

# Clarification Regarding How to Obtain Authorization for Physical, Occupational, and Speech Therapy Re-evaluation Procedure Codes

Information posted April 29, 2016

**Note:** *This article applies to claims submitted to TMHP for processing. For claims processed by a Medicaid managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, prior authorization, and reimbursement.*

HHSC is releasing additional clarification on Texas Medicaid's physical (PT), occupational (OT), and speech therapy (ST) medical benefits for the Coordinated Care Program (CCP) (clients who are birth through 20 years of age) and for Adult Clients age 21 and older. The benefit changes remain effective May 1, 2016.

Providers can refer to the following articles for additional information about the PT, OT, and ST benefit changes effective May 1, 2016:

- [Texas Medicaid Physical, Occupational, or Speech Therapy \(PT, OT, ST\) Prior Authorization Form Updated to Allow Tapered Down or Variable Frequencies – 5/1/2016](#)
- [New Therapy Prior Authorization Form Effective May 1, 2016 is Revised - 3/31/2016](#)
- [Changes to CCP Physical, Occupational, and Speech Therapy Policy for Clients Who Are Birth through 20 Years of Age - 3/31/2016](#)
- [New Therapy Prior Authorization Form to be Effective May 1, 2016 - 2/5/2016](#)
- [Effective May 1, 2016, Policy to Change for Physical, Occupational, and Speech Therapy Services for Clients 21 Years of Age and Older - 2/1/2016](#)
- [Effective May 1, 2016, Physical Therapy, Occupational Therapy, and Speech Therapy Policy to Change for the Comprehensive Care Program - 2/1/2016](#)

## Initial Evaluation and Consideration for Treatment

- A therapy evaluation is considered current when it is performed within 60 days before the prior authorization request is received.

While this is a clarification to the benefits effective May 1, 2016, it is the current practice for initial authorizations for physical, occupational, and speech therapy services and authorization requests are currently processed under this requirement.

## Recertification Submissions

- A complete recertification request must be received no earlier than 30 days before the current authorization period expires.

While this is a clarification to the benefits effective May 1, 2016, it is the current practice for reauthorizations submitted for physical, occupational, and speech therapy services and authorization requests are currently processed under this requirement.

## **Recertification Requests for Chronic Therapy Services Only**

- A therapy re-evaluation is considered current when it is performed within 60 days before the current authorization period expires.
- The therapy re-evaluation must occur within 30 days of the signed and dated order from the prescribing provider.

Effective May 1, 2016, re-evaluations require authorization, and HHSC has extended the time period for how long a re-evaluation will be considered current. In the past, a re-evaluation was considered current when performed within 30 days before the prior authorization request was received.

## **Reevaluation Authorization and Reimbursement**

- A provider must state the date the re-evaluation was performed on the PA form.
- The re-evaluation procedure code must be submitted on the PA form when submitted with a request for recertification.
- When submitting claims for re-evaluations, providers should use the authorization number as referenced on the authorization letter.
- Reimbursement for the re-evaluation is not tied to continuation of services. If a therapy provider performs a re-evaluation of a client, and the therapy provider determines services are no longer necessary, a provider may state that they intend to discharge the client. The intent to discharge should be stated on the PA form in the "projected tapered-down frequency" section.

To summarize the process for obtaining authorization for a re-evaluation, HHSC expects providers to:

- Obtain an order for reevaluation from the client's prescribing provider before performing a reevaluation
- Perform a reevaluation within 30 days of the signed and dated order
- Submit PA form with recommended frequency and duration to continue services to prescribing provider. Or follow written or verbal order procedure as specified in policy.
- Submit to TMHP no earlier than 30 days before the current authorization period expires:
  - The request for recertification with all elements required for recertification, including the plan of care (see requirements for initial authorization and recertification outlined below)
  - The PA form, or electronic equivalent, signed and dated by the therapist. The prescribing provider must sign the PA form or therapist must follow written/verbal order per policy.
  - Include the appropriate reevaluation code, and date reevaluation performed, on the PA form so that the submitted claim associated with the reevaluation procedure can be considered for reimbursement.

