MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hearing Aid Dealer 02-02
Hearing and Speech Center 02-02
Home Health 02-02
Hospital 02-02
Practitioner 02-02

Issued: January 2, 2002

Subject: Therapies in Hearing and Speech Center, Home, and Outpatient Hospital Settings
- Occupational Therapy
- Physical Therapy
- Speech-Language Pathology

Clarifications

Effective: As Indicated

Programs Affected: Medicaid, Children's Special Health Care Services

This bulletin and its attachments transmit policy for therapies provided in hearing and speech center, home, and outpatient hospital settings for the Medicaid and Children's Special Health Care Services (CSHCS) fee-for-service programs. **NOTE:** While Medicaid health plans (MHPs) (formerly referred to as qualified health plans [QHPs]) and CSHCS special health plans (SHPs) must offer the same array of services available to the fee-for-service beneficiaries, the plans may establish different prior approval requirements. Providers are responsible for contacting the applicable health plans to determine any prior approval requirements they may have.

The bulletin also clarifies MSA 00-06 bulletin, issued July 1, 2000.

Therapies in Hearing and Speech Center, Home, and Outpatient Hospital Settings

Attachments I, II, and III address occupational therapy, physical therapy, and speech-language pathology (respectively) in hearing and speech center, home, and outpatient hospital settings.

These attachments provide a centralized location for providers to review a detailed explanation of Medicaid's coverage, procedures, and processes. They contain "current operating procedures" as well as some new policy. These policies and procedures are effective for dates of service on and after February 1, 2002.

The following policy items are addressed:

- For outpatient hospital and hearing and speech center settings, prior approval is not required for the first 90 consecutive calendar days of therapy, with a maximum of 36 visits within those 90 days, IF the beneficiary remains Program eligible during the period therapy is provided and a copy of the physician's signed and dated (within 30 days prior to initiation of services) prescription for therapy is on file in the beneficiary's medical record.
- Documentation requirements are detailed.
- Occupational and physical therapy may be provided by a home health agency in the home setting for beneficiaries of all ages. However, therapy may only be provided for 60 consecutive calendar days, with a maximum of 24 visits within those 60 days, before prior approval is required.
- Speech and language rehabilitation services and speech-language therapy may be provided by a Medicaid enrolled home health agency in the home setting for CSHCS beneficiaries in exceptional cases. **NOTE:** Prior approval is required for all speech and language treatment provided in the home (i.e., even the first 60 consecutive calendar days/24 visit period requires prior approval).

Clarification of MSA 00-06 Bulletin

The CSHCS program no longer requires hearing and speech centers or hearing aid dealers to be authorized in the CSHCS eligibility system. The CSHCS program no longer sends the Provider Authorization Notice (Form MG-041) to hearing and speech centers or hearing aid dealers as an authorization of services. Since these provider types are no longer within the provider groups that must be authorized, the Client Eligibility Notice (Form MG-040) sent to the beneficiary does not include them in the list of approved providers. Because of this, the provider may wish to request that the child's family present a copy of the child's Client Eligibility Notice to verify that the child has a CSHCS qualifying diagnosis. **NOTE:** If the provider needs to verify beneficiary eligibility on the date of service, he/she must now contact MediFAX®.

These policies and procedures apply to all children not enrolled in an MHP or SHP (i.e., children covered only by Medicaid on a fee-for-service basis; children covered only by CSHCS on a fee-for-service basis; or children covered by both Medicaid and CSHCS on a fee-for-service basis) needing a hearing aid(s). Medicaid-covered children are no longer required to enroll in CSHCS to obtain a hearing aid(s). Standard hearing aids no longer require prior approval if the requirements presented in MSA 00-06 bulletin are met. Any Medicaid-enrolled hearing and speech center or hearing aid dealer may provide services to a Medicaid- and/or CSHCS-enrolled beneficiary.

1. The provision of service remains the same:

    - If the beneficiary is under 18 years of age, he/she must obtain a signed statement from the otolaryngologist that a medical evaluation indicates that a hearing aid(s) is medically necessary and there are no contraindications to the use of a hearing aid(s). **NOTE:** This statement is referred to as a "medical concurrence."

- If the beneficiary is 18 years of age or older, he/she must obtain a signed statement from an otolaryngologist OR the primary care physician indicating that a hearing aid(s) is medically necessary and there are no contraindications to the use of a hearing aid(s). **NOTE:** This statement is referred to as a "medical concurrence."

2. The beneficiary takes the appropriate medical concurrence to a:

   - Medicaid-enrolled hearing and speech center for beneficiaries under 18 years of age.
   - Medicaid-enrolled hearing and speech center or outpatient hospital for beneficiaries 18 years of age and older.

