MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-29

Distribution: Practitioners, Local Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Medicaid Health Plans, Tribal Health Centers, Hearing Aid Dealers, Hearing Centers, Outpatient Hospitals, Nursing Facilities, Home Health Providers

Issued: August 31, 2018

Subject: Enrollment and Reimbursement Changes for Occupational Therapists, Physical Therapists, Speech-Language Pathologists, and Audiologists; New Medicaid Provider Manual Therapy Services Chapter; Revised Therapy Prior Authorization Form (MSA-115); Therapy Service Modifier Update

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, MIChild, Maternity Outpatient Medical Services, Children's Waiver, Serious Emotional Disturbance (SED) Waiver

The purpose of the bulletin is to notify providers of enrollment and reimbursement changes for Occupational Therapists (OT), Physical Therapists (PT), Speech-Language Pathologists (SLP), and Audiologists. The bulletin also introduces a new Therapy Services chapter in the Medicaid Provider Manual, revises the Michigan Department of Health and Human Services (MDHHS) Occupational Therapy – Physical Therapy – Speech Therapy Prior Approval Request/Authorization (MSA-115), and updates the modifier requirements for therapy services. The new chapter and updated MSA-115 form are attached.

This policy applies to Medicaid fee-for-service (FFS) beneficiaries. For beneficiaries enrolled in a Medicaid Health Plan, providers should contact the individual health plan for enrollment, coverage, and reimbursement information.

I. Provider Enrollment and Reimbursement Changes

A. Occupational and Physical Therapists

Medicaid currently only enrolls OTs and PTs in private practice for reimbursement of the Medicare co-insurance and deductible on behalf of dual eligible (Medicare/Medicaid) beneficiaries. Effective for dates of service on and after January 1, 2018, MDHHS will enroll and directly reimburse private practice OTs and PTs serving any eligible Medicaid beneficiary, including Medicaid-only beneficiaries.

B. Speech-Language Pathologists

Effective January 1, 2018, licensed SLPs can enroll in the MDHHS Community Health Automated Medicaid Processing System (CHAMPS) and be directly reimbursed for covered speech-language services provided to eligible Medicaid beneficiaries.

C. Audiologists

Effective January 1, 2018, licensed audiologists can enroll in CHAMPS to be directly reimbursed for covered audiology services provided to eligible Medicaid beneficiaries. Audiologists are no longer required to affiliate with a freestanding hearing center as a condition of enrollment.

D. Provider Requirements and Enrollment

All providers must be properly enrolled through CHAMPS prior to rendering, ordering, or billing for covered services. Individual practitioners are eligible to enroll as either a Rendering/Servicing-only Provider or an Individual/Sole Provider. Private practice providers may work in a sole or group practice.

Providers in Michigan must be currently licensed by the Department of Licensing and Regulatory Affairs. Out-of-state providers must be currently licensed by the appropriate standard-setting authority in the state where they are practicing and must comply with Michigan Medicaid's policy requirements regarding the provision of out-of-state services.

Occupational and physical therapy assistants, individuals in their clinical fellowship year, or students completing their clinical affiliation are not eligible to enroll as providers or be directly reimbursed by Medicaid. Services provided by these individuals must be performed under the supervision of an enrolled licensed provider of the same profession. As defined in Section 333.16109 of the Public Health Code (Public Act 368 of 1978), students completing their clinical affiliation must provide services under the direct supervision of a licensed provider of the same profession. Services are billed to Medicaid with the National Provider Identifier (NPI) of the supervising provider.

Tribal Health Centers Only – To comply with 42 CFR 431.110, licensed health professionals employed by a Tribal Health Program must be licensed and in good standing in at least one state, but do not need to be licensed in the state where they are practicing.

Refer to the Medicaid Provider Manual, General Information for Providers Chapter, for information about provider enrollment procedures and regulations. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. Additional information regarding provider enrollment is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Provider Enrollment, or by contacting Provider Support at 800-292-2550.

E. Reimbursement

Effective for dates of service on and after January 1, 2018, private practice OTs, PTs, SLPs, and audiologists are eligible for direct reimbursement of covered services delivered in accordance with medical guidelines, Medicaid policy, and within their professional scope of practice to eligible Medicaid beneficiaries. Rates for services are established through a fee schedule which is published on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Therapies. For additional coverage and billing information, providers should refer to the Medicaid Provider Manual or the Medicaid Code and Rate Reference tool accessible via the External Links menu within CHAMPS.

II. New Therapy Chapter

In addition to the enrollment and reimbursement changes described above, this bulletin provides notification of the elimination of the therapy sections in the Nursing Facility and Home Health chapters of the Medicaid Provider Manual. Information contained in those sections, along with information from the Outpatient Therapy chapter, has been combined into a new Therapy Services chapter. The new chapter contains updated language and policy clarification effective October 1, 2018.

