

Effective May 1, 2016, Physical Therapy, Occupational Therapy, and Speech Therapy Policy to Change for Texas Medicaid Clients Birth Through 20 Years of Age

Effective for dates of service on or after May 1, 2016, policy for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) will change for Texas Medicaid clients birth through 20 years of age.

Key policy changes for PT, OT, and ST services for the Texas Medicaid children's policy, which are described in detail in this article, include the following (**Note: Authorization requirements apply to Fee-For-Service (FFS)**):

- Chronic therapy services will only be offered to clients who are birth through 20 years of age.
- The authorization period for chronic therapy services will be 180 days.
- Reevaluations require authorization and are part of the authorization/recertification process for chronic therapy service, and they will only be reimbursed when appropriate and when submitted with a recertification request.
- A standardized test and standard deviation score must be submitted with each authorization or recertification request for chronic therapy services.
- A new FFS prior authorization form for all therapy services will be available to providers for use on dates of service on or after May 1, 2016. The new form will be available as a fillable PDF on the TMHP website. Starting May 1, 2016, providers can submit FFS prior authorization requests using either the three existing FFS prior authorization forms or the new FFS prior authorization form until the electronic prior authorization portal is available on May 27, 2016.
- Starting May 27, 2016, providers requesting authorization for FFS clients will be required to use the new FFS prior authorization form, Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form.
- All acute therapy services for clients birth through 20 years of age must be accompanied with the AT modifier. Acute therapy services require prior authorization, and the authorization period for acute therapy services is 60 days and will be limited to 120 days total.
- Reevaluations require authorization and are part of the authorization/recertification process for acute therapy services, and they will only be reimbursed when appropriate and when submitted with a recertification request. A progress note must be submitted with the recertification request for acute therapy services.
- Clients who are birth through 20 years of age who do not meet the acute therapy services criteria may be considered for additional services under the chronic therapy services criteria.
- Co-treatment services are outlined in this article, and all co-treatment services must be submitted with the U3 modifier.
- All therapy services rendered by a licensed therapy assistant must be submitted with the UB modifier.

Below is a draft of the Texas Medicaid FFS policy for physical, occupational, and speech therapy services for clients who are 20 years of age and younger to be effective for

dates of service on or after May 1, 2016. This medical policy addresses acute and chronic physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services for clients birth through 20 years of age. This policy does not address freestanding inpatient rehabilitation services.

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

PT, OT, and ST are benefits of Texas Medicaid in a Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Rehabilitation Facility (ORF) for clients birth through 20 years of age.

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

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

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

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

Acute Services

Acute PT, OT, and ST services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition.

- Treatments are expected to significantly improve, restore or develop physical functions diminished or lost as a result of a recent trauma, illness, injury, disease, surgery, or change in medical condition in a reasonable and generally predictable period of time (60 days), based on the prescribing provider's and therapist's assessment of the client's restorative potential.

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

- Treatments are directed 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, PT, OT, and ST may continue for a maximum of 120 days for an acute medical condition or an acute exacerbation of a chronic medical condition.
- Once the client's condition is no longer considered acute, continued therapy for a chronic condition will only be considered for clients who are birth through 20 years of age.
- PT, OT, ST are benefits of Texas Medicaid in a Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Rehabilitation Facility (ORF) settings for clients birth through 20 years of age.

Chronic Services

Chronic PT, OT, and ST 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, All eligible clients who are birth through 20 years of age may continue to receive all medically necessary therapy services, with documentation proving medical necessity:

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

- Services do not duplicate those provided concurrently by any other therapy.
- Services must meet acceptable standards of medical practice and be specific and effective treatment for the client's condition.
- Services are provided within the provider's scope of practice, as defined by state law.

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

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

- If the service could be performed by the average nonmedical person, the absence of a competent person (such as a family member or medical assistant) to perform it does not cause it to be a skilled therapy service.
- If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy.

Overview of Policy

Medical Necessity criteria for therapy services provided in the home must be based on the supporting documentation of the medical need and the appropriateness of the

equipment, service, or supply prescribed by the provider for the treatment of the individual.

