Physical, Occupational, and Speech Therapy Guideline

Guideline #	Categories	This Guideline Applies To:
12333	Subcategories of Clinical not selected. →Subcategories of Clinical not selected.	Texas Children's Health Plan
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GUIDELINE STATEMENT: Texas Children's Health Plan (TCHP) performs authorization of physical, occupational, and speech therapy treatment.

DEFINITIONS:

Standardized tests: tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares results to an appropriate normative sample.

Criterion-referenced tests: tests that measure an individual's performance against a set of predetermined criteria or performance standards (e.g., descriptions of what an individual is expected to know or be able to do at a specific stage of development or level of education). Criterion referenced procedures can also be developed informally to address specific questions (e.g., understanding of wh- questions,) and to assess response to intervention (RTI).

Co-treatment: two different therapy disciplines that are performed on the same member 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, Occupational Therapy Examiners or the State Board of Examiners for Speech-Language Pathologists and Audiologists

Functional Goals: a series of behaviors or skills that allow the member to achieve an outcome relevant to his/her health, safety, or independence within the context of everyday environments. These goals are specific to the member, objectively measurable within a specified time frame, attainable in relation to the member's prognosis or developmental delay, relevant to the member and family, and based on a medical need.

Acute medical condition: an illness or trauma with a rapid onset and short duration. 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 member's restorative potential.

Chronic medical condition: a 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.

Guardian: member's parent, primary caregiver or legal representative.

GUIDELINE

1. **Physical 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:

    1.1. The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the patient's condition.

    1.2. 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 physical therapist and requires the skills and judgment of the licensed therapist to perform education and training.

    1.3. The therapy is aimed at achieving functional goals.
    - Functional mobility describes a member's ability to move around within the context of everyday environment and carry out the physical movements
    - and duties in daily life. Some examples include walking, rolling/scooting out of bed, and rising from a chair.

    1.4. 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.

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

    1.6. The member has an acute or chronic medical condition affecting the musculoskeletal or neuromuscular system.

    1.7. The therapy is:
    - Aimed at improving, adapting or restoring functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality; OR
    - Intended to maintain, develop or improve skills needed to perform ADLs or IADLs which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality.

1.8. The therapy is for conditions that require the unique knowledge, skills, and judgment of a physical therapist for education and training that is part of an active skilled plan of treatment.

1.9. There is an expectation that the therapy will result in a practical improvement in or maintain the level of functioning within a reasonable and predictable period of time

1.9.1. An individual's function could not reasonably be expected to improve as the individual gradually resumes normal activities; AND

1.9.2. An individual's expected restoration potential would be significant in relation to the extent and duration of the therapy service required to achieve such potential; AND

1.9.3. The therapy documentation objectively verifies progressive functional improvement over specific time frames; AND

1.10. The services are delivered by a qualified provider of physical therapy services (Physical therapy may be provided by a physician or physical therapist within their licensed scope of practice).

1.11. The services require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity and sophistication of the therapy and the medical condition of the individual.

2. **Occupational therapy services** must be medically necessary to the treatment of the member'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:

2.1 The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the member's condition.

2.2 The services requested must be of a level of complexity or the member's condition must be such that the services required can only be effectively performed by or under the supervision of a licensed occupational therapist, and requires the skills and judgment of the licensed therapist to perform education and training.

2.3 The member's ability to function in daily activities is impaired.

2.4 There is an expectation that the therapy will result in a practical improvement in or maintain the level of functioning within a reasonable and predictable period of time.

2.5 Member's function could not reasonably be expected to improve as the member gradually resumes normal activities.

2.6 Member's expected restoration potential would be significant in relation to the extent and duration of the therapy service required to achieve such potential.

2.7. The therapy documentation objectively verifies progressive functional improvement over specific time frames.

2.8. The therapy is aimed at:

2.8.1. Achieving functional goals.

2.8.2 Improving, developing, maintaining, or restoring functions impaired or lost through developmental deficits, illness, injury, or deprivation.

2.8.3. Improving the ability to perform tasks for independent functioning when functions are impaired or lost.

2.8.4. Preventing, through early intervention, initial or further impairment or loss of function.

2.8.5. Using purposeful activities to obtain or regain skills needed for activities of daily living (ADL) and/or independent activities of daily living (IADL) or functional skills needed for daily life lost through an acute medical condition, acute exacerbation of a medical condition, or chronic medical condition related to injury, disease, or other medical causes.