A. Maintenance Visits

The skills of a therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits are covered up to four times per 90-day period in an outpatient or nursing facility and should be billed using the appropriate therapy re-evaluation Current Procedural Terminology (CPT) code. Maintenance visits in a home care setting are covered up to four times per 60-day period and should be billed with the appropriate home therapy visit code. Maintenance visit claims must include the appropriate therapy modifiers along with the TS modifier to identify the service as maintenance related.

B. Serial Casting

Serial casting may be covered when performed by, or under the direct supervision of, a qualified PT or OT and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone.

Effective for dates of service on or after October 1, 2018, MDHHS will discontinue the use of procedure code 97760 to identify serial casting services. Serial casting should be reported using CPT code 97140 along with appropriate therapy modifiers.

C. Additional Key Changes

Providers should note the following additional key changes in the Therapy Services chapter effective October 1, 2018:

- Prescription requirements for therapy services have been updated and clarified.
- Providers wishing to serve Children's Special Health Care Services (CSHCS) beneficiaries are no longer required to submit resumes to the Program Review Division. Outpatient therapy providers should refer to the Children's Special Health Care Services chapter of the Medicaid Provider Manual for information specific to CSHCS beneficiaries and CSHCS provider requirements.
- Outpatient therapy treatment periods have been changed from a 12-consecutive month period to a calendar year.

III. Revised Therapy Prior Authorization Form (MSA-115)

The Occupational Therapy–Physical Therapy–Speech Therapy Prior Approval Request/Authorization form (MSA-115) is being revised to coincide with the new Therapy Services chapter. Providers should begin using the updated form for services provided on or after October 1, 2018.

IV. Therapy Service Modifier Update

Effective October 1, 2018, therapy services furnished to all beneficiaries must be billed with the appropriate modifier to distinguish the discipline under which the service is delivered. Modifiers GP, GO, or GN should be used to identify physical, occupational, or speech-language therapy services respectively. Services should also be reported with the appropriate modifier that represents the nature of the therapy performed. Modifier 96 should be used to identify habilitative therapy and modifier 97 should be used to identify rehabilitative therapy.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kathy Stiffler, Acting Director
Medical Services Administration

Attachments

Michigan Department of Health and Human Services
Completion Instructions for MSA-115
Occupational Therapy - Physical Therapy - Speech Therapy
Prior Approval Request/Authorization

General Instructions

The MSA-115 must be used by Medicaid-enrolled outpatient hospitals, outpatient therapy providers, nursing facilities and home health agencies to request prior authorization (PA) for therapy services. MDHHS requires that the MSA-115 be typewritten, handwritten forms will not be accepted. Fill-in enabled copies of this form can be downloaded from the Michigan Department of Health and Human Services (MDHHS) website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The PA request must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary.

PA may be authorized for a period not to exceed six months for outpatient therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities. If continued treatment is necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is determination is received.

For complete information on covered services, PA, and documentation requirements, refer to the Therapy Services Chapter of the Michigan Medicaid Provider Manual located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

Attachments/Additional Documentation

All additional attachments/documentation submitted with the request must contain the beneficiary name and **mihealth** card number, provider name and address, and the provider's National Provider Identifier (NPI) number.

When requesting the initial PA, the provider must attach a copy of the initial evaluation and treatment plan to the PA request.

Form Completion

The following fields must be completed unless stated otherwise:

Box Number(s)	Instructions
Box 1	MDHHS use only.
Box 2 - 3	The Medicaid enrolled provider's name and NPI.
Box 4 - 6	The provider's telephone number (including area code), address and fax number (including area code).
Box 7- 10	The beneficiary's name (last, first, and middle initial), sex, **mihealth** card number, and birth date (in the eight-digit format: MM/DD/YYYY). The information should be taken directly from the **mihealth** card and should be verified through the Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction).
Box 11	The date the beneficiary was most recently admitted to the hospital or facility.
Box 12	Enter the beneficiary's diagnosis(es) code(s) and description(s) that relate to the service being requested.
Box 13	The date of onset must be entered. The approximate date of exacerbation must be cited if the beneficiary has a chronic disease (e.g., arthritis) and recently suffered such exacerbation.
Box 14 -16	The therapist's name, office telephone number (including area code), and applicable license/certification number.
Box 17	**Initial:** The treatment authorization request is the initial prior authorization request for the beneficiary under this treatment plan. **Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under the treatment plan.
Box 18	The date MDHHS approved the last approved prior authorization request for the given diagnosis.
Box 19	The requested date range for which treatment is to be rendered, in a eight-digit format (e.g mm/dd/yyyy to mm/dd/yyyy).

