Physical, Occupational, and Speech Therapy Benefits for All Ages to Change for Texas Medicaid September 1, 2017

Information June 30, 2017

**Note:** Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.

Effective for dates of service on or after September 1, 2017, physical therapy (PT), occupational therapy (OT), and speech therapy (ST) benefits for all ages will change for Texas Medicaid.

This notification describes changes to the PT, OT, and ST Medicaid benefit, which may be different from the Early Childhood Intervention (ECI) or school health and related services (SHARS) Medicaid benefit. A future notification will be released to describe changes to the ECI program.

**New Information**

Changes to this medical benefit policy include the following:

- Billing structure changes for PT, OT, and ST services
- Procedure codes end-dating August 31, 2017
- Prior authorization changes
- Required modifiers
- Claims filing changes
- Clarification to benefits

**Reminders**


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.

**Billing Structure Changes for PT/OT/ST**

Billing structure for PT/OT/ST evaluations and re-evaluations will not change.

**PT/OT Treatment Procedure Codes**
The billing structure for PT/OT individual treatment procedure codes will change for Home Health Agencies (HHA) from per visit to time-based increments of 15-minute units. Time-based treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour. PT and OT time-based treatment codes are payable as 15-minute units for all provider types.

All time-based PT and OT treatment procedure codes in the table below will be cumulatively limited to four units (one hour) per date of service per discipline:

<table>
<thead>
<tr>
<th>Timed Treatment Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to a combined total of 4 units (one hour) per date of service per discipline</td>
</tr>
<tr>
<td>97032</td>
</tr>
<tr>
<td>97124</td>
</tr>
<tr>
<td>97750</td>
</tr>
<tr>
<td>Limited to a total of 3 units (45 minutes) per date of service per discipline; may be combined with other time-based codes</td>
</tr>
<tr>
<td>97036**</td>
</tr>
<tr>
<td>Limited to a combined total of 2 units (thirty minutes) per date of services per discipline; may be combined with other time-based codes</td>
</tr>
<tr>
<td>97034</td>
</tr>
</tbody>
</table>

*Birth through 20 years of age only
**Not payable in the home setting
***Provider type and age restrictions apply. Refer to the fee schedule for restrictions.

Untimed PT and OT Treatment Procedure Codes

Untimed PT/OT treatment codes for supervised modalities (procedure codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, and 97028), group treatment (procedure code 97150), and unlisted procedure (procedure code 97799) will no longer count towards the four units per day restriction.

Supervised Modality Codes

The following PT/OT treatment procedure codes representing supervised modalities are limited to one encounter each, per day, per discipline.

The medical necessity for each modality code billed must be described in the plan of care and must be prior authorized.

The following codes may only be reimbursed when billed with one or more time-based procedure codes listed in the Treatment Procedure Codes table above:

<table>
<thead>
<tr>
<th>Untimed Treatment Procedure Codes Limited to Once Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
</tr>
<tr>
<td>97026</td>
</tr>
</tbody>
</table>
Procedure Code for Requesting an Unlisted PT/OT Service (Untimed)

Separate prior authorization is required for medically necessary therapeutic procedures not addressed by procedure codes outlined in the TMPPM. The procedure code in the table below requires supporting documentation indicating why an unlisted procedure code is required. The following code is untimed and payable once per day.

<table>
<thead>
<tr>
<th>Untimed Treatment Procedure Code Limited to Once Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>97799</td>
</tr>
</tbody>
</table>

Group Treatment (Untimed)

PT, OT, and ST group treatment will be payable as an untimed procedure code for all providers for PT, OT, and ST.

The billing structure for PT/OT group treatment (procedure code 97150) will change for comprehensive outpatient rehabilitation facility (CORF), outpatient rehabilitation facility (ORF), and independent therapists from timed and payable in units to payable per encounter and reimbursed once per day for all providers.

The billing structure for ST group treatment (procedure code 92508) will change for CORF/ORF and independent therapists from timed and payable in units to payable per encounter and reimbursed once per day for all providers.

<table>
<thead>
<tr>
<th>Group Treatment Procedure Codes Limited to Once Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>97150        PT/OT group treatment</td>
</tr>
<tr>
<td>92508        ST group treatment</td>
</tr>
</tbody>
</table>

Individual Speech Therapy Treatment Procedure Codes

The billing structure for individual ST treatment (procedure codes 92507 and 92526) will change for CORF/ORF and independent therapists from timed and payable in units to payable per encounter and limited to once per day for all providers.

ST individual treatment will be defined per encounter for all provider types.

Note: An encounter is defined as face-to-face time with a patient and/or caregiver, and is anticipated to last 40 to 60 minutes.

Only one of the following encounter-based speech therapy treatment procedure codes is payable per date of service per provider:

<table>
<thead>
<tr>
<th>Individual Speech Therapy Treatment Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507 92526</td>
</tr>
</tbody>
</table>

The rendering ST provider should select the code that best reflects the totality of the session delivered.