2.9. Activities of daily living (ADLs) are activities that include:

- Bathing: selecting appropriate water temperature and flow speed, turning water on and off; laying out and putting away supplies; transferring in and out of bathtub or shower; washing and drying hair and body; clean up after task is completed.
- Dressing: putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; choosing and laying out weather appropriate clothing.
- Eating: feeding self; using utensils or special or adaptive eating devices; clean up after task is completed.
- Personal hygiene: routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.
- Toileting: using commode, bedpan, urinal, toilet chair; transferring on and off; cleansing; changing diapers, pad, incontinence supplies; adjusting clothing; clean up after task is completed.
- Positioning: positioning their body while in a chair, bed, or other piece of furniture or equipment; changing and adjusting positions; moving to or from a sitting position; turning side-to-side; assisting the member to sit upright.
- Transferring: moving from one surface to another with or without a sliding board; moving from bed, chair, wheelchair, or vehicle to a new surface; moving to or from a standing or sitting position; moving the member with lift devices.

2.10. Instrumental activities of daily living (IADLs) are activities that include:

- Telephone use or other communication: assisting the member in making or receiving telephone calls; managing and setting up communication devices; making and receiving the call for the member.
- Grocery or household shopping: shopping for or assisting members in shopping for grocery and household items; preparing a shopping list; putting food and household items away; picking up medication and supplies.
- Light housework: performing or assisting the member in performing light housework such as: cleaning and putting away dishes; wiping countertops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.
- Laundry: assisting the member with doing laundry; gathering, sorting, washing, drying, folding, and putting away personal laundry, bedding, and towels; removing bedding to be washed and remaking the bed; using a laundry facility.
- Meal preparation: assisting members in preparing meals and snacks; cooking; assembling ingredients; cutting, chopping, grinding, or pureeing food; setting out

food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning area after meal; washing dishes.
- Money management: assisting the member with managing their day-to-day finances; paying bills; balancing checkbook; making deposits or withdrawals; assisting in preparing and adhering to a budget.

3. **Speech therapy services** must be medically necessary to the treatment of the member'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:

3.1. The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the patient's condition.

3.2. 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 speech-language pathologist, and requires the skills and judgment of the licensed therapist to perform education and training.

3.2.1 Speech-language pathologists treat speech sounds and motor speech disorders, stuttering, voice disorders, aphasia and other language impairments, cognitive disorders, social communication disorders and swallowing (dysphagia) deficits.

3.3. Speech therapy must be aimed at achieving functional goals.

3.4. Speech therapy is medically necessary for the treatment of chronic (for members 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 speech language pathologist (or SLP assistant) within their licensed scope of practice.

3.4.1. Speech therapy is designed to ameliorate, restore, or rehabilitate speech language communication and swallowing disorders that have been lost or damaged because 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. This includes the following disorders:

3.4.2. **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.

- Aphasia - a language impairment that affects speech production or comprehension of language as a result of a stroke or brain injury.
- Pragmatic dysfunction - an impairment in understanding the social aspects of language

3.4.3. **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 including:

- Aphonia - inability to produce sounds from the larynx due to paralysis, excessive muscle tension, or disease of laryngeal nerves.
- Apraxia - inability to form words to speak, despite one's ability to use oral and facial muscles to make sounds.
- Dysarthria - difficult or defective speech that involves disturbances in muscular control (paralysis, weakness, or lack of coordination) of the speech mechanism (oral, lingual, pharyngeal, or respiratory muscles) resulting from damage to the central or peripheral nervous system.
- Dysphonia - difficulty in speaking due to impaired ability of muscles involving voice production.
- Voice disorder - conditions involving abnormal pitch, loudness or quality of the sound produced by the larynx and thereby affecting speech production

3.4.4. **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.

- Dysphagia - difficulty in swallowing.

