

OHCA Guideline

Medical Procedure Class:	Pediatric Physical Therapy (PT)
Initial Implementation Date:	July 2017
Last Review Date:	September 2026
Effective Date:	October 01, 2026
Next Review/Revision Date:	October 2029
* This document is not a contract, and these guidelines do not reflect or represent every conceived situation. Although all items contained in these guidelines may be met, this does not reflect or imply any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.	
☒ New Criteria ☒ Revision of Existing Criteria	
Summary	
Purpose:	To provide guidelines to assure medical necessity and consistency in the prior authorization process.
Definitions	
Disability: According to the World Health Organization (WHO), “disability” is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.	
Licensed Qualified Clinician: May include a Physical Therapist or Physical Therapist Assistant that is board certified by and in good standing with the State’s Medical Board. Students in either profession are not “licensed” clinicians.	
Physical Therapist (PT): A licensed professional health care provider who is a graduate of a program accredited by the Commission on Accreditation of Physical Therapy Education (CAPTE) or approved successor organization, has fulfilled state requirements for licensure, certification, or registration, and who provides physical therapy services including evaluation, treatment program design/management/modification, and supervision of delegated portions of a treatment program.	
Physical Therapist Assistant (PTA): A licensed health care provider who is a graduate of a program accredited by CAPTE or approved successor organization, has fulfilled state requirements for licensure, certification, or registration, and who performs selected physical therapy procedures and related tasks under the direction and supervision of a Physical Therapist.	
Student Physical Therapist: Any person enrolled in and in good standing with a CAPTE-accredited Physical Therapy education program and fulfilling supervised field work experience leading to a degree in the profession. This is not a licensed professional health care provider and therefore requires direct supervision by a Physical Therapist. Any note completed by the student requires signature from both the student and the supervising physical therapist.	
Accepted Referring Providers: A Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician’s Assistant (PA), Doctor of Chiropractic (DC), Doctor of Podiatry (DPM), Doctor of Dentistry (DDS), or an Advanced Practice Registered Nurse (APRN) who is currently contracted with Sooner Care.	
Description	

The purpose of Physical Therapy is to examine, evaluate, and develop a treatment plan to improve a person's ability to move, reduce or manage pain, restore function, and prevent disability.

Physical therapy practitioners are knowledgeable about and deliver services in accordance with APTA standards, policies, guidelines, and state, federal, and other regulatory payer requirements relevant to practice and service delivery.

Physical Therapy services are expected to result in significant functional improvement in a reasonable amount of time. The complexity of the intervention and/or patient's condition must require the skilled level of judgment and knowledge of a licensed, qualified therapist. Services must be delivered according to currently accepted standards of practice (based on credible scientific evidence and cannot be considered experimental). Physical therapy practitioners are knowledgeable about evidence-based practice and apply it ethically and appropriately to provide services consistent with best practice approaches.

Physical Therapist (PT): A PT incorporates all components of evidence-based practice, integrating best research evidence, clinical expertise, and the individual's values and circumstances to make decisions regarding services for clients. A PT has overall responsibility for the development, documentation, and implementation of a specified plan of care, based upon the evaluation and prognosis of the client and client's goals. When delegating aspects of the PT intervention to the PTA, the PT is responsible for providing appropriate supervision as outlined in the Oklahoma Administrative Code.

Physical Therapist Assistant (PTA): A PTA shall provide selected PT interventions only under the supervision and direction of the evaluating PT. A PTA shall make judgments that are commensurate with their education and legal qualifications.

CPT Codes Covered Requiring Prior Authorization (PA)

97022 Whirlpool
97110 Therapeutic Exercise
97112 Neuromuscular Re-education
97113 Aquatic Therapy
97116 Gait Training
97124 Therapeutic Massage
97140 Manual Therapy
97150 Group Therapy
97164 PT Re-Evaluation
97530 Therapeutic Activity
97535 Selfcare Home Management
97542 Wheelchair Management
97602 Wound Care Debridement
97755 Assistive Technology Assessment
97760 Initial Orthotic Management and Training
97761 Initial Prosthetic Management and Training
97763 Subsequent Orthotic/Prosthetic Management and Training

Only those in **BOLD** are also eligible for coverage via telehealth. Appropriate modifiers should be used. See CPT Manual for definition of codes.

