

	<h2>Physical Therapy Guidelines</h2>	
Guideline # 6197	Categories Clinical → Care Management CM, TCHP Guidelines, Utilization Management UM	This Guideline Applies To: Texas Children's Health Plan
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GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of physical therapy treatment.

DEFINITIONS:

- **Standardized tests** are 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** are 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 and to assess response to intervention (RTI).
- **Co-treatment** is defined as 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.
- **Acute therapy:** Services for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition. Treatments are expected to significantly improve, restore or develop functions diminished or lost as a result of a recent (occurring within the past 90 days of the provider's evaluation of the condition) 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 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.

- Guardian may be defined as the parent, primary caregiver or legal representative for a member.

GUIDELINE

1. ECI services do not require prior authorization and must comply with policy stipulated in the Texas Medicaid Provider Procedure Manual Children's Services Handbook.
2. All requests for prior authorization for physical therapy services are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.
 - 2.1. Authorization requests must be received no later than five business days from the date therapy treatments are initiated.
 - 2.2. Requests received after the five-business-day period will be denied for dates of service that occurred before the date that the request was received.
3. School-based Services
 - 3.1. Members who are eligible for Physical Therapy through the public school system (SHARS), may only receive additional therapy if medical necessity criteria are met as outlined in this guideline.
 - 3.1.1. Services provided to a member on school premises are only permitted when delivered before or after school hours.
4. Acute Therapy Services
 - 4.1. Acute therapy evaluation do not require prior authorization when provided by an in-network provider.
 - 4.2. Requests for **acute physical therapy** will require documentation from the prescribing provider that a visit for the acute injury or acute exacerbation of the medical condition requiring therapy has occurred within the last 90 days **for members over age 21 only**.
 - 4.2.1. After two 60 day authorized periods, any continued requests for therapy services must be considered under the chronic therapy sections of this guideline.
 - 4.2.2. Out-of-Network acute physical therapy services will also need to comply with TCHP Out of Network Services Guidelines
5. Chronic Therapy Services
 - 5.1. Initial chronic therapy evaluations
 - 5.1.1. Initial chronic therapy evaluations do not require prior authorization when provided by an in-network provider however the therapy provider is responsible for

maintaining the following documentation in the member record, which must be made available when requested:

- 5.1.1.1. A signed and dated prescribing provider's order for the evaluation
- 5.1.1.2. Clinical documentation that identifies and supports the medical need for the therapy evaluation
- 5.1.2. Out of Network chronic therapy evaluations require submission of:
 - 5.1.2.1. Signed physician order requesting a therapy evaluation, dated within 60 days prior to the therapy evaluation date
 - 5.1.2.1.1. Clear documentation of the medical necessity of the requested evaluation – this may include:
 - 5.1.2.1.1.1. Copy of a physician/physician extender visit note that identifies a need for evaluation **Or,**
 - 5.1.2.1.2 Letter of Medical Necessity signed by the ordering physician that identifies the medical need of the therapy evaluation

5.2. Initial Treatment

- 5.2.1. Order or prior authorization form signed by the referring provider that is dated within 60 days of submission and specifies the frequency and duration of the requested service
 - 5.2.1.1. Frequency and dates of service requested cannot exceed those listed on the provider order and the evaluation plan of care
- 5.2.2. Evaluation report and Plan of Care dated within 60 days of submission signed by the ordering physician that includes:
 - 5.2.2.1. Documentation of the diagnosis and reason for referral
 - 5.2.2.2. Documentation of the date of onset Date of Onset of the member's Condition Requiring Therapy or Exacerbation as Applicable - If the date of onset is congenital, providers should state onset date at birth.
 - 5.2.2.3. Brief statement of the member's medical history and any prior therapy treatment. Providers may reference information provided by the member or member's family and identify it as such.
 - 5.2.2.4. A description of the member's current level of functioning or impairment, to include current **norm-referenced standardized assessment scores.
 - 5.2.2.4.1. Developmental age should be adjusted for children born before 37 weeks gestation (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 of age. The age adjustment should not exceed 16 weeks.