Box Number(s)	Instructions
Box 20	The date treatment was started for the given diagnosis (if treatment was initiated previously).
Box 21	The total number of sessions rendered since the development of the treatment plan.
Box 22	Goals must be measurable. In functional terms, the provider's expectation for the beneficiary's ultimate achievement and the length of time it will take (e.g., ambulation unassisted for 20 feet; able to dress self within 15 minutes; oral expression using 4-5 word phrases to express daily needs). See Medicaid Provider Manual for additional documentation requirements.
Box 23	Documentation of the beneficiary's progress from the prior period to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of the beneficiary's nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel. See Medicaid Provider Manual for additional documentation requirements.
Box 24	Indicate if the beneficiary is receiving therapy services through school-based services program.
Box 25	Indicate the treatment plan frequency (e.g., 1x/week, 3x/week, 1x/month, etc.) and duration per visit in 15-minute increments, i.e., units (e.g. 2 units/visit, 4 units/visit, etc.).
Box 26	Complete a separate line for each unique HCPCS code/modifiers combination.
Box 27	The Therapies Database on the MDHHS website lists the HCPCS codes that describe covered services. The database is located at the MDHHS website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
Box 28	The Billing & Reimbursement Chapter in the Medicaid Provider Manual list the required modifiers used to describe covered services for therapy providers. The Medicaid Provider Manual is located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters, & Forms >> Medicaid Provider Manual.
Box 29	The total number of units the service is to be provided during the requested treatment period.
Box 30	The authorized prescribing practitioner must indicate if this is an initial certification or a re-certification and sign and date. Signature is required each time a request is made.
Box 31	The therapist certification is the signature of an authorized representative. The business office of a hospital may designate the director of the department providing the service as its representative. All unsigned requests will be returned for signature.
Box 32-35	MDHHS use only.

Form Submission:
PA request forms for all eligible Medicaid beneficiaries must be submitted electronically*, mailed or faxed to:

MDHHS – Program Review Division
P.O. Box 30170
Lansing, Michigan 48909
Fax Number: **(517) 335-0075**

If submitting electronically, the completed MSA-115 must be uploaded along with the supporting clinical documentation required.

To check the status of a PA request, contact the Program Review Division via telephone at **1-800-622-0276** or electronically via the **CHAMPS Provider Portal** located at https://milogintp.michigan.gov.

Authority: Title XIX of the Social Security Act.	**Completion**: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.	

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCCUPATIONAL THERAPY - PHYSICAL THERAPY – SPEECH THERAPY
PRIOR APPROVAL REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment. All fields must be completed and typewritten.

2. TREATMENT SITE (Medicaid enrolled provider's name)	3. PROVIDER NPI NUMBER	4. PHONE NUMBER
5. ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		6. FAX NUMBER

7. BENEFICIARY NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. MIHEALTH CARD NUMBER	10. BIRTH DATE	11. ADM. DATE

12. ICD DIAGNOSIS(ES) CODE(S) AND DESCRIPTION(S) TO BE TREATED/EVALUATED	13. ONSET DATE

14. THERAPIST NAME (LAST, FIRST, MIDDLE INITIAL)	15. OFFICE PHONE NUMBER	16. LICENSE/CERTIFICATION NUMBER

17. TREATMENT AUTHORIZATION REQUEST ☐ INITIAL ☐ CONTINUING	18. LAST AUTHORIZATION	19. TREATMENT MONTHS / / to / /	20. DATE STARTED	21. # PREV. SESSIONS

22. GOALS (NOTE: SEE MEDICAID PROVIDER MANUAL FOR ADDITIONAL DOCUMENTATION REQUIREMENTS.)

SHORT TERM GOALS	LONG TERM GOALS

23. PROGRESS SUMMARY (NOTE: SEE MEDICAID PROVIDER MANUAL)

24. SCHOOL THERAPY PROGRAMS ☐ YES ☐ NO

25. TREATMENT REQUESTED
FREQUENCY:
DURATION VISIT: (UNITS)

26. LINE NO.	27. PROCEDURE CODE	28. MODIFIER	29. TOTAL UNITS PER PA
01			
02			
03			
04			
05			

30. PHYSICIAN CERTIFICATION

I certify ☐ re-certify ☐ that I have examined the patient named above and have determined that skilled therapy is necessary; that services will be furnished on an in-patient and/or out-patient basis while the patient is under my care; that I approve the above treatment goals and will review every 60 days or more frequently if the patient's condition requires.

PRESCRIBING PRACTITIONER'S NAME (TYPE OR PRINT)

PRESCRIBING PRACTITIONER'S SIGNATURE DATE

MDHHS USE ONLY

32. REVIEW ACTION:
- APPROVED ☐
- RETURNED ☐
- DENIED ☐
- NO ACTION ☐
- APPROVED AS AMENDED ☐

33. AUTHORIZATION PERIOD APPROVED

34. CONSULTANT REMARKS

☐ See CHAMPS

31. THERAPIST CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

THERAPIST'S SIGNATURE DATE

35. CONSULTANT SIGNATURE DATE

THERAPY SERVICES

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Private Practice, Outpatient, Nursing Facility, and Home Health Agency therapy providers.

The term Medicaid throughout this chapter refers to all programs administered by MDHHS unless specifically stated otherwise. The primary objective of Medicaid is to ensure that essential health care services are made available to those individuals who would not otherwise have the financial resources to purchase them. Policies are aimed at maximizing medically necessary health care services available to eligible Medicaid beneficiaries.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services related to a CSHCS qualifying diagnosis as recommended by a CSHCS authorized subspecialist. Providers should refer to the Children's Special Health Care Services chapter of this manual for information specific to CSHCS only beneficiaries.

