Chapter 17

Medicaid Provider Manual

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17.1 OCCUPATIONAL THERAPY

17.1.1 Description

Occupational therapy is a Medicaid covered treatment service, provided by a qualified, certified and licensed occupational therapist to restore, maintain or improve the patient's function. The occupational therapist must be certified by the American Occupational Therapy Association.

17.1.2 Amount, Duration and Scope

a) Medicaid covers occupational therapy services, which provide maximum reduction of a physical disability and restoration of the patient to the best possible functional level. Services should be directed toward restoring a disabled person to self-care and possible independent living or gainful employment or maximizing the person's functional status. Services must be included in a plan of care and must be prescribed by a physician. Necessary supplies and equipment used in the therapy shall be included as part of the service. Please refer to Chapter 11 for additional information regarding Outpatient Hospital Services.

b) Justifiable conditions for occupational therapy may include, but are not limited to, strokes, "accident" injuries, brain injury, spinal cord injury or any condition resulting in some paralysis. Occupational therapy may be prescribed by a physician when medically necessary and when the following conditions are met:

- The services are considered under accepted standards of medical practice, to be a specific and effective treatment for the patient's condition;
- The services are of a level of complexity that requires that they be performed by a qualified occupational therapist. Maintenance therapy for the purpose of maintaining function is not covered. Also, not covered are services that do not require the skills of a qualified occupational therapist and are not personally performed by the therapist;
- There is an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician of the patient's restoration potential, or the services are necessary to establish a safe and effective maintenance program required in connection with a specific disease state; and the amount, frequency and duration of services are reasonable.

17.1.3 Exclusions

Long-term maintenance and group exercise programs are not covered.

17.1.4 Limitations

Refer to Section 17.3 Physical/Occupational Authorization and Limitations below.

17.2 PHYSICAL THERAPY

17.2.1 Description

Physical therapy is a Medicaid covered treatment service, provided by a qualified, licensed physical therapist or physician to restore or improve the patient's function.

17.2.2 Amount, Duration and Scope

a) Medicaid covers physical therapy, which provides maximum reduction of a physical disability and restoration of the patient to the best possible functional level. Services should be directed toward restoring a disabled person to self-care and possible independent living or gainful employment. Services must be included in a plan of care and must be prescribed by a physician. Necessary supplies and equipment shall be included as part of the service.

b) Physical therapy must be medically necessary and meet the following conditions:

- The services are considered under accepted standards of medical practice, to be a specific and effective treatment for the patient's condition;
- The services are of a level of complexity requiring services that can be performed only by a qualified therapist. Maintenance therapy for the purpose of maintaining function is not covered. Also, not covered are services that do not require the skills of a qualified physical therapist and are not personally performed by the therapist;
- There is an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician of the patient's restoration potential, or the services are necessary to establish a safe and effective maintenance program to be provided by caretakers in connection with a specific disease state; and
- The amount, frequency and duration of services are reasonable.

17.2.3 Exclusions

a) Massage therapy is not covered.

b) Long-term maintenance and group exercise programs are not covered.

17.2.4 Limitations

Refer to Section 17.3 Physical/Occupational Authorization and Limitations below.

17.3 PHYSICAL/OCCUPATIONAL THERAPY AUTHORIZATIONS

Occupation and/or Physical Therapy services are available without prior authorization within the following guidelines:

•The initial evaluation for physical or occupation therapy does not require prior authorization. Additionally, prior authorization is not required for a re-evaluation of the client's status/progress towards meeting quantifiable functional goals if it is performed to develop a plan of care for the additional services that have been deemed medically necessary by the client's physician.

•Clients are allowed up to 36 units or 12 visits of PT and/or OT as long as these services(s) does not/do not exceed 36 units, or 12 visits for PT and/or OT in a 12-day period.

•For modalities designated in 15-minute units, Medicaid will cover up to 3, 15-minute units per day (45 minutes) or total of 36 units.

