

<b>Division of Medicaid</b>	<b>New: -X</b>	<b>Date: 02/01/06</b>
<b>State of Mississippi</b>	<b>Revised: X</b>	<b>Date: 07/01/06</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Outpatient Physical Therapy</b>	<b>Section: 47.03</b>	
	<b>Pages: 2</b>	
<b>Subject: Exclusions</b>	<b>Cross Reference:</b>	

Outpatient therapy services **not** covered/reimbursed by the Division of Medicaid include, but are not limited to, the following:

- Services not certified/ordered by a physician, physician assistant, or nurse practitioner
- Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes
- Services that do not meet medical necessity criteria
- Services that do not require the skills of a licensed therapist
- Services when documentation supports that the beneficiary has attained the therapy goals or has reached the point where no further significant practical improvement can be expected
- Services when documentation supports that the beneficiary has not reached therapy goals but is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen
- Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members
- Services that duplicate other concurrent therapy/rehabilitation services (example: occupational therapist and physical therapist providing the same treatment to the same beneficiary)
- Maintenance and/or palliative services which maintain function and generally do not involve complex procedures or the professional skill, judgment, or supervision of a licensed therapist
- Services for conditions that could be reasonably expected to improve spontaneously without therapy
- Services ordered daily or multiple times per day from the initiation of therapy through discharge, i.e., frequency should decrease as the beneficiary's condition improves
- Services provided in multiple settings for the same beneficiary (example: ~~school and outpatient clinic~~ speech-language therapy services provided in both the school and the outpatient clinic).
- Services normally considered part of nursing care
- Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF)
- Separate fees for self care/home management training (beneficiary and caregiver education is inclusive in covered therapy services)
- Services which are related solely to employment opportunities (i.e., on-the-job training, work skills, or work settings)
- General wellness, exercise, and/or recreational programs

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- Services provided by students
  - Services provided by physical therapy assistants **except** in the outpatient department of a hospital
  - Services provided by physical therapy aides
  - Group therapy
  - Co-therapy
  - Services that are investigative or experimental
  - Acupuncture or biofeedback
  - Services outside the scope/and or authority of the therapist's specialty and/or area of practice
  - Services and items requiring pre-certification if the pre-certification has not been requested and/or denied, or the pre-certification requirements have not been satisfied by the provider
  - Services not specifically listed as covered by the Division of Medicaid
  - Exclusions listed elsewhere in the Mississippi Medicaid Provider Manual, bulletins, or other Mississippi Medicaid publications

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<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Outpatient Physical Therapy</b>	<b>Section: 47.04</b>	
	<b>Pages: 1-2</b>	
<b>Subject: General Coverage Criteria</b>	<b>Cross Reference:</b>	

Outpatient physical therapy services must meet general coverage criteria as follows:

- Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- The beneficiary must be under the care of and referred for therapy services by a state-licensed physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)
- Services must be provided by a state-licensed physical therapist. Exception: services may be provided by a state-licensed physical therapy assistant under the direct supervision of a state-licensed physical therapist in the outpatient department of a hospital. Refer to Section 47.06 of this manual.
- Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date the POC before initiation of treatment OR within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.
- ~~Services must be provided according to a plan of care (POC) developed by the therapy provider and certified (signed and dated) by the prescribing provider within fourteen (14) calendar days of the initiation of treatment. The plan must be re-certified by the prescribing provider at least every sixty (60) calendar days from the date of the initial evaluation or most recent re-evaluation.~~
- The discipline in which the therapist is licensed must match the order for therapy services, i.e., only a state-licensed physical therapist may evaluate, plan care, and deliver physical therapy services.
- Services must be conducted one-on-one (beneficiary and therapist). Group physical therapy is not covered.
- Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Services must not duplicate another provider's services.

### **Exclusions**

A list of therapy services **not** covered/reimbursed by the Division of Medicaid may be found in Section 47.03 of this manual.

### **Pre-Certification**

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to therapy providers and are approved by the Division of Medicaid. Refer to Section 47.09 of this manual.

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**NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program policies.**

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: X Current:</b>	<b>Date: 02/01/06 Date: 07/01/06</b>
<b>Section: Outpatient Physical Therapy</b>	<b>Section: 47.09 Pages: 3</b>	
<b>Subject: Prior Authorization/Pre-certification</b>	<b>Cross Reference:</b>	

Prior authorization or pre-certification serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit DOM to require authorization for any service where it is anticipated or known that the services could either be abused by providers or beneficiaries or could easily result in excessive, uncontrollable Medicaid costs. Certification as referred to in this policy is synonymous with prior authorization.

