Texas Children's	Occupational Therapy Guidelines	
Guideline # 6191	***Categories*** Clinical →Care Management CM, TCHP Guidelines, Utilization Management UM	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Lisa Hollier

Texas Children's Health Plan (TCHP) performs authorization of all occupational 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 (e.g., understanding of wh- 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 client's restorative potential.
- **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 Occupational therapy services are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.

3. School-based Services

3.1. Members who are eligible for Occupational 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. Occupational Therapists in the Comprehensive Care Program are eligible to provide telehealth services as written in the current Texas Medicaid Provider Procedures Manual - Telecommunication Services Handbook.

5. Acute Therapy Services

5.1. Acute therapy evaluations do not require prior authorization when provided by an in-network provider

5.2. Requests for acute occupational therapy services 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.

5.2.1. Acute occupational therapy authorization will not require evidence of current Texas Health Steps well checkup for therapy treatment requests of 60 days or less.

5.2.1.1. Therapy services for greater than 60 days will require evidence that the member is current in their Texas Health Steps Checkup via

5.2.2. Documentation of ordering provider attestation

5.2.3. Copy of the current Texas Health Steps Checkup

5.2.4. If evidence that the member is current in their Texas Health Steps Checkup was not submitted, therapy requests may be approved for a maximum of 90 days with medical director approval.

5.2.5. After two 60 day authorized periods, any continued requests for therapy services must be considered under the chronic therapy sections of this guideline.

5.2.6. Out-of-Network acute occupational therapy services will also need to comply with TCHP Out of Network Services Guidelines

6. Chronic Therapy Services

6.1. Initial chronic therapy evaluations

6.1.1. 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:

6.1.1.1. A signed and dated prescribing provider's order for the evaluation

6.1.1.2. Clinical documentation that identifies and supports the medical need for the therapy evaluation

6.1.2. Out of Network chronic therapy evaluations require submission of:

6.1.2.1. Signed physician order requesting a therapy evaluations, dated within 60 days prior to the therapy evaluations date

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

6.1.2.1.1.1. Copy of a physician/physician extender visit note that identifies a need for evaluation OR

6.1.2.1.1.1.1. For children with chronic underlying medical condition associated with developmental delay (Autism, Autism Spectrum Disorder, Pervasive Developmental Disorder, Down Syndrome, Cerebral Palsy, etc.) the visit note identifying the need for services should be dated within the last 12 months. A note from a subspecialist will be accepted.

6.1.2.1.1.1.2. For undiagnosed conditions, developmental delays or isolated fine motor disorders the visit note identifying the reason for evaluation must be the most recent age-appropriate well child exam including results of the age-appropriate developmental screening tool required by THSteps (PEDS or ASQ) periodicity schedule conducted at the well child visit. The well child exam must be current per the THSteps periodicity schedule. If the most recent well child exam did not identify the delay, a provider may submit a subsequent visit that identifies the need for occupational therapy.

6.1.2.1.1.2. Letter of Medical Necessity signed by the ordering physician that identifies the medical need of the therapy evaluation

6.2. Initial Treatment

6.2.1. 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

6.2.1.1. Frequency and dates of service requested cannot exceed those listed on the provider order and the evaluation plan of care

6.2.2. Evaluation report and Plan of Care dated within 60 days of submission signed by the ordering physician that includes:

6.2.2.1. Documentation of the diagnosis and reason for referral

6.2.2.2. 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.

6.2.2.3. 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.

6.2.2.4. A description of the member's current level of functioning or impairment, to include current **norm-referenced standardized assessment scores.

6.2.2.4.1. 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.

6.2.2.4.2. In addition, criterion-referenced assessment tools can be used to identify and evaluate a member's strengths and weaknesses.

6.2.2.5. A clear diagnosis and reasonable prognosis;

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

6.2.2.6.1. 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

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

6.2.2.7.1. 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.

6.2.2.8. 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.

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

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

6.2.3. Evidence that the member is current in their Texas Health Steps Checkup via:

6.2.3.1. Documentation of ordering provider attestation

6.2.3.2. Copy of the current Texas Health Steps Checkup

6.3. 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:

6.3.1. Signed physician order dated within 60 days for re-evaluation.

6.3.2. Requests for re-evaluation should be submitted no sooner than 30 days prior to the expiration of the current treatment authorization period.

