Rehabilitation Agency

Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. REHABILITATION AGENCIES ELIGIBLE TO PARTICIPATE

A rehabilitation agency is eligible to participate in Medicaid if it is certified eligible to participate as a rehabilitation agency in the Medicare program.

B. COVERAGE OF SERVICES

Covered services are physical therapy, occupational therapy, and speech therapy. Policy regarding coverage of these services is primarily that of the Medicare program.

To be reimbursable under Medicaid, the services must meet all the following conditions:

- All services must be determined to be medically necessary and reasonable.
- All services must meet a significant need of the member that cannot be met by a significant other, a friend, or medical staff; must meet accepted standards of medical practice.
- All services must be specific and effective treatment for a member's medical or disabling condition.
- A licensed skilled therapist must complete a plan of treatment every 30 days and indicate the type of service required.
- The plan must contain the information noted under Plan of Treatment.

There is no specific limit on the number of visits that Medicaid will cover, as long as the amount of service:

- Is medically necessary in the individual case, and
- Is related to a diagnosed impairment or disabling condition, and
- Meets current standard of practice in each related field, and
- Is within the limits described later in this chapter.

Submit documentation with each claim to support the need for the number of services provided.

Payment shall be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a member's rehabilitation potential and appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic therapy or trial therapy.

A unit of treatment is considered to be 15 minutes in length. Therapy sessions must meet the following criteria:

- There must be face-to-face patient contact.
- Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month may not exceed that for individual therapy.
- Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date, unless more than 60 minutes of service is required for a treatment session due to the member's specific condition.

  If more than a 60-minute session is required for a treatment session, submit additional documentation of the specific condition and the need for the longer treatment with the claim.
- Progress must be documented in measurable statistics on either the care plan or the progress notes for services to be reimbursed.

With the three rehabilitation therapy modes, specific conditions must be met for reimbursement to be made. Those conditions are listed under the individual therapy modes.

1. Diagnostic or Trial Therapy

Payment is made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a member's rehabilitation potential and appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic therapy or trial therapy.

When members do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to established goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for members who need evaluation in multiple environments to determine their rehabilitative potential adequately. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the member's response to treatment in the member's environment.

When, during diagnostic or trial therapy, a member has been sufficiently evaluated to determine potential for restorative or maintenance therapy (or lack of therapy potential), diagnostic or trial therapy ends. When, as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy is reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the member has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue requires documentation reflecting a significant change.

Further diagnostic or trial therapy for the same issue is not considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required. They will be reviewed to determine the medical necessity of the number of hours of service provided.

The following criteria additionally must be met:

- There must be face-to-face interaction with a licensed therapist. (An aide's services are not payable.)
- Services must be provided on an individual basis. (Diagnostic or trial therapy is not payable in a group setting.)
- Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the member's response.

- If the member has a previous history of rehabilitative services, trial therapy for the same type of services generally is payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist:
  - New onset,
  - New problem,
  - New need,
  - New growth issue,
  - A change in vocational or residential setting that requires a reevaluation of potential, or
  - Surgical intervention that may have caused new rehabilitative potentials.
- For members who received previous rehabilitation treatment, consideration of trial therapy generally should occur only if the member has incorporated any regimen recommended during prior treatment into daily life to the extent of the member's abilities. (In the case of speech therapy, this criteria does not apply if the only goal of prior rehabilitative treatment was to learn the prerequisite speech components.)
- Documentation should include any previous attempt to resolve problems using non-therapy personnel (e.g., residential group home staff or family members) and whether follow-up programs from previous therapy have been carried out.
- Referrals from residential, vocational, or other rehabilitation personnel that do not meet present evaluation, restorative, or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity, and the current medical condition, including any secondary rehabilitative diagnosis, shall be submitted with the claim.
- Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

Use the following revenue codes for billing diagnostic or trial therapy:

429 Physical therapy
439 Occupational therapy
449 Speech therapy

2. 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 provider
- 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.

a. 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.

b. 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 (IAC) Chapter 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.

3. Location of Service

Services may be provided in the member's home or in a nursing care facility or residential care facility by a speech pathologist, physical therapist, or occupational therapist employed by or contracted by the agency.