1.1 SERVICE PROVISION

Therapy may be provided by Medicaid-enrolled providers when performed by properly credentialed/licensed or appropriately supervised professionals in the following settings:

- Occupational Therapy (OT) and Physical Therapy (PT)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - Commission on Accreditation of Rehabilitation Facilities (CARF)-Accredited Outpatient Medical Rehabilitation Program
  - Physical Therapist or Occupational Therapist in Private Practice
  - Physician's Office/Clinic
  - Optometrist's Office
  - Nursing Facility
  - Home Health Agency
- Speech-Language Therapy (ST)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - CARF-Accredited Outpatient Medical Rehabilitation Program
  - Council on Academic Accreditation (CAA)-Accredited University Graduate Education Program
  - Speech-Language Pathologist in Private Practice

- Physician's Office/Clinic
- Nursing Facility
- Home Health Agency

Medicaid covers medically necessary rehabilitative therapy services for beneficiaries of all ages. Rehabilitative services include teaching or training someone to perform or develop a level of reasonable functional proficiency of tasks or skills that were previously learned, with or without compensatory strategies. Examples may include, but are not limited to:

- PT to regain functional ambulation using a cane following a stroke, or to advance from ambulation with an assistive device/physical assistance to ambulation without an assistive device or physical assistance;
- OT to achieve independent dressing following a spinal cord injury, or to develop dressing independence without an assistive device or physical assistance;
- Speech-Language Pathology (SLP) to improve articulation and fluency following a traumatic brain injury or develop communication skills utilizing an augmentative communication strategy.

Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. Habilitation therapy includes teaching/training someone to perform/develop a level of reasonable functional proficiency of a task that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes. Examples may include, but are not limited to:

- PT for a child who is not walking at a typically expected age.
- OT teaching normal dressing skills beyond the typically expected age of learning.
- SLP for communication skills including articulation errors beyond the typically expected age of learning or syntax and semantics for a person with significant hearing impairment.

Documentation must objectively support the request for rehabilitative and/or habilitative therapy.

1.2 Therapy Database

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the MDHHS Therapies Database on the MDHHS website or the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS). (Refer to the Directory Appendix for website information.) The database includes covered private practice, outpatient, nursing facility, and home health therapy codes, applicable limits, and prior authorization requirements.

1.3 Documentation in Beneficiary Medical Record

Therapy providers must retain all applicable documentation in the beneficiary's medical record for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the service performed.

1.4 Practitioner Signatures

In all documentation requiring a signature, the signature must be hand written by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of "signature on file" will not be accepted. NOTE: An electronic signature must specifically identify and authenticate the individual practitioner. This applies to signatures for ordering, referring, and treating practitioners.

1.5 Modifiers

Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. To differentiate between habilitative and rehabilitative therapy, services should also be reported with the appropriate modifier that represents the nature of the therapy being performed. Only Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. In addition to these modifiers, maintenance therapy services should be billed with the MDHHS identified modifier to categorize the service as maintenance related.

Therapy services submitted without these modifiers may be denied. Refer to the Billing and Reimbursement chapters in this manual for additional modifier information.

1.6 Reimbursement

Reimbursement structure is based on the provider's enrollment type. Reimbursement methodologies include the MDHHS Outpatient Prospective Payment System or the Medicaid fee screens. (Refer to the Medicaid Code and Rate Reference tool in CHAMPS or the MDHHS Therapies Database on the MDHHS website.) For Not Otherwise Classified codes or covered codes without established fee screens, the authorized reimbursement amount is indicated on the approved prior authorization request.

SECTION 2 – PROVIDER REQUIREMENTS

2.1 OUTPATIENT HOSPITALS

Outpatient OT, PT and ST services may be provided to beneficiaries of all ages in the outpatient hospital.

2.2 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and rehab agencies may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. All CORFs and rehab agencies must provide proof of Medicare certification when enrolling in Medicaid.

2.3 COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES-ACCREDITED OUTPATIENT MEDICAL REHABILITATION PROGRAMS

Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited outpatient medical rehabilitation programs may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. The program must not be part of, or owned by, a hospital, CORF or rehab agency. All CARF-accredited outpatient medical rehabilitation programs must provide proof of their current CARF accreditation when enrolling in Medicaid.

2.4 NURSING FACILITY

A Medicaid-certified nursing facility (NF) is defined as a nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

In situations where the therapist is not an employee of the facility, the facility must establish a valid contract with a therapist/speech-language pathologist who meets applicable licensure/certification/accreditation requirements. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

2.5 HOME HEALTH AGENCY

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, OT, PT, ST and home health aide services. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid conditions of participation.

OT, PT, and ST services may be provided by an HHA if Medicare/Medicaid conditions of participation, including medical necessity, are met. A therapist in the home health setting may be responsible for supervision of the home health aide. Refer to the Home Health chapter for additional information.

