The drafted policies are open for a two-week public comment period. This box is not part of the drafted policy language itself and is intended for use only during the comment period to provide readers with a summary of what has changed.

As mandated by House Bill 4, 87th Legislature, Regular Session, 2021, HHSC is performing a targeted review regarding telehealth services for Medicaid clients in the following policies:

* Physical, Occupational Therapy, and Speech Therapy – Children (Acute and Chronic)
* Physical, Occupational, and Speech Therapy- Adult/Clients Age 21
* Mobility Aids- Home Health
* Mobility Aids- Comprehensive Care Program (CCP)
* Augmentative Communication Devices

The following is a summary of changes in scope for this policy review:

* Added telehealth language to Physical Therapy, Occupational Therapy, and Speech Therapy – Children policy
* Added telehealth language to Physical Therapy, Occupational Therapy, and Speech Therapy – Adult policy
* Added telehealth language to Mobility Aids- Home Health and CCP policies regarding assessments
* Added telehealth language to Augmentative Communication Devices policy regarding assessments

Some policy language that is out of scope for this review is included in this document for context. Unchanged policy language appears without underlining. New policy language has been underlined and deleted language has been struck-through to highlight proposed policy changes.

Note: The current language regarding Physical, Occupational, and Speech Therapy —Children (Acute and Chronic) can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Vol 2: Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.

The current language regarding Physical, Occupational, and Speech Therapy- Adult/Clients Age 21 and Over can be found in the TMPPM, Vol 2: Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.

The current language regarding Mobility Aids- Home Health can be found in the TMPPM, Vol 2: Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook.

The current language regarding Mobility Aids- CCP can be found in the TMPPM, Vol 2: Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook.

The current language regarding Augmentative Communication Devices can be found in the TMPPM, Vol 2: Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook.

**Texas Medicaid**

# PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY—CHILDREN (ACUTE AND CHRONIC)

## Statement of Benefits

1. This medical policy addresses acute and chronic physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services for clients who are birth through 20 years of age. This policy does not address freestanding inpatient rehabilitation services.
2. Unless otherwise specified, “days” refers to calendar days.
3. PT, OT, and ST are benefits of Texas Medicaid in Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs) only for clients aged birth through 20 years.
4. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only PT, OT, and ST services that can be delivered during school hours are therapy services provided by school districts as School Health and Related Services (SHARS).
5. 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.
6. For specific guidelines related to therapy services provided through Early Childhood Intervention, refer to the Early Childhood Intervention (ECI) Services - CCP policy.
7. 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:
   1. Licensed therapy assistant
   2. 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.

1. PT/OT/ST services are provided in one of the following places of service by setting and provider:
   1. Office
      1. Physician and podiatrist
      2. Physical/Occupational Therapy Group
      3. Independently enrolled therapists
      4. ECI
      5. SHARS
   2. Home
      1. Home Health Agency
      2. Independently enrolled therapists
      3. Physical/Occupational Therapy Group
      4. ECI
      5. SHARS
   3. Outpatient
      1. Comprehensive outpatient rehabilitation facility (CORF)/ Outpatient rehabilitation facility (ORF)
      2. Physician and Podiatrist
      3. Hospitals
      4. Prescribed Pediatric Extended Care Centers
         1. Home Health Agency
         2. Independently enrolled therapists
         3. Physical/Occupational Therapy Group
         4. ECI
   4. Other
      1. ECI
      2. SHARS
      3. Independently enrolled therapists
      4. Physical/Occupational Therapy Group
      5. Home Health Agency

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

1. 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.
   1. 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.
   2. 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.

### Acute Services

1. 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.
   1. 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.

* 1. Treatments are directed toward restoration of or compensation for lost function.
  2. Services do not duplicate those provided concurrently by any other therapy.
  3. Services must meet acceptable standards of medical practice and be specific and effective treatment for the client’s condition.
  4. Services are provided within the provider’s scope of practice, as defined by state law.
  5. Acute is defined as an illness or trauma with a rapid onset and short duration.

1. 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.
2. 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.
3. 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.