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

Frequency must always be commensurate with the client's medical and skilled therapy needs, level of disability, and standards of practice; it is not for the convenience of the client or the responsible caregivers. For prior authorization criteria, refer to the Frequency and Duration section.

Physical Therapy (PT)

The practice of PT includes the following:

- 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 PT 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. PT may be provided by a physician or physical therapist within their licensed scope of practice.

Occupational Therapy (OT)

The practice of OT includes the following:

- Evaluation or treatments 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; or
 - 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 OT to the skilled treatment of clients whose ability to function in life roles is impaired. OT may be provided by a physician or OT within their licensed scope of practice. OT uses purposeful activities to obtain or regain activities of daily living (ADLs) performance skills lost through acute, acute exacerbation of a medical condition or chronic medical condition related to injury, disease or other medical causes. ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility.

Speech Therapy (ST)

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

Speech-language pathologists treat the following:

- Speech sound and motor speech disorders
- Stuttering
- Voice disorders
- Aphasia and other language impairments
- Cognitive disorders
- Social communication disorders
- Swallowing (dysphagia) deficits

Speech therapy is designed to ameliorate, restore speech/language communication and swallowing disorders that have been lost or damaged as a result of a chronic, acute, or acute exacerbation of a medical condition due to a recent injury, disease or other medical conditions, or congenital anomalies or injuries.

Types of Communication Disorders

Types of communication disorders include the following:

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.

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

- The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the patient's condition,
- The services requested must be of such a level of complexity or the patient's condition must be such that the services required can only be effectively performed by or under the supervision of a licensed occupational therapist, physical therapist, or speech-language pathologist, and requires the skills and judgment of the licensed therapist to perform education and training,
- The goals of the requested services to be provided are directed at improving, adapting, restoring, or maintaining functions which have been lost or impaired due to a recent illness, injury, loss of body part or congenital abnormality or as a result of developmental delay or the presence of a chronic medical condition.
- Testing must establish a client with developmental delay and meet the medical necessity criteria as defined in this article, see developmental delay section of this article.

Co-treatment

Co-treatment is defined as two different therapy disciplines that are performed on the same client at the same time by a licensed therapist for each therapy discipline. The co-treatment must be rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners or the 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 PT, licensed OT, or licensed speech-language pathologist (SLP)), to perform the therapy safely and effectively to reach the client's goals as determined by the approved plan of care, signed and dated by the client's prescribing provider.

When performing co-treatment, a primary therapist must be designated by the two performing therapists. Only the primary performing therapist may submit claims for the therapy services that were rendered. The secondary therapist will not be reimbursed for assisting a designated primary performing therapist with co-treatment services.

Co-treatment documentation requirements are 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 client achieve the treatment plan goals.
- An explanation of why the client requires and will receive multidisciplinary team care, defined as at least two therapy disciplines (physical, occupational, or speech therapy).
- Retrospective review may be performed to ensure documentation supports that the medical necessity of the co-treatment performed and that the billing was appropriate for the services provided by the designated primary performing therapist.

Group Therapy

Group therapy consists of simultaneous treatment to two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief intermittent personal contact, or giving the same instructions to two or more clients at the same time the treatment is recognized as group therapy. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one client contact is not required.

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

- Prescribing provider prescription for group therapy
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements,
- The licensed therapist involved in group therapy services must be in constant attendance (in the same room) and active in the therapy,
- Each client participating in the group must have an individualized treatment plan for group treatment, including interventions and short-and long-term goals and measurable outcomes.

Texas Medicaid does not limit the number of clients who can participate in a group therapy session. Providers are subject to certification and licensure board standards regarding group therapy.

Group Therapy Documentation Requirements

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

- Prescribing provider prescription for group therapy, individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals,
- Name and signature of licensed therapist providing supervision over the group therapy session,
- Specific treatment techniques utilized during the group therapy session and how the techniques will restore function,
- Start and stop times for each session,

- Group therapy setting or location, and
- Number of clients in the group.