2.6 UNIVERSITY AFFILIATED SPEECH-LANGUAGE PATHOLOGY GRADUATE EDUCATION PROGRAMS

University graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation (CAA) in Audiology and Speech-Language Pathology may enroll with Medicaid for reimbursement of outpatient speech-language therapy provided

by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF or rehab agency. All university programs must provide proof of their current ASHA-CAA when enrolling in Medicaid.

2.7 Physical Therapists, Occupational Therapists, and Speech-Language Pathologists' Private Practice

PT, OT, and ST services may be provided to beneficiaries of all ages when provided by a Medicaid enrolled physical therapist, occupational therapist, or speech-language pathologist employed by an individual/sole, partnership, or group practice. These providers are eligible for direct reimbursement.

2.8 Physician's Office or Clinic

PT, OT, and ST services may be provided to beneficiaries of all ages in a physician's office or one of the following clinics: Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department.

SECTION 3 – PRIOR AUTHORIZATION REQUESTS

Prior authorization is required for certain therapy services before the services are rendered. To determine which therapy services require prior authorization, refer to the Standards of Coverage and Service Limitations Section of this chapter, the Medicaid Code and Rate Reference tool in CHAMPS, or the MDHHS Therapies Database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Prior authorization is not required for the first 60-days of home health therapy if the beneficiary has not received home therapy within the last year (365 consecutive days from the date of service) and services do not exceed the visit maximum. If a beneficiary has previously received home health therapy and services were provided more than 60 days ago but less than 365 days, authorization is needed.

Prior authorization (PA) is needed when therapy limits are exceeded regardless of diagnosis.

PA may be authorized for a period not to exceed six months for outpatient and private practice therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities.

Nursing facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or coinsurance amounts when Medicare approves the services.

If a beneficiary is approved for ventilator care and requires therapy, prior authorization for the therapy must be obtained under the Ventilator Dependent Care Unit (VDCU) National Provider Identification (NPI).

Prior authorization requests must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Required medical documentation must accompany the form.

The information on the MSA-115 must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including the appropriate HCPCS procedure codes, must be provided on the form. The form and all documentation must include the beneficiary's name and **mihealth** card ID number, provider name and address, and the provider's NPI number.

Whenever a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request.

Prior authorization requests should be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested and a modifier that represents the nature of the therapy being requested (habilitative vs rehabilitative therapy). Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information.

For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-115 must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a prior authorization request in CHAMPS or

by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)

Prior authorization requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-115 must be attached to each electronic prior authorization request.

A copy of the prior authorization determination letter must be retained in the beneficiary's medical record.

3.1 Emergency / Verbal Prior Authorization

A provider may contact MDHHS to obtain a verbal prior authorization when the prescribing practitioner (practicing within their scope of practice as defined by state law) has indicated that it is medically necessary to provide therapy services without delay. If a therapy service is required during MDHHS nonworking hours, providers must contact the Program Review Division the next working day.

To obtain verbal prior authorization, providers may call or fax a request to the Program Review Division. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for a copy of form MSA-115 and completion instructions.) If the provider faxes a request, the request must state "verbal prior authorization required."

The following steps must be completed before a prior authorization number is issued for billing purposes:

- The verbal authorization date must be entered on the MSA-115 or electronically in CHAMPS via FFS DDE.
- The MSA-115 or FFS DDE prior authorization request must be submitted to the Program Review Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted with the prior authorization request.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible for Medicaid when the therapy service was provided.
- The Program Review Division does not receive the completed MSA-115 and documentation within 30 days of the verbal authorization.
- The prescription is dated after the date the verbal authorization was requested.

3.2 Retroactive Prior Authorization

Therapy services provided before prior authorization is requested will not be covered unless the beneficiary was not eligible on the date of service and a subsequent eligibility determination was made retroactive to the date of service. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive prior authorization will be denied.

- Exception for nursing facilities: When a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, retroactive authorization may be requested to ensure continuity of a treatment regimen if the request is filed within ten days following admission. Retroactive

authorization may be granted when the service is rendered within Program guidelines for coverage (e.g., is restorative in nature).

3.3 Beneficiary Eligibility

Approval of a therapy service on the prior authorization request confirms that the service is authorized for the beneficiary. Approval of a prior authorization request does not guarantee beneficiary eligibility or payment. It is the provider's responsibility to verify the beneficiary's eligibility prior to rendering the service.

3.4 Billing Authorized Services

After prior authorization is issued, the information (e.g., prior authorization number, HCPCS/ CPT procedure code, modifier, and quantity) that was approved on the prior authorization must match the information on the claim form.

Therapy rendered to a nursing facility beneficiary must be billed by the nursing facility.

Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.

SECTION 4 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

4.1 OCCUPATIONAL THERAPY

MDHHS uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for occupational therapy services when provided by any of the following:

- A licensed occupational therapist.
- A licensed occupational therapy assistant under the supervision of an occupational therapist (i.e., the occupational therapy assistant services must follow the evaluation and treatment plan developed by the occupational therapist, and the occupational therapist must supervise and monitor the occupational therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising occupational therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) an occupational therapist. All documentation must be reviewed and co-signed by the supervising occupational therapist.