Approval Criteria

I. GENERAL INFORMATION

- A. Medical Necessity must be met. The physical therapy note submitted to request services or substantiate previously provided services must demonstrate, through adequate medical records, evidence sufficient to justify the member's need for the service in accordance with the OAC 317:30-3-1(f).
- B. Initial evaluations do not require prior authorization; However, re-evaluation requests require prior authorization, and the 97164 CPT code can be listed as a line-item on the HCA-61 prior authorization request form (see forms below). While an annual/initial evaluation can be reimbursed no earlier than one year from the date of the previously performed evaluation, a re-evaluation can be requested no earlier than six months from the date of the previous evaluation when criteria are met.
- C. Physical Therapy services are covered with a prior authorization for the pediatric population from 0-20 years of age when medical necessity is met.
- D. Frequent changes of therapists within the same entity should be avoided as it impacts continuity of care and may negatively impact a child's ability to make progress. If the member is to receive services from more than one provider at a location, list the name of the entity as the rendering provider and the NPI of that entity on the HCA-61 therapy prior authorization request form. A change in service providers to another location (with the same entity) or a different entity should be reported via a new PA submission and inclusion of an HCA SC-16 Change of Provider Form, along with all other required documents (see below for additional information on this topic).
- E. Treatments are expected to be evidence-based and result in significant, functional improvement in a reasonable and generally predictable period of time or are necessary for the establishment of a safe and effective maintenance program.
- F. The complexity of the therapy and the patient's condition must require the judgment and knowledge of a licensed qualified PT as defined above practicing within the scope of practice for the service. Requests for services must show the skilled need of the qualified professional.
- G. Treatment goals that may be addressed in an academic setting and/or do not require skilled services of a PT do not meet medical necessity.

II. REQUIRED DOCUMENTS (4) FOR ALL PRIOR AUTHORIZATION REQUEST:

- A. **First:** A signed/dated prescription requesting the specific service(s) from a contracted qualified health professional licensed as a physician or surgeon with unlimited license (MD/DO), the physician assistant of the person so licensed (PA), Doctor of Dentistry (DDS), Doctor of Chiropractic (DC), Doctor of Podiatry (DPM), or Advanced Practice Registered Nurse (APRN) – referrals from the latter four being limited to their respective areas of training and practice.
 - 1. A referral to "evaluate and treat" is valid for 12 months from the date of signature, unless specified otherwise with specific parameters (ex: 2x a week for 6 weeks). Request end-dates should be adjusted accordingly.
 - 2. If parameters are specified, any subsequent prior authorization request needs to provide either a new referral, or a progress note with the referring provider's dated signature on it.

3. The SC-10 OHCA Referral Form can always be used to meet this requirement. In this form, the 'reason for referral' section must specify the discipline/s to which the referral is being sent, along with the diagnosis.

B. **Second:** A signed/dated parental consent form that is completed in its entirety. Submission of an HCA SC-15 Parental Consent Form is needed to meet this requirement (use Spanish version when necessary) when member is <18 years old.

1. Another version of a parental consent form can be accepted if all information from the SC-15 Form is included.
2. Parental consent forms are valid for 12 months from the date of parent/caregiver signature. Request end-dates should be adjusted accordingly.

C. **Third:** An entirely completed HCA-61 Therapy Prior Authorization Request form; Another version of this form must include all applicable information. This form needs to be filled accurately in all applicable fields with line-item (CPT code) units requested equating the usable total amount for all timed sessions. For example, a request for 12 sessions to be held at 60 minutes each cannot exceed 48 units.

D. **Fourth:** A Physical Therapy **initial/annual evaluation, re-evaluation, or progress note** supporting the need for requested services.

1. Either of the above three note types provided for review must be tied to a visit and include the sections listed in the note requirements (see below) ensuring all the necessary information to make a determination.
2. This document must be signed/dated by the supervising physical therapist and include their credentials.
3. Reports must be legible and performed within 30 days of the anticipated prior authorization request start date. Timely PA submission should be prioritized for appropriate continuity of care.
4. If 30 days are exceeded between the PT visit being performed and the anticipated prior authorization request start date, then an up-to-date progress note will be required. It is recommended that progress note visits occur at least every 30 days following the start of care, and the benefits of using this timeline include: effective tracking of goals achieved, recognizing changes secondary to gaps in service, establishing support for demonstrating medical necessity, creating a cohesive history for submission of future PA requests, and for purposes of handoff when necessary.
5. To ensure legibility, hand-written PT notes should be limited.