Services provided to a member residing in a nursing facility or residential care facility are payable when the provider submits a statement signed by the facility representative verifying that the facility does not have these services available. The statement need only be submitted with the claim at the start of care, unless the situation changes.

Payment will not be made to a rehabilitation agency for therapy provided to a member residing in an intermediate care facility for the intellectually disabled, since these facilities are responsible for providing or paying for such services required by members. Payment will not be made for service provided in a hospital.

4. Maintenance Therapy

Generally, maintenance therapy means services to a member whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than post-hospital.

Maintenance therapy is also appropriate for persons whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels. Where a maintenance program is appropriate, the initial evaluation and the instruction of the member, family members, home health aides, facility personnel or other caregiver to carry out the program are considered a covered service.

Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of twelve months. The plan of treatment must specify the anticipated monitoring activities of any supervisor. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After twelve months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation is considered medically necessary only if there is a significant change in residential or employment situation or the member exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously counter-indicated restorative therapy. A statement by a developmentally disabled member's interdisciplinary team recommending a reevaluation and stating the basis for medical necessity is considered as supporting the necessity of a reevaluation and may expedite approval.

Examples of covered services:

- A member with Parkinson's Disease who has not been under a restorative physical therapy program may require a maintenance program established by a qualified physical therapist.
- A member who has received gait training has reached maximum restoration potential. The physical therapist is teaching the member and family how to safely perform the activities which are a part of the maintenance program being established. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) are covered since they are needed to establish the program.
- An adult with an intellectual disability has reached a plateau in progress in a restorative speech language therapy program; potential for further progress seems minimal though a discrepancy exists between the member's cognitive skills and communication abilities. A maintenance program may be established to ensure continued present level of functioning.

- A member who has suffered a stroke or a member with an intellectual disability (for example) exhibits deficits in communication function relative to the member's cognitive abilities, but requires a therapy plan that slowly progresses in complexity and involves repetitious exercises or activities. A program may be established to help the member advance through the levels. However, since it is of a less complex design, it does not require the constant contact with a skilled therapist and is payable as a maintenance program only.

5. Occupational Therapy

To be covered under rehabilitation agency services, occupational therapy services must:

- Be included in a plan of treatment.
- Improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the member's ability to perform tasks required for independent functioning.
- Be prescribed by a physician under a plan of treatment.
- Be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapy assistant under the general supervision of a qualified licensed occupational therapist, as allowed by Iowa licensure.
- Be reasonable and necessary for the treatment of the member's illness, injury, or disabling condition.

Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition. However, in cases where there is a valid expectation of improvement at the time the occupational therapy program is instituted, but the expectation is not realized, services are covered only up to the time one would reasonably conclude the member would not improve. Refer to Restorative Therapy. See Diagnostic or Trial Therapy.

For coverage of design and monitoring of a maintenance program, refer to Maintenance Therapy.

For coverage of diagnostic or trial therapy, refer to Diagnostic or Trial Therapy.

The selection and teaching of tasks designed to restore physical function are covered.

Planning and implementing therapeutic tasks are covered. Examples include activities to restore sensory-integrative functions, and providing motor and tactile activities to increase input and improve responses for a stroke patient.

The teaching of activities of daily living and energy conservation to improve the level of independence of a member which requires the skill of a licensed therapist and meets the definition of restorative therapy is covered. Refer to Restorative Therapy for further information.

The designing, fabricating, and fitting of orthotic self-help devices are considered covered services if they relate to the member's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

Vocation and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

6. Physical Therapy

The coverage decision for physical therapy shall be based on the need for the skills of a therapist and not only on the diagnosis.

To be covered under rehabilitation agency services, physical therapy services must:

- Relate directly and specifically to an active written treatment plan.
- Follow a treatment plan established by the licensed skilled therapist after consultation with the physician.
- Be reasonable and necessary to the treatment of the member's illness, injury, or disabling condition.
- Be specific and effective treatment for the member's medical or disabling condition.
- Be of such a level of complexity and sophistication, or the condition of the member must be such, that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

The initial physical therapy evaluation must be provided by a licensed physical therapist.

A qualified physical therapy assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as allowed by Iowa licensure.