OT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects occupational therapists and occupational therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. OT must be medically necessary, reasonable and required to achieve one or more of the following:

- 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.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Occupational Therapy	Nursing Facility Occupational Therapy	Home Health Occupational Therapy
• Up to 144 units of OT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• Prior authorization is required.	• Up to 24 visits of OT in a 60-consecutive day period. • Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.

OT is expected to result in measurable improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his/her chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Healthy Michigan Plan.

Medicaid only covers OT services that require the skills, knowledge, and education of an occupational therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, physical therapist, family member, teacher, etc.).

Occupational therapy may be covered for one or more of the following:	▪ Therapeutic use of everyday life activities/occupations*. ▪ Adaptation of environments and processes to enhance functional performance in occupations*. ▪ Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*. ▪ Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration). ▪ Design, fabrication, application, or training in the use of assistive technology or orthotic/prosthetic devices. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.) *Covered occupations include: ▪ Activities of daily living (self-care activities). ▪ Instrumental activities of daily living (multistep activities to care for self and others, such as household management and childcare).

Occupational therapy is not covered for the following:	▪ If provided solely for educational, vocational, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.) ▪ Feeding for a beneficiary whose status is nothing per oral cavity (NPO), with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating). ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection (below). ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO). ➢ Services covered by the facility's per diem rate, including diversional OT, reality orientation, restorative nursing functions, routine maintenance, or the development of the therapy and treatment plan.

4.1.A. Duplication of Services

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., dysphagia, assistive technology, sitting and standing balance/tolerance, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

4.1.B. Access to Services for School-Aged Beneficiaries

School based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's maximum functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to the Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.1.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool may be reimbursed when billed using the HCPCS code describing the covered procedure if the service meets all Medicaid coverage requirements.

4.1.D. Group Therapy

OT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) contact between the beneficiary and the therapist.

4.1.E. Serial Casting

Serial casting is a process in which a joint(s) that lacks full range of motion is immobilized with a rigid or semi-rigid cast. During this procedure, the affected joint(s) is gradually and progressively set in a more anatomically correct alignment to improve joint alignment, increase muscle length, or to achieve a decrease in abnormal tone, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, until full range of motion, flexibility, or plateau is reached. Upon removal of each cast, the limb is stretched, and a new cast is applied to hold the limb in place.

Serial casting is a covered benefit when performed by, or under the direct supervision of, a qualified therapist and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone. The referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence, via signature, of any treatment plan that includes serial casting.

4.1.F. Prescription Requirements

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for occupational therapy. Home health and nursing facility therapy require a prescription from a physician for occupational therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy). All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Evaluations of swallowing function may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. OT evaluations/re-evaluations must be completed and signed by the occupational therapist and include all the following: ▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short- and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension). Oral function/swallowing evaluations must also include: ▪ Presence/absence of coughing; ▪ History of recent respiratory illness; ▪ Current diet, documenting difficulties with food consistencies; ▪ Aversion/sensitivity during eating; ▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages; ▪ Report or copy of a video fluoroscopy and any other formal testing, if available; and ▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.

Treatment Plan/Plan of Care	The OT treatment plan that results from the evaluation must be medically necessary, signed by the occupational therapist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function or mobility; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.
Initiation of Services	OT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid-eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for occupational therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., a speech-language pathologist may not provide treatment under an occupational therapist's evaluation); and ▪ There is a change in medical status resulting in decreased activities of daily living skills, oral motor skills, or functional ability.

Requirements of Continued Therapy	The occupational therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate. ▪ A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.

Maintenance Visits	The skills of an occupational therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the therapist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the therapist must request prior authorization. The occupational therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating occupational therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period. ▪ A copy or description of the maintenance program. ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ The anticipated frequency and duration of maintenance visits. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care above.

4.1.G. DISCHARGE SUMMARY

MDHHS requires the occupational therapist to document a discharge summary to identify the completion of OT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional achievement over the course of therapy;
- 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;
- A copy or description of the maintenance program, if appropriate;
- Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and

- Recommendations/referral to other services, if appropriate.

4.1.H. Supplies and Equipment

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy.

4.2 Physical Therapy

MDHHS uses the terms Physical Therapy, PT, and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for physical therapy services when provided by any of the following:

- A licensed physical therapist.
- A licensed physical therapy assistant under the supervision of a physical therapist (i.e., the physical therapy assistant services must follow the evaluation and treatment plan developed by the physical therapist, and the physical therapist must supervise and monitor the physical therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising physical therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a physical therapist. All documentation must be reviewed and co-signed by the supervising physical therapist.

PT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects physical therapists and physical therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. PT must be medically necessary, reasonable and required to achieve one or more of the following:

- 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.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Physical Therapy	Nursing Facility Physical Therapy	Home Health Physical Therapy
• Up to 144 units of PT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• Prior authorization is required.	• Up to 24 visits of PT in a 60-consecutive day period. • Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.