   After the appropriate audiologic procedures have been completed and it is determined that the beneficiary requires a hearing aid(s), a recommendation for the hearing aid must be completed and signed by the audiologist. This recommendation, as well as a copy of the physician's medical concurrence (both of which must be dated within six months prior to dispensing the hearing aid[s]), are given to the beneficiary along with a list of Medicaid-enrolled hearing aid dealers in the area. **NOTE:** You may obtain a list of Medicaid-enrolled hearing aid dealers in your county (and the surrounding counties) by contacting the Medical Services Administration's Review and Evaluation Division at 1-800-622-0276 or you may fax your request to (517) 335-0075 (please be specific as to which county[ies] you are requesting, and also include the name of a contact person and your fax number). The list does not guarantee that the hearing aid dealer is accepting Medicaid beneficiaries as patients.

3. The beneficiary takes the medical concurrence and audiologist's recommendation to any Medicaid-enrolled hearing aid dealer. If the hearing aid dealer did not provide the previous aid, the dealer may call 1-800-622-0276 to ascertain when the last Medicaid-covered hearing aid was dispensed, because the frequency of Medicaid-covered hearing aids has not changed (i.e., once every three years unless medical necessity warrants a shorter time frame). **NOTE:** If prior approval is required (e.g., the recommended hearing aid is BICROS, the beneficiary does not meet the hearing loss criteria), it is the hearing aid dealer's responsibility to obtain it from the Medical Services Administration.

Administration of a "Hearing Handicap Inventory" was mentioned in bulletin MSA 00-06 but no samples were included. Please refer to attachments IV and V of this bulletin for samples of screening inventories for adults (HHIA-S) and elderly (HHIE-S). These are samples only; providers may have others they prefer to use.

General Clarification

Effective for dates of service on and after October 1, 2000, a 4% increase was applied to procedure codes used by hearing aid dealers and hearing and speech centers. The increase applies to the dispensing fee portion as well as the maximum allowable amount for hearing aid(s), regardless of whether or not the aid(s) required prior approval. For example:

- Procedure Code 90305 has a maximum allowable amount of $650. This allows $221.20 for the dispensing portion and an acquisition cost of up to $428.80.
- Procedure Code 90307 has a maximum allowable amount of $1,248. This allows $380.79 for the dispensing portion and an acquisition cost of up to $867.21.

NOTE: Effective for dates of service on and after February 1, 2002, providers must use appropriate procedure codes and billing requirements presented in bulletins MSA 01-23 and MSA 02-02.

Reimbursement for a hearing aid includes the following items and services (i.e., they may not be billed in addition to the acquisition cost of the hearing aid):

- the original ear impressions and earmold, as required and specified (binaural aids include an additional earmold),
- hearing aid(s),
- hearing aid delivery and orientation,
- one standard package of appropriate batteries per aid (or charger for rechargeable models),
- one-year warranty on parts and labor repairs,
- one-time-per-one-year manufacturer's replacement guarantee (at no cost to the beneficiary, Program, or hearing aid dealer) for a lost, broken, or stolen hearing aid(s),
- a minimum 30-day trial/adjustment period, and
- all necessary components that may include cords, tubing, connectors, receiver, huggies.

Co-payment policies and procedures remain the same.

Manual Maintenance

Retain this bulletin and attachments for future reference.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

James K. Haveman, Jr.
Director

Robert M. Smedes
Deputy Director for
Medical Services Administration

OCCUPATIONAL THERAPY IN OUTPATIENT HOSPITAL AND HOME SETTINGS

The terms "occupational therapy," "therapy," and "OT" are used interchangeably.

Place of Service
Occupational therapy may be provided in the following settings:

- home (provided by a home health agency)
- outpatient hospital

Provider Responsibilities
The home health agency or outpatient hospital must be appropriately enrolled with Medicaid.

The Code of Ethics, Standards of Practice, and Practice Guidelines provided by the American Occupational Therapy Association (AOTA) are available and should serve as the basis of appropriate standard of practice. It is expected that registered occupational therapists (OTRs) and certified occupational therapy assistants (COTAs) will utilize the most ethically appropriate therapy within their scope of practice, as defined by Michigan law and/or the appropriate national professional association.

Coverage Conditions
Services can only be reimbursed as occupational therapy when provided by

- an occupational therapist currently registered in Michigan (OTR)
- a certified occupational therapy assistant (COTA) under the supervision of a currently-Michigan-registered OTR (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). **NOTE:** All documentation must be reviewed and signed by the appropriately registered supervising OTR.
- a student completing his/her clinical affiliation under the direct supervision of (i.e., in the presence of) a currently-Michigan-registered OTR. **NOTE:** All documentation must be reviewed and signed by the appropriately registered supervising OTR.

For CSHCS beneficiaries, OT must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.

For beneficiaries 21 years of age and older, therapy is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.

For all beneficiaries, OT must be medically necessary, reasonable, and required to:

- return the beneficiary to the functional level prior to illness or disability
- return the beneficiary to a functional level that is appropriate to a stable medical status
- prevent a reduction in medical or functional status had the therapy not been provided

It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to the beneficiary's chronologic, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

Therapy must be skilled (i.e., require the skills, knowledge, and education of an OTR). Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT]), family member, or caregiver would not be reimbursable as OT by this Program.

