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 heath 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 may refer to the current *Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (TMPPM)*, section 7.2.1. “Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units,” for additional information on how to calculate billing 15-minute units.

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:

Timed Treatment Procedure Codes					
Limited to a combined total of 4 units (one hour) per date of service per discipline					
97032	97033	97110	97112	97113***	97116
97124	97140	97530	97535***	97537***	97542
97750	97760*	97761*	97762*		
Limited to a total of 3 units (45 minutes) per date of service per discipline; may be combined with other time-based codes					
97036**					
Limited to a combined total of 2 units (thirty minutes) per date of services per discipline; may be combined with other time-based codes					
97034	97035				
***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.

Untimed Treatment Procedure Codes Limited to Once Per Day					
97012	97014	97016	97018	97022	97024
97026	97028				

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.

Untimed Treatment Procedure Code Limited to Once Per Day
97799

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.

Group Treatment Procedure Codes Limited to Once Per Day	
97150	PT/OT group treatment
92508	ST group treatment

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:

Individual Speech Therapy Treatment Procedure Codes	
92507	92526

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:

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

Modifier	Description
AT	To identify acute treatment
GP	Services delivered under an outpatient physical therapy plan of care
GO	Services delivered under an outpatient occupational therapy plan of care
GN	Services delivered under an outpatient speech language pathology plan of care
U3	To identify co-treatment

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 <u>health</u>, safety, <u>or</u> ~~and~~ 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 ~~which~~ do~~es~~ 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.