PT is expected to result in measurable improvement that is significant to the beneficiary's ability to perform mobility skills appropriate to his/her chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid only covers PT services that require the skills, knowledge, and education of a physical therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed occupational therapist, family member, teacher, etc.).

Physical therapy may be covered for one or more of the following:	▪ If expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills. ▪ PT service that is diagnostic. ▪ For a temporary condition that creates decreased mobility and/or function. ▪ Training in functional mobility skills (e.g., ambulation, transfers, floor mobility, transitions, wheelchair mobility, etc.). ▪ Stretching for improved flexibility. ▪ Modalities to allow gains of function, strength, or mobility. ▪ Training in the use of orthotic/prosthetic devices and assistive technology devices. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)

Physical therapy is not covered for the following:	▪ If provided solely for educational, vocational, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection below. ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO); ➢ Services covered by the facility's per diem rate, including routine maintenance and the development of the therapy and treatment.

4.2.A. Duplication of Services

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., assistive technology, hand therapy, sitting and standing balance/tolerance, transfers, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

4.2.B. Access to Services for School-Aged Beneficiaries

School-based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's maximum functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.2.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool may be reimbursed when billed using the HCPCS code describing the covered procedure if the service meets all Medicaid coverage requirements.

4.2.D. Group Therapy

PT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) contact between the beneficiary and the therapist.

4.2.E. Serial Casting

Serial casting is a process in which a joint(s) which lacks full range of motion is immobilized with a rigid or semi-rigid cast. During this procedure, the affected joint(s) is gradually and progressively set in a more anatomically correct alignment to improve joint alignment, increase muscle length, or to achieve a decrease in abnormal tone, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, until full range of motion, flexibility, or plateau is reached. Upon removal of each cast, the limb is stretched, and a new cast is applied to hold the limb in place.

Serial casting is a covered benefit when performed by, or under the direct supervision of, a qualified therapist and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone. The referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the prescribing provider must provide written concurrence, via signature, of any treatment plan that includes serial casting.

4.2.F. Prescription Requirements

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for

physical therapy. Home health and nursing facility therapy require a prescription from a physician for physical therapy.

A treatment plan meeting all of the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services; and
- Diagnosis.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. PT evaluations/re-evaluations must be completed and signed by the physical therapist and include all the following: ▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short-and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
Treatment Plan/Plan of Care	The PT treatment plan that results from the evaluation must be medically necessary, signed by the physical therapist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function or mobility; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency, and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.

Initiation of Services	PT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid-eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for physical therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., occupational therapist cannot provide treatment under a physical therapist's evaluation); and ▪ There is a change in medical status resulting in decreased mobility skills or functional ability.
Requirements of Continued Therapy	The physical therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes; ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate; ▪ A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established in this subsection. A treatment plan meeting all the prescription requirements is considered a prescription; and ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.

Maintenance Visits	The skills of a physical therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the therapist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the therapist must request prior authorization. The physical therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating physical therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested; ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period; ▪ A copy or description of the maintenance program; ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ The anticipated frequency and duration of the maintenance visits; ▪ The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months); ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).

4.2.G. DISCHARGE SUMMARY

MDHHS requires the physical therapist to document a discharge summary to identify the completion of PT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional potential over the course of therapy;
- 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;
- A copy or description of the maintenance program, if appropriate;
- Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and

- Recommendations/referral to other services, if appropriate.

4.2.H. Supplies and Equipment

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy.

4.3 Speech-Language Therapy

MDHHS uses the terms speech therapy, SLP, speech-language pathology, speech-language therapy (ST), and therapy to mean speech and language services and speech-language therapy. Speech-language therapy is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses services for speech-language therapy when provided by any of the following:

- A speech-language pathologist with a current license and who is authorized by ASHA to use Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) credentials.
- An appropriately supervised speech-language pathologist candidate (i.e., in their clinical fellowship year) or having completed all requirements but has not obtained a license. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed speech-language pathologist. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.

ST is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects speech-language pathologists to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. ST must be medically necessary, related to a medical diagnosis, reasonable, and required to achieve one or more of the following:

- 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; and
- Prevent a reduction in medical or functional status had the therapy not been provided.

Speech-Language therapy is limited to services for:

- Articulation
- Language
- Fluency
- Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration)

- Training in the use of a speech-generating device (SGD)/Augmentative and Alternative Communication (AAC) device/Augmentative Communication Device (ACD)
- Evaluation and instruction in the use of an oral-pharyngeal prosthesis
- Voice
- Rehabilitation of executive skills function status post neurological insult (examples may include reasoning, decision making, judgement, and language)
- Audiologic/Aural Rehabilitation

Speech-Language Therapies (ST) provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Speech-Language Therapy	Nursing Facility Speech-Language Therapy	Home Health Speech-Language Therapy
• Up to 36 visits of ST per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• Prior authorization is required.	• Home Health ST is covered for CSHCS beneficiaries only. • Prior authorization is required.