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

Non-Covered Services

The following services are not a benefit of Texas Medicaid:

- Therapy services that are provided after the client has reached the maximum level of improvement or is now functioning with normal limits.
- Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition.
- Separate reimbursement for VitalStim therapy for dysphagia.
- Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee.
- Therapy services related to activities for the general good and welfare of clients who are not considered medically necessary because they do not require the skills of a therapist, such as: (1) General exercises to promote overall fitness and flexibility or improve athletic performance, (2) Activities to provide diversion or general motivation and, (3) Supervised exercise for weight loss.
- Treatment solely for the instruction of other agency or professional personnel in the client's PT, OT, or ST program.
- Training in nonessential tasks (e.g. homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling).
- Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment.
- Therapy prescribed primarily as an adjunct to psychotherapy.
- Treatments not supported by medically peer reviewed literature, including, but not limited to, investigational treatments such as sensory integration (with the exception of cognitive rehabilitation for client's with traumatic brain injury due to illness or injury who are able to actively participate in the treatment program), vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback.
- Therapy not expected to result in practical functional improvements in the client's level of functioning.
- Treatments that do not require the skills of a licensed therapist to perform in the absence of complicating factors (i.e., massage, general range of motion exercises,

repetitive gait, activities and exercises that can be practiced by the client on their own or with a responsible adult's assistance).

- Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided.
- 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 PT, OT, or ST 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.

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

FFS Authorization Requirements for PT, OT, and ST (Acute and Chronic Services)

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

Initial Evaluation and Consideration for Treatment

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

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization requirements documentation through fax or mail, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved electronic method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the service(s) requested.

The physician must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

Therapy services, occurring after the initial evaluation, regardless of place or provider, require prior authorization. PT, OT, or ST services may be prior authorized to be provided in the following locations: Home of the client, home of the caregiver or guardian, client's daycare facility, or the client's school.

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

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

Note: *Initial prior authorization requests must be received no later than 5 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.
- For chronic 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.
 - For acute services: documentation of the acute or acute exacerbation of the medical condition requiring therapy
- Evaluation and Treatment Plan or Plan of Care (POC) Requirements 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 assessment tools
 - 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 time the service is requested
- Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services.
- Therapy treatment plan/POC to include specific modalities and treatments planned
- Documentation of client's primary language
- Documentation of client's age and date of birth
- Prognosis for improvement
- Time in and time out on the evaluation note
- Requested dates of service for planned treatments after the completion of the evaluation
- Responsible adult's expected involvement in client's treatment
- History of prior therapy and referrals as applicable
- Dated signature of treating therapist
- Additional Evaluation 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 or 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.

Bilingual Testing

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 them in the documentation.

The therapist will show the highest score of the two languages to determine whether the child qualifies and which language will be used for the child's therapy. Testing for all subsequent re-evaluations should only be conducted in the language used in therapy.

Written and Verbal Orders

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

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

Requests for Recertification - Acute Therapy Services

A recertification for prior authorization of acute therapy services may be considered up to a maximum of 60 day increments when services continue to meet authorization criteria. Re-evaluation codes (Procedure codes 97002, 97004, and S9152) require authorization for acute therapy services and must be submitted with the recertification request. Therapy for clients who are birth through 20 years of age who do not meet the acute therapy services criteria may be considered for chronic therapy services.

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

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

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:

- A Texas Medicaid Physical, Occupational or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent signed and dated by the therapist and signed and dated by the prescribing 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

- A revised treatment plan or plan of care including all of the following:
 - Date therapy services started
 - Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan
 - Documentation of reasons continued therapy services are medically needed
 - Documentation of client's participation in treatment, as well as client/responsible adult's participation or adherence with a home exercise program
 - New treatment plan or plan of care for the recertification dates of service requested
 - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable
 - Prognosis with clearly established discharge criteria
 - Documentation of consults with other professionals and services or referrals made and coordination of service when applicable (e.g., for school aged clients, documentation of the coordination of care and referrals made for school therapies)
 - The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

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

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

Requests for Recertification - Chronic Therapy Services

Reevaluation (every 180 days)

- A reevaluation is a comprehensive evaluation and must take place every 180 days and contains all the elements of an initial evaluation. It may be used to make a determination whether or not skilled therapy is medically necessary, or when determining the effectiveness of the current plan, or when the current plan requires significant modification and revision of the interventions and goals due to changes in the client's medical status or lack of progress with the current treatment.
- A re-evaluation (Procedure codes 97002, 97004, and S9152) requires authorization and must be submitted with the recertification request.
- 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 the section 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 at least 28 days before the current authorization period expires. Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the request is received.