- 5.2.2.4.2. In addition, criterion-referenced assessment tools can be used to identify and evaluate a member's strengths and weaknesses.
- 5.2.2.5. A clear diagnosis and reasonable prognosis;
- 5.2.2.6. A statement of the prescribed treatment modalities and their recommended frequency and duration
 - 5.2.2.6.1. 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
- 5.2.2.7. Short and long-term functional treatment goals which are specific to the member's diagnosed condition or impairment
 - 5.2.2.7.1. Functional goals refer to 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. Functional goals must be specific to the member, objectively measurable within a specified time frame, attainable in relation to the member's prognosis or developmental delay, relevant to member and family, and based on a medical need.
- 5.2.2.8. 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.
- 5.2.2.9. Prescribed home exercise program including the guardian's expected involvement in the member's treatment.
 - 5.2.2.10. Plan for collaboration with ECI, Head Start, or SHARS when applicable
- 5.3. Formal Re-evaluations (should be performed every 180 days or if required sooner due to changes in the member's status). Re-evaluations do not require authorization for payment when rendered in-network. The following documentation is required to request a re-evaluation by an out-of-network provider:
 - 5.3.1. Signed physician order dated within 60 days for re-evaluation.
 - 5.3.2. Requests for re-evaluation should be submitted no sooner than 60 days prior to the expiration of the current treatment authorization period.
- 5.4. Ongoing treatment requests will require the following documentation:
 - 5.4.1. A complete request must be received no earlier than 30 days before the current authorization period expires.
 - 5.4.2. Order or prior authorization form signed by the referring provider that is dated within 60 days of submission and specifies the frequency and duration of the requested service

- 5.4.2.1. Frequency and dates of service requested cannot exceed those listed on the provider order and the re-evaluation plan of care
- 5.4.3. Evaluation report and Plan of Care dated within 60 days of submission signed by the ordering physician that includes:
 - 5.4.3.1. Documentation of the diagnosis and reason for referral
 - 5.4.3.2. Documentation of the date of onset Date of Onset of the member's Condition Requiring Therapy or Exacerbation as Applicable - If the date of onset is congenital, providers should state onset date at birth.
 - 5.4.3.3. Brief statement of the member's medical history and any prior therapy treatment. Providers may reference information provided by the member or member's family and identify it as such.
 - 5.4.3.4. A description of the member's current level of functioning or impairment, to include current **norm-referenced standardized assessment scores
 - 5.4.3.4.1. The same **norm-referenced standardized tests must be utilized for re-evaluation as were used to evaluate the member initially unless these are no longer appropriate for the member's age.
 - 5.4.3.4.2. Re-evaluations should document comparison to prior **norm-referenced standardized test scores.
 - 5.4.3.4.3. Developmental age should be adjusted for children born before 37 weeks gestation (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 of age. The age adjustment should not exceed 16 weeks.
 - 5.4.3.5. A clear diagnosis and reasonable prognosis including assessment of the member's capability for continued measurable progress;
 - 5.4.3.6. A statement of the prescribed treatment modalities and their recommended frequency / duration;
 - 5.4.3.7. 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
 - 5.4.3.8. Short and long-term functional treatment goals which are specific to the member's diagnosed condition or impairment including objective demonstration of the member's progress towards previous treatment goals.
 - 5.4.3.8.1. Functional goals refer to 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. Functional goals must be specific to the member, objectively measurable within a specified time frame, attainable in relation to the member's prognosis or

developmental delay, relevant to member and family, and based on a medical need.

- 5.4.3.9. Prescribed home exercise program including the guardian's expected involvement in the member's treatment
- 5.4.3.10. 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.
- 5.4.3.11. Documentation of collaboration with ECI, Head Start, PPECC or SHARS when applicable
- 5.4.4. 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.