## **Reminders about the PT, OT, and ST Benefits Effective May 1, 2016**

The following are exact excerpts from Texas Medicaid's physical, occupational and speech therapy benefits effective May 1, 2016. These excerpts are for the authorization requirements and include the clarifying language that is outlined in the beginning of this notification. The clarifying language is underlined and italicized.

The benefit information identified below includes the additions made in the article titled "[Changes to CCP Physical, Occupational, and Speech Therapy Policy for Clients Who Are Birth through 20 Years of Age](#)," which was posted to this website on March 31, 2016; and the article titled "[Changes to Physical, Occupational, and Speech Therapy Policy for Adult Clients Age 21 and Over](#)," which was posted to this website on April 1, 2016.

### **Physical, Occupational and Speech Therapy Policy - Children (Acute and Chronic)**

#### ***Authorization Requirements PT/OT/ST***

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures. For additional information about electronic signatures, please refer to the 'Electronic Signatures in Prior Authorizations' medical policy.

Therapy services performed in the acute care inpatient setting do not require prior authorization.

#### **Initial Evaluation and Considerations for Prior Authorization for Treatment**

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

*A therapy evaluation is considered current when it is performed within 60 days before the prior authorization request is received.*

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

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

To avoid unnecessary denials, the prescribing provider must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The prescribing provider must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

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

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

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

Initial prior authorization (PA) requests must be received no later than five business days from the date therapy treatments are initiated. Requests received after the five-business-day period will be denied for dates of service that occurred before the date that the PA request was received.

All of the following documentation is required when submitting an initial request for therapy services initiated after the completion of the evaluation for acute or chronic services:

- A completed Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form signed and dated by both the therapist and by the prescribing provider is required. When the request form is unsigned by the prescribing provider, it must be accompanied by a signed and dated written order or prescription or a documented verbal order delineating the prescribed therapy services.
- The prescribing provider must certify that the Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days. Signature of prescribing provider on PA form will attest that this service has been provided. If prescribing provider provides verbal order or written order separate from PA form, staff member who conveys the verbal or written order must communicate that prescribing provider attests that Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.
- For acute services: Documentation from the prescribing provider that a visit for the acute or acute exacerbation of the medical condition requiring therapy has occurred within the last 90 days.
- Evaluation and Treatment Plan or Plan of Care (POC) with all of the following required elements:
  - Client's medical history and background
  - All medical diagnoses related to the client's condition
  - Date of onset of the client's condition requiring therapy or exacerbation date as applicable

- Date of evaluation
- Time in and time out
- Baseline objective measurements based on standardized testing performed or other standard assessment tools. For chronic services, see section on Developmental Delay Criteria.
- Explanation of how identified limitations impair the overall function of the client
- Safety risks
- Client-specific, measurable short and long-term functional goals within the length of time the service is requested
- Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services
- Therapy treatment plan/POC to include specific modalities and treatments planned
- Documentation of client's primary language
- Documentation of client's age and date of birth
- Prognosis for improvement
- Time in and time out on the evaluation note
- Requested dates of service for planned treatments after the completion of the evaluation
- Responsible adult's expected involvement in client's treatment
- History of prior therapy and referrals as applicable
- Signature and date of treating therapist

#### Additional Evaluation and Documentation Requirements for Speech Therapy

- Additional evaluation and documentation requirements for speech therapy includes one or more of the following:
  - Language evaluations - oral-peripheral speech mechanism examination and formal or informal assessment of hearing, articulation, voice and fluency skills;
  - Speech production (voice) - formal screening of language skills, and formal or informal assessment of hearing, voice and fluency skills;
  - Speech production (fluency and articulation) - formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills;
  - Oral Motor/Swallowing/Feeding - In addition to formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills, if swallowing problems and/or signs of aspiration are noted, then a statement indicating that a referral has been made to the client's prescribing provider to consider a video fluoroscopic swallow study must be included.