6.4. Ongoing treatment requests will require the following documentation:

6.4.1. A complete request must be received no earlier than 60 days before the current authorization period expires.

6.4.2. 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

6.4.2.1. Frequency and dates of service requested cannot exceed those listed on the provider order and the re-evaluation plan of care

6.4.3. Evidence that the member is current in their Texas Health Steps Checkup via:

6.4.3.1. Documentation of ordering provider attestation

6.4.3.2. Copy of the current Texas Health Steps Checkup

6.4.4. Evaluation report and Plan of Care dated within 60 days of submission signed by the ordering physician that includes:

6.4.4.1. Documentation of the diagnosis and reason for referral

6.4.4.2. 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.

6.4.4.3. 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.

6.4.4.4. Objective documentation of compliance: BOTH guardian/member attendance to therapy sessions AND guardian/member's participation in prescribed home exercise program.

6.4.4.5. A description of the member's current level of functioning or impairment, to include current **norm-referenced standardized assessment scores

6.4.4.5.1. 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.

6.4.4.5.2. Re-evaluations should document comparison to prior **norm-referenced standardized test scores.

6.4.4.5.3. 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.

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

6.4.4.7. A statement of the prescribed treatment modalities and their recommended frequency / duration;

6.4.4.8. 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

6.4.4.9. 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.

6.4.4.9.1. 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.

6.4.4.10. Prescribed home exercise program including the guardian's expected involvement in the member's treatment and objective compliance with the program

6.4.4.11. 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.

6.4.4.12. Documentation of collaboration with ECI, Head Start, PPECC or SHARS when applicable

6.4.5. 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.

7. Special documentation considerations:

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

7.2. Change of therapy provider:

7.2.1. 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:

7.2.1.1. A change-of-therapy provider letter that includes the following:

7.2.1.2. Signature of the member or responsible adult,

7.2.1.3. Documents the date that the member ended therapy (effective date of change) with the previous provider, or last date of service,

7.2.1.3.1. The name of the new provider and previous provider

7.2.1.3.2. 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.

7.3. Change of coverage/Continuity of Care:

7.3.1. 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.

7.3.2. The services will be honored for the shorter of 90 days or until expiration of the authorization.

7.3.2.1. 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.

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

7.3.3. 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.

7.4. Coordination of care with PPECC:

7.4.1. 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.

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

8.1. 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.

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

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

8.1.1.2. 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)

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

8.1.1.4. 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:

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

8.1.1.4.2. Therapy summary documenting all of the following:

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

8.1.1.4.2.2. Identification of the functional skill which will be achieved with high frequency therapy

8.1.1.4.2.3. Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.

8.1.2. 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.

8.2. Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:

8.2.1. The member is making very good functional progress toward goals.

8.2.2. The member is in a critical period to gain new skills or restore function or is at risk of regression.

8.2.3. 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.

8.2.4. The member has complex needs requiring on-going education of the responsible adult.

8.3. 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:

8.3.1. 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.

8.3.2. 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.

8.3.3. 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.

8.4. 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:

8.4.1. Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration,

8.4.2. The documentation submitted shows the member may be making limited progress toward goals, or goal attainment is extremely slow

8.4.3. 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),

8.4.4. 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.

9. Occupational therapy (OT) services are considered medically necessary when ALL the following criteria are met:

9.1. Occupational 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:

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

9.1.2. 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 occupational therapist, and requires the skills and judgment of the licensed therapist to perform education and training.

9.1.3. 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.

9.2. The member's ability to function in life roles is impaired.

9.3. The therapy is aimed at:

9.3.1. Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.

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

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

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

9.3.4.1. ADLs are activities that include:

9.3.4.1.1. Bathing—Completing any or all parts of bathing; selecting appropriate water temperature and flow speed, turning water on and off; laying out and putting away supplies; transferring in and out of bathtub or shower; washing and drying hair and body; clean up after task is completed.

9.3.4.1.2. Dressing— Completing any or all parts of getting dressed; putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; choosing and laying out weather-appropriate clothing.