•For modalities designated on a per visit basis, (procedure codes: 97012, 97014. 97018, & 97022) Medicaid will cover up to 12 visits. If based on the therapist's re-evaluation and recommendations, the physician determines that a Medicaid re-cipient needs more than the initial 36 units or 12 PT and/or OT visits, the follow-ing must be done:

a) Submit and 1144 form no earlier than 2 months (60days) from the start date of ther-apy or after at least 8 initial therapy visits have been completed.

b) Write on the top of the 1144 form "EXCEEDS LIMITS".

c) Submit the specific CPT code (s) with the appropriate modifier; "GP" for PT and "GO" for OT services.

d) Submit the initial comprehensive evaluation reflecting the medical necessity for the initial PT and/or OT service, and the re-evaluation justifying the need for additional therapeutic services.

e) All authorization requests must specifically and clearly address the following:

1) Diagnosis

2) Current physical functional ability level and improvements in the patient's functional abilities that are expected at the completion of treatment,

3) Include a description of procedures; specific modalities and exercises to be used in treatment: the frequency and estimated duration of the services; and the number of ses-sion/ visits being requested).

4) For chronic cases, the above information is required plus a plan of care containing short term and long-term goals that are expected to relieve pain and restore the patient to the maximum possible level of function and a reasonable estimate of when the goals will be reached. A new Form 1144 and Form CMS 701(11-91) must be submitted for each extension requested

f) The quantity is based on the description of the procedure code with 15 minutes equaling one unit.

g) Initial occupational therapy evaluations may be performed without medical authorization if done to assess the medical need for therapy and/or to formulate a plan of care.

The following chart shows daily and unit limitations for administer therapies before authorization is necessary.

NO PA REQUIRED:

Code	Description	Limit	Comments
97001	PT evaluation.	1 per 120 days	Initial evaluation including assessment and development of the treatment plan and establishment of goals.
97002	Pt re-evaluation.	1 per 90 days	Re-evaluation, including assessment of treatment plan and progress toward goals and modifications of the treatment plan.
97003	OT evaluation.	1 per 120 days	See 97001
97004	OT re-evaluation.	1 per 90 days	See 97002
97005	Physical performance test or measurement with written report, each 15 minutes	6 units per 12 months	This code does not require PA when performed as a comprehensive wheelchair assessment. Any

			other use of this code requires a PA.
97010-97140; 97530-97535; 97542	Modalities and Therapies.	12 visits or 36 therapy and or modality units per 120 days for PT and OT.	Pts and Ots may sometimes use the same codes. Thus, no PA is required for 12 PT and/or 12 OT visits per 120 days. Codes 97039 and 97799 require reports. Gp and Go mods must be used on these codes.

PA REQUIRED **NON-COVERED**:

97545,97546	Work hardening		97150	Group P.T.
97597-97606	Active wound care manage-ment		97537	Community/work reintegration (shopping, money-management, etc.).
97755	Assistive tech-nology assess-ment.		97005,97006	Athletic, training evaluation and re-evaluation.

17.4 SPEECH THERAPY

17.4.1 Description

Speech therapy is a Medicaid covered treatment service, provided by a qualified, licensed speech therapist/pathologist to restore, maintain or improve the patient's function. Speech therapy is covered if it is directed toward evaluation and treatment of disorders that impair speech, voice, language or swallowing.

17.4.2 Amount, Duration and Scope

Services for individuals with a speech disorder(s) means diagnostic, screening, preventive or corrective services provided by, or under the direction of a speech pathologist to whom a patient is referred by a physician. Necessary supplies and equipment shall be included. A physician may prescribe services for patients with speech disorders who are expected to improve in a reasonable period of time with therapy.

17.4.3 Exclusions

a) Maintenance and long term speech pathology services aimed at maintaining rather than improving function are not covered.

b) Group speech therapy is not covered.