6. Special documentation considerations:

- 6.1. Requests for co-treatment services will follow current guidance in the Texas Medicaid Provider Manual Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.
- 6.2. Change of therapy provider:
 - 6.2.1. 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:
 - 6.2.1.1. A change-of-therapy provider letter that includes the following:
 - 6.2.1.2. Signature of the member or responsible adult,
 - 6.2.1.3. Documents the date that the member ended therapy (effective date of change) with the previous provider, or last date of service,
 - 6.2.1.4. The name of the new provider and previous provider
 - 6.2.1.4.1. 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.
- 6.3. Change of coverage/Continuity of Care:
 - 6.3.1. When services were not prior authorized by Texas Children's Health Plan, (through another MCO or TMHP) the authorization request must include a copy of the previously approved authorization letter.
 - 6.3.2. The services will be honored for the shorter of 90 days or until expiration of the authorization.

6.3.2.1. If an ***in-network provider*** submits all documentation required by TCHP for the service requested and it meets medical necessity criteria outlined in this Guideline– TCHP will honor the authorization request for the duration of the original authorization even if it extends past 90 days.

6.3.3. If a request to transfer an authorization is submitted after the end date of the previous authorization - it will have to meet all of the documentation requirements and submission guidelines for the specific service type.

6.3.4. The request will not be considered retrospective if submitted within the same month of the enrollment date.

6.4. Coordination of care with PPECC:

6.4.1. 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.

7. Specific criteria for approval of frequency of therapy services:

7.1. **High Frequency** (three times per week) Therapy services- can only be considered for a limited duration (approximately four weeks or less) or as recommended by the prescribing provider with documentation of the medical need to achieve an identified new skill or recover function lost due to surgery, illness, trauma or acute medical condition, with well-defined specific, achievable goals within the intensive period requested.

7.1.1. Therapy provided three times a week may be considered for two or more of these exceptional situations:

7.1.1.1. The member has a medical condition that is rapidly changing

7.1.1.2. 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)

7.1.1.3. The member's therapy plan and home program require frequent modification by the licensed therapist

7.1.1.4. 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:

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

7.1.1.4.2. Therapy summary documenting all of the following:

7.1.1.4.2.1. Purpose of the high frequency requested (e.g., close to achieving a milestone)

- 7.1.1.4.2.2. Identification of the functional skill which will be achieved with high frequency therapy
 - 7.1.1.4.2.3. Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.
 - 7.1.2. 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.
 - 7.2. **Moderate Frequency:** Therapy provided two times a week may be considered when documentation shows one or more of the following:
 - 7.2.1. The member is making very good functional progress toward goals.
 - 7.2.2. The member is in a critical period to gain new skills or restore function or is at risk of regression.
 - 7.2.3. 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.
 - 7.2.4. The member has complex needs requiring on-going education of the responsible adult.
 - 7.3. **Low Frequency:** Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:
 - 7.3.1. The member is making progress toward 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.
 - 7.3.2. 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.
 - 7.3.3. 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.
 - 7.4. **Maintenance Level/Prevent Deterioration:** This frequency level (e.g., every other week, monthly, every three months) is used 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:
 - 7.4.1. Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration,
 - 7.4.2. The documentation submitted shows the member may be making limited progress toward goals, or goal attainment is extremely slow

- 7.4.3. 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),
 - 7.4.4. 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.
8. Physical Therapy services are considered medically necessary when **ALL** the following criteria are met:
- 8.1. 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:
 - 8.1.1. The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the patient's condition.
 - 8.1.2. 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.
 - 8.1.3. The therapy is aimed at achieving functional goals. Functional goals refer to 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. Functional goals must be specific to the member, objectively measurable within a specified time frame, attainable in relation to the member's prognosis or developmental delay, relevant to member and family, and based on a medical need.
 - 8.2. The member has an acute or chronic medical condition affecting the musculoskeletal or neuromuscular system.
 - 8.3. The therapy is:
 - 8.3.1. 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**
 - 8.3.2. 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
 - 8.4. 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; **AND**
 - 8.5. 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; **AND**