Occupational therapy services may be covered for one or more of the following reasons:

- therapeutic use of occupations*
- adaptation of environments and processes to enhance functional performance in occupations*
- graded tasks (performance components) in activities as prerequisites to engagement in occupations*
- design, fabrication, application, or training in the use of assisted technology or orthotic devices
- skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. **NOTE:** Routine provision of the maintenance/prevention program is not reimbursable as therapy.

Occupational evaluations and therapy are covered when provided by a Medicaid-enrolled home health agency in the home setting when:

- there is a need for adaptation of procedures, equipment, appliance, or prosthesis in the home setting identified by the OTR
- services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse (e.g., registered nurse [RN], nurse practitioner [NP])
- the OTR, LPT, SLP, physician, or treating nurse (e.g., RN, NP) documents problems with access to an outpatient facility, or coordination or continuity of services.

NOTE:

- OT evaluations and therapy services do not require concurrent skilled nursing care but must be provided through a Medicaid-enrolled home health agency.
- If therapy is not initiated within 30 days of the prescription date, a **new** prescription is required.
- OT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.
- The CSHCS specialized home care and CHILDS programs are not affected by allowing OT in the home health setting.

Noncovered Services

For beneficiaries of all ages, occupational therapy is not covered:

- when provided by an independent OTR. **NOTE:** An independent OTR may enroll in Medicaid if he/she provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.
- for educational, vocational, or recreational purposes.
- if services are required to be provided by another public agency (e.g., community mental health services provider, school-based services).
- if therapy that requires prior approval is rendered before prior approval is granted.
- if therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks in the past.
- if therapy is designed to facilitate the normal progression of development without compensatory techniques or processes.

* Occupations are goal-directed activities that extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. EXAMPLES: Doing dishes is a repeated task. Choosing and buying dishes happens once; therefore, does not extend over time. It is a goal-directed activity but is NOT an occupation.

- for development of perceptual motor skills and sensory integrative functions to follow a normal sequence. **NOTE:** If the beneficiary exhibits severe pathology in the perception of or response to sensory input to the extent that it significantly limits the ability to function, OT may be covered.
- continuation of therapy that is maintenance in nature.

If Medicare determines that the service is not medically necessary, Medicaid will also consider the service not medically necessary.

Duplication of Services
Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) will not be covered. It is the OTR's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

Services to School-aged Beneficiaries
School-aged beneficiaries may be eligible to receive OT through multiple sources.

Educational occupational therapy is expected to be provided by the school system, and is not covered by Medicaid or CSHCS. Examples of educational OT are coordination for handwriting, increasing attention span, identifying colors and numbers.

Only medically necessary OT, as defined in this bulletin attachment, may be provided in the outpatient setting or by a home health agency in the home setting. Coordination between all occupational therapy providers should be continuous to ensure a smooth transition between sources.

Prescription Requirements
To be acceptable for Medicaid or CSHCS coverage, a physician's prescription is required for an occupational therapy evaluation and preparation of the treatment plan. The prescription must include:
- name of the beneficiary
- therapy prescribed
- diagnosis(es) or medical condition(s)

If therapy is not initiated within 30 days of the prescription date, a <u>new</u> prescription is required.

Evaluation
Evaluations do not require prior approval. Evaluations are formalized testing in the early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate the disposition of the beneficiary's treatment.

Evaluations may be provided for the same medical diagnosis without prior approval twice in a 365-day period with a physician's prescription. If an evaluation is needed more frequently, prior approval is required. Evaluations must include standardized tests and/or measurable functional baselines.

The occupational therapy evaluation must be completed by an OTR. It must include:
- the treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis (e.g., medical diagnosis of cerebral palsy with contractures being treated)
- OT provided previously, including facility/site, dates, duration, and summary of change
- current therapy being provided to the beneficiary in this or other settings
- medical history as it relates to the current course of therapy
- the beneficiary's current functional status (functional baseline)
- the standardized and other evaluation tools used to establish the baseline and to document progress

- assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function
- assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension)

Treatment Plan
The therapy treatment plan, which is an immediate result of the evaluation, will consist of:

- time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals
- long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy
- anticipated frequency and duration of treatment required to meet short-term and long-term goals
- plan for discharge from service, including the development of follow-up activities/maintenance programs
- a statement detailing coordination of services with other therapies (e.g., medical and educational)
- signature of physician verifying acceptance of the treatment plan. **NOTE:** CSHCS beneficiaries must have a treatment plan signed by the referring specialist physician.

Initiation of Services
Therapy may be initiated without prior approval upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the patient record. For the initial 60-day treatment period, up to 24 OT services may be provided in the home setting. For the outpatient hospital setting, up to 36 OT services may be provided in the initial 90-day treatment period. **NOTE:** If therapy is not initiated within 30 days of the prescription date, a <u>new</u> prescription is required.

<u>Therapy must be provided by the evaluating discipline. For example, a speech-language pathologist cannot provide treatment under an occupational therapist's evaluation. Co-signing of evaluations and sharing treatments would require prior approval</u>.

