PHYSICAL MEDICINE AND REHABILITATION

CSHCN SERVICES PROGRAM PROVIDER MANUAL

NOVEMBER 2026

TEXAS
Health and Human
Services

PHYSICAL MEDICINE AND REHABILITATION

Table of Contents

30.1 Enrollment 3
30.2 Benefits, Limitations, and Authorization Requirements 3
30.2.1 Osteopathic Manipulative Treatment (OMT) 3
30.2.2 Physical Therapy (PT), and Occupational Therapy (OT) 4
30.2.3 Time-based PT and OT Treatment Procedure Codes 5
30.2.4 Untimed PT and OT Treatment Procedure Codes 6
30.2.5 Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units 6
30.2.6 Group Therapy 7
30.2.6.1 Group Therapy Guidelines 7
30.2.6.2 Group Therapy Documentation Requirements 7
30.2.7 Noncovered Services 8
30.2.8 Authorization Requirements 8
30.2.8.1 Initial Prior Authorization Requests 9
30.2.8.2 Extension of Services Requests 10
30.2.8.3 Discontinuation of Therapy or Change of Provider 10
30.3 Coordination with the Public School System 11
30.4 Claims Information 11
30.5 Reimbursement 12
30.6 TMHP-CSHCN Services Program Contact Center 12

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

30.1 Enrollment

To enroll in the CSHCN Services Program, physical medicine and rehabilitation providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state physical medicine and rehabilitation providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

30.2 Benefits, Limitations, and Authorization Requirements

Physical therapy (PT) and occupational therapy (OT) services are benefits of the CSHCN Services Program for clients with an acute or chronic medical condition when documentation from the prescribing physician and the treating therapist shows there is or will be progress made toward goals.

Note: *An advanced practice registered nurse (APRN) or physician assistant (PA) may sign and date all documentation related to the provision of PT or OT services on behalf of the client's physician when the client's physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number are required.*

The CSHCN Services Program reimburses licensed physical or occupational therapists, physicians, home health agencies, hospitals, and outpatient facilities based on the procedure codes listed in this chapter. Therapy sessions include the time span the therapist is with the client, time spent preparing the client for the session, and the time spent completing documentation.

30.2.1 Osteopathic Manipulative Treatment (OMT)

OMT services provided by a licensed physician are benefits when they are performed with the expectation of restoring the client's level of function that has been lost or reduced due to injury or illness.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

OMT may be considered for reimbursement by the CSHCN Services Program in the following situations:

- Acute musculoskeletal condition
- Acute exacerbation of a chronic condition
- Acute treatment pre- or postsurgery that is directly related to the surgery

Procedure codes 98925, 98926, 98927, 98928, and 98929 must be used when billing for OMT.

30.2.2 Physical Therapy (PT), and Occupational Therapy (OT)

Therapy goals for an acute or chronic medical condition include, but are not limited to, improving, maintaining, and slowing the deterioration of function.

PT and OT evaluations and treatment must be ordered or prescribed by the client's physician, APRN, or PA and be based on medical necessity.

A client may receive any combination of physical, occupational, or speech therapy in the office, home, or outpatient setting, up to the limits outlined in this chapter for each type of therapy.

Therapy evaluations and re-evaluations are limited to 180 days, any provider. Therapy re-evaluations are a benefit when documentation supports one of the following:

- A change in the client's status
- A request for extension of services
- A change of provider

Additional therapy evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter that is signed and dated by the client, parent, or guardian that documents all of the following:
  - The date that the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation of why providers were changed

An evaluation or re-evaluation will be denied when billed by any provider on the same date of service as therapy treatment from the same discipline.

An evaluation or re-evaluation performed on the same day as therapy treatment from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

If an initial evaluation and a re-evaluation from the same therapy discipline are billed for the same date of service by any provider, the re-evaluation will be denied.

Outpatient OT or PT treatment services will deny if billed on the same date of service as procedure codes G0152 or G0151, respectively.

PT and OT services must be rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners or performed by a physician within their scope of practice.

> ***Note:*** *Therapy services provided by a licensed therapist assistant must be submitted by the licensed supervising provider.*

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

All documentation that is related to the therapy services that were prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client's medical record and made available upon request. Each therapy discipline provided must be of the level of complexity that requires the judgment, knowledge, and skill of a licensed physical or occupational therapist, or physician. The documentation that is maintained in the client's medical record must identify the therapy provider's name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client's response to therapy

Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

Providers must use the following procedure codes for claim submission when billing for physical and occupational therapy services:

Procedure Codes									
97012	97016	97018	97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124	97140	97150	97161
97162	97163	97164	97165	97166	97167	97168	97530	97535	97537
97542	97750	97755	97760	97761	97763	97799			

Physical therapists must use procedure code 97161, 97162, or 97163 for evaluations and procedure code 97164 for re-evaluations. Occupational therapists must use procedure code 97165, 97166, or 97167 for evaluations and procedure code 97168 for re-evaluations. These codes are untimed and do not require modifiers.