### Chronic Services

1. Chronic physical, occupational, and speech therapy services are benefits of Texas Medicaid for the medically necessary treatment of chronic medical conditions and developmental delay when a medical need is established for the developmental delay as indicated in this policy. 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.
2. 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.
   1. Services do not duplicate those provided concurrently by any other therapy.
   2. Services must meet acceptable standards of medical practice and be specific and effective treatment for the client’s condition.
   3. Services are provided within the provider’s scope of practice, as defined by state law.
3. Treatment for chronic medical conditions and developmental delay will only be considered for clients who are birth through 20 years of age.

## Policy Overview/Scope

1. Physical, occupational and speech therapy services must be medically necessary to the treatment of the individual’s chronic or acute need. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, all of the following conditions must be met:
   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,
   2. 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,
   3. 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.
   4. 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.
   5. Testing must establish a client with developmental delays meets the medical necessity criteria as defined in this policy, see Developmental Delay Criteria section in this policy.
2. 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.
3. The therapy service must be related to the client’s medical condition, rather than primarily for the convenience of the client or provider.
4. 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.
   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 client’s anticipated therapy treatment needs.
   2. An example of a tapered down frequency request initiated with a high frequency is: 3 times a week for 2 weeks, 2 times a week for 2 weeks, 1 time a week for 2 weeks, 1 time every other week).
5. For prior authorization criteria for frequency, see the Frequency and Duration Criteria for PT/OT/ST section under the Authorization section in this policy.

## Authorization Requirements

### Telehealth Services

1. Providers must defer to the needs of the person receiving services, allowing the mode of service delivery (synchronous audiovisual or in-person) to be accessible, person- and family-centered, and primarily driven by the person’s choice and not provider convenience.
2. Evaluation, reevaluation, and treatment of some PT, OT, and ST services may be provided by synchronous audiovisual technology.
3. Telehealth services for OT, PT or ST by synchronous audiovisual technology are allowed for specific procedure codes if clinically appropriate as determined by the practitioner, per standard of care, safe, agreed to by the person receiving services or by the legally authorized representative (LAR), and in compliance with each discipline’s rules.
4. The following procedure codes may be provided by synchronous audiovisual technology:
   1. Physical Therapy Evaluations- Low, Moderate, and High Complexity and re-evaluation (procedure codes 97161, 97162, 97163, 97164)
   2. Occupational Therapy Evaluation – Low, Moderate, and High Complexity and re-evaluation (procedure codes 97165, 97166, 97167, 97168)
   3. PT or OT Services (individual or group) (procedure codes 97110, 97112, 97116, 97150, 97530, 97535, 97750, 97537)
      1. Community reintegration (procedure code 97537) may be provided if the person receiving services is currently receiving other therapeutic procedure codes and may not be billed separately.
   4. Speech Evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, S9152)
   5. ST (individual or group) services (procedure codes 92507, 92508, 92526)
   6. The provider should obtain informed consent for treatment from the patient, patient’s parent, or the patient’s legal guardian prior to rendering a telehealth service. Verbal consent is permissible and should be documented in the client’s medical record.
   7. Services delivered by synchronous audiovisual technology may require participation of a parent or caregiver to assist with the treatment.
   8. Therapy assistants may deliver services and receive supervision by synchronous audiovisual technology within limits outlined in each discipline’s rules. Providers should refer to state practice rules and national guidelines regarding supervision requirements for each discipline.
   9. Providers must use modifier 95 to indicate remote delivery. Providers are reminded to use the required modifiers GP, GO, and GN on all claims for physical, occupational, or speech therapy treatment.
5. During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

## Reimbursement/Billing Guidelines

1. Physical, occupational therapy and speech therapy services are reimbursed in accordance with 1 TAC §355.
2. Providers must use the appropriate procedure codes and modifiers for claims submitted for PT, OT, or ST services.
   1. Modifier AT indicates an acute service and must be billed with appropriate physical, occupational or speech therapy procedure codes identifying the therapy service provided is acute.
   2. Providers must use modifier GP for PT services.
   3. Providers must use modifier GO for OT services.
   4. Providers must use modifier GN for ST services.
   5. Providers must use modifier 95 for services delivered by synchronous audiovisual technology.
3. 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.
4. 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.
5. 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.
6. 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.
7. Procedure codes for PT/OT/ST evaluations are payable once every three years to the same rendering provider.
8. For acute services, PT/OT/ST re-evaluations may be reimbursed once every 60 days to any provider when a recertification of services is planned.
9. For chronic services, PT/OT/ST re-evaluations are reimbursed once every 180 days to any provider when a recertification of services is planned.
10. Additional PT, OT, or ST evaluations or re-evaluations exceeding the limits outlined in this policy may be considered for with documentation of one of the following:
    1. A significant change in the client’s medical condition as documented in the plan of care or treatment plan
    2. A change of provider has occurred and a change of provider letter is submitted with the appeal.
    3. The re-evaluation is required for recertification of an existing authorization.