4. **Telehealth**: Physical, Occupational, and Speech Therapists in the Comprehensive Care Program are eligible to provide telehealth services as written in the current Texas Medicaid Provider Procedures Manual, Telecommunication Services Handbook

4.1. Therapy may be delivered in-person or via telehealth with the following **exclusions**:

4.1.1. Synchronous telephone (audio-only) technology is excluded from coverage

4.1.2. Procedure codes required to be provided in-person will be referenced from Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook, Telehealth Exclusions

5. **Children Services**: Members 20 years of age and younger

5.1. **Acute Services**: Acute therapy is a benefit of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition.

5.1.1. Acute/recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.

5.1.1.1. The prescribing provider's evaluation of condition can be established by order/referral to therapy services dated within 90 days, recent clinical notes from the prescribing provider dated within 90 days, or prescribing provider's signature on the therapy evaluation/plan of care that documents acute or acute exacerbation within 90 days.

5.2. **Chronic Services**: Benefit 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 Section 5.3.

5.3. **Developmental delay criteria:** all of the following criteria must be met:

5.3.1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
5.3.2. 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 member's status or restricted age range of the testing tool, provider should explain the reason for the change.
5.3.3. Eligibility for initial 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.
5.3.4. When the member's test score is less than 1.5 SD below the mean for initial therapy or 1.33 SD below the mean for ongoing therapy, a criterion-referenced test along with informed evidenced-based clinical opinion must be included to support the medical necessity of services.
5.3.5. 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.
5.3.6. 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.

5.4. **Speech specific developmental delay criteria requirements**:

5.4.1 **Articulation**: For members whose norm-referenced standardized test scores do not match their conversational intelligibility – treatment may be approved according to the member's age and intelligibility standards noted below:

Age	Expected Intelligibility for familiar listeners	Expected intelligibility for non-familiar listeners	Clinically significant variance level indicating treatment need
18 months	25%	0-25%	10% or less to familiar listeners
24 months	50-75%	50%	30% or less to familiar or unfamiliar listeners
36 months	75-100%	75%	50% or less to familiar or unfamiliar listeners

48 + months	100%	100%	75% or less to familiar or unfamiliar listeners

5.4.2. **Swallowing or feeding**: documentation must include an in-depth, functional profile of oral motor structures and function.

5.4.3. **Voice**: a medical evaluation is required for eligibility on the initial request for services and based on medical referral

5.4.4. **Bilingual Testing Requirements**: Bilingual and multilingual speakers are frequently misclassified as developmentally delayed. Equivalent proficiency in both languages should not be expected.

5.4.4.1. Requests for speech therapy must document the member's primary language and any other languages spoken at home; the language in which the therapy will be conducted should also be documented.

5.4.4.2. 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.

5.4.4.3. 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.

5.5. **School-based Services**

5.5.1. Members who are eligible for Physical, Occupational, and Speech Therapy through the public school system (SHARS) may receive additional therapy if medical necessity criteria are met as outlined in this guideline.

5.5.2. Services provided to a member on school premises are only permitted when delivered before or after school hours

5.6. **ECI services** do not require prior authorization and must comply with policy stipulated in the Texas Medicaid Provider Procedure Manual Children's Services Handbook.

6. **Adult Services**: Members 21 years of age and older

6.1. **Acute Services**: Acute therapy is a benefit of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition.

6.1.1. Acute/recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.

6.1.1.1. The prescribing provider's evaluation of condition can be established by order/referral to therapy services dated within 90 days, recent clinical notes from the prescribing provider dated within 90 days, or prescribing provider's signature on the therapy evaluation/plan of care that documents acute or acute exacerbation within 90 days.

6.1.2. 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.

6.1.3. Adult therapy services can be approved for up to 60 days per authorization period based on the definition of an acute medical condition.

6.2. **Chronic Services**: Chronic therapy is not a benefit for members who are 21 years of age and older.

6.3. **Speech therapy provided in the home:** excluded from coverage and NOT a benefit for members 21 years of age and older

7. **Authorization requirements**: All requests for prior authorization for physical, occupational, and speech therapy services are received via fax, mail, and electronically by the Utilization Management Department and processed during normal business hours.