Prior approval is not required for the initial period of skilled therapy for the first 60 consecutive calendar days in the home setting or the first 90 consecutive calendar days in the outpatient hospital setting for a new treatment diagnosis or new medical diagnosis if:

- the beneficiary remains Program eligible during the period therapy is provided
- a copy of the physician's signed and dated (within 30 days of initiation of services) prescription for occupational therapy is on file in the beneficiary's medical record

Providers may also initiate services without prior approval when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

Requirements for Continued Active Therapy
To request approval to continue therapy beyond the initial 60 or 90 days (as applicable), the OTR must complete an MSA-115 (Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization). The OTR may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting.

Requests to continue active therapy must be accompanied by:

- a treatment summary of the previous period of OT, including measurable progress on each short-term and long-term goal. This should include the treating OTR's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. **NOTE:** Do not send daily treatment notes.
- a progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.

- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- a copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring physician and dated within 30 days prior to initiation of the continued service.
- a discharge plan.

Requests for prior approval may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

After processing, the MSA returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record.

Maintenance/Monitoring Services
In some cases the beneficiary does not require active treatment, but the skills of an OTR are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers or continued follow-up for the fit and function of orthotic or prosthetic devices. Prior approval is NOT required for these types of services for up to four times per 60-day period in the home or 90-day period in the outpatient hospital settings.

Requirements for Prior Approval of Continued Maintenance/Monitoring Services
Prior approval requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The OTR must complete an MSA-115, which must include:

- a service summary including a description of the skilled services being provided. This should include the treating OTR's analysis of the rate of progress and justification for any change in the treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested.
- a comprehensive description or copy of the maintenance/activity plan.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- the anticipated frequency and duration of continued maintenance/monitoring.
- a discharge plan.

Requests for continued maintenance/monitoring may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

Discharge Summary
When the beneficiary is discharged from therapy services, a discharge summary should be on file with the OTR as a mechanism for identifying completion of services and status at discharge. The discharge summary should include:

- dates of service (i.e., initial and discharge dates)
- description of services provided
- functional status related to treatment areas/goals at discharge
- analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status
- description or copy of follow-up or maintenance program put into place, if appropriate
- identification of orthotic/prosthetic and adaptive equipment provided (e.g., hand splint) and its current utilization, if appropriate
- recommendations/referral to other services, if appropriate

Resuming Therapy
If services must be resumed within a 12-month period for the same diagnosis, prior approval is required. A discharge summary for the previous therapy OR an explanation of the changes in functional or medical status must accompany the request. If this information is missing, the Medical Services Administration cannot approve resumption of therapy for the beneficiary. These requests may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

Therapy may be resumed within a 12-month period without prior approval if there are functional changes due to a change in the treatment diagnosis (e.g., decreased active range of motion resulting in an inability to dress the upper extremities).

PHYSICAL THERAPY IN OUTPATIENT HOSPITAL AND HOME SETTINGS

The terms "physical therapy," "PT," and "therapy" are used interchangeably.

Place of Service
Physical therapy may be provided in the following settings:

- home (provided by a home health agency)
- outpatient hospital

Provider Responsibilities
The home health agency or outpatient hospital must be appropriately enrolled with Medicaid.

The Code of Ethics, Standards of Practice, and Practice Guidelines provided by the American Physical Therapy Association (APTA) are available and should serve as the basis of appropriate standard of practice. It is expected that licensed physical therapists (LPTs) and certified physical therapy assistants (CPTAs) will utilize the most ethically appropriate therapy within their scope of practice, as defined by Michigan law and/or the appropriate national professional association.

Coverage Conditions
Services can only be reimbursed as physical therapy when provided by a Michigan-licensed LPT or an appropriately supervised CPTA (i.e., the LPT supervises and monitors the CPTA's performance with continuous assessment of the beneficiary's progress). **NOTE:** All documentation must be reviewed and signed by the appropriately licensed supervising LPT.

For CSHCS beneficiaries, physical therapy must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary. Functional progress must be demonstrated and documented.

For beneficiaries 21 years of age and older, therapy is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations, or participation restrictions.

For all beneficiaries, physical therapy must be medically necessary, reasonable, and necessary to return the beneficiary to the functional level prior to illness or disability or to a functional level that is appropriate to a stable medical status within a reasonable amount of time.

It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform mobility skills appropriate to the beneficiary's chronologic, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

Physical therapy must be skilled (i.e., require the skills, knowledge, and education of an LPT). Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse [RN], registered occupational therapist [OTR]), family member, or caregiver would not be reimbursable as physical therapy by this Program.

Therapy services may be covered for one or more of the following reasons:

- therapy can be expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills.
- the service is diagnostic.
- therapy is for a condition that is temporary in nature and creates decreased mobility.

- skilled services are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. **NOTE:** Routine provision of the maintenance/prevention program is not reimbursable as therapy.

