# Texas Medicaid
# Physical, Occupational, or Speech Therapy(PT, OT, ST)
# Prior Authorization Form Instructions

**General Instructions:**

Effective July 1, 2017, all providers requesting therapy services for Fee for Service (FFS) clients must use the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form. This form is to be used for clients of all ages, for initial authorization requests, and for all subsequent recertification requests. Prior Authorization requests may be submitted by mail, fax, or on-line at www.tmhp.com.

- Providers requesting Acute and Chronic Therapy services, regardless of practice setting, for clients birth through 20 years of age, should submit prior authorization and recertification requests to the Comprehensive Care Program (CCP) at TMHP, which now processes all requests for children's therapy services.
- Providers requesting Acute Therapy services in the home, for clients ages 21 and over, should submit prior authorization and recertification requests to Home Health Services at TMHP, and
- Providers requesting Acute Therapy services in the outpatient setting, for clients ages 21 and over, should submit prior authorization and recertification requests to Special Medical Prior Authorization at TMHP.

Before requesting prior authorization for PT, OT, or ST services, providers must complete all required documentation, and obtain necessary orders and signatures, as outlined in the Texas Medicaid Providers Procedures Manual (TMPPM). Initial prior authorization requests must be received by TMHP no later than five business days from the date therapy services began. All recertification requests must be received before the current authorized period expires. Providers must submit recertification requests no earlier than 30 days before the current authorization period expires.

For all initial prior authorization requests not received by TMHP within the five business-day period from the date therapy services began, dates of service prior to the date the request is received will be denied. Similarly, for recertification requests, requests not received before the current authorized period expires, the dates of service prior to the date the request is received will be denied.

Note: Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

Directions for completing the Texas Medicaid Physical, Occupational, or Speech Therapy (PT, OT, ST) Prior Authorization Form**:**

| Field | Explanation |
|---|---|
| Client Name* | Enter the client's name including middle name or initial if known. |
| Medicaid Number* | Enter client's Medicaid 9-digit identification number. |
| Date of Birth* | Enter the client's date of birth. |
| Condition: ☐ Acute ☐ Chronic | All acute therapy services must have the AT modifier on the submitted claim. |
| Treatment Diagnoses | Enter client's ICD-10 Code(s) or diagnoses for the medical conditions that require therapy services. |
| Medical Diagnoses | Enter client's other relevant ICD-10 Code(s) or diagnoses. |
| Place of Service Requested | Enter the place of service requested as appropriate to provider type.<br>For services rendered in a PPECC, providers must check the **outpatient facility** box. |
| Date of Last Therapy Evaluation or Re-evaluation (PT, OT, ST) | Enter the applicable dates for PT, OT, or ST evaluations or re-evaluations.<br>**Note:** ***A copy of the applicable therapy evaluation or re-evaluation, for each therapy discipline requested, must be submitted with the request form.*** |

* Essential/Critical field

| Field | Explanation |
|---|---|
| Discipline and Modifier<br>Dates of Service, From, Through* | On the line for each therapy discipline (PT, OT or ST) requested enter the requested service dates:<br>The From date should be the date therapy treatment services are initiated.<br>The Through date should be the last date the therapy services are requested.<br>**Note:** ***For chronic conditions, under CCP only, the authorization period is 180 calendar days. For acute conditions, the authorization period is 60 calendar days*.** |
| Projected Frequency (per week or per month) ** | Enter the number of therapy sessions planned for the client each week or per month. Monthly frequencies are limited to 1, 2, or 3 times per month. Requested periods must always be noted in weeks or by the month. Refer to the TMPPM for information about additional documentation required when requesting a frequency of 3 times a week or more.<br>If the projected frequency will be tapered down or variable, indicate the frequency plans in the space provided. |
| Total Number of Units or Encounters Requested* | Calculate and enter the total number of 15-minute units requested for time-based procedure codes.<br>Calculate and enter the total number of encounters for encounter based procedure codes.<br>Indicate unit or encounter with each request.<br>When requesting a combination of encounter and unit-based therapy treatment codes, please describe the combination in the field designated for tapered down frequency requests. |
| Procedure Codes Requested* | Enter all relevant procedure codes the provider is requesting, including re-evaluation and/or treatment procedure codes. |
| Specialist, Printed Name, Signature, Date | Each therapy provider (PT, OT, or ST) who will be delivering services to the client is required to print, sign and date his/her name. |
| Requesting Provider, Printed Name, Signature, Date* | If the prescribing provider is signing the form, the provider must print, sign and date the form. The form may be submitted without the prescribing provider's signature and date, but the form must be accompanied by a signed and dated written order, prescription, or documented verbal order. All verbal orders must be co-signed by practitioners that include verbal orders within their scope of practice. |
| Requesting Provider NPI and License No.* | Enter the prescribing provider's NPI and License Number. |
| Date client last seen by prescribing provider | Enter the date the client was last seen by the prescribing provider. This date will be used for reference by TMHP PA staff to determine if the acute condition or acute exacerbation of a condition is within 90 calendar days of the requested therapy services. |
| Therapy Rendering Provider Information | This section is for the provider or agency who is billing for the therapy services. |
| Name, Telephone, Address, Fax, Tax ID, NPI* | Enter the contact information for the provider or agency. The telephone and fax number will be used by TMHP for authorization approvals or to request additional information. The address should be the same as the one associated with the provider's NPI or Tax ID. |
| Taxonomy and Benefit Code* | Providers need to enter taxonomy code and benefit code. |

* Essential/Critical field