Effective for dates of services on and after July 1, 2005, pre-certification of certain outpatient therapy services is required by the Division of Medicaid. Providers must prior authorize/pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. Failure to obtain prior authorization will result in denial of payment to the providers billing for services.

The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

Pre-certification for outpatient therapy services is only required for certain CPT codes when the services fall into one of the following categories:

- Therapy services provided to beneficiaries under age twenty-one (21) through the EPSDT Expanded Services program by individual therapists in offices or therapy clinics. Services provided to adult beneficiaries age twenty-one (21) and over are not covered in individual therapist's offices or clinics.
- Therapy services provided to beneficiaries (adult and/or children) in the outpatient department of hospitals.
- Therapy services provided to beneficiaries under age twenty-one (21) in physician offices/clinics. Services provided to adult beneficiaries age twenty-one (21) and over are not covered in physician offices/clinics.
- Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted.
- Therapy services provided to beneficiaries under age twenty-one through the following providers: Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and State Department of Health.

**A complete list of CPT codes that require pre-certification may be obtained from the UM/QIO.**

### **Exclusions**

Pre-certification is **not required**, regardless of the CPT codes used, when the services fall into one of the following categories:

- Therapy services billed by school providers
- Therapy services provided to beneficiaries in nursing facilities

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- Therapy services provided to beneficiaries in an ICF/MR
  - Therapy services provided to beneficiaries in a hospice
  - Therapy services provided to beneficiaries in Home and Community Based Services (HCBS) waiver programs
  - Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted

### **Prior Authorization Request**

Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth in the UM/QIO therapy manual.

Certification/recertification acknowledges the medical necessity and appropriateness of services. It does not guarantee payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

**Therapy providers must use standardized forms provided by the UM/QIO.** Required forms include the following:

- Pre-certification Review Request
- Certification of Medical Necessity for Initial Referral/Orders
- Outpatient Therapy Evaluation/Re-Evaluation (specific to the therapy requested)
- Outpatient Therapy Plan of Care (specific to the therapy requested)

~~The initial evaluation and the first therapy session should **not** be done on the same day to allow time to develop a plan of care and obtain pre-certification from the UM/QIO. In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.~~

The initial evaluation and the first therapy session should **not** be done on the same day to allow time to develop a plan of care and obtain pre-certification from the UM/QIO. However, the UM/QIO is authorized to accept retrospective requests for the following exceptions:

#### **Urgent Services**

In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

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### **Same Day/Non-Urgent Services**

In rare instances where same day/non-urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Same day/ non-urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services that do not meet the definition of urgent, but completion of services on the same day as the evaluation significantly impacts the beneficiary's treatment (example: therapeutic activities, such as the use of crutches, on the same day as diagnosis/treatment of leg fracture). If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

### **Review Outcomes**

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for therapy, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the criteria are not met or the review outcome results in a denial, written notification will be sent to the beneficiary/representative, therapy provider, and prescribing provider.

### **Reconsideration Process**

The beneficiary, therapy provider, or prescribing provider may appeal a utilization review denial to the UM/QIO through the reconsideration process outlined in the UM/QIO manual.

### **Administrative Appeal**

Disagreement with the UM/QIO reconsideration determination may be appealed by the beneficiary/legal representative. The beneficiary/legal representative must submit a written request for administrative appeal within thirty (30) calendar days of the UM/QIO reconsideration review determination notice. The process for requesting an administrative appeal is included in the denial notice that is sent to the beneficiary/representative.

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<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Outpatient Physical Therapy</b>	<b>Section: 47.10</b>	
	<b>Pages: 2</b>	
<b>Subject: Prescribing Provider Orders/Responsibilities</b>	<b>Cross Reference:</b>	

**Prescribing Provider**

The Division of Medicaid provides benefits for therapy services that are medically necessary, as certified by the prescribing provider. For the purpose of this policy, prescribing provider is defined as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

**Certificate of Medical Necessity for Initial Referral/Orders**

The prescribing provider has a major role in determining the utilization of services provided by therapy providers. The prescribing provider **must** complete a Certificate of Medical Necessity for Initial Referral/Orders form and submit it to the therapist **prior** to therapy evaluation. The form is available through the UM/QIO.

**Therapy Plan of Care**

Therapy services must be furnished according to a written plan of care (POC). The plan of care must be **approved** by the prescribing provider **before** treatment is begun. For the purpose of this policy, approved means that the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline, i.e., only a speech therapist may develop a speech therapy evaluation, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. **Providers must use the standardized outpatient therapy plan of care form specific to the therapy requested.** Forms are available through the UM/QIO.

The plan must at a minimum include the following:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Dates of service (from/to)
- Diagnosis/symptomatology/conditions and related ICD-9 codes
- Specific diagnostic and treatment procedures/modalities and related CPT codes
- Reason for