7.1. Therapy initial evaluations do not require prior authorization when provided by an in-network provider.

7.1.1. Re-evaluations do not require authorization when provided by an in-network provider.

7.2. Out of Network therapy evaluations require submission of:

7.2.1. Signed order from an in-network practitioner requesting a therapy evaluation, dated within 60 days prior to the therapy evaluation date

7.2.1.1. Clear documentation of the medical necessity of the requested evaluation – this may include:

- Copy of a physician/physician extender visit note that identifies a need for out of network evaluation Or,
- Letter of medical necessity signed by the ordering physician that identifies the medical need of the out-of-network therapy evaluation

7.3. Prior authorization (PA) requests must be received no later than seven calendar days from the date therapy treatments are initiated. Requests received after the seven-business-day period will be considered retrospective and will follow TCHP Retrospective Review Procedure.

7.3.1. Initial requests must be received no earlier than 60 days before the start date of services.

7.3.2. Ongoing requests must be received no earlier than 30 days before the current authorization period expires.

7.4. Prescribing or ordering providers, dispensing providers, member's responsible adults, and members may sign prior authorization forms and supporting documentation using electronic or wet signatures. Stamped signatures, typed fonts, and images of wet signatures are not accepted.

8. **Initial treatment requests documentation requirements**

8.1. **A completed Texas Medicaid Prior Authorization Form** signed and dated within 60 days of submission by both the therapist and by the prescribing provider is required that specifies the frequency and duration of the requested service.

8.1.1. 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.

8.1.1.1. Texas Medicaid Provider Procedures Manual for requirements for written and verbal orders must be met

8.1.1.2. A prescribing provider signature on the Therapy Plan of Care will suffice as a signed and dated Texas Medicaid Prior Authorization Form or written/verbal order

8.1.2. Frequency and dates of service requested cannot exceed those listed on the provider order and/or the evaluation plan of care, whichever document is signed by the prescribing provider.

8.2**. Initial Evaluation and Treatment Plan or Plan of Care (POC)** with all required elements as follows:

8.2.1. Member's medical history and background, prior therapy history, and all medical diagnoses related to the member's condition

8.2.2. Documentation of member's primary language

8.2.3. Documentation of the date of onset of the member's condition requiring therapy or exacerbation of a condition as applicable. If the date of onset is congenital, providers should state onset date at birth.

8.2.4. A description of the member's current level of functioning or impairment assessed within 60 days of the submission.

8.2.4.1. This should include baseline objective measurements based on standardized testing performed or other standard assessment tools per Section 5.3, Developmental Delay Criteria

8.2.5. A clear diagnosis and reasonable prognosis including interpretation of the results of the evaluation

8.2.6. A statement of the prescribed treatment modalities and their recommended frequency and duration

8.2.6.1. 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 member's anticipated therapy treatment needs

8.2.7. Short and long-term functional treatment goals which are specific to the member's diagnosed condition or impairment

8.2.8. List any adaptive equipment or assistive devices that contribute toward member function. If the member does not have adaptive equipment or assistive devices, indicate that this element is not applicable

8.2.9. Prescribed home exercise program including the guardian's expected involvement in the member's treatment

8.2.10. Requested dates of service for planned treatments after the completion of the evaluation

8.2.11. Plan for collaboration with ECI, Head Start, or SHARS when applicable

8.2.12. Signature and date of treating therapist

9. **Recertification (ongoing treatment) documentation requirements**

9.1. **A completed Texas Medicaid Prior Authorization Form** signed and dated within 60 days of submission by both the therapist and by the prescribing provider is required that specifies the frequency and duration of the requested service.

9.1.1. 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.

- Texas Medicaid Provider Procedures Manual for requirements for written and verbal orders must be met
- A prescribing provider signature on the Therapy Plan of Care will suffice as a signed and dated Texas Medicaid Prior Authorization Form or written/verbal order

9.1.2. Frequency and dates of service requested cannot exceed those listed on the provider order and/or the evaluation plan of care, whichever document is signed by the prescribing provider.

9.2. **Recertification for acute therapy services**:

9.2.1. A progress summary that contains all of the following:

9.2.1.1. A summary of member's response to therapy and current treatment plan

9.2.1.2. Documentation of objective measures of functional progress related to each treatment goal established on the initial evaluation

9.2.1.3. Updated or new functional and measurable short and long-term treatment goals with time frames, as applicable

9.2.1.4. An assessment of the member's therapy prognosis and overall functional progress

9.2.1.5. Documentation of member's participation in treatment as well as member or responsible adult's participation or adherence with a home treatment program

9.2.1.6. Documentation of member's continued need for therapy

9.2.1.7. The progress summary must be signed and dated by the therapist responsible for the therapy services.

9.3. **Formal Re-evaluation and Treatment Plan or Plan of Care** (POC) **for chronic therapy services**: performed every 180 days or if required sooner due to changes in the member's status with all of the following required elements:

9.3.1. Member's medical history and background, prior therapy history, and all medical diagnoses related to the member's condition

9.3.2. Documentation of the date of onset of the member's condition requiring therapy or exacerbation of a condition as applicable. If the date of onset is congenital, providers should state onset date at birth.

