Claims Clarification: Therapy Evaluation and Reevaluation

UnitedHealthcare Community Plan in Texas is sharing this information from the Texas Health and Human Services Commission so you know what's needed when billing for Physical, Occupational and Speech Therapy Evaluations and Reevaluations.

Therapy service evaluations should be done to determine appropriate treatment, and reevaluations help determine if treatment plans are effective. Claims for evaluations and reevaluations that exceed required timelines may be denied, but may be reconsidered with appropriate documentation.

Please review the following information to better understand therapy service types, billing procedures and documentation requirements for submitting claims, reconsideration requests and appeals for physical, occupational and speech therapy evaluations and reevaluations.

Therapy Service Types

Acute Therapy: Acute services are short-term and address an illness or trauma with a rapid onset or acute exacerbation of a chronic medical condition. Reevaluations should occur every 60 calendar days (not to exceed two reevaluations in 120 calendar days).

Chronic Therapy: Chronic services are for the treatment of chronic medical conditions and/or developmental delays in circumstances when the condition is not expected to resolve or may progress slowly. Reevaluations should occur every 180 calendar days.

Evaluations: Therapy service evaluations are necessary to determine appropriate treatment.

Reevaluations: A reevaluation has the same elements as the evaluation and helps determine if the current treatment plan is effective. Reevaluations are also an opportunity to make changes to the treatment plan.

Claim Guidelines

Evaluations

Claims for evaluations are paid once every three years. Claims for evaluations that exceed the 60-day timeline from the prior authorization request date may be denied. Payment may be reconsidered when you submit a claim reconsideration request within 120 days from the date of the claim disposition with documentation of one of the following:

- A significant change in the member's medical condition
- A change in provider

Reevaluations

Before you can perform a reevaluation, you'll need:

- A current order from the referring care provider dated within **30 calendar days** of the prior authorization request date
- Confirmation that the member's Texas Health Steps medical checkup is current (for Medicaid members ages 20 and under), or that a developmental screening was performed by the primary care provider in the last 60 days

Claims for reevaluations that exceed the timeline may be denied. Payment may be considered when you submit a claim reconsideration within 120 days from the date of the claim disposition with documentation of one of the following:

- Significant change in medical condition
- Change in care provider
- Required recertification of an existing authorization (only available for members through age 20). This exception is only available if we require a recertification to be performed prior to the 180-day limit, for example, if a reevaluation is needed to request a new authorization.

In addition, if an evaluation or reevaluation procedure code and like therapy procedure code are billed for the same date of service by any provider, the like therapy evaluation or reevaluation will be denied.

Additional Evaluations and Reevaluations

Additional evaluations and reevaluations that exceed the limits may be reconsidered with the following documentation.

- For a significant change in the member's medical condition, please include:
  - Date of onset along with a description of the significant change of the member's medical condition or any new therapy-related diagnosis. Please also include this information in the member's treatment plan.
- For a change in provider, please include:
  - The date the member ended therapy with the previous provider
  - The name of the new provider and previous provider
  - Acknowledgement signature of the member, or legally responsible adult
- For required recertification of an existing authorization, please include:
  - The provider's order that has been dated and signed within 30 days of the completed reevaluation

You can submit another claim reconsideration 120 days after the disposition, even when the disposition was part of a claims reconsideration up to 12 months of the date of service. You have the right to a one-time appeal anytime within those same 12 months.

Questions?

For more information, go to tmhp.com > Providers > Medicaid Provider Manual > Texas Medicaid Provider Procedures Manual > Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook. Or, go to UHCprovider.com/TXcommunityplan > Care Provider Manuals > Texas.

We're Here to Help

If you have questions, please call your Provider Advocate. You can also call our Customer Services at **888-887-9003,** from 8 a.m. to 6 p.m. Central Time, Monday through Friday.

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