PT may include:

- training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility)
- stretching for improved flexibility
- instruction of family or caregivers
- modalities to allow gains of function, strength, or mobility
- training in the use of orthotic/prosthetic devices

Physical therapy and evaluations are covered when provided by a Medicaid-enrolled home health agency in the home setting when:

- services will prevent undue exposure to infection and stress for the beneficiary, as identified by the physician or treating nurse (e.g., registered nurse [RN], nurse practitioner [NP])
- documented problems of access to an outpatient facility, coordination of services, or continuity of services as identified by an LPT, OTR, SLP, physician, or treating nurse (e.g., RN, NP)

NOTE:

- PT does not require concurrent skilled nursing care but must be provided through a Medicaid-enrolled home health agency.
- If therapy is not initiated within 30 days of the prescription date, a **new** prescription is required.
- PT may be provided up to a maximum of 24 times within the first 60 consecutive calendar days in the home setting without prior approval.

Noncovered Services

For beneficiaries of all ages, PT is not covered:

- when provided by an independent LPT. **NOTE:** An independent LPT may enroll in Medicaid if he/she provides Medicare-covered therapy and intends to bill Medicaid for Medicare coinsurance and/or deductible only.
- for educational, vocational, or recreational purposes.
- if services are required to be provided by another public agency (e.g., community mental health services provider, school-based services).
- if therapy that requires prior approval is rendered before prior approval is granted.
- if therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks in the past.
- if therapy is designed to facilitate the normal progression of development without compensatory techniques or processes.
- for continuation of therapy that is maintenance in nature.
- when therapy is being provided to meet developmental milestones.

If Medicare determines that the service is not medically necessary, Medicaid will also consider the service not medically necessary.

Duplication of Services

Some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) will not be covered. It is the LPT's responsibility to communicate with other therapists and coordinate services. Documentation should include a report of this coordination.

Services to School-aged Beneficiaries
School-aged beneficiaries may be eligible to receive PT through multiple sources.

Educational physical therapy is expected to be provided by the school system, and is not covered by Medicaid or CSHCS. Examples of educational PT are strengthening to play school sports, etc.

Only medically necessary PT, as defined in this bulletin attachment, may be provided in the outpatient setting or by a home health agency in the home setting. Coordination between all physical therapy providers should be continuous to ensure a smooth transition between sources.

Prescription Requirements
To be acceptable for Medicaid or CSHCS coverage, a physician's prescription is required for a physical therapy evaluation and preparation of the treatment plan. The prescription must include:

- name of the beneficiary
- therapy prescribed
- diagnosis(es) or medical condition(s)

If the therapy is not initiated within 30 days of the prescription date, a new prescription is required.

Evaluation
Evaluations do not require prior approval. Evaluations are formalized testing in the early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate the disposition of the beneficiary's treatment.

Evaluations may be provided for the same diagnosis without prior approval twice in a 365-day period with a physician's prescription. If an evaluation is needed more frequently, prior approval is required. Evaluations must include standardized tests and/or measurable functional baselines.

The physical therapy evaluation must be completed by an LPT. It must include:

- the treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait being treated)
- physical therapy provided previously, including facility/site, dates, duration, and summary of change
- current therapy being provided to the beneficiary in this or other settings
- medical history as it relates to the current course of therapy
- the beneficiary's current functional status (i.e., functional baseline)
- the standardized and other evaluation tools used to establish the baseline and to document progress
- assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function
- assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension)

Treatment Plan
The physical therapy treatment plan, which is an immediate result of the evaluation, will consist of:

- time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility
- long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy
- anticipated frequency and duration of treatment required to meet short-term and long-term goals
- plan for discharge from service, including the development of follow-up activities/maintenance programs

- a statement detailing coordination of services with other therapies (e.g., medical and educational)
- signature of physician verifying acceptance of the treatment plan. **NOTE:** CSHCS beneficiaries must have a treatment plan signed by the referring specialist physician.

Initiation of Services
Therapy may be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without prior approval. For this initial period, PT may be provided up to a maximum of 24 times in the 60-day home setting or up to 36 times in the 90-day outpatient hospital setting. **NOTE:** If PT is not initiated within 30 days of the prescription date, a new prescription is required.

Therapy must be provided by the evaluating discipline. For example, an occupational therapist cannot provide treatment under a physical therapist's evaluation. Co-signing of evaluations and sharing treatment would require prior approval.

Prior approval is not required for the initial period of skilled therapy for the first 60 consecutive calendar days in the home setting or the first 90 consecutive calendar days in the outpatient hospital setting for a new treatment diagnosis or new medical diagnosis if:

- the beneficiary remains Program eligible during the period therapy is provided
- a copy of the physician's signed and dated (within 30 days of initiation of services) prescription for physical therapy is on file in the beneficiary's medical record

Providers may also initiate services without prior approval when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

Requirements for Continued Active Therapy
To request approval to continue therapy beyond the initial 60 or 90 days (as applicable), the LPT must complete an MSA-115 (Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization). The LPT may request up to 90 consecutive calendar days of continued active therapy in the outpatient hospital setting or up to 60 consecutive calendar days in the home setting.

Requests to continue active therapy must be accompanied by:

- a treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating LPT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. **NOTE:** Do not send daily treatment notes.
- a progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- a copy of the prescription hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided for each request.
- a discharge plan.

