 97163, 97165, 97166, and 97167); 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.

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5.2.1.1 Initial Evaluation for Acute and Chronic Therapy Services

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 handbook.

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 (THSteps) 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 THSteps 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

Refer to: Subsection 5.3, "Developmental Delay Criteria" in this handbook for information about chronic services.

  - 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
  - Adaptive equipment or assistive devices, as applicable

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- Prognosis for improvement
- 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

5.2.2 Additional Evaluation and Documentation Requirements for Speech Therapy

Additional evaluation and documentation requirements for speech therapy include 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 and articulation)—Formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills;
- 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.

5.2.2.1 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 include 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.

5.2.3 Written and Verbal Orders

For new authorizations and recertifications of therapies, if the submitted request form is not signed and dated by the prescribing provider, the request must be accompanied by a verbal or written order.

The request form or written or verbal order must be signed and dated within the 60-day period before the initiation of services. A prescribing provider's order to evaluate and treat is acceptable for the evaluation or re-evaluation, but is not acceptable for the therapy treatment. The therapy treatment order must contain the prescribing provider's ordered frequency, duration, and affirmation that the client's THSteps checkup is current or that a developmental screening has been performed within the last 60 days.

The documentation for a verbal order must meet the following criteria:

- It must be signed and dated by the licensed professional who by state and federal law may take a verbal order.
- It must have the name and credentials of the licensed professional who took the order and who is responsible for furnishing or supervising the ordered services.

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- The verbal order must include the date on which the verbal order was taken.
- The verbal order must include the services, frequency, and duration that was prescribed by the ordering provider.

5.2.4 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 97164, 97168, 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 recertification 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 or 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
  - Adaptive equipment or assistive devices, 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.

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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 and 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 or 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.

5.2.5 Requests for Recertification - Chronic Therapy Services

5.2.5.1 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, including affirmation that the client's THSteps checkup is current or that a developmental screening was performed by the prescribing provider within the last 60 days. 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 97164, 97168, 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.

Refer to: Subsection 5.3, "Developmental Delay Criteria" in this handbook for information about documentation about 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.

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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:
  - Documentation that the THSteps checkup is current or that a developmental screening was performed by the prescribing provider within the last 60 days

    Note: *Additional documentation is not necessary if the prescribing provider signs the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form.*
  - 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

  Refer to: Subsection 5.3, "Developmental Delay Criteria" in this handbook for information about documentation about developmental delay criteria.
  - Documentation of client's participation in treatment, as well as client or 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.

5.2.6 Requests for Revisions to Existing Prior Authorizations or Recertification for 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.

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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 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.

5.2.7 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.

5.2.8 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
- Therapy providers must sign each date of entry with full signature and credentials

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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.

Note: *Documentation requirements for a telehealth service are the same as what is required for an in-person visit and must accurately reflect the services rendered. Additionally, documentation must identify the means of delivery when provided by telehealth.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth services documentation requirements.

5.3 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.
- Retesting 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 reuse 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 will 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 are as follows:

- 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.

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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 handbook.

5.4 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.

5.5 PT, OT, and ST Procedure Codes

PT, OT, and ST treatment procedure codes are either time-based and billable in units or untimed and billable per daily encounter.

5.5.1 Timed PT and OT Treatment Procedure Codes

All time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service per discipline (4 units).

The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 2 units (thirty minutes) per date of service per discipline:

Procedure Codes	
97034	97035

The following time-based PT and OT treatment procedure code must be billed in 15 minute increments, is limited to a combined total of 3 units (45 minutes) per date of service per discipline, and is not payable in the home or other setting:

Procedure Codes
97036

The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 4 units (one hour) per date of service per discipline:

Procedure Codes									
97032	97033	97110	97112	97113	97116	97124	97140	97530	97535
97537	97542	97750	97760	97761	97763				

Note: *Procedure code 97113 is not payable to home health agencies.*

5.5.2 Untimed PT and OT Treatment Procedure Codes

The following supervised modality PT and OT treatment procedure codes are limited to once per date of service per procedure code and must be delivered on the same date of service as one or more time-based PT and OT procedure codes and are subject to CMS NCCI relationships:

Procedure Codes							
97012	97014	97016	97018	97022	97024	97026	97028

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The following PT and OT group therapy treatment procedure code is limited to once per date of service:

Procedure Codes
97150

Separate prior authorization is required for medically necessary therapeutic procedures not addressed by procedure codes outlined in this handbook.