9.3.3. Date therapy services started

9.3.4. A description of the member's current level of functioning or impairment assessed within 60 days of the submission.

9.3.5. Documentation of developmental delay and reasons continued therapy services are medically needed per Section 5.3

9.3.6. A clear diagnosis and reasonable prognosis including assessment of the member's capability for continued measurable progress

9.3.7. New treatment plan or POC for the dates of service requested

9.3.7.1. 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 member's anticipated therapy treatment needs

9.3.8. Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable. Previous authorization period's goals and objective progress towards the previous goals must be included.

9.3.9. List any adaptive equipment or assistive devices that contribute toward member function. If the member does not have adaptive equipment or assistive devices, indicate that this element is not applicable

9.3.10. Prescribed home exercise program including the guardian's expected involvement in the member's treatment

9.3.11. Requested dates of service for planned treatments after the completion of the evaluation

9.3.12. Plan for collaboration with ECI, Head Start, or SHARS when applicable

9.3.13. Signature and date of treating therapist

9.4. Routine reassessments that occur during each treatment session, a progress report required for an extension of services, or a discharge summary are not considered a comprehensive re-evaluation.

10. **Special Documentation considerations**

10.1. Co-treatment: requests for co-treatment services will follow current guidance in the Texas Medicaid Provider Manual Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.

10.1.1. Duplication of therapy services is not allowed. When members receive physical, occupational, or speech therapy, the therapists should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals.

10.2. Group therapy: Group therapy must follow current guidance in the Texas Medicaid Provider Manual Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.

10.3. Change of provider: If a provider or member discontinues therapy during an existing prior authorized period and the member 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:

10.3.1. A new therapy evaluation that meets established documentation requirements that is performed by the new therapy service provider

10.3.2 A change-of-therapy provider letter that includes all of the following:

10.3.2.1. Signature of the member or responsible adult,

10.3.2.2. Date that the member ended therapy or last date of service with the previous provider

10.3.2.3. The names of the previous provider and the new provider

10.3.3. When a provider or member discontinues therapy during an existing prior authorization period and the member 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. No change of provider letter is required when changing therapist within the same provider group.

10.4 **Change of Coverage/Continuity of Care**

10.4.1. Services approved through another MCO or TMHP:

10.4.1.1. The authorization request must include a copy of the previously approved authorization letter.

10.4.1.2. Services will be honored for the shorter of 90 days or until expiration of the previous MCO authorization.

10.4.1.3. TCHP will honor the authorization request for the duration of the original authorization even if it extends past 90 days when submitted by an in-network provider

10.4.2. Requests to transfer an authorization submitted after the end date of the previous authorization, must meet all of the documentation and submission guidelines for the specific service type.

10.4.3. Requests will not be considered retrospective if submitted within the same month of the enrollment date.

10.5 **Requests for revisions**

10.5.1 Prior authorization is required when the frequency is increased or services requiring separate authorization are added.

10.5.2. A completed Texas Medicaid Prior Authorization Form signed and dated within 60 days of submission by both the therapist and by the prescribing provider is required that specifies the frequency and duration of the requested service.

10.5.2.1. 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.

- Texas Medicaid Provider Procedures Manual for requirements for written and verbal orders must be met

10.5.3. Frequency and dates of service requested cannot exceed those listed on the provider order and/or the evaluation plan of care, whichever document is signed by the prescribing provider.

10.5.4. A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

10.5.5. Progress summary indicating the medical rationale for the change requested

10.5.6. 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.

10.5.7. The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

10.5.8. Extending dates of service to accommodate missed visits does not qualify for an authorization revision and will be processed under Section 9 of this guideline "Ongoing Treatment Requests Documentation Requirements."