17.4.4 Limitations

All recommended speech evaluations shall require prior authorization by the department's medical consultants according to the following procedures:

- For evaluation, information indicating diagnosis, age, and duration of the clinical condition; and
- For therapy, information indicating the evaluation and results of standardized objective tests and a plan of therapy with goals and time frames.

17.4.5 Authorization

a) Requests for authorization must be submitted as follows:

- For all initial service authorization requests, Form CMS-700 (11-91) Plan of Treatment for Outpatient Rehabilitation must be submitted with Form 1144. Refer to Appendix 5 for a sample of the CMS-700 (11-91) Form.
- For authorization requests to extend services, Form CMS-701 (11-91) Updated Plan of Progress for Outpatient Rehabilitation must be submitted with Form 1144. Refer to Appendix 5 for a sample of the CMS-701 (11-91) Form.

b) Inpatient (excluding acute level of care) and outpatient speech therapy require prior approval on Form 1144, with the appropriate CMS form attached. Inpatient speech therapy rendered to patients in an acute level of care do not require authorization as these services are included in the facility's Prospective Payment System (PPS) reimbursement.

c) A medical authorization is required for speech therapy for patients age 0 – 6 years old (See Appendix 6 – Rehabilitative Services for Children 0-6 Years Old and Guidelines).

d) Requests for evaluations must indicate the patient's diagnosis, age, and duration of the clinical condition. Requests for therapy should include an evaluation using a standard test (i.e., Porch, Minnesota Aphasix Test) and a plan of therapy with goals and time frames. Speech therapy requests for speech delay must include non-language developmental age, including social and motor developmental age.

17.5 REHABILITATIVE SERVICES FOR CHILDREN 0-6 YEARS OLD

Guidelines were developed in joint cooperation between the Medical Consultants and the Child Development Committee of the State Planning Council on Developmental Disabilities. All children for whom therapy is requested must have a determination of functional level clearly stated in the plan of care and based on one of the two suggested grading schemes, which can be found in Appendix 6.

Reimbursement for evaluations that conform to the above mentioned guidelines will be at a flat rate per 15 minutes not to exceed one hour and a half (a total of six 15 minute periods) per evaluation. Only one extensive evaluation will be reimbursed every six months for each therapeutic service.

17.6 HOME HEALTH AGENCY REHABILITATIVE SERVICES

a) No authorization is required for PT and /OT services provided in the first (1st) sixty (60) –day Home Health Care Certification period (documented on the Form CMS-485).

b) Medical authorization however, is required for all PT and/or OT services provided in subsequent certification periods. To assure continuation of services, the HHA must submit the 1144 and the corresponding CMS-485, signed and dated by the physician, to ACS for medical authorization within 30-days of the initiation of PT and/or OT services.

c) The Medicaid Guidelines for Home Health Therapy Services will be used in determining reasonable and medically necessary PT, OT and ST services. If the PT, OT and/or ST services do not meet the criteria in the guidelines, services will be denied. The Medicaid Guidelines for Home Health Therapy Services can be found in Appendix 6. The PT, OT, and ST must be part of the patient's plan of care.

17.7 REHABILITATIVE SERVICES IN LONG TERM CARE FACILITIES

a) Rehabilitative Services in Long Term Care Facilities are covered with limitations.

b) Authorization on the Form 1144 and on the Form 1147c is required. The Form 1147c authorizes the therapy as a covered restorative therapy that meets the requirements for the skilled nursing facility (SNF) level of care. Form 1144 authorizes the specific modalities by procedure code that will be employed. Restorative rehabilitation services to long term care patients may be billed by the facility or the individual therapist. If the facility is not a Medicare certified facility and does not qualify to become one, then the licensed individual therapist providing the service should bill using the CMS (formerly HCFA) 1500 claims form. Long-term care patient services may be billed using 15-minute time increments. However, if billings are for outpatient services, time increments must be described by procedure code. Please refer to Appendix 4 for details pertaining to the 1144 and 1147c forms.