Procedure Codes - Allowable for Telehealth

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

### 

### Therapy Modifiers

#### Telehealth

Table O: Modifiers—Modifier for telehealth

|  |  |
| --- | --- |
| Modifier | Description |
| 95 | Services delivered by synchronous audiovisual technology |

## Documentation Requirements

### Treatment Note

1. The following documentation must be kept on file by the treating provider and be available when requested:
   1. Client’s name
   2. Date of service
   3. Time in and out of each therapy session
   4. Objectives addressed (should coincide with plan of care) and progress noted, if applicable
   5. A description of specific therapy services provided and the activities rendered during each therapy session, along with a form of measurement.
   6. Assessments of client’s progress or lack of progress
   7. Treatment notes must be legible
   8. Therapy providers must sign each date of entry with full signature and credentials
2. All documentation for evaluations, re-evaluations, progress summaries, treatment notes, and discharge summaries must show client’s name, date of service, time in and time out of each therapy session.

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

## Exclusions

### Telehealth Exclusions

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

Procedure Codes – Not Allowable for Telehealth

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

# PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY-ADULT/CLIENTS AGE 21 AND OVER

## Statement of Benefits

Unless otherwise specified, “days” refers to calendar days.

1. Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition for adult clients 21 years of age and older.
   1. 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 physician’s and therapist’s assessment of the client’s restorative potential.

Note:Recent is defined as occurring within the past 90 days of the physician’s evaluation of condition.

* 1. Treatments are directed towards restoration of or compensation for lost function.
  2. Services do not duplicate those provided concurrently by any other therapy.
  3. Services must meet acceptable standards of medical practice and be specific and effective treatment for the client’s condition.
  4. Services are provided within the provider’s scope of practice, as defined by state law.
  5. Acute is defined as an illness or trauma with a rapid onset and short duration.

1. 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.
2. 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.
3. Physical and occupational therapy services for acute conditions are benefits of the Texas Medicaid program for adult clients in the office, outpatient and home settings.
4. Speech therapy services for acute conditions are a benefit of Texas Medicaid for adult clients in the office and outpatient setting only.
5. Therapy services must be performed by one of the following: a licensed physical therapist, licensed occupational therapist, licensed speech-language pathologist, or a physician within their scope of practice, or one of the following under the supervision of a licensed therapist of the specific discipline:
   1. Licensed therapy assistant,
   2. Licensed speech-language pathology intern (Clinical Fellow)
6. Acute Therapy services are provided in one of the following places of service:
   1. PT/OT Services by setting and provider
      1. Office
         1. Independently enrolled physical therapist
         2. Physicians and podiatrists
         3. Independently enrolled occupational therapist
      2. Home
         1. Home health agency
         2. Independently enrolled physical therapist
         3. Independently enrolled occupational therapist
         4. Physical/Occupational therapy group
      3. Outpatient
         1. Hospitals
         2. Physician and podiatrist
      4. Other
         1. Independently enrolled physical therapist
         2. Independently enrolled occupational therapist
         3. Physical/Occupational therapy group
   2. ST services by setting and provider
      1. Office
         1. Independently enrolled speech-language pathologist
         2. Physicians
      2. Outpatient
         1. Hospitals
         2. Physicians
7. In determining whether a service requires the skill of a licensed therapist, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and therapy practice guidelines.
   1. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled therapy service.
   2. 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.