There must be an expectation that there will be a significant, practical improvement in the member's condition in a reasonable amount of time, based on the member's restorative potential assessed by the physician. See Diagnostic or Trial Therapy.

It must be demonstrated that there is a need to establish a safe and effective maintenance program related to a specific illness, injury, or disabling condition.

The amount, frequency, and duration of the services must be reasonable.

When a member is under a restorative physical therapy program, the member's condition is regularly re-evaluated and the program adjusted by the physical therapist. It is expected then, that the physical therapist has designed a maintenance program before discharge.

Consequently, maintenance programs that are not established until after the restorative program has been completed are not considered reasonable and necessary to the treatment of the member's condition and are excluded from coverage. Refer to Restorative Therapy for further information.

For coverage of design and monitoring of a maintenance program, see Maintenance Therapy.

For coverage of diagnostic or trial therapy, refer to Diagnostic or Trial Therapy.

Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require skills of a qualified physical therapist. These are covered when the condition is complicated by other conditions, such as circulatory deficiency or open wounds, or if the service is an integral part of a skilled physical therapy procedure.

Gait training and gait evaluation and training constitute a covered service if the member's ability to walk has been impaired by a neurological, muscular, or skeletal condition or illness. The gait training must be expected to significantly improve the member's ability to walk.

Repetitious exercise to increase endurance of weak or unstable members can be safely provided by supportive personnel, e.g., aides or nursing personnel. Therefore, it is not a covered physical therapy service.

Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

Range-of-motion tests must be performed by a qualified physical therapist. Range-of-motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility. Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored. Range-of-motion to unaffected joints only does not constitute a covered physical therapy service.

Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy, e.g., work-hardening programs. Initial instruction for such programs is a covered service.

Therapeutic exercise may constitute a physical therapy service due either to the type of exercise employed or the condition of the member.

Use of isokinetic or isotonic equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament, or tendon injury or postsurgical trauma. Billing can be made only for the time the therapist actually spends instructing the member and assessing the member's progress.

7. Plan of Treatment

A plan of treatment must either be:

- Established by the physician, or
- Established by a qualified therapist and signed by the physician.

Use the Medicare plan of treatment when all the minimum information is provided in it. The minimum information to be included on treatment plans includes:

- The certification period.
- The physician's signature and date (within the certification period).
- The date the member was last seen by the physician (if available).*
- The member's current medical condition.
- The member's current functional abilities, including any disabling condition.
- The member's functional limitations.
- A diagnosis relevant to the medical necessity of treatment.
- Dates of onset of any diagnosis for which treatment is being rendered (if applicable).*
- Prior treatment (history related to current diagnosis), if applicable or known.*
- Dates of prior hospitalization (if applicable or known).*
- Dates of prior surgery (if applicable or known).*
- The date of the last episode of instability, or the date of the last episode of acute recurrence of illness or symptoms (if applicable).*
- A brief summary of the initial evaluation or baseline.
- The member's prognosis.
- The member's rehabilitative potential.
- The member's progress in measurable statistic. (See Diagnostic or Trial Therapy.)
- The extent to which the member has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions. (See Diagnostic or Trial Therapy.)

- Quantitative, measurable short-term and long-term functional goals. (See Diagnostic or Trial Therapy.)
- The services to be rendered.
- The frequency of the services.
- The discipline of the person providing the service.
- Assistance devices to be used.
- The place services are rendered.
- The period of time of the session.
- The anticipated duration of the service.
- The estimated date of discharge, if applicable.

* Attempt to gather the minimum information to be included in treatment plans by reviewing the nursing home records and by contacting the referring physician.

When developing plans for teaching, training, and counseling, include the following information at a minimum:

- The medical necessity of the service
- Prior teaching, training, or counseling provided
- Progress in response to the services
- The identification of specific services and goals
- To whom the services are provided (member, family member, etc.)
- The date of the start of the services
- The frequency of the service
- The estimated length of time services will be needed

8. Restorative Therapy

Restorative therapy must be reasonable and necessary to the treatment of the member's illness, injury, or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the member's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that the demonstrable measurable increases have occurred in the member's level of independence outside the therapeutic environment. If at any point of an illness or disabling condition, it is determined that this expectation will not be realized, the services are no longer considered reasonable and necessary.