### ***Bilingual Testing Requirements***

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

Criterion-referenced assessment tools can be used to identify and evaluate a client's strengths and weaknesses, as opposed to norm-referenced testing, which assesses an individual relative to a group. When possible, use culturally and linguistically adapted test equivalents in both languages to compare potential deficits and included in the documentation. The therapist will show the highest score of the two languages to determine whether the child qualifies and which language will be used for the child's therapy. Testing for all subsequent re-evaluations should only be conducted in the language used in therapy.

### ***Written and Verbal Orders***

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

- A signed and dated written order or prescription or documented verbal order for the therapy services (documenting the frequency ordered). The order must be dated within the 30 day period before the initiation of services and include the frequency ordered by the client's prescribing provider based on the evaluation and services requested by the therapist (the order for the evaluation may be obtained separately), and a prescribing provider's order to evaluate and treat is acceptable for the evaluation, but not acceptable for the therapy treatment. Written orders must contain the prescribing provider ordered frequency and duration and affirmation that client's Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.
- Documentation of a verbal order to include all of the following:
  - Signed and dated by the licensed professional who by state and federal law may take a verbal order
  - Name and credentials of the licensed professional taking the order who is responsible for furnishing or supervising the ordered services
  - Verbal order includes the date the verbal order was taken.
  - Verbal order includes the services, frequency and duration prescribed by the ordering provider.
  - Verbal order includes attestation from prescribing provider that client's Texas Health Steps checkup is current or that a developmental screening has been performed within the last 60 days.

### ***Requests for Recertification - Acute Therapy Services***

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

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

*A complete recertification request must be received no earlier than 30 days before the current authorization period expires.*

Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

Prior authorization for recertification requests may be considered for increments up to 60 days for each therapy service request, with documentation supporting the medical necessity including all of the following:

- [Texas Medicaid Physical, Occupational or Speech Therapy \(PT/OT/ST\) Prior Authorization Form](#) or electronic equivalent signed and dated by the therapist and signed and dated by the prescribing provider. When the request form is unsigned by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.
- A progress summary (see progress summary documentation requirements), and
- A revised treatment plan or plan of care for the recertification dates of service requested, including all of the following:
  - Date therapy services started
  - Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan
  - Documentation of reasons continued therapy services are medically needed
  - Documentation of client's participation in treatment, as well as client/responsible adult's participation or adherence with a home treatment program
  - New treatment plan or plan of care for the recertification dates of service requested
  - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable
  - Prognosis with clearly established discharge criteria
  - Documentation of consults with other professionals and services or referrals made and coordination of service when applicable (e.g., for school aged clients, documentation of the coordination of care and referrals made for school therapies)
  - The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.
- A progress summary, which may be contained in the last treatment note, must be included with the recertification request and contains all of the following:
  - Date therapy started
  - Date the Summary completed
  - Time period (dates of service) covered by the summary
  - Client's medical and treatment diagnoses
  - A summary of client's response to therapy/current treatment plan, to include:
    - Documentation of any issues limiting the client's progress

- Documentation of objective measures of functional progress related to each treatment goal established on the initial evaluation
- An assessment of the client's therapy prognosis and overall functional progress
- Documentation of client's participation in treatment as well as client/responsible adult's participation or adherence with a home treatment program
- Updated or new functional and measurable short and long-term treatment goals with time frames, as applicable
- Documentation of client's continued need for therapy
- Clearly established discharge criteria
- Documentation of consults with other professionals and services or coordination of service when applicable.
- The progress summary must be signed and dated by the therapist responsible for the therapy services.

## ***Requests for Recertification - Chronic Therapy Services***

### **Re-evaluation (every 180 days)**

A re-evaluation is a comprehensive evaluation and must take place every 180 days and contains all the elements of an initial evaluation. It may be used to make a determination whether or not skilled therapy is medically necessary, or when determining the effectiveness of the current plan, or when the current plan requires significant modification and revision of the interventions and goals due to changes in the client's medical status or lack of progress with the current treatment. A re-evaluation requires authorization and must be submitted with the recertification request (Procedure codes 97002, 97004, and S9152).

- Routine reassessments that occur during each treatment session or visit or for a progress report required for an extension of services or discharge summary are not considered a comprehensive re-evaluation.
- Tests used must be norm-referenced, standardized and specific to the

A recertification request may be considered, when services will be medically needed after the previously approved authorization period ends.