ST is expected to result in a measurable improvement that is significant to the beneficiary's ability to demonstrate communication and/or oral motor function appropriate to his/her chronological, developmental, cognitive, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid only covers ST services that require the skills, knowledge, and education of a speech-language pathologist. MDHHS does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed physical therapist, family member, teacher, etc.).

Speech-Language therapy that is related to a medical diagnosis may be covered for one or more of the following:	▪ It is expected to result in the restoration or amelioration of the beneficiary's ability to communicate wants, needs, and desires to their previous level of function following illness or injury. ▪ A temporary condition that results in decreased comprehension and expression, fluency, and/or oral function. ▪ Training to improve articulation. ▪ Training to improve receptive and expressive language. ▪ Training to improve fluency. ▪ Training to improve oral and/or pharyngeal phases of swallowing. ▪ Training in the use of a SGD/AAC/ACD device. ▪ Training in the use of an oral-pharyngeal prosthesis. ▪ Training in voice disorders. ▪ Training in the use of compensatory communication strategies. ▪ Training in restoration of executive skill functions. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)

Speech-Language therapy is not covered for the following:	▪ If provided solely for educational, vocational, social/emotional, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.). ▪ If therapy is rote practice of achieved skills. ▪ Feeding for a beneficiary whose status is NPO, with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating). ▪ Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.). ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection (below). ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO) is not a covered benefit for beneficiaries in a nursing facility. ➢ Services covered by the facility's per diem rate including routine maintenance and the development of the therapy and treatment.

4.3.A. Duplication of Services

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., dysphagia, assistive technology, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

4.3.B. Access to Services for School-Aged Beneficiaries

School-based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.3.C. Group Therapy

Group therapy requires documentation justifying the benefit of group therapy in addition to, or in place of, individual therapy. No more than one session of individual speech-language therapy and one session of group speech-language therapy may be provided on the same date of service. Group therapy is not covered in the home setting.

4.3.D. Prescription Requirements

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for speech-language therapy. Home health and nursing facility therapy require a prescription from a physician for speech-language therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy. All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Oral function or swallowing evaluations may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. Speech-Language therapy evaluations/re-evaluations must be completed and signed by the speech-language pathologist and include all the following: ▪ Standardized tests and/or objective functional baseline measures used to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short-and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ Assessment of the beneficiary's performance components (e.g., functional communication, receptive, expressive, articulation, fluency, voice, oral function, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension). Oral function/swallowing evaluations must also include: ▪ Presence/absence of coughing; ▪ History of recent respiratory illness; ▪ Current diet, documenting difficulties with food consistencies; ▪ Aversion/sensitivity during eating; ▪ Report or copy of a video fluoroscopy and any other formal testing, if available; ▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages; ▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.

Treatment Plan/Plan of Care	The ST treatment plan that results from the evaluation must be medically necessary, signed by the speech-language pathologist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication needs; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.
Initiation of Services	Speech-Language therapy may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for speech-language therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., an occupational therapist cannot provide treatment under a speech-language pathologist's evaluation); and ▪ If there is a change in medical status resulting in decreased communication skills, oral motor skills, or functional ability.

Requirements of Continued Therapy	The speech-language pathologist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate. ▪ A copy of the prescription indicating the date range of the requested treatment period must be submitted with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.

Maintenance Visits	The skills of a speech-language pathologist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the speech-language pathologist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the speech-language pathologist must request prior authorization. The speech-language pathologist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. The summary must include the treating speech-language pathologist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-consecutive day period immediately prior to that period for which prior authorization is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period. ▪ A copy or description of the maintenance program. ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ The anticipated frequency and duration of the maintenance visits. ▪ The anticipated discharge plan for the current course of therapy (up to 12 consecutive months). ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).

4.3.E. DISCHARGE SUMMARY

MDHHS requires the speech-language pathologist to document a discharge summary to identify the completion of speech-language therapy services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional achievement over course of therapy;
- 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;
- A copy or description of the maintenance program, if appropriate;

- Identification of assistive technology devices provided (e.g., SGD/AAC, switches) and its current utilization, if appropriate; and
- Recommendations/referrals to other services, if appropriate.

4.3.F. Supplies and Equipment

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy. Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional information regarding SGDs, including trial periods.

4.3.G. Evaluations and Follow-Up for Speech-Generating Devices/Voice Prostheses

An evaluation by the speech-language pathologist for recommendation of a SGD may be billed once in three years. Prior authorization is required for evaluations exceeding standard coverage limitations. The results of this evaluation must be shared with the provider submitting the SGD prior authorization request.

SGD set-up, programming, and modification services that require the skills of a speech-language pathologist (beyond those provided by the SGD vendor) may be billed up to two times per year.

Prior authorization is required for all SGDs. The Special Services Prior Approval-Request/Authorization form (MSA-1653-B) must be submitted for all original, replacement, upgrade, or repair of SGDs. (Refer to the Forms Appendix for additional information.)

Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional information regarding SGDs.

An evaluation for the use and/or fitting of a voice prosthetic device to supplement oral speech may be billed only if the evaluation was done to determine the need for an electro-larynx. The evaluation may be provided once in three years.