Requests for prior approval may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

After processing, the MSA returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record.

Maintenance/Monitoring Services
In some cases, the beneficiary does not require active treatment, but the skills of an LPT are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. Prior approval is NOT required for these types of services for up to four times per 60-day period in the home setting or 90 days in the outpatient hospital setting.

Requirements for Prior Approval of Continued Maintenance/Monitoring Services
Prior approval requests for continued maintenance/monitoring may ask approval for up to 90 consecutive calendar days in the outpatient setting and up to 60 consecutive calendar days in the home setting. The LPT must complete an MSA-115, which must include:

- a service summary including a description of the skilled services being provided. This should include the treating LPT's analysis of the rate of progress and justification for any change in the treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested.
- a comprehensive description or copy of the maintenance/activity plan.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- a discharge plan.

Requests for continued maintenance/monitoring may ask for up to three months of service and may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

Discharge Summary
When the beneficiary is discharged from PT, it is requested that a discharge summary be on file with the LPT as a mechanism for identifying the completion of services and the status at discharge. The discharge summary should include:

- dates of service (i.e., initial and discharge dates)
- description of services provided
- functional status related to treatment areas/goals at discharge
- analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status
- description or copy of follow-up or maintenance program put into place, if appropriate
- identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate
- recommendations/referral to other services, if appropriate

Resuming Therapy
If services must be resumed within a 12-month period for the same diagnosis, prior approval is required. A discharge summary for the previous therapy OR an explanation of the changes in functional or medical status must accompany the request. If this information is missing, the Medical Services Administration cannot approve resumption of PT for the beneficiary. These requests must be submitted to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

The copy of the MSA-115 returned to the provider should be retained in the beneficiary's medical record.

Therapy may be resumed within a 12-month period without prior approval if there are functional changes due to a change in treatment diagnosis.

SPEECH AND LANGUAGE THERAPY IN HEARING AND SPEECH CENTER, OUTPATIENT HOSPITAL, AND HOME SETTINGS

The terms "speech therapy," "speech-language pathology," "speech-language therapy," and "therapy" are used to mean speech and language rehabilitation services and speech-language therapy.

Place of Service
Speech therapy may be provided in the following settings:

- hearing and speech center
- home (only for Children's Special Health Care Services [CSHCS] beneficiaries) when provided by a home health agency in exceptional cases
- outpatient hospital

Provider Responsibilities
The hearing and speech center or outpatient hospital must be appropriately enrolled with Medicaid.
NOTE: In addition to covering services in these settings, CSHCS may approve and reimburse speech therapy provided through a Medicaid-enrolled home health agency.

The Code of Ethics, Standards of Practice, and Practice Guidelines provided by the American Speech and Hearing Association (ASHA) are available and should serve as the basis of appropriate standard of practice. It is expected that all speech-language pathologists (SLPs) will utilize the most ethically appropriate therapy within their scope of practice, as defined by Michigan law and/or the appropriate national professional association.

Coverage Conditions
Services can only be reimbursed as speech-language therapy when provided by:

- a speech-language pathologist possessing a current Certificate of Clinical Competence (CCC) or Letter of Equivalency
- an appropriately supervised SLP candidate (i.e., in his/her clinical fellowship year [CFY] or having completed all requirements but has not obtained a CCC or Letter of Equivalency). **NOTE:** All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- a student completing his/her clinical affiliation under the direct supervision of (i.e., in the presence of) an SLP having a current CCC or Letter of Equivalency. **NOTE:** All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

For Medicaid beneficiaries (i.e., those not enrolled with CSHCS) under 21 years of age, therapy must be obtained from a Medicaid enrolled hearing and speech center.

For CSHCS beneficiaries (i.e., those not enrolled in Medicaid; only enrolled with CSHCS), speech therapy must be directly related to the CSHCS eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary.

For Medicaid beneficiaries 21 years of age and older, therapy may be provided by an outpatient hospital or a hearing and speech center.

For all beneficiaries, speech therapy must relate to a medical diagnosis. Coverage is limited to services for:

- articulation
- language
- rhythm
- swallowing
- training in the use of an augmentative communication device

- training in the use of an oral-pharyngeal prosthesis
- voice

Therapy must be reasonable, medically necessary, and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the therapy not provided.

Speech therapy services must be skilled (i.e., they must require the skills, knowledge, and education of a certified speech-language pathologist to assess the beneficiary for deficits, develop a treatment program, and provide therapy). Interventions that could be expected to be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [LPT], registered occupational therapist [OTR]), family member, or caregiver would not be reimbursable as speech therapy by this Program.

Coverage Criteria in the Home Setting
In exceptional cases, speech evaluations and therapy are covered for CSHCS beneficiaries when:

- there is a need for adaptation of procedures or equipment in the home setting as identified by an SLP
- services will prevent undue exposure to infection and stress for a child at risk, as identified by the physician or treating nurse (e.g., registered nurse [RN], nurse practitioner [NP])
- documented problems of access to an outpatient hospital, coordination of services, or continuity of service is identified by an SLP, OTR, LPT, physician, or treating nurse (e.g., RN, NP)
- prior approval is obtained (this includes therapy for the initial 60 consecutive calendar days, continued active treatment, and maintenance/monitoring services).