9.3.4.1.3. Eating— completing any or all parts of eating and drinking; feeding self; using utensils or special or adaptive eating devices; clean up after task is completed.

9.3.4.1.4. Personal hygiene: Completing any or all parts of personal hygiene; routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, perineum; basic nail care; applying deodorant; routine skin care; clean up after task is completed.

9.3.4.1.5. Toileting— Completing any or all parts of toileting; using commode, bedpan, urinal, toilet chair; transferring on and off; cleansing; changing diapers, pad, incontinence supplies; adjusting clothing; clean up after task is completed.

9.3.4.1.6. Locomotion or mobility— completing any or all parts of moving between locations;

9.3.4.1.7. Positioning— Completing any or all parts of positioning their body while in a chair, bed, or other piece of furniture or equipment; changing and adjusting positions; moving to or from a sitting position; turning side-to-side; assisting the client to sit upright.

9.3.4.1.8. Transferring— Completing any or all parts of moving from one surface to another with or without a sliding board; moving from bed, chair, wheelchair, or vehicle to a new surface; moving to or from a standing or sitting position; moving the client with lift devices.

9.3.4.2. IADLs are activities that include:

9.3.4.2.1. Telephone use or other communication—Assisting the client in making or receiving telephone calls; managing and setting up communication devices; making and receiving the call for the client.

9.3.4.2.2. Grocery or household shopping—Shopping for or assisting clients in shopping for grocery and household items; preparing a shopping list; putting food and household items away; picking up medication and supplies.

9.3.4.2.3. Light housework—Performing or assisting the client in performing light housework such as: Cleaning and putting away dishes; wiping countertops; dusting; sweeping, vacuuming or mopping; changing linens and making bed; cleaning bathroom; taking out trash.

9.3.4.2.4. Laundry—Assisting the client with doing laundry; gathering, sorting, washing, drying, folding, and putting away personal laundry, bedding, and towels; removing bedding to be washed and remaking the bed; using a laundry facility.

9.3.4.2.5. Meal preparation—Assisting clients in preparing meals and snacks; cooking; assembling ingredients; cutting, chopping, grinding, or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning area after meal; washing dishes.

9.3.4.2.6. Money management—Assisting the client with managing their day-to-day finances; paying bills; balancing checkbook; making deposits or withdrawals; assisting in preparing and adhering to a budget.

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

9.5. 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

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

9.5.2. 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

9.5.3. The therapy documentation objectively verifies progressive functional improvement over specific time frames; and

9.6. The services are delivered by a qualified provider of occupational therapy services (see definition); and

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

10. Occupational therapy services are considered not medically necessary if any of the following is determined:

10.1. Therapy services that are provided after the member has reached the maximum level of improvement or is now functioning with normal limits.

10.2. The therapy is not 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.

10.3. The therapy is not aimed at developing, improving or maintaining functions, which would normally develop.

10.4. The therapy is for conditions for which therapy would be considered routine educationally-based (i.e., via school systems) or involved routine education, training, conditioning, or fitness. This includes treatments or activities that require only routine supervision.

10.5. The expectation does not exist that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.

10.5.1. If function could reasonably be expected to improve as the individual gradually resumes normal activities, then the therapy is considered not medically necessary.

10.5.2. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of the therapy service required to achieve such potential, the therapy would be considered not medically necessary.

10.5.3. The therapy documentation fails to objectively verify functional progress over a reasonable period of time.

10.6. The physical modalities are not preparatory to other skilled treatment procedures.

10.7. Treatments that do not generally require the skills of a qualified provider of OT services are considered not medically necessary. Examples include general range of motion or exercise programs, massage, repetitive gait, maintenance therapy, activities that an individual can self-practice independently or with a caregiver, swimming and routine water aerobics programs, general conditioning or fitness, or educational, recreational or work-related activities that do not require the skills of a therapist. Routine reevaluations not meeting the above criteria.

10.8. Treatments that are not supported in peer-reviewed literature, including, but not limited to, investigational treatments such as sensory integration (with the exception of cognitive rehabilitation for member's with traumatic brain injury due to illness or injury who are able to actively participate in the treatment program), vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, the Wilbarger brushing protocol, and low-energy neuro-feedback.