## Policy Overview/Scope

1. Physical, occupational and speech therapy services must be medically necessary to the treatment of the individual’s 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. The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the patient’s condition.
   2. 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.
   3. The goals of the requested services to be provided are directed at improving, adapting or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part and restore client’s function to within normal activities of daily living (ADL).
   4. 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 relevant to client and family, and based on a medical need.
   5. There must be reasonable expectation that therapy will result in a meaningful or practical improvement in the client’s ability to function within a reasonable and predicable time period.
2. 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 physician for the treatment of the individual.
3. The therapy service must be related to the client’s medical condition, rather than primarily for the convenience of the client or provider.
4. Frequency must always be commensurate with the client’s medical and skilled therapy needs and standards of practice; it is not for the convenience of the client or the responsible caregivers. Treatment plans and plans of care developed must include not only the initial frequency (high, moderate or low) but the expected changes of frequency throughout the duration period requested based on the client’s anticipated therapy treatment needs. An example of a tapered down frequency request initiated with a high frequency is: 3 times a week for 2 weeks, 2 times a week for 2 weeks, 1 time a week for 2 weeks, 1 time every other week).
5. For prior authorization criteria see the Frequency and Duration section under the Authorization section in this policy

## Authorization Requirements

### Telehealth Services

1. Providers must defer to the needs of the person receiving services, allowing the mode of service delivery (synchronous audiovisual or in-person) to be accessible, person- and family-centered, and primarily driven by the person’s choice and not provider convenience.
2. Evaluation, reevaluation, and treatment of some PT, OT, and ST services may be provided by synchronous audiovisual technology.
3. Telehealth services for OT, PT or ST by synchronous audiovisual technology are allowed for specific procedure codes if clinically appropriate as determined by the practitioner, per standard of care, safe, agreed to by the person receiving services or by the legally authorized representative (LAR), and in compliance with each discipline’s rules.
4. The following procedure codes may be provided by synchronous audiovisual technology:
   1. Physical Therapy Evaluations- Low, Moderate, and High Complexity and re-evaluation (procedure codes 97161, 97162, 97163, 97164)
   2. Occupational Therapy Evaluation – Low, Moderate, and High Complexity and re-evaluation (procedure codes 97165, 97166, 97167, 97168)
   3. PT or OT Services (individual or group) (procedure codes 97110, 97112, 97116, 97150, 97530, 97535, 97750, 97537)
      1. Community reintegration (procedure code 97537) may be provided if the person receiving services is currently receiving other therapeutic procedure codes and may not be billed separately.
   4. Speech Evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, S9152)
   5. ST (individual or group) services (procedure codes 92507, 92508, 92526)
   6. The provider should obtain informed consent for treatment from the patient, patient’s parent, or the patient’s legal guardian prior to rendering a telehealth service. Verbal consent is permissible and should be documented in the client’s medical record.
   7. Telehealth may require participation of a caregiver to assist with the treatment.
   8. Therapy assistants may provide services and receive supervision by synchronous audiovisual technology within limits outlined in each discipline’s rules. Providers should refer to state practice rules and national guidelines regarding supervision requirements for each discipline.
   9. Providers must use modifier 95 to indicate remote delivery. Providers are reminded to use the required modifiers GP, GO, and GN on all claims for physical, occupational, or speech therapy treatment.
5. During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

## Reimbursement/Billing Guidelines

1. Physical, occupational therapy and speech therapy services are reimbursed in accordance with 1 TAC §355.
2. Providers must use the appropriate procedure codes and modifiers for claims submitted for PT, OT, or ST services.
   1. Modifier AT indicates an acute service and must be billed with appropriate physical, occupational or speech therapy procedure codes identifying the therapy service provided is acute.
   2. Providers must use modifier GP for PT services.
   3. Providers must use modifier GO for OT services.
   4. Providers must use modifier GN for ST services
   5. Providers must use modifier 95 for services delivered by synchronous audiovisual technology.
3. A client may receive therapy in more than one discipline (physical, occupational or speech) in the outpatient, office or home setting in one day.
4. If a therapy evaluation or re-evaluation procedure code and like therapy procedure codes are billed for the same date of service by any provider, the like therapy evaluation or re-evaluation will be denied.
5. 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.
6. 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.
7. Procedure codes for PT/OT/ST evaluations are payable once every three years to the same rendering provider.
8. For acute services, PT/OT/ST re-evaluations may be reimbursed once every 60 days to any provider when a recertification of services is planned.
9. Additional PT, OT, or ST evaluations or re-evaluations exceeding the limits outlined in this policy may be considered for reimbursement on appeal with documentation of one of the following:
   1. A significant change in the client’s medical condition as documented in the plan of care or treatment plan,
   2. A change of provider has occurred and a change of provider letter is submitted with the appeal.
   3. The re-evaluation is required for recertification of an existing authorization.