10.6. Coordination of care with PPECC. When the member receives therapy services in a PPECC setting, the therapy provider must provide evidence of care coordination with the prescribed pediatric extended care center (PPECC) provider.

11. **Frequency** - Frequency must always be commensurate with the member's medical and skilled therapy needs, level of disability (for member who are 20 years of age and younger), and standards of practice; it is not for the convenience of the member or the responsible caregivers.

11.1. **High frequency therapy** (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.

11.1.1. High frequency therapy provided 3 times a week may be considered for 2 or more of these exceptional situations:

- The member has a medical condition that is rapidly changing.
- The member 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 member's therapy plan and home program require frequent modification by the licensed therapist.

11.1.2. 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:

11.1.2.1. Letter of medical need from the prescribing provider documenting the member's rehabilitation potential for achieving the goals identified,

11.1.2.2. 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.

11.1.3. 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 member's medical needs.

11.2. **Moderate frequency therapy** (2 times a week) may be considered when documentation shows one or more of the following:

- The member is making very good functional progress toward goals.
- The member 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 member's therapy plan and home program weekly or more often than weekly based on the member's progress and medical needs.
- The member has complex needs requiring ongoing education of the responsible adult.

11.3. **Low frequency therapy** (1 time per week or every other week) may be considered when the documentation shows one or more of the following:

- The member is making progress toward the member's goals, but the progress has slowed, or documentation shows the member is at risk of deterioration due to the member's development or medical condition.
- The licensed therapist is required to adjust the member's therapy plan and home program weekly to every other week based on the member's progress.
- Every week or every other week therapy is supported for members whose medical condition is stable, they are making progress, and it is anticipated the member will not regress with every other week therapy.
- As the member improves and medical need for therapy decreases, it is expected that the therapy frequency will decrease as well.

11.4. **Maintenance therapy** - (e.g., every other week, monthly, every 3 months) may be considered for members who are 20 years of age and younger only, when the therapy plan changes very slowly, the home program is at a level that may be managed by the member 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 member requires skilled therapy for ongoing periodic assessments and consultations and the member 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 member may be making limited progress toward goals or that goal attainment is extremely slow.
- Factors are identified that inhibit the member's ability to achieve established goals (e.g., the member cannot participate in therapy sessions due to behavior issues or issues with anxiety).
- Documentation shows the member 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 member's needs.

12. **Discontinuation of Therapy**: Ongoing therapy may not be approved in one or more of the following situations.

12.1. The member no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care.

12.2. The member has returned to baseline function.

12.3. Member can continue therapy and maintain status with a home exercise program and deficits no longer require a skilled therapy intervention

12.4. The member has adapted to the impairment with assistive equipment or devices and is able to perform ADL's with minimal to no assistance from caregiver at an age appropriate level
12.5. Member has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy.
12.6. Member 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.
12.7. Testing shows member no longer has a developmental delay.
12.7.1. All test scores have improved to within 1.33 SD from the mean
- 80 or more for tests with a mean of 100
- 7 or more for tests with a mean of 10

12.8. Member demonstrates a plateau in response to therapy/lack of progress towards therapy goals. This may be an indication for therapeutic pause in treatments or for those under age 21, transition to maintenance level therapy.
12.9. The member has not made significant progress towards meeting goals and/or improvement in norm-referenced standardized test** scores
12.10. Non-compliance due to poor attendance and with member or responsible adult, non-compliance with therapy and home treatment program.

13**. Exclusions/Noncovered Services**: The following services are not a benefit of Texas Medicaid.
13.1 Therapy services provided by a licensed therapist who is the member's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage).
13.2. Treatment solely for the instruction of other agency or professional personnel in the member's PT, ST, or OT program.
13.3. 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 member on their own or with a responsible adult's assistance).
13.4. 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.
13.5. 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
13.6. Therapy services that are provided after the member has reached the maximum level of improvement or is now functioning with normal limits.
13.6. Therapy not expected to result in practical functional improvements in the member's level of functioning.

13.7.Treatments that maintain function using routine, repetitious, or reinforced procedures that are neither diagnostic nor therapeutic (for example, practicing word drills for developmental articulation errors.

13.8. Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition.
13.9. Therapy services related to activities for the general good and welfare of members 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
- Activities to provide diversion or general motivation
- Supervised exercise for weight loss.