The following procedure code requires supporting documentation indicating why an unlisted procedure code is required and is limited to once per date of service:

Procedure Codes
97799

If the therapy treatment services that are billed exceed one hour (four units per day), the claim will be denied, and it 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.

For clients who are 20 years of age and younger, when physical or occupational group therapy is administered, providers can bill procedure code 97150 for each member of the group.

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.

5.5.3 ST Treatment Procedure Codes

Individual speech treatment is limited to one encounter per date of service any provider. Only one of the following individual speech treatment procedure codes will be reimbursed per date of service:

Procedure Codes	
92507	92526

An encounter for speech therapy individual treatment is defined as face-to-face time with the patient and/or caregiver for a length of time compliant with nationally recognized professional speech-language pathology standards for a typical session.

The following group speech therapy procedure code is limited to once per date of service:

Procedure Codes
92508

5.5.4 PT, OT, and ST Evaluation and Re-evaluation Codes

Evaluation and re-evaluation procedure codes in the following table are untimed:

Procedure Codes									
92521	92522	92523	92524	92610	97161	97162	97163	97164	97165
97166	97167	97168	S9152						

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5.5.5 PT, OT, and ST Reimbursement Guidelines

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.

Therapy services provided in the nursing home setting are limited to the nursing facility because these services 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, and ST evaluations are payable once every three years to the same rendering provider.

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

For chronic services, PT, OT, and 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 handbook 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.

The following procedure codes are billable for telehealth services:

Procedure Codes									
92507	92508	92521	92522	92523	92524	92526	92610	97110	97112
97116	97150	97161	97162	97163	97164	97165	97166	97167	97168
97530	97535	97750	97537	S9152					

Therapy services may be billed when rendered in a PPECC even if the provider would typically be restricted to a home setting. Home health providers rendering therapy services in a PPECC must include the PPECC's NPI number on their institutional claim form, in addition to their own NPI. Therapy providers who bill using a professional claim form must include the PPECC name and NPI number on the claim and indicate outpatient hospital as the place of service. The therapy provider and PPECC must have a written agreement for each client related to the provision of therapy services provided at the PPECC. The written agreement must address responsibilities of both parties, and how the parties will coordinate related to the client's plan of care. The written agreement must be maintained in the client's medical record.

A modifier must be used to indicate when treatment services have been rendered by a licensed therapist/ prescribing provider or a therapy assistant under supervision of a licensed therapist. Providers must use modifier 95 for services delivered by synchronous audiovisual technology.

The following modifiers are not required for evaluation or re-evaluation codes because those services may not be rendered by therapy assistants.

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Modifier	Description
UB	Services delivered by a licensed therapy assistant under supervision of a licensed therapist
U5	Services delivered by a licensed therapist or physician

5.5.6 Therapy Co-Treatment

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

Modifier	Description
U3	Therapy Co-Treatment Modifier

Claims for telehealth must be submitted with modifier 95:

Modifier	Description
95	Services delivered by synchronous audiovisual technology

6 Adult Services

6.1 Services, Benefits, and Limitations

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

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 clients who are 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 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 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 Texas Medicaid for adult clients in the office, outpatient, and home settings.

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

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Therapy services must be performed by one of the following:

- Licensed physical therapist
- Licensed occupational therapist
- Licensed speech-language pathologist
- Physician within their scope of practice

Therapy services may also be performed by 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)

6.1.1 Adult Acute Therapy Place of Service

PT and OT providers render acute therapy services for adult clients who are 21 years of age and older in one of the following places of service:

Place of Service	Provider types
Office	Physician; podiatrist; independently enrolled therapist; physical/occupational therapy group
Home	Home health agency; independently enrolled physical therapist; and physical/occupational therapy group
Outpatient	Physician; podiatrist; outpatient hospital/clinic
Other	Independently enrolled therapist; home health agency; physical/occupational therapy group

ST providers render acute therapy services for adult clients who are 21 years of age and older in one of the following places of service:

Place of Service	Provider types
Office	Physician; independently enrolled speech-language pathologist
Outpatient	Physician; outpatient hospital/clinic

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.