- 8.5.1. An individual's function could not reasonably be expected to improve as the individual gradually resumes normal activities; **AND**
- 8.5.2. 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
- 8.5.3. The therapy documentation objectively verifies progressive functional improvement over specific time frames; **AND**
- 8.6. The services are delivered by a qualified provider of physical therapy services (see definition); **AND**
- 8.7. 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.
- 8.8. Initial Physical therapy may be approved for scores > 1.5 standard deviations below the mean in at least one subtest area for norm-referenced standardized tests with a mean of 100 (<78), and > 1.33 standard deviations below the mean in at least one subtest area for norm-referenced standardized tests with a mean of 10 (<6). Behavioral observations, psychosocial factors, and pertinent past history should be included in the assessment.
 - 8.8.1. In the unusual circumstance that tests with criterion-referenced age equivalency scores are utilized, physical therapy may be approved if the functional age equivalency is 65% or less than the chronological age.
- 8.9. Ongoing therapy may not be approved when any of the following:
 - 8.9.1. All test scores have improved to within 1.33 SD from the mean
 - 8.9.1.1. 80 or more for tests with a mean of 100
 - 8.9.1.2. 7 or more for tests with a mean of 10
 - 8.9.2. The member has not made significant progress towards meeting goals and/or improvement in **norm-referenced standardized scores
 - 8.9.3. 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
 - 8.9.4. Member can continue therapy and maintain status with a home exercise program and deficits no longer require a skilled therapy intervention
 - 8.9.5. Member no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care.
 - 8.9.6. Member has returned to baseline function.
 - 8.9.7. Member has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy.
 - 8.9.8. 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.

- 8.9.9. 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.

9. The following are **NOT** considered medically necessary:

- 9.1. Therapy services that are provided after the member has reached the maximum level of improvement or is now functioning with normal limits.
- 9.2. Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition.
- 9.3. 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.
- 9.4. 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:
 - 9.4.1. General exercises to promote overall fitness and flexibility or improve athletic performance
 - 9.4.2. Activities to provide diversion or general motivation
 - 9.4.3. Supervised exercise for weight loss.
- 9.5. Treatment solely for the instruction of other agency or professional personnel in the member's PT program.
- 9.6. Training in nonessential tasks (e.g. homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling).
- 9.7. Therapy not expected to result in practical functional improvements in the member's level of functioning.
- 9.8. 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).
- 9.9. 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).

10. The following services are excluded from coverage and **NOT** a benefit:

- 10.1. Physical Therapy for chronic medical conditions for members who are 21 years of age and older.
 - 10.2. 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)
 - 10.3. Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided
11. Providers should bill for therapy services in accordance with guidance in the current Texas Medicaid Provider Procedure Manual.
12. All requests for physical 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.
13. 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.

ADDITIONAL INFORMATION

**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.)

Test	Abbreviation
Alberta Infant Motor Scale	AIMS
Adaptive Behavior Inventory	ABI
Adaptive Behavior Scale — School, Second Edition	ABS-S:2
Ashworth Scale	
Assessment of Adaptive Areas	AAA
Bruininks-Oseretsky test of Motor Proficiency	BOMP
Bruininks-Oseretsky Test of Motor Proficiency, Second Edition	BOT-2
Comprehensive Trail-Making Test	CTMT
Functional Independence Measure for Children	WeeFIM
Functional Independence Measure — 7 years of age to adult	FIM
Gross Motor Function Measure	GMFM
Movement Assessment Battery for Children	Movement ABC
Peabody Developmental Motor Scales	PDMS

Test	Abbreviation
Peabody Developmental Motor Scales, Second Edition	PDMS-2
Pediatric Balance Scale	PBS
Pediatric Evaluation of Disability Inventory	PEDI
NOTE: 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.	
Range of Motion — Functional Performance Impairments	ROM
Sensory Processing Measure	SPM
Sensory Processing Measure-Preschool	SPM-P
Test of Infant Motor Performance	TIMP
Test of Gross Motor Development, Second Edition	TGMD-2
Toddler and Infant Motor Evaluation	

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