Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-358
Employees' Manual, Title 8
Medicaid Appendix

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OCCUPATIONAL THERAPY MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***OCCUPATIONAL THERAPY MANUAL***, Title Page, new; Table of Contents, new;

Chapter I, ***General Program Policies***, Title Page, Table of Contents (pages 1, 2, and 3), pages 1 through 55, and the following forms:

470-4166	*Iowa Medicaid Provider Form Request*
470-4708	*Medicare Crossover Invoice (Professional)*
470-4707	*Medicare Crossover Invoice (Institutional)*
RC-0113	*List of Emergency Diagnosis Codes*
470-3744	*Provider Inquiry*
470-0040	*Credit/Adjustment Request*

Chapter II, ***Member Eligibility***, Title Page, Table of Contents (pages 1 and 2), pages 1 through 63, and the following forms:

470-2747	*Foster Care Provider Medical Letter*
470-2747(S)	*Foster Care Provider Medical Letter* (Spanish)
470-2979	*Proof of Application for Medicaid*
470-1911	*Medical Assistance Eligibility Card*
470-2580	*Presumptive Medicaid Eligibility Notice of Decision*
470-2580(S)	*Presumptive Medicaid Eligibility Notice of Decision* (Spanish)
470-4164	*IowaCare Medical Card*
470-3931	*Medically Needy Expense Deletion Request*
470-4299	*Verification of Emergency Health Care Services*
470-4299(S)	*Verification of Emergency Health Care Services* (Spanish)
470-2927	*Health Services Application*
470-2927(S)	*Health Services Application* (Spanish)
470-4990	*Application for Authorization to Make Presumptive Medicaid Eligibility Determination for Children*
470-2582	*Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*

470-4855	*Application: Presumptive Health Care Coverage for Children*
470-4855(S)	*Application: Presumptive Health Care Coverage for Children* (Spanish)
470-2579	*Application for Authorization to Make Presumptive Medicaid Eligibility Determinations for Pregnant Women*
470-2629	*Presumptive Medicaid Income Calculation*
470-3864	*Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*

Chapter III, ***Provider-Specific Policies***, Title Page, new; Table of Contents (page 1), new; and pages 1 through 4, new.

Chapter IV, ***Billing Iowa Medicaid***, Title page, Contents (pages 1, 2, and 3), pages 1 through 160, and the following forms:

470-3969	*Claim Attachment Control*
UB-04	*Claim Form* (CMS-1450)
CMS-1500	*Health Insurance Claim Form*
	ADA 2012 Dental Claim Form
470-0039	*Iowa Medicaid Long Term Care Claim*
470-4708	*Medicare Crossover Invoice (Professional)*
470-4707	*Medicare Crossover Invoice (Institutional)*
470-2486	*Claim for Targeted Medical Care*
470-0829	*Request for Prior Authorization*
470-3970	*Prior Authorization Attachment Control*
470-3744	*Provider Inquiry*
470-0040	*Adjustment Request*
470-4987	*Recoupment Request*

Appendix, Title Page, Table of Contents, and pages 1 through 27

Summary

This letter transmits a new manual for providers in Occupational Therapy. The manual is comprised of five sections:

- Chapter I contains information about Iowa Medicaid administration, coverage, and reimbursement that applies to all types of providers.
- Chapter II describes the different ways of attaining and demonstrating Medicaid eligibility. It also applies to all provider types.
- Chapter III explains Medicaid requirements specific to public health agencies. The chapter:
  - Aligns with current policies, procedures, and terminology.
  - Ensures that current contact information is provided.
  - Includes links to forms to ensure that the most recent version of the form is accessible.

- Chapter IV contains instructions and forms to bill Iowa Medicaid. It also applies to all provider types.
- The Appendix contains directories of local offices of the Department of Human Services and the Social Security Administration and EPSDT care and coordination agencies.

Date Effective

Upon receipt.

Material Superseded

None.

Additional Information

The new provider manual can be found at:
http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/OccTher.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

Occupational Therapy

Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. OCCUPATIONAL THERAPISTS ELIGIBLE TO PARTICIPATE

For Medicaid payment purposes, a qualified occupational therapist is licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll. Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

Occupational therapists who provided services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

B. COVERAGE OF OCCUPATIONAL THERAPY SERVICES

Total Medicaid payment for services provided by an independently practicing occupational therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid Services (CMS). Click here to view the current cap information.

For Medicaid purposes, occupational therapy services are those services furnished a patient that meet all of the following conditions:

- The services are directly and specifically related to an active written treatment regimen that is:
  - Designed by the physician after any needed consultation with the qualified occupational therapist, and
  - Included in the final treatment plan.
- The services are of such a level of complexity and sophistication or the condition of the patient is such that the judgment, knowledge, and skills of a qualified occupational therapist are required.
- The services are in fact performed by or under the supervision of a qualified occupational therapist, meaning that the qualified occupational therapist:
  - Provides authoritative procedural guidance for the rendering of the services with initial direction and periodic inspection of the actual act, and
  - Is on the premises if the person performing the service does not meet the assistant-level qualifications.

- The services either:
  - Are provided with the expectation that the patient will improve significantly in a reasonable and generally predictable period of time, based on the physician's assessment of the patient's restorative potential after any needed consultation with a qualified occupational therapist, or
  - Are necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.
- The services are considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition.
- The services are reasonable and necessary to the treatment of the patient's condition.

Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute occupational therapist for Medicaid purposes.

Additional services may be covered above the limit above if medically reasonable and necessary. The medical record must document the need for medically reasonable and necessary services. The claim must be submitted with documentation of the medically reasonable and necessary services up to the limit established by the Medicare program for occupational therapy services.

C. INTERPRETER SERVICES

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing agency
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

1. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

2. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

D. BASIS OF PAYMENT

The basis of payment for the services of an independently practicing occupational therapist is based on a fee schedule.

Click here to view the fee schedule for Occupational Therapy.

E. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. Surgical procedures not covered by Medicare may be identified as payable by Medicaid. Reimbursement rates are established by the Medicaid program for those surgical procedures. The five-digit procedure code must be followed by an EP modifier if the service is the result of an EPSDT (Early and Periodic Screening, Diagnosis and Treatment) physical.

It is the provider's responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Occupational Therapy are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click here.

To view billing instructions for the CMS-1500, click here.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at: http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.