13.10. 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
- Wilbarger brushing protocol

13.11. Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment
13.12. Therapy prescribed primarily as an adjunct to psychotherapy
13.13 Learning skills which should be remediated in the classroom environment such as handwriting, cutting, writing, reading, or other subjects which are part of a school curriculum.
13.14. Developmental articulation errors that are self-correcting.

- Language therapy for young children with natural disfluency (stuttering). Disfluency is a common condition in young children with onset after age 3 and is usually self-correcting by age 6 to 7. This is not an indication for speech therapy.

13.15. A child being bilingual is not considered developmental delay and speech therapy is usually not a covered health service, except when other criteria for speech therapy are met
13.16. Separate reimbursement for VitalStim therapy for dysphagia. VitalStim must be a component of a comprehensive feeding treatment to be considered a benefit.

14. Providers should bill for therapy services in accordance with guidance in the current Texas Medicaid Provider Procedure Manual.

15. All requests for therapy evaluations and treatment that do not meet the guidelines referenced here will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

16. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and

exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

APPENDIX:

**Tests used must be norm-referenced, standardized, age appropriate and specific to the suspected area(s) of deficit. The following list of tests is not all-inclusive. (Newer editions of currently listed tests are also acceptable.)

Physical Therapy:

- Alberta Infant Motor Scale (AIMS)
- Bayley Scales of Infant and Toddler Development (BSID)
- Bruininks-Oseretsky Test of Motor Proficiency, Second Edition (BOT-2)
- Developmental Assessment of Young Children Second Edition (DAYC-2)
- Functional Independence Measure for Children (WeeFIM)
- Functional Independence Measure — 7 years of age to adult (FIM)
- Gross Motor Function Measure (GMFM)
- Peabody Developmental Motor Scales PDMS Peabody Developmental Motor Scales, Second/Third Edition (PDMS-2/3)
- Range of Motion — Functional Performance Impairments (ROM)
- Test of Gross Motor Development, Second Edition (TGMD-2)
- Pediatric Evaluation of Disability Inventory
    - The PEDI can also be used for older children whose functional abilities fall below that expected of a 7 ½ year old with no disabilities. In this case, the scaled score is the most appropriate score to consider. (PEDI or PEDI-CAT)

Speech Therapy:

- Clinical Assessment of Articulation and Phonology (CAAP)
- Clinical Evaluation of Language Fundamentals — Preschool (CELF-P)
- Clinical Evaluation of Language Fundamentals, Third/Fourth Edition (CELF-3/4)
- Developmental Assessment of Young Children Second Edition (DAYC-2)
- Expressive One-Word Picture Vocabulary Test, Fourth Edition (EOWPVT-4)
- Goldman-Fristoe Test of Articulation, Third Edition (GFTA-3)
- Khan-Lewis Phonological Analysis (KLPA-3)
- Oral and Written Language Scales (OWLS)
- Preschool Language Scale, Fifth Edition (PLS-5)
- Receptive-Expressive Emergent Language Test, Second/Third Edition (REEL-2/3)
- Receptive One-Word Picture Vocabulary Test, Fourth Edition (ROWPVT-4)
- Stuttering Severity Instrument for Children and Adults (SSI-4)
- Test of Early Language Development, Third Edition (TELD-3)
- Test of Language Development, Third Edition (TOLD-3)

Occupational Therapy:

- Beery-Buktenica Developmental Test of Visual-Motor Integration (Beery VMI)
- Bruininks-Oseretsky Test of Motor Proficiency — Second Edition (BOT-2)
- Developmental Assessment of Young Children Second Edition (DAYC-2)
- Functional Independence Measure — young version (WeeFIM)
- Functional Independence Measure — 7 years of age to adult (FIM)
  Peabody Developmental Motor Scales PDMS Peabody Developmental Motor Scales, Second/Third Edition (PDMS-2/3)
  Roll Evaluation of Activities of Life (REAL)
- Pediatric Evaluation of Disability Inventory (PEDI or PEDI-CAT)
    - The PEDI can also be used for older children whose functional abilities fall below that expected of a 7 ½ year old with no disabilities. In this case, the scaled score is the most appropriate score to consider. (PEDI or PEDI-CAT)

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