NOTE:

- Speech-language evaluations and therapy services do not require concurrent skilled nursing care; however, **treatment always requires prior approval** and must be provided through a Medicaid-enrolled home health agency.
- If therapy is not initiated within 30 days of the prescription date, a **new** prescription is required.
- Therapy may be requested for up to 60 consecutive calendar days in the home setting.

Noncovered Services
For beneficiaries of all ages, therapy is not covered:

- when provided by an independent SLP
- for educational, vocational, social/emotional, or recreational purposes
- if services are required to be provided by another public agency (e.g., community mental health services provider, school-based services)
- when intended to improve communication skills beyond premorbid levels (i.e., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status)
- if it requires prior approval but is rendered before prior approval is granted
- if it is habilitative. Habilitative treatment includes teaching someone communication skills for the first time without compensatory techniques or processes. This may include syntax of semantics (which are developmental) or articulation errors that are within the normal developmental process.
- if it is designed to facilitate the normal progression of development without compensatory techniques or processes
- if continuation is maintenance in nature
- if provided to meet developmental milestones

If Medicare determines that the service is not medically necessary, Medicaid will also consider the service not medically necessary.

Duplication of Services
Some areas of service (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., occupational therapy, physical therapy, speech-language therapy) in more than one setting. Duplication of service (i.e., where two disciplines are working on similar areas/goals) will not be covered. It is the treating therapist's responsibility to communicate with other practitioners and coordinate services. Documentation should include a report of this coordination.

Services to School-aged Beneficiaries
School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources.

Educational speech is expected to be provided by the school system, and is not covered by Medicaid or CSHCS. Examples of educational speech are enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, identifying colors and numbers.

Only medically necessary speech-language therapy, as defined in this bulletin attachment, may be provided in the outpatient setting (or by a home health agency in the home for a CSHCS beneficiary). Coordination between all speech-language therapy providers should be continuous to ensure a smooth transition between sources.

Prescription Requirements
To be acceptable for Medicaid or CSHCS coverage, a prescription for therapy must include:

- name of the beneficiary
- therapy prescribed
- diagnosis(es) or medical condition(s)

NOTE: If therapy is not initiated within 30 days of the prescription date, a <u>new</u> prescription is required.

Evaluation
Evaluations do not require prior approval. Evaluations are formalized testing in the early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate the measurable functional change resulting from the beneficiary's treatment.

Evaluations may be provided for the same diagnosis without prior approval twice in a 365-day period with a physician's prescription. If an evaluation is needed more frequently, prior approval is required. Evaluations must include standardized tests and/or measurable functional baselines.

The speech-language evaluation must be completed by an SLP. It must include:

- the disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphagia as the speech disorder being treated)
- speech therapy provided previously, including facility/site, dates, duration, and summary of measurable change
- current rehabilitation services being provided to the beneficiary in this or other settings
- medical history as it relates to the current course of therapy
- the beneficiary's current functional communication status (functional baseline)
- the standardized and other evaluation tools used to establish the baseline and to document progress
- assessment of the beneficiary's functional communication skill level, which must be measurable
- medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy

Evaluations may include, but are not limited to:

- Articulation – standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis.
- Language – standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es).
- Rhythm – standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication, and a medical diagnosis.
- Swallowing – copy of the videofluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment.
- Voice – copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.

Treatment Plan
The speech-language therapy treatment plan, which is an immediate result of the evaluation, will consist of:

- time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication needs
- long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services
- anticipated frequency and duration of treatment required to meet short-term and long-term goals
- plan for discharge from service, including the development of follow-up activities/maintenance programs
- a statement detailing coordination of services with other therapies (e.g., medical and educational)
- signature of physician verifying acceptance of stated treatment plan. **NOTE:** CSHCS beneficiaries must have a treatment plan signed by the referring specialist physician.

Initiation of Services for Outpatient Hospital and Hearing and Speech Center Settings
Therapy may be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without prior approval. For this initial period, speech may be provided up to a maximum of 36 times during the 90 consecutive calendar days in the hearing and speech center or outpatient hospital. **NOTE:** If therapy is not initiated within 30 days of the prescription, a new prescription is required.

Therapy must be provided by the evaluating discipline. For example, an occupational therapist cannot provide treatment under a speech-language pathologist's evaluation. Co-signing of evaluations and sharing treatments would require prior approval.

Prior approval is not required for the initial period of skilled therapy for the first 90 consecutive calendar days in the outpatient hospital or hearing and speech center for a new treatment diagnosis or new medical diagnosis if:

- the beneficiary remains Program eligible during the period services are provided
- a copy of the physician's signed and dated (within 30 days of initiation of services) prescription for speech-language therapy is on file in the beneficiary's medical record

Providers may also initiate services without prior approval when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.

Requirements for Continued Active Treatment for ALL Settings
To request approval to continue therapy beyond the initial 60 or 90 days (as applicable), the SLP must complete a prior approval request (the applicable form depending upon the setting).