6.2 Authorization Requirements for Outpatient and Home Health —PT, OT, and ST Services

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.

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Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Coverage periods do not coincide necessarily with calendar weeks or months, but cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization period.

6.2.1 Initial Evaluation and Considerations for Prior Authorization for Treatment

Initial evaluations do not require prior authorization (procedure codes 92521, 92522, 92523, 92524, 92610, 97161, 97162, 97163, 97165, 97166, and 97167); 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.

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 facilitate the determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation of medical necessity for the equipment, supplies, and services requested and is subject to retrospective review. 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. 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. 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.

6.2.1.1 Documentation

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 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.
- 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

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- 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
- When a client also receives PPECC services, indicate if therapy services will be delivered in a PPECC setting, the amount, frequency, and duration of the therapy services to be delivered in a PPECC setting in contrast with other locations (e.g., the home)
- 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
- Adaptive equipment or assistive devices, as applicable
- 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's expected involvement in client's treatment
- History of prior therapy and referrals as applicable
- Signature and date of treating therapist

Additional requirements for speech therapy include 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.

6.2.2 Written and Verbal Orders

For new authorizations and recertifications of therapies, if the submitted request form is not signed and dated by the prescribing provider, the request must be accompanied by a verbal or written order.

The request form or written or verbal order must be signed and dated within the 60-day period before the initiation of services. A prescribing provider's order to evaluate and treat is acceptable for the evaluation or re-evaluation, but is not acceptable for the therapy treatment. The therapy treatment order must contain the prescribing provider's ordered frequency and duration.

The documentation for a verbal order must meet the following criteria:

- It must be signed and dated by the licensed professional who by state and federal law may take a verbal order.

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- It must have the name and credentials of the licensed professional who took the order and who is responsible for furnishing or supervising the ordered services.
- The verbal order must include the date on which the verbal order was taken.
- The verbal order must include the services and the frequency and duration that was prescribed by the ordering provider.

6.2.3 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 97164, 97168, and S9152) require prior authorization and must be submitted with the recertification request. Required documentation for recertifications includes a progress summary and Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form.

A complete recertification 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.

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:

- 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 provider. When the request form is unsigned by the 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
- An updated treatment plan or POC 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 and responsible adult's participation or adherence with a home treatment program
  - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable
  - Adaptive equipment or assistive devices, 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
  - 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

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- 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 and 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 and 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.

6.2.4 Requests for Revisions to Existing Prior Authorization or 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 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 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, 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.

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6.2.5 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 all of 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.

6.2.6 Treatment Note

The following 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
- Therapy providers 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 for each therapy session.

Note: *Documentation requirements for a telehealth service are the same as what is required for an in-person visit and must accurately reflect the services rendered. Additionally, documentation must identify the means of delivery when provided by telehealth.*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telehealth services documentation requirements.

6.3 PT, OT, and ST Procedure Codes

PT, OT, and ST treatment procedure codes are either time-based and billable in units or untimed and billable per daily encounter.

6.3.1 PT and OT Treatment Procedure Codes

All time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service per discipline (4 units).

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The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 2 units (thirty minutes) per date of service per discipline:

Procedure Codes	
97034	97035

The following time-based PT and OT treatment procedure code must be billed in 15 minute increments, is limited to a combined total of 3 units (45 minutes) per date of service per discipline, and is not payable in the home or other setting:

Procedure Codes
97036

The following time-based PT and OT treatment procedure codes must be billed in 15 minute increments and are limited to a combined total of 4 units (one hour) per date of service per discipline:

Procedure Codes									
97032	97033	97110	97112	97113	97116	97124	97140	97530	97535
97537	97542	97750							

Note: *Procedure code 97113 is not payable to home health agencies.*

6.3.2 Untimed PT and OT Treatment Procedure Codes

The following supervised modality PT and OT treatment procedure codes are limited to once per date of service per procedure code and must be delivered on the same date of service as one or more time-based PT and OT procedure code(s) and are subject to CMS NCCI relationships:

Procedure Codes							
97012	97014	97016	97018	97022	97024	97026	97028

The following PT and OT group therapy treatment procedure code is limited to once per date of service:

Procedure Codes
97150

Separate prior authorization is required for medically necessary therapeutic procedures not addressed by procedure codes outlined in this handbook.