For example, if most of the session time is devoted to language and communication therapy consistent with procedure code 92507, that procedure code should be selected,
even if swallowing treatment (procedure code 92526) was also delivered, but for less
time during the session.

Refer to the Texas Medicaid Provider Procedures Manual, Physical Therapy,
Occupational Therapy, and Speech Therapy Services Handbook, subsection 5.2.8,
“Treatment Note” for documentation requirements.

**Procedure Codes End-dating August 31, 2017**

- Treatment procedure codes 97039, 97139, and S8990 will be end-dated for dates of
  service on or after September 1, 2017, and they will no longer be benefits of Texas
  Medicaid. Procedure code 97799 will remain available for medically necessary
  procedures not otherwise outlined in the TMPPM (Refer to section Procedure Code
  for Requesting an Unlisted PT/OT Service (Untimed) of this notification).

- Treatment procedure code 97535 with the GN modifier will be end-dated only for ST
  providers for dates of service on or after September 1, 2017. Any open
  authorizations for this code will be updated to procedure code 92507.

**Prior Authorization Changes**

TMHP will update prior authorizations that span the effective date of September 1, 2017.

Beginning July 24, 2017, TMHP will begin sending out updated prior authorization letters
and continue this process through the end of August for clients with existing
authorizations that will be active on or after September 1, 2017. The letters will provide
updated authorization information that will align with the new billing structure effective
September 1, 2017.

Starting July 24, 2017, new requests for therapy authorizations will begin processing
according to the new billing structure for dates of service on or after September 1, 2017.
Dates of service prior to September 1, 2017 will be authorized using the current billing
structure.

The case reference number (prior authorization number, or PAN) will not change for
updated authorizations that will be active on or after September 1, 2017.

Existing authorizations for PT and OT delivered by HHAs will be converted using the
formula of one visit equals four units of time-based PT/OT procedure codes.

**Prior Authorization (PA) Form Update**

The Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior
Authorization Form and the Texas Medicaid Physical, Occupational, or Speech Therapy
(PT, OT, ST) Prior Authorization Form Instructions will be updated and available no later
than August 1, 2017.

The TMHP Prior Authorization (PA) department will accept the previous version of the
form through October 31, 2017. Beginning November 1, 2017, TMHP will only accept the
most current version of the form as posted on tmhp.com. Following the allowed grace
period, if providers are not using the current PA form, PA staff will void/fax back the
incorrect PA form. If the request is a portal submission, PA staff will pend for the current
PA form following existing processes.

**Required Modifiers**
Licensed therapists and physicians must use a modifier to designate whether a therapy treatment was delivered to the client by a licensed therapy assistant.

One of the following modifiers is required on all claims for PT, OT, and ST treatment procedure codes:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UB</td>
<td>Services delivered by a licensed therapy assistant under supervision of a licensed therapist</td>
</tr>
<tr>
<td>U5</td>
<td>Services delivered by a licensed therapist or a physician</td>
</tr>
</tbody>
</table>

**Note:** Since therapy evaluations and re-evaluations may not be performed by licensed therapy assistants, evaluation and re-evaluation procedure codes do not require a UB or U5 modifier.

Providers must continue to use the most appropriate modifier below in addition to UB or U5 modifiers:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>To identify acute treatment</td>
</tr>
<tr>
<td>GP</td>
<td>Services delivered under an outpatient physical therapy plan of care</td>
</tr>
<tr>
<td>GO</td>
<td>Services delivered under an outpatient occupational therapy plan of care</td>
</tr>
<tr>
<td>GN</td>
<td>Services delivered under an outpatient speech language pathology plan of care</td>
</tr>
<tr>
<td>U3</td>
<td>To identify co-treatment</td>
</tr>
</tbody>
</table>

**Claims Filing Changes**

For dates of service beginning September 1, 2017, providers will need to submit claims for services provided in appropriate amounts of units or daily encounters authorized according to the new billing structure.

**Clarification to Benefits**

Benefit language in the *Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Handbook* will be updated for clarity purposes effective September 1, 2017. The text below has been underlined or struck-through to highlight the updated language. Subheadings have been used to assist with locating the matching language in the current *Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Handbook*.

**Therapy Services Overview**

The following statement about functional goals has been updated:

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 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.

Criteria for Discontinuation of Therapy/Exclusions (Non-covered Services)

The following statement will be moved from the “Criteria for Discontinuation of Therapy” subsection to the “Exclusions (Non-covered Services)” subsection:

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

Initial Evaluations and Reevaluations for Acute and Chronic Therapy Services: New Documentation Requirement

The following statement has been added to required documentation for initial evaluations and re-evaluations for acute and chronic therapy services:

*Adaptive equipment or assistive devices, as applicable*

The clinician should list adaptive equipment or assistive devices related to the client’s function and/or plan of care. The clinician should document if not applicable to the client.

Provider Type and Place of Service Updates

A future notification will be posted prior to September 1, 2017, with detailed information on provider type and place of service updates for applicable procedure codes per discipline.

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