The following modifiers must be used to indicate when treatment services have been rendered by a licensed therapist or physician, or by a licensed therapy assistant under supervision of a licensed therapist:

Modifier	Description
U5	Services delivered by a licensed therapist or physician
UB	Services delivered by a therapy assistant under supervision of a licensed therapist

Note: *These modifiers are not required for evaluation and re-evaluation procedure codes because those services may not be rendered by licensed therapy assistants.*

30.2.3 Time-based PT and OT Treatment Procedure Codes

PT and OT time-based treatment procedure codes are payable as 15-minute units for all provider types.

Time-based treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

All time-based PT and OT treatment procedure codes listed in the table below will be cumulatively limited to four units (one hour) per date of service, per discipline:

Procedure Codes									
Limited to a combined total of 4 units (one hour) per date of service per discipline									
97032	97033	97110	97112	97113	97116	97124	97140	97530	97535
97537	97542	97750	97755	97760	97761	97763			
Limited to a total of 3 units (45 minutes) per date of service per discipline; may be combined with other time-based codes; not payable in the home setting									
97036									
Limited to a combined total of 2 units (30 minutes) per date of service per discipline; may be combined with other time-based codes									
97034	97035								

30.2.4 Untimed PT and OT Treatment Procedure Codes

The following PT and OT treatment procedure codes are limited to one each, one time per day, per discipline.

Procedure Codes								
97012	97016	97018	97022	97024	97026	97028	97150	97799

The following untimed procedure codes may only be reimbursed when billed on the same date of service with one or more time-based procedure codes listed in the Time-Based PT and OT Treatment Procedure Codes table above.

Procedure Codes						
97012	97016	97018	97022	97024	97026	97028

30.2.5 Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units

All claims for reimbursement of these procedure codes are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit=15 minutes), partial units should be rounded up or down to the nearest quarter hour.

To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service.

If the total billable minutes are not divisible by 15 and are greater than seven, the minutes are converted to one (1) unit of service. If the total billable minutes are not divisible by 15 and are seven minutes or fewer, the minutes are converted to zero (0) units.

Example: *68 total billable minutes/15 = four units + eight minutes. Since eight minutes are more than seven minutes, those eight minutes are converted to one unit. Therefore, 68 total billable minutes equals five units of service.*

Time intervals for one through eight units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Units	Number of Minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes

30.2.6 Group Therapy

Group therapy consists of simultaneous treatment to two or more clients who may or may not be doing the same activities. If the therapist is dividing attention among the clients, providing only brief, intermittent personal contact, or giving the same instructions to two or more clients at the same time, the treatment is recognized as group therapy. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one client contact is not required.

30.2.6.1 Group Therapy Guidelines

In order to meet CSHCN Services Program criteria for group therapy, all of the following applies:

- Physician prescription for group therapy.
- Performance by or under the general supervision of a qualified licensed therapist as defined by licensure requirements.
- The licensed therapist involved in group therapy services must be in constant attendance (meaning in the same room) and active in the therapy.
- Each client participating in the group must have an individualized treatment plan for group treatment, including interventions, short- and long-term goals, and measurable outcomes.

Note: *The CSHCN Services Program does not limit the number of clients who can participate in a group therapy session. Providers are subject to certification and licensure board standards regarding group therapy.*

30.2.6.2 Group Therapy Documentation Requirements

The following documentation must be maintained in the client's medical record:

- Physician prescription for group therapy
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals

Documentation for each group therapy session must include the following:

- Name and signature of the licensed therapist providing supervision over the group therapy session
- Treatment goal addressed in the group
- Specific treatment technique(s) utilized during the group therapy session
- How the treatment technique will restore function
- Start and stop times for each session
- Group therapy setting or location
- Number of clients in the group

The client's medical record must be made available upon request.

Group therapy procedure code 97150 must be reported for each member of the group.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

30.2.7 Noncovered Services

The following services are not a benefit of the CSHCN Services Program:

- Therapy services provided by the following:
  - Unlicensed physical therapy aides, orderlies, students, or technicians
  - Unlicensed occupational therapy aides, interns, orderlies, students, or technicians
- Unattended electrical stimulation, as unattended services are not covered
- Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment
- Treatment solely for the instruction of other agency or professional personnel in the client's physical or occupational therapy program
- Procedure code 98960
- Procedure code 97010 (This does not require special medical training)
- Training in nonessential tasks, such as homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling, or teaching a second language
- VitalStim therapy for dysphagia
- Services and procedures that are investigational or experimental

30.2.8 Authorization Requirements

PT and OT evaluations and re-evaluations do not require prior authorization. All other PT and OT services require prior authorization.