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:

A 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 physician, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.

A re-evaluation to include a revised treatment plan or plan of care including all of the following:

- Date therapy services started
- Changes in the treatment plan, the rationale, and the requested change in frequency of visits
- Documentation of reasons continued therapy services are medically needed
- Documentation of client's participation in treatment, as well as client/responsible adult's participation or adherence with a home exercise 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
- 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

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

- A revision to an existing authorization/recertification must be documented in the client's record when significant changes occur in the frequency or treatment plan. When frequency is increased or services requiring separate authorization are added a request for revision must be submitted for prior authorization.
- Requests for revisions must be received no later than five business days from the date the revised therapy treatments are initiated. Requests for revisions received after the five business day period will be denied for dates of service that occurred before the date the request was received.
- A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.
- Requests for revision must be submitted with the following documentation:
 - Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form, including the date the revision was initiated, signed and dated by the therapist and signed and dated by the prescribing provider. When the request form is not signed and dated by the 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 functional outcomes vs goals.
- The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

Change of Therapy Provider

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

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, therefore, the authorization period will not change.

Treatment Note

The following documentation must be kept on file by the treating provider and be available when requested:

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

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

Frequency and Duration Criteria for PT/OT/ST

Frequency must always be commensurate with the client's medical and skilled therapy needs, level of disability, and standards of practice; it is not for the convenience of the client or the responsible adult. Exceptions to therapy limitations may be covered if medically necessary criteria are met and documentation proving medical necessity is met for the following:

- Presentation of new acute condition, or
- Therapist intervention is critical to the realistic habilitative/restorative goal(s)

Frequency may be defined as high, moderate, or low as follows:

- **High Frequency** (three times per week): Can only be considered for a limited duration (approximately four weeks or less) or as otherwise requested by the prescribing provider with documentation of medical need to achieve an identified new skill or recover function lost due to surgery, illness, or trauma with well-defined specific, achievable goals within the intensive period requested. 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.
- Therapy provided three times a week may be considered for two 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
- When therapy is initiated, the therapist must provide education and training of the client and responsible caregivers develop and instruct them in a home exercise program to promote effective carryover of the therapy program and management of safety issues. A higher frequency (4 or more times per week) may be considered on a case-by-case basis with clinical documentation supporting why 3 times a week will not meet the client's medical needs.
- **Moderate Frequency:** Therapy provided two times a week may be considered when documentation shows one or more of the following:
 - The client is making very good functional progress toward goals.
 - The client is in a critical period to gain new skills or restore function or is at risk of regression.
 - The licensed therapist needs to adjust the client's therapy plan and home program weekly or more often than weekly based on the client's progress and medical needs.
 - The client has complex needs requiring on-going education of the responsible adult.
- **Low Frequency:** Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
 - The client is making progress toward the client's goals, but the progress has slowed, or documentation shows the client is at risk of deterioration due to the client's development or medical condition.
 - The licensed therapist is required to adjust the client's therapy plan and home program weekly to every other week based on the client's progress.
 - Every other week therapy is supported for clients whose medical condition is stable, they are making progress, and it is anticipated the client will not regress with every other week therapy.
- **Maintenance Level/Prevent Deterioration:** This frequency level (e.g., every other week, monthly, every three 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 documentation submitted shows the client may be making limited progress toward goals, or goal attainment is extremely slow,
- Factors are identified that inhibit the client's ability to achieve established goals (e.g., the client cannot participate in therapy sessions due to behavior issues or issues with anxiety),
- Documentation shows the client and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the client's needs.