Procedure Codes - Allowable for Telehealth

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

## Therapy Modifiers

#### Telehealth

Table O: Modifiers—Modifier for telehealth

|  |  |
| --- | --- |
| Modifier | Description |
| 95 | Services delivered by synchronous audiovisual technology |

## Documentation Requirements

### Treatment Note

1. The following documentation must be kept on file by the treating provider and available when requested:
   1. Client’s name
   2. Date of service
   3. Time in and out of each therapy session
   4. Objectives addressed (should coincide with plan of care) and progress noted, if applicable
   5. A description of specific therapy services provided and the activities rendered during each therapy session, along with a form of measurement.
   6. Assessments of client’s progress or lack of progress
   7. Treatment notes must be legible
   8. Therapy providers must sign each date of entry with full signature and credentials
2. All documentation for evaluation; re-evaluations, progress summaries, treatment, notes, and discharge summaries must show client’s name, date of service, time in and time out for each therapy session

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

## Exclusions

### Telehealth Exclusions

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

**Procedure Codes – Not Allowable for Telehealth**

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

# MOBILITY AIDS – HOME HEALTH

## Statement of Benefits

1. Mobility aids and related supplies, including, but not limited to, canes, crutches, walkers, wheelchairs, and ramps as detailed in this policy are a benefit through Title XIX Home Health Services to assist clients to move about in their environment when the following criteria are met:
   1. The client must be eligible for home health benefits
   2. The equipment requested must be medically necessary
   3. The criteria listed in this policy for the requested equipment must be met
   4. Federal financial participation must be available
   5. The client’s mobility status would be compromised without the requested equipment
   6. The requested equipment or supplies must be safe for use in the home

Note:A mobility aid for a client who is birth through 20 years of age is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.

1. Durable medical equipment (DME) is defined as medical equipment or appliances manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client’s disability, condition, or illness. Since there is no single authority (such as a federal agency) that confers the official status of “durable medical equipment” on any device or product, the Health and Human Services Commission (HHSC) retains the right to make such determinations with regard to DME covered by Texas Medicaid.

Note:Refer to the [Appendix](#_bookmark80) for procedure codes and benefit limitations.

## Exclusions

### Noncovered Services

1. The following mobility aids are not a benefit of Texas Medicaid:
   1. Items including, but not limited to, tire pumps, a color for a wheelchair, gloves, back packs, and flags (not considered medically necessary)
   2. Mobile standers, including a power standing system on a wheeled mobility device
   3. Vehicle lifts and modifications
   4. Permanent ramps, vehicle ramps, and home modifications
   5. Stairwell lifts of any type
   6. Elevators or platform lifts of any type
   7. Chairs with incorporated seat lifts
   8. An attendant control, for safety, all power chairs are to include a stop switch
   9. PMD for use only outside the home
2. Specialized evaluations required for the provision of new complex rehabilitation technology, such as power mobility and adaptive seating systems, require physical in-person presence of the rendering provider.
   1. Texas Medicaid will only reimburse for seating assessments, regardless of provider type, completed in-person.

Note: Mobility aids that do not meet criteria for coverage through Title XIX Home Health Services may be considered for clients who are birth through 20 years of age through THSteps-CCP.

Note: For clients 21 years of age or older, requests for mobility aids that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health - Durable Medical Equipment (DME) Exceptional Circumstances process.