10.9. Occupational Therapy is not recognized as traditional therapy and is not considered medically necessary for Attention Deficit Hyperactivity Disorder (ADHD).

10.10. Occupational Therapy is not considered medically necessary as adjunctive therapy for behavioral diagnoses or as an adjunct to psychotherapy.

10.11. Occupational therapy is not considered medically necessary when the sole purpose is to address learning skills, which should be remediated in the classroom environment, including handwriting, cutting, or other subjects which are part of a school curriculum.

10.12. Services are duplicative. When individuals receive physical, occupational, or speech therapy, the therapists should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals.

10.13. 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.

10.14. Therapy not expected to result in practical functional improvements in the member's level of functioning.

10.15. 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).

10.16. 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).

10.17. Initial Occupational 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.

10.17.1. In the unusual circumstance that tests with criterion-referenced age equivalency scores are utilized, occupational therapy may be approved if the functional age equivalency is 65% or less than the chronological age.

10.18. Ongoing therapy may not be approved when any of the following:

10.18.1. All test scores have improved to within 1.33 SD from the mean

10.18.1.1.1. 80 or more for tests with a mean of 100

10.18.1.1.2. 7 or more for tests with a mean of 10

10.18.2. The member has not made significant progress towards meeting goals and/or improvement in ** norm-referenced standardized scores

10.18.3. The member/family is not compliant with attendance or home exercise program expectations.

10.18.4. The member has adapted to the impairment with assistive equipment or devices and is able to perform ADL's with minimal to no assistance from caregiver at an age appropriate level

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

10.18.6. Member no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care.

10.18.7. Member has returned to baseline function.

10.18.8. Member has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy.

10.18.9. 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.

10.18.10. 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.

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

11.1. Chronic Occupational Therapy for members who are 21 years of age and older

11.2. 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)

11.3. Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided

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

13. All requests for occupational 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.

14. 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
Adaptive Behavior Scale — School Edition	ABS-S
Ashworth Scale	
Box & Block Test of Manual Dexterity	BBT
Bruininks-Oseretsky Test of Motor Proficiency	BOMP
Bruininks-Oseretsky Test of Motor Proficiency — Second Edition	BOT-2
Children's Handwriting Evaluation Scale	CHES
Cognitive Performance Test	CPT

Test	Abbreviation
DeGangi-Berk Test of Sensory Integration	TSI
Developmental Test of Visual Motor Integration	VMI
Developmental Test of Visual Perception, Second Edition	DTVP
Evaluation Tool of Children's Handwriting	ETCH
Functional Independence Measure — young version	WeeFIM
Functional Independence Measure — 7 years of age to adult	FIM
Jacobs Prevocational Skills Assessment	
Kohlman Evaluation of Living Skills	KELS
Miller Function and Participation Scales	M-Fun
Milwaukee Evaluation of Daily Living Skills	MEDLS
Motor Free Visual Perception Test	MVPT
Motor Free Visual Perception Test — Revised	MVPT-R
Peabody Developmental Motor Scales	PDMS
Peabody Developmental Motor Scales — 2	PDMS-2
Pediatric Evaluation of Disability Inventory 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.	PEDI
Purdue Pegboard Test	
Range of Motion	ROM
Sensory Integration and Praxis Test	SIPT
Sensory Integration Inventory Revised	SII-R
Sensory Processing Measure	SPM
Sensory Processing Measure—Preschool	SPM-P
Sensory Profile, Adolescent/Adult	
Sensory Profile, Infant/Toddler	
Sensory Profile	
Sensory Profile School Companion	
Test of Handwriting Skills	THS
Test of Infant Motor Performance	TIMP
Test of Visual Motor Integration	TVMI
Test of Visual Motor Skills	TVMS
Test of Visual Motor Skills — R	TVMS-R
Test of Visual Perceptual Skills	TVPS

Test	Abbreviation
Test of Visual Perceptual Skills — Upper Level	TVPS
Toddler and Infant Motor Evaluation	TIME
Wide Range Assessment of Visual Motor Abilities	WRAVMA

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