Developmental Delay Criteria

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

- Tests used must be norm-referenced, standardized and specific to the therapy provided.
- Re-testing with norm-referenced standardized test tools for re-evaluations must occur every 180 days. Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation.
- Eligibility for therapy will be based upon a score of at least 1.5 standard deviations (SD) below the mean in at least one subtest area of composite score on a norm-referenced, standardized test.
- When the SD is less than 1.5 SD below the norm as indicated by the test performed, a criterion-referenced test along with informed evidenced based clinical opinion must be included to support the medical necessity of services and may be sent to physician review to determine medical necessity.
- If a child cannot complete norm-referenced standardized assessments, then a functional description of the child's abilities and deficits must be included. Measurable functional short and long term goals will be considered along with SD score. 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 include the following:

- **Language:** at least one norm-referenced, standardized test with good reliability and validity, SD of at least 1.5, and clinical documentation of an informal assessment that supports the delay
- **Articulation:** at least one norm-referenced, standardized test with good reliability and validity, SD of at least 1.5, and clinical documentation of an informal assessment that supports the delay

- **Apraxia:** at least one norm-referenced, standardized test with good reliability and validity, SD of at least 1.5, and clinical documentation of an informal assessment that supports the delay
- **Fluency:** at least one norm-referenced, standardized test with good reliability, SD of at least 1.5, 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 client has standard deviation scores is equal to or less than 1.5 SD, additional documentation supporting the client's medical need for therapy will be considered and the request will be sent to the physician for review to determine medical necessity.

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

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 of age. The age adjustment cannot exceed 16 weeks.

Criteria for Discontinuation of Therapy

Discontinuation of therapy may be considered when the client has achieved treatment goals as evidenced by one or more of the following:

- No longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care;
- Has returned to baseline function;
- Can continue therapy and maintain status with a home therapy exercise program and deficits no longer require a skilled therapy intervention;
- Has adapted to impairment with assistive equipment or devices, is able to perform ADLs with minimal to no assistance from caregiver;
- 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 repetitive exercises in the home exercise program and the skills of a therapist are not needed to provide or supervise the service;
- Testing shows client is no longer developmental delayed;
- Non-compliance due to poor attendance and with responsible adult non-compliance with therapy and home program.

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

FFS Reimbursement /Billing Guidelines

PT, OT, and ST procedure codes submitted by a home health agency are reimbursed at the statewide visit rate calculated in accordance with 1 TAC §355.8021(a). Therapy procedure codes billed by other therapy providers are reimbursed in accordance with 1 TAC §355.8441.

When physical or occupational group therapy is administered bill procedure code 97150 for each member of the group.

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

Providers may request PT, OT, or ST services frequency by week.

- A week includes the day of the week on which the prior authorization period begins and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday.
- The number of therapy services authorized for a week must be provided in that prior authorization week.
- Services billed in excess of those authorized for the prior authorization week are subject to recoupment.

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

- The appeal must document the prior authorization period week for the date of service appealed.
- The appeal must include an attestation that the provider has billed all therapy services for the week in question.

Providers must use the appropriate procedure codes and modifiers for the therapy services performed. Modifier AT indicates an acute/rehabilitative service and must be billed with the appropriate PT, OT, or ST procedure codes, identifying the therapy service provided is rehabilitative.

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

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

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

- The date the client ended therapy (effective date of change) with the previous provider
- The name of the new provider and previous provider

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

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

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

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to zero units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Time intervals for 1 through 8 units are as follows:

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

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

Time-based PT, OT, and ST treatment procedure codes that may be billed in multiple quantities of 15 minutes each are limited to one hour per date of service per discipline (4 units). Procedure codes listed in the following table must be billed in 15 minute increments:

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

Procedure Codes

92507	92508	92526	97032	97033	97034
97035	97036	97039	97110	97112	97113
97116	97124	97139	97140	97530	97535
97537	97542	97750	97760	97761	97762
97799	S8990				

Table C*: Codes Limited to Once per Day

Procedure Codes					
97012	97014	97016	97018	97022	97024
97026	97028	97150			

*Home Health Agencies are reimbursed at state wide rate.

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

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

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

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

Procedure codes for PT, OT, or ST evaluations maybe payable once every three years to the same provider.

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

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

Additional PT, OT, and ST evaluations or re-evaluations exceeding the limits outlined in this policy may be considered 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 or evaluation is required for recertification of an existing authorization.

Therapy Assistant Modifier

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

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

Therapy Co-Treatment

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