# Mobility Aids – CCP

## Statement of Benefits

1. Mobility aids and related supplies, including but not limited to, strollers, special needs car sears, travel safety restraints, and thoracic-hip-knee-ankle orthoses (THKAO)/parapodiums are a benefit of Texas Medicaid to assist clients to move about in their environment. Mobility aids equipment includes, but is not limited to, the items detailed in this policy.
2. Mobility aids and related supplies may be considered for reimbursement through the Comprehensive Care Program (CCP) for clients who are 20 years of age or younger who are THSteps-CCP eligible when the following criteria are met:
   1. The equipment requested must be medically necessary
   2. Federal financial participation must be available
   3. The client’s mobility status would be compromised without the requested equipment
   4. The requested equipment or supplies must be safe for use in the home
3. DME is medical equipment/appliances manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client’s disability, condition, or illness. Since there is no single authority (such as a federal agency) that confers the official status of “durable medical equipment” on any device or product, the Health and Human Services Commission (HHSC) retains the right to make such determinations with regard to DME covered by Texas Medicaid.
4. Mobility aids may be considered through THSteps-CCP if the requested equipment is not available through Title XIX Home Health Services or the client does not meet criteria through Title XIX Home Health.

Note:Refer to the Home Health Mobility Aids policy.

1. Mobility aid lifts for vehicles, and vehicle modifications are not reimbursed through Texas Medicaid according to Federal Regulations.

Note:Permanent ramps, vehicle ramps, and home modifications are not a benefit of Texas Medicaid.

## Seating Assessment

1. A seating assessment is required for:
   1. The rental or purchase of any device meeting the definition of a wheeled mobility system as defined in this policy.
   2. The purchase of any device meeting the definition of a wheelchair as defined in this policy for a client with a congenital or neurological condition, myopathy, or skeletal deformity, which requires the use of a wheelchair.
2. A seating assessment with measurements, including specifications for exact mobility/seating equipment and all necessary accessories, must be completed by a physician, or a licensed occupational therapist, or physical therapist.

Note: For CCP clients, the licensed occupational or physical therapist may not be associated with a DME provider for purposes of performing a seating assessment for a wheeled mobility system.

1. A QRP directly employed or contracted by the DME provider must be present at and participate in all seating assessments, including those provided by a physician.
2. Upon completion of the seating assessment, the QRP must attest to his or her participation in the assessment by signing the Wheelchair, Scooter, Stroller Seating Assessment form. This form must be submitted with all requests for wheeled mobility systems.
3. When the practitioner completing the seating assessment is an OT or PT, the OT or PT may perform the seating assessment as the therapist, or as the QRP, but may not perform in both roles at the same time. If the OT or PT is attending the seating assessment as the QRP, the OT or PT must meet the credentialing requirements and be enrolled in Texas Medicaid as a QRP.
4. If the practitioner completing the seating assessment is a physician, the seating assessment is considered part of the evaluation and management service provided.

Note: If a client who is birth through 20 years of age requires seating support and meets the criteria for a seating system, a stroller may be considered through CCP, or a wheelchair may be considered through Texas Medicaid Title XIX Home Health Services.

1. Specialized evaluations required for the provision of new complex rehabilitation technology, such as power mobility and adaptive seating systems, require physical in-person presence of the rendering provider.
   1. Texas Medicaid will only reimburse for seating assessments, regardless of provider type, completed in-person.

# AUGMENTATIVE COMMUNICATION DEVICE (ACD) SYSTEM – HOME HEALTH

## Statement of Benefits

1. An augmentative communication device (ACD) system is a benefit of Texas Medicaid Title XIX Home Health Services.
2. An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client with an expressive speech-language disorder to electronically represent vocabulary and express thoughts or ideas, in order to meet the client’s functional speech needs.
3. For the purpose of this policy, the term “ACD system” refers to the ACD and all medically necessary components and accessories.
4. Digitized speech devices and synthesized speech devices are benefits of Texas Medicaid Title XIX Home Health Services.
5. A digitized speech device, sometimes referred to as a “whole message” speech-output device, uses words or phrases that have been recorded by someone other than the ACD system user for playback upon command by the ACD system user.

## Exclusions

### Noncovered ACD System Items

1. Noncovered items that are not related to the ACD system or software components and that are not necessary to operate the system are not a benefit of Texas Medicaid.
2. Noncovered items include, but are not limited to, the following:
   1. Printer
   2. Wireless internet access devices
3. Specialized evaluations required for the provision of new complex rehabilitation technology, such as augmentative communication devices, require physical in-person presence of the rendering provider.

Note**:** For clients 21 years of age or older, requests for ACD systems that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health - Durable Medical Equipment (DME) Exceptional Circumstances process.