Examples of covered service:

- Physician has ordered gait evaluation and training for a member whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the member's gait, to establish a gait training program, and to provide the skilled services necessary to implement the program are covered.
- A member who has had a total hip replacement is ambulatory, but demonstrates weakness and is unable to climb stairs safely. Physical therapy is reasonable and necessary to teach the member to safely climb and descend stairs.
- A physician orders occupational therapy for a member who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting, and bathing. The occupational therapist establishes goals for the member's rehabilitation (to be approved by the physician), and will undertake the teaching of the techniques necessary for the member to reach the goals. Occupational therapy services are covered at a duration and intensity appropriate to the severity of the member's impairment and the response to treatment.
- Teaching a member who has lost the use of an arm how to pare potatoes and chop vegetables with one hand is covered.
- Teaching a stroke patient new techniques to enable the member to perform feeding, dressing, and other activities of daily living as independently as possible is covered.
- Construction of a device which enables a member to hold a utensil and feed himself/herself independently is covered.
- Construction of a hand splint for a member with rheumatoid arthritis to maintain the hand in a functional position is covered.
- A member with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of the member's condition. The member is now wheelchair-bound and, for the first time, without any expectation of achieving ambulation again.

The physician has ordered physical therapy to select the proper wheelchair for the member's long-term use and to teach safe use of the wheelchair and safe transfer techniques to the member and the family. Physical therapy is reasonable and necessary to:

- Evaluate the member's overall needs,
- Make the selection of the proper wheelchair, and
- Teach the member and family safe use of the wheelchair and proper transfer techniques.

♦ Stimulating and retraining a member who has suffered a stroke and who has lost speech or language skills to communicate orally or through augmentative means is covered.

♦ Retraining communications skills of a laryngectomized person is covered.

♦ Training an abnormally dysfluent child or adult to speak more fluently is covered.

♦ Training new patterns of voice production for a child or adult exhibiting vocally abusive behaviors is covered.

♦ Stimulating and training a language or speech delayed child's communications skills to more closely approximate age level is covered.

♦ Training oral or augmentative communication skills of an intellectually disabled or physically handicapped person where a significant discrepancy occurs between the person's cognitive abilities and current level of communication function is covered.

9. Speech Therapy

To be covered by Medicaid as rehabilitation agency services, speech therapy services must:

♦ Be included in a plan of treatment established by a licensed, skilled therapist after consultation with the physician.

♦ Relate to a specific medical diagnosis or disabling condition which will significantly improve a member's practical, functional level in a reasonable and predictable time period. See Diagnostic or Trial Therapy.

♦ Require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

Speech therapy activities which are considered covered services include restorative therapy services to restore functions affected by illness, injury, or a disabling condition resulting in communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of:

- Voice
- Fluency
- Articulation
- Language
- Swallowing disorders resulting from any condition other than mental impairment

Treatment of these conditions is payable if restorative criteria are met. Refer to Restorative Therapy.

Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to members who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the member's illness, injury, or disabling condition. Group therapy is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

Teaching a member to use sign language or to use an augmentative communication device is reimbursable. The member must show significant progress outside the therapy sessions for these services to be reimbursable. See Diagnostic or Trial Therapy.

Where a maintenance program is appropriate, the initial evaluation, the instruction of the member and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program, in accordance with the requirements of maintenance therapy, and monitoring the progress are covered. For coverage of design and monitoring of a maintenance program, see Maintenance Therapy.

C. BASIS OF PAYMENT

Payment for services is based on Medicare reimbursement principles. Submit claims for payment using the applicable Current Procedural Terminology (CPT) codes.

Click here to view the fee schedule for Rehabilitation Agencies.

D. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from the IME.

It is the provider's responsibility to select the procedure code that best describes the item dispensed. A claim submitted without a procedure code and a corresponding diagnosis code will be denied.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Rehabilitation Agencies are billed on federal form UB-04, *Health Insurance Claim Form*.

Click here to view a sample of the UB-04.

Click here to view billing instructions for the UB-04.

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://dhs.iowa.gov/sites/default/files/all-iv.pdf