*A complete recertification request must be received no earlier than 30 days before the current authorization period expires.*

Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the request is received.

*A therapy re-evaluation is considered current when it is performed within 60 days before the current authorization period expires.*

*The therapy re-evaluation must occur within 30 days of the signed and dated order from the prescribing provider.*

Prior authorization for recertification requests may be considered for increments up to 180 days for each request with documentation supporting the medical necessity including all of the following:

- [Texas Medicaid Physical, Occupational, or Speech Therapy \(PT, OT, ST\) Prior Authorization Form](#) or electronic equivalent signed and dated by the therapist and by the prescribing provider. When the request form is unsigned by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.
- A re-evaluation must include a revised treatment plan or plan of care including all of the following:
  - Date therapy services started
  - Changes in the treatment plan, the rationale, and the requested change in frequency of visits
  - Documentation of reasons continued therapy services are medically needed
  - Documentation of developmental delay. See section on Developmental Delay Criteria.
  - Documentation of client's participation in treatment, as well as client/responsible adult's participation or adherence with a home treatment program
  - New treatment plan or POC for the recertification dates of service requested
  - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable. Previous authorization period's goals and progress must be included.
  - Prognosis with clearly established discharge criteria. The discharge plan must reflect realistic expectations from the episode of therapy.
  - Documentation of consults with other professionals and services or referrals made and coordination of service when applicable (e.g., for school aged clients, documentation of the coordination of care and referrals made for school therapies)
  - The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

The Following Sections Apply to Both Acute and Chronic Therapy Services

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

A revision to an existing authorization/recertification must be documented in the client's record when significant changes occur in the frequency or treatment plan. When frequency is increased, or services requiring separate authorization are added, a request for revision must be submitted for prior authorization.

Requests for revisions must be received no later than five business days from the date the revised therapy treatments are initiated. Requests for revisions received after the five business day period will be denied for dates of service that occurred before the date the request was received.

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

Requests for revision must be submitted with the following documentation:

- [Texas Medicaid Physical, Occupational, or Speech Therapy \(PT, OT, ST\) Prior Authorization Form](#), including the date the revision was initiated, signed and dated by the therapist and signed and dated by the prescribing provider. When the request form is not signed and dated by the prescribing provider, it must be accompanied by a written order or prescription or a verbal order for the prescribed services.
- Progress Summary for acute or chronic services indicating the medical rationale for the change requested, and
  - Updated treatment plan or POC addressing all the elements of the previous plan and addressing all revisions to the services planned, including 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.
- The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

## **Physical, Occupational, and Speech Therapy Policy - Adult/Clients Age 21 and Over**

### ***Authorization Requirements Outpatient and Home Health - PT/OT/ST***

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures. For additional information about electronic signatures, please refer to the 'Electronic Signatures in Prior Authorizations' medical policy.

### **Initial Evaluation and Considerations for Prior Authorization for Treatment**

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

*A therapy evaluation is considered current when it is performed within 60 days before the prior authorization request is received.*

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

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization requirements documentation through any approved

electronic method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

Therapy services, regardless of place or provider, occurring after the initial evaluation, require prior authorization. Prior authorization requests may not exceed a 60 day period.

Prior authorization (PA) requests must be received no later than five business days from the date therapy treatments following the evaluation are initiated. Requests received after the five-business-day period will be denied for dates of service that occurred before the date that the PA request is received.