- MSA-1653-B (Special Services Prior Approval – Request/Authorization) must be used for the hearing and speech center setting.
- MSA-115 (Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization) must be used for the outpatient hospital setting and services requested through a home health agency for CSHCS.

The SLP may request up to 90 consecutive calendar days of continued active therapy in the hearing and speech center or outpatient hospital settings or up to 60 consecutive calendar days for the CSHCS beneficiary receiving therapy in the home setting.

Requests to continue active treatment must be accompanied by:

- a treatment summary of the previous period of service, including measurable progress on each short-term and long-term goal. This should include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. **NOTE:** Do not send daily treatment notes.
- a progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
- documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate.
- the anticipated frequency and duration of maintenance/monitoring
- a discharge plan.
- a copy of the prescription hand-signed by the referring physician and dated within 30 days prior to initiation of continued service must be provided for each request.

Requests for prior approval may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

After processing, the MSA returns a copy of the prior approval. This copy should be retained in the beneficiary's medical record.

Maintenance/Monitoring Services
In some cases, the beneficiary does not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by family and/or caregivers. In the outpatient hospital or hearing and speech center, these types of service may be provided without prior approval for up to four times per 90-day period. For the home setting, these types of services require prior approval for a 60-day period.

Requirements for Approval of Continued Maintenance/Monitoring Services
Continued maintenance/monitoring requires prior approval in all settings. The SLP must complete the prior approval request, which must include:

- a service summary including a description of the skilled services being provided. This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. Documentation must relate to the period immediately prior to that time period for which prior approval is being requested. It can cover up to three months.
- a comprehensive description or copy of the maintenance/activity plan
- a statement of the beneficiary's response to treatment, including factors that have affected progress during this interim
- a statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate
- the anticipated frequency and duration of continued maintenance/monitoring
- a discharge plan

Requests for continued maintenance/monitoring may be mailed to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

The copy of the PA request returned to the provider should be retained in the beneficiary's medical record.

Discharge Summary
When the beneficiary is discharged from therapy services, it is requested that a discharge summary be on file with the SLP as a mechanism for identifying completion of services and status at discharge. The discharge summary should include:

- dates of service (i.e., initial and discharge dates)
- description of services provided
- functional status related to treatment areas/goals at discharge
- analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status
- description or copy of follow-up or maintenance program put into place, if appropriate
- identification of adaptive equipment provided and its current utilization, if appropriate
- recommendations/referral to other services, if appropriate

Resuming Therapy
If services must be resumed within a 12-month period for the same diagnosis, prior approval is required. A discharge summary of the previous therapy OR an explanation of the changes in functional or medical status must accompany the request. If this information is missing, the Medical Services Administration cannot approve resumption of speech therapy for the beneficiary. These requests must be submitted to:

TECHNICAL ASSISTANCE SECTION
REVIEW AND EVALUATION DIVISION
QUALITY IMPROVEMENT AND CUSTOMER SERVICES BUREAU
PO BOX 30170
LANSING MI 48909-7670

OR

FAXED TO: (517) 335-0075

The original copy of the approved prior authorization request must be retained in the beneficiary's medical record.

Therapy may be resumed within a 12-month period without prior approval if there are functional changes due to a change in the treatment diagnosis.

Hearing Handicap Inventory – Screening Version (HHIA-S)

Sample

The purpose of this scale is to identify the problems your hearing loss may cause you. Circle Yes, Sometimes or No for each question. Do not skip a question if you avoid a situation because of your hearing problem.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?
   Yes Sometimes No
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?
   Yes Sometimes No
3. Do you have difficulty hearing or understanding co-workers, clients or customers?
   Yes Sometimes No
4. Do you feel handicapped by a hearing problem?
   Yes Sometimes No
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?
   Yes Sometimes No
6. Does a hearing problem cause you difficulty in the movies or in the theatre?
   Yes Sometimes No
7. Does a hearing problem cause you to have arguments with family members?
   Yes Sometimes No
8. Does a hearing problem cause you difficulty when listening to TV or radio?
   Yes Sometimes No
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
   Yes Sometimes No
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
    Yes Sometimes No

Hearing Handicap Inventory – Screening Version (HHIE-S)

Sample

The purpose of this scale is to identify the problems your hearing loss may cause you. Circle Yes, Sometimes or No for each question. Do not skip a question if you avoid a situation because of your hearing problem.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?
   Yes Sometimes No
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?
   Yes Sometimes No
3. Do you have difficulty hearing when someone speaks in a whisper?
   Yes Sometimes No
4. Do you feel handicapped by a hearing problem?
   Yes Sometimes No
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?
   Yes Sometimes No
6. Does a hearing problem cause you to attend religious services less often than you would like?
   Yes Sometimes No
7. Does a hearing problem cause you to have arguments with family members?
   Yes Sometimes No
8. Does a hearing problem cause you difficulty when listening to TV or radio?
   Yes Sometimes No
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
   Yes Sometimes No
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
    Yes Sometimes No