Prior authorization for therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition that results in a significant decrease in functional ability and will benefit from therapy services in an office or outpatient setting.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice as defined by state law.

An initial prior authorization may be granted for a period not to exceed 180 days. Requests for extensions of ongoing treatment services may be granted up to an additional 180 days for chronic conditions with documentation of medical necessity.

Time-based PT and OT treatment procedure codes are cumulatively limited to one hour per date of service, per discipline, up to four units per day. Four units are equal to one hour.

PT and OT services that are billed in 15-minute units are limited to a combined maximum of 4 units (1 hour) per day per therapy type. Untimed PT and OT treatment procedure codes are limited to one each, one time per date of service, per discipline.

Each supervised modality code must be requested on the prior authorization form and may only be reimbursed when billed with one or more time-based PT/OT procedure codes.

To complete the prior authorization process by paper, the provider must submit the prior authorization requirements documentation through fax or mail and must retain 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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

To complete the prior authorization process electronically, the provider must submit the prior authorization requirements documentation through any approved method and must retain 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, APRN, or PA must submit correct and complete information including documentation of medical necessity for the service requested. The ordering practitioner 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 for therapy.

30.2.8.1 Initial Prior Authorization Requests

The initial request for prior authorization must be approved before therapy treatments are initiated. Requests that are received after therapy initiation will be denied for dates of service that occurred before the date that the request was approved.

Note: *If medically necessary services are provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day.*

The following medical necessity documentation is required when submitting a request for PT or OT therapy services:

- A completed CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form. The request form must be signed and dated by the ordering physician, APRN, or PA, and the therapy provider. A request form that is missing required information is considered incomplete.

  Note: *The ordering practitioner must sign and date the treatment plan and request form on or after the date the evaluation was performed.*

- A current evaluation and comprehensive treatment plan with all of the following:
  - Date of evaluation
  - Diagnoses
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short-and long-term treatment goals for the therapy discipline, and associated disciplines, requested related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested dates of service
  - Date and signature of the licensed therapist

  Note: *A therapy evaluation is current when performed within 60 days before the initiation of therapy treatment services.*

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

30.2.8.2 Extension of Services Requests

A prior authorization request for extension of ongoing treatment services must be received and approved no earlier than 30 days prior to the expiration of the current prior authorization period. Requests received after the current prior authorization expires will be denied for dates of service occurring before the request's approval date.

Prior authorization requests for extension of ongoing treatment services may be considered for increments up to 180 days for chronic conditions with documentation of medical necessity and includes all of the following:

- A completed CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form signed and dated by the ordering physician, APRN, or PA, and the therapy provider. A request form that is missing required information is considered incomplete.

  Note: *The ordering practitioner must sign and date the updated treatment plan and request form on or after the date the evaluation or re-evaluation was performed.*

- A current therapy evaluation or re-evaluation, and updated treatment plan with all of the following:
  - Date of evaluation or re-evaluation
  - Diagnoses
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - Prior and new short- and long-term treatment goals documenting the client's progress towards prior treatment goals
  - A description of the specific treatment modalities that are being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested date of service
  - Dated signature of licensed therapist

  Note: *A therapy evaluation or re-evaluation is current when performed within 60 days before the request for extension of ongoing services.*

30.2.8.3 Discontinuation of Therapy or Change of Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit evidence of the following, including all documentation required for an initial request for therapy services:

- A change-of-provider letter, which has been signed and dated by the client, parent, or guardian and documents the date that the client ended therapy (effective date of change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed.

A change of provider during an existing authorization period will not extend the original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond the limitations outlined above.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form

CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form

Note: *Fax transmittal confirmations are not accepted as proof of timely authorization submission.*

30.3 Coordination with the Public School System

Clients may receive therapy services from both the CSHCN Services Program and school districts only when the therapy provided by the CSHCN Services Program addresses different client needs. If the client is of school age, therapy provided through the CSHCN Services Program is not intended to duplicate, replace, or supplement services that are the legal responsibility of other entities or institutions.

The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client's ability to progress.

30.4 Claims Information

To be considered for reimbursement, claims must identify the specific therapy type. Claims for PT treatment services must include modifier GP, and claims for OT treatment services must include modifier GO. Evaluation and re-evaluation procedure codes do not require the modifiers.

Outpatient therapy services provided by a physical or occupational therapist or by an outpatient facility must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Note: *NCCI guidelines do not apply to therapy procedure codes if a valid prior authorization number is submitted on the claim.*

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

30.5 Reimbursement

PT or OT providers may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

Outpatient hospital services are reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

30.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.