The following procedure code requires supporting documentation indicating why an unlisted procedure code is required and is limited to once per date of service:

Procedure Codes
97799

If the therapy treatment services that are billed exceed one hour (four units per day), the claim will be denied, and it 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.

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

For clients who are 21 years of age and older, when physical or occupational group therapy is administered, providers should bill procedure code 97150 for each member of the group.

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

6.3.3 ST Treatment Procedure Codes

Individual speech treatment is limited to one encounter per date of service any provider. Only one of the following individual speech treatment procedure codes will be reimbursed per date of service:

Procedure Codes	
92507	92526

An encounter for speech therapy individual treatment is defined as face-to-face time with the patient and/or caregiver for a length of time compliant with nationally recognized professional speech-language pathology standards for a typical session.

The following group speech therapy procedure code is limited to once per date of service:

Procedure Codes
92508

6.3.4 PT, OT, and ST Evaluation and Re-evaluation Procedure Codes

Evaluation and re-evaluation procedure codes in the following table are untimed:

Procedure Codes									
92521	92522	92523	92524	92610	97161	97162	97163	97164	97165
97166	97167	97168	S9152						

6.3.5 PT, OT, and ST Reimbursement Guidelines

If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes 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.

Therapy services provided in the nursing home setting are limited to the nursing facility because these services 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 rendering provider.

For acute services, PT, OT, ST re-evaluations may be reimbursed once every 60 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 handbook may be considered for reimbursement on appeal 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,

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- 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.

The following procedure codes are billable for telehealth services:

Procedure Codes									
92507	92508	92521	92522	92523	92524	92526	92610	97110	97112
97116	97150	97161	97162	97163	97164	97165	97166	97167	97168
97530	97535	97750	97537	S9152					

A modifier must be used to indicate when treatment services have been rendered by a licensed therapist/prescribing provider or a therapy assistant under supervision of a licensed therapist. Providers must use modifier 95 for services delivered by synchronous audiovisual technology.

The following modifiers are not required for evaluation or re-evaluation codes because those services may not be rendered by therapy assistants:

Modifier	Description
UB	Services delivered by a licensed therapy assistant under supervision of a licensed therapist
U5	Services delivered by a licensed therapist or physician

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

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

Modifier	Description
U3	Therapy Co-Treatment Modifier

Claims for telehealth must be submitted with modifier 95:

Modifier	Description
95	Services delivered by synchronous audiovisual technology

7 Claims Filing and Reimbursement

7.1 Claims Information

Therapy services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms. Claims may be filed electronically in a CMS-1500 format as long as the nine-digit prior authorization number is reflected in the equivalent electronic field.

CORF and ORF providers must submit services in an approved electronic claims format or on the UB-04 CMS-1450 paper claim form from the vendor of their choice. TMHP does not supply the forms. Revenue and Current Procedural Terminology (CPT) procedure codes are used when submitting claims for CORF and ORF services. The only POS is outpatient facility (POS 5).

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

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Refer to: Subsection 2.8, "Home Health Agency Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional claim information for Home Health agencies.

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

7.2 Reimbursement/Billing Guidelines

Physical, occupational, and speech therapy services are reimbursed in accordance with 1 TAC § 355. See the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

Therapy providers are reimbursed in accordance with 1 TAC §355.8085.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.4, "Claims Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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 handbook 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 name of the new provider and previous provider

7.2.1 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.

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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.

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:

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

7.3 Claims Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Location
Appendix A: State, Federal, and TMHP Contact Information	Appendix A (*Vol. 1, General Information*)
Appendix D: Acronym Dictionary	Appendix D (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Appendix A: State, Federal, and TMHP Contact Information (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5 (*Vol. 1, General Information*)
Section 3: TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 6.2 (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6 (*Vol. 1, General Information*)

7.4 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday-Friday from 7 a.m. to 7 p.m., Central Time.

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8 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

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

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