All of the following documentation is required when submitting an initial request for therapy services initiated after the completion of the evaluation:

- A completed [Texas Medicaid Physical, Occupational, or Speech Therapy \(PT, OT, ST\) Prior Authorization Form](#) signed and dated by the therapist and signed and dated by the physician is required. When the request form is unsigned by the physician, it must be accompanied by a signed and dated written order or prescription or a documented verbal order delineating the prescribed therapy services.
- Documentation of the acute or acute exacerbation of the medical condition requiring therapy. Evaluation and Treatment Plan or Plan of Care (POC) with all of the following required elements:
  - Client's medical history and background
  - All medical diagnoses related to the client's condition
  - Date of onset of the client's condition requiring therapy, or exacerbation date as applicable
  - Date of evaluation
  - Baseline objective measurements documented based on any testing performed
  - Explanation of how identified limitations impair the overall function of the client
  - Safety risks
  - Client-specific, measurable short and long-term functional goals within the length of service time requested
  - Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services
  - Therapy treatment plan/POC to include specific modalities and treatments planned
  - Documentation of client's primary language
  - Documentation of client's age and date of birth
  - Prognosis for improvement

- Time in and time out on evaluation
- Requested dates of service for planned treatments after the completion of the evaluation
- Responsible adult expected involvement in client's treatment
- History of prior therapy and referrals as applicable
- Signature and date of treating therapist
- Additional requirements for speech therapy includes one or more of the following:
  - Language evaluations - oral-peripheral speech mechanism examination and formal or informal assessment of hearing, articulation, voice and fluency skills;
  - Speech production (voice) - formal screening of language skills, and formal or informal assessment of hearing, voice and fluency skills;
  - Speech production (fluency) - formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills;
  - Oral Motor/Swallowing/Feeding - If swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a video fluoroscopic swallow study has been made; formal screening of language skills, formal or informal assessment of hearing, voice and fluency skills;

### ***Written and Verbal Orders***

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

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

## ***Requests for Recertification: Up to an Additional 60 Days for Acute Services***

A recertification request may be considered when services will be medically needed after the previously approved authorization period ends.

Re-evaluation codes (Procedure codes 97002, 97004, and S9152) require authorization and must be submitted with the recertification request. Required documentation for recertifications includes a Progress Summary and [Texas Medicaid Physical, Occupational, or Speech Therapy \(PT, OT, ST\) Prior Authorization Form](#).

*A complete recertification request must be received no earlier than 30 days before the current authorization period expires.*

Requests for recertification services received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was received.

One recertification request may be considered for an additional 60 days for each therapy service request with documentation supporting the medical necessity including all of the following:

- Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form or electronic equivalent signed and dated by the therapist and signed and dated by the ordering physician. When the request form is unsigned by the physician, it must be accompanied by a written order or prescription or a verbal order for the prescribed therapy services.
- A progress summary (see progress summary documentation requirements), and
- An updated treatment plan or POC for the recertification dates of service requested, including all of the following:
  - Date therapy services started
  - Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan
  - Documentation of reasons continued therapy services are medically needed
  - Documentation of client's participation in treatment, as well as client/responsible adult's participation or adherence with a home treatment program
  - Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable
  - Prognosis with clearly established discharge criteria
  - Documentation of consults with other professionals and services or referrals made and coordination of service when applicable
  - The updated treatment plan or plan of care must be signed and dated by the therapist responsible for the therapy services.
- A progress summary which may be contained in the last treatment note, must be included with the recertification request and contains all of the following:
  - Date therapy started
  - Date the summary completed

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

### ***Requests for Revisions to Existing Prior Authorization/Recertification***

A revision to an existing authorization/recertification must be documented in the client's record when significant changes occur in the frequency or treatment plan. When the frequency is increased or services requiring separate authorization are added, a request for revision must be submitted for prior authorization.

Requests for revisions must be received no later than five business days from the date the revised therapy treatments are initiated.

Requests for revisions received after the five business day period will be denied for dates of service that occurred before the date the request was received.

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

Requests for revision must be submitted with the following documentation:

- [Texas Medicaid Physical, Occupational, or Speech Therapy \(PT, OT, ST\) Prior Authorization Form](#), including the date the revision was initiated, signed and dated by the therapist and signed and dated by the physician. When the request form is not signed and dated by the physician, it must be accompanied by a written order or prescription or a verbal order for the prescribed services.
- Progress summary including the medical rationale for the change requested, and

- Updated treatment plan or POC addressing all the elements of the previous plan and addressing all revisions to the services planned, including functional outcomes vs. goals.
- The updated treatment plan or POC must be signed and dated by the therapist responsible for the therapy services.

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