Provider Support

- www.Michigan.gov/MedicaidProviders
- 1-800-292-2550
- ProviderSupport@Michigan.gov

Therapy Coverage and Billing Resources

- Michigan Medicaid Provider Manual >> Therapy Services Chapter
- MDHHS Therapy Database
- Medicaid Code and Rate Reference tool

FFS Prior Authorization (PA) Resources and Tools

- Steps on How to Enter a Prior Authorization Directly in CHAMPS
- CHAMPS PA Resources
- Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115)

PA Program Review Division (PRD)

- 1-800-622-0276
- Fax 517-335-0075

Medicaid Health Plan (MHP)

- Medicaid Health Plan Website
- List of Medicaid Health Plan Contact and Service Listing

Integrated Care Organization (ICO)

- MI Health Link Website
- List of Integrated Care Organizations and Service Listing

Additional Resources

- CHAMPS Website
- Training Website
- Provider Alerts
- Sign up for Listserv

Outpatient Therapy Services

Medicaid and Children Special Health Care Services (CSHCS) cover medically necessary rehabilitative physical (PT), occupational (OT), and Speech-Language (ST) therapy services for beneficiaries of all ages when provided by Medicaid enrolled licensed therapists or appropriately supervised professionals. Medicaid and CSHCS beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may also be eligible for habilitative therapy. All services must be ordered by the beneficiary's primary care or specialty medical provider.

Outpatient Coverage

Refer to the Therapy Chapter of the Medicaid Provider Manual for coverage and service requirements.

Rehabilitative Therapy	Covered up to 144 units of PT per calendar year, 144 units of OT per calendar year, and 36 visits of ST per calendar year. Additional units/visits require PA.
Habilitative Therapy	Covered for some beneficiaries. When eligible, covered up to 144 units of PT per calendar year, 144 units of OT per calendar year, and 36 visits of ST per calendar year. Additional units/visits require PA. Special modifier requirements apply.
Maintenance Therapy	Covered up to 4 times per 90 days. 4 visits should not total more than 16 units. Additional units/visits require PA. Special modifier requirements apply.
Co–Treatment Therapy	Covered within the therapy benefit limits. Therapists must not work on duplicate goals. Must be prior authorized even if therapy limits have not been exhausted.
Group Therapy	Not Covered.
Therapy in Multiple Settings	Covered. Therapy may be provided in more than one setting (i.e. school based, pre-paid inpatient hospital (PIHP) specialty benefit) when the goals and purpose for each are distinct.
Telemedicine Therapy	Covered. Some therapy services may be provided via telemedicine. Review the Telemedicine database for a list of covered services. Evaluations must be performed in-person.

Prepaid Inpatient Health Plan (PIHP) Updates

Beneficiaries eligible for behavioral health treatment through a Prepaid Inpatient Health Plan (PIHP) may also have related PT, OT, and ST services covered under the PIHP benefit.

Refer to the covered services section (OT, PT, & ST subsections) of the Behavioral Health and Intellectual and Developmental Disability Supports chapter of the Medicaid Provider Manual for coverage and service requirements.

Fee-For-Service (FFS) Prior Authorization Requirements

Medicaid and CSHCS require PA for outpatient therapy services when the beneficiary's treatment exceeds the standard coverage limits, regardless of the diagnosis. The purpose of PA is to review the medical need for continued therapy services. Approval confirms that the service is authorized for the beneficiary, but does not guarantee eligibility or payment. Providers must verify both the beneficiary's and provider's eligibility prior to rendering the service. Continued outpatient therapy may be requested up to 6 months at a time. Submit PAs electronically via CHAMPS Direct Data Entry whenever possible. Providers may also track PA requests and determination letters directly via CHAMPS.

Prior Authorization is Required in the Following Scenarios

To avoid delays in the beneficiary receiving ongoing services, additional outpatient therapy should be requested at least three weeks prior to the beneficiary reaching their limits. PA will not be granted retroactively. When urgent access to therapy is required, verbal PA may be requested by contacting the MDHHS Program Review Division (PRD).

Refer to the Therapy Chapter of the Medicaid Provider Manual for complete PA and coverage requirements.

Occupational Therapy	• Rehabilitative or habilitative treatment that exceeds 144 units per calendar year. • Maintenance therapy that exceeds 4 times and/or 16 units per 90 days.
Physical Therapy	• Rehabilitative or habilitative treatment that exceeds 144 units per calendar year. • Maintenance therapy that exceeds 4 times and/or 16 units per 90 days.
Speech-Language Therapy	• Rehabilitative or habilitative treatment that exceeds 36 visits per calendar year. • Maintenance therapy that exceeds 4 visits per 90 days.

*Not all Medicaid beneficiaries are eligible for habilitative treatment. Refer to the Therapy Services chapter for complete coverage details.

PA Clinical Documentation Requirements

PA requests must be submitted with a signed, complete OT-PT-ST Prior Approval Request/Authorization Form (MSA-115) and the following required medical documentation:

- **Copy of the most recent evaluation/re-evaluation**. This should include standardized tests and/or objective functional baseline measures used to establish goals and document progress.
- **Summary of previous treatment period**. Include progress on short- and long-term goals, response to treatment, and any factors that have affected progress. Do not send daily treatment notes.
- **Revised goals and justification for any change in the treatment plan**. Goals for the requested period must be measurable, functional, significant to the beneficiary's level of function, time-related as defined in policy, and include corresponding baseline measures.
- **Copy of the prescription**. Including the date range of the requested treatment.
- **Evaluation and treatment plan signed by the therapist and ordering provider**. The plan must include the anticipated type, frequency and duration of therapy required to meet short- and long- term goals and functional outcomes.

Modifiers

- All therapy PA requests and claims must include the appropriate therapy modifier to distinguish the plan of care under which the service is delivered (GN,GO,GP).
- Habilitative therapy PAs and claims must be reported with modifier 96 along with the discipline modifier. Maintenance therapy must be reported with the TS modifier in addition to the discipline modifier.

Third Party Liability/Other Insurance

Federal regulations require state Medicaid agencies to identify other (third party) payers that may be available to pay for the care and services provided to Medicaid beneficiaries and ensure that Medicaid pays secondary to those payers.

◊ Third Party Liability Coordination of Benefits
◊ Additional eligibility resources

Billing Tip!

For services requiring a PA, the information (e.g., PA approval tracking number, CPT, modifier, and quantity) that was approved on the PA request must match the information reported on the claim. Claims Resources

Benefit and PA requirements listed apply only to Medicaid and CSHCS Fee-For-Service (FFS) beneficiaries. MHPs and ICOs must provide the full range of Medicaid covered services but may develop PA requirements and criteria that differ from FFS requirements. ***For beneficiaries enrolled in an MHP or ICO, the provider must check with the beneficiary's health plan.***