III. **NOTE REQUIREMENTS FOR ALL REQUESTS FOR PHYSICAL THERAPY:**

A. Subjective section for an evaluation or re-evaluation should be detailed and include:

1. Member/caregiver self-reported history of current presentation.
2. Member/caregiver reason for seeking services (evaluation) or perceived benefit with services to date (if re-evaluation).
3. A narrative of the member and/or caregiver priorities or desired outcomes.
4. If providing a progress note: above is not necessary, however, current subjective measures should be elaborated for relevant goals within the goals section.
5. Regardless of note type, mention of additional services the member is currently receiving should be included in this section, including school services and Early Intervention.

B. Objective section for an evaluation or re-evaluation should have a detailed report of tools, tests, or measures administered (when applicable) to include:

1. Description of the tool, test or measure used.

2. Reason for choosing the tool, test, or measure.
3. Detail of the degree of delay and/or variation from “norms” if applicable.
4. A detailed narrative of the measure of change over time.
5. Interpretation and results of the testing.
6. If providing a progress note: above is not necessary, however, current objective measures should be elaborated for relevant goals within the goals section.

C. Goals section should list functional and measurable goals tied to subjective and objective measurements using the following format:

1. Name the member and the activity they will complete.
2. Specify the exact timeframe in which you expect the activity to be completed (can be applicable for all goals).
3. Describe the conditions under which the activity is expected to be completed.
4. Provide the clinical rationale for the goal (can be applicable for all goals).
5. Predict the prognosis, provide comments describing current level of progress, and state if the goal is baseline/abandoned/modified/continued.
6. Example for Initial Visit: Member will elicit ability to perform a single leg hop for at least 75cm for the R. LE by 6 months without compensatory movement patterns suggesting good synergistic LE muscle activation for a safe return to age-appropriate activities and participation in high school basketball. (*Current Progress: baseline, unable to hop secondary to precautions; Prognosis: excellent*)
7. Example for Progress Note, Re-Evaluation, or Annual Evaluation (during a continuation request): Member will elicit ability to perform a single leg hop for at least 75cm for the R. LE by 6 months without compensatory movement patterns suggesting good synergistic LE muscle activation for a safe return to age-appropriate activities and participation in high school basketball. (*Current progress: continue, member demonstrated ability to perform SL hop safely at almost 6 months post-op today, member can perform 55cm with mild upper body swaying present eliciting continued need to improve plyometric strength and synergistic LE stabilization when landing; Prognosis: excellent with continued coverage over the next auth period.*)

D. Assessment section should include:

1. Continuation requests need to elaborate the member’s ability to tolerate the treatment to date and reasons if an intervention was unsuccessful i.e., unable to train family/caregiver.
2. Continuation requests should also include a statement regarding any new skills if they were developed within the previous authorization period.
3. All requests should entail a summary of the member’s current status regarding their presentation, associated activity limitations and participation restrictions, and therapist’s clinical commentary on member’s progress and/or potential for continued progress with services (confirming medical necessity).

E. Plan section for any note type should include:

1. Specific frequency and duration of the visits requested and the anticipated timeline for which services will be rendered (matching the total visits, timeline, and units requested on the HCA 61 form).
2. Efforts to include the member and/or family/caregiver in the management and carry-over of the intervention into the home setting.
3. A titration plan for services towards eventual discharge.

IV. REQUIRED DOCUMENTS FOR CONTINUATION REQUESTS:

- A. A **progress note, re-evaluation, or annual evaluation** performed within 30 days of the

anticipated prior authorization request start date including all necessary note sections (see L to P) **AND**

- The goals section must include a narrative on the current level of progress for continued goals, and newly added baseline measurements should be included if new goals are added.

B. A fully completed **HCA SC-15 parental consent form** **AND**

C. A fully completed **HCA-61 Therapy Prior Authorization Request form** **AND**

- To avoid any overlap in requests, there needs to be at least 24 hours between the previous authorization's end date and the requested new authorization's start date.

D. A fully completed **prescription for services** or HCA SC-10 referral form **AND**

- A dated signature of the referring provider on the PT progress or re-evaluation note that is being submitted within the year of the evaluation is acceptable. If an evaluation is submitted, a referral will always be necessary along with it.

E. A fully completed HCA SC-16 change of provider form **if**: services are going to be provided by a new entity or a different location of the same entity (Provider ID change). It is the previous location's responsibility to perform a progress note meeting criteria when informed by member/caregiver about desire/need to change provider. It is the previous location's responsibility to share this progress note and related prescription for services with the new location of service. Failure to perform this task can be a detriment to a member's continuity of care.

- When a change of provider form is being submitted by the new location, the new therapist of record can submit the progress note being received from the previous location if the clinic aims to continue treatment with focus on the established goals. All other required forms must be submitted along with this progress note.
- If the provided progress note visit is dated greater than 30 days from the new location's anticipated start date or if the previous location did not send a progress note, a new progress note visit will need to be performed at the new location.
 - The new clinic can perform an initial evaluation and submit a PA with provision of all required paperwork; however, it is important to note that evaluations are reimbursed once per member per year.

F. For additional information on required documentation on a per PA scenario basis, review the January 2026 provider newsletter's Therapy FAQ.

G. The following applies for submission of an **amendment** to an active PA with an HCA-60 Prior Authorization Amendment Form:

1. If removing servicing provider – The presence of a service provider ID often results in issues with filling claims and removal should be prioritized. An amendment submission with an HCA-60 form is required for this. Note that this is different from a change of provider, where the entity or location of service is being changed.
2. If there is a provider number change – The information listed in U should be followed for a true change of provider situation. In rare cases, such as a clinic buyout, when the location remains the same, but the Provider ID is set to change, an amendment with the HCA-60 form can be submitted with this box checked.
3. If there is a member RID number change – An HCA-60 form amendment submission will be necessary.
4. If requesting a date change – To extend the end date, the request should be submitted within the active authorization period with the HCA-60 form along with an

evaluation/progress note/re-evaluation performed within the past 30 days. Service start date will only be backdated when TEFRA or Transfer-Back PA requirements are met. It is important to note the signed date on the parental consent form and the signed date on the referral form when extending the end date or backdating the start date.

5. If requesting a unit change – The addition of units or the subtraction and transfer of units from one CPT code to another should occur within the active authorization period with the HCA-60 form along with an evaluation/progress note/re-evaluation performed within the past 30 days.
6. If requesting a code change – If a change of CPT code is needed, this should occur within the active authorization period with the HCA-60 form along with an evaluation/progress note/re-evaluation performed within the past 30 days. Additionally, this code change amendment is only possible when there are no existing claims for the original CPT code, if claims exist, see additional line-item request below.
7. If requesting a change in modifier – ‘GP’ is the primary modifier used for approval of any of the applicable PT CPT codes listed in this guideline. An ‘SC’ modifier can be added as a secondary modifier on the PA request in urgent situations involving initial post-operative surgeries (no greater than three months from date of initial surgical procedure) or acute injuries (no greater than two weeks from initial injury date). The ‘GT’ modifier should be listed as a secondary modifier for claims submitted when services are delivered via telehealth (this modifier should not be listed as a secondary modifier on PAs, only on telehealth claims).
8. If requesting an additional line-item (CPT code) – If additional line-item(s) are needed, this should occur within the active authorization period with the HCA-60 form along with an evaluation/progress note/re-evaluation performed within the past 30 days. When approved, the addition of a new line-item shall go into effect on the date of the amendment submission.

H. The following applies to submissions for Prior Authorization requests for equipment needs:

1. If a member is being seen solely to meet equipment-related needs – A PT note is not necessary but the other three of four forms for prior authorization request are needed.
2. If a member presents an equipment-related need mid-treatment for another issue – An amendment request using the HCA-60 Form with addition of the appropriate line-item(s) will be necessary (see above).

- I. In special circumstances, additional information may be requested to further validate a prior authorization request. Subscribe to the provider newsletter for updates related to Therapies PA request submissions.

Denial Criteria: Request is outside the guidelines and/or fails to prove medical necessity.

Approval Period: Up to 12 months depending on the signed/dated parental consent, prescription, and medical necessity.

References

1. American Physical Therapy Association. [Code of Ethics for the Physical Therapist](#) (HOD 506-20-28-25). (Updated 2020).
2. American Physical Therapy Association. [The Standards of Practice for Physical Therapy](#). (HOD 506-20-35-29). (Updated 2020).

3. Centers for Medicare & Medicaid Services. [Billing and Coding: Outpatient Physical and Occupational Therapy Services](#). (Updated 2023).
4. Oklahoma Health Care Authority; Policies & Rules, [OAC 317](#): 30-3-1; 317:30-3-65.5; 317:30-5, Part 17.
5. Oklahoma Medical Board. Oklahoma Administrative Code Title 435. [Chapter 20. Physical Therapists and Assistants](#). (Updated 2023).
6. Oklahoma Medical Board. [Physical Therapy Practice Act](#). Title 590.5; Sections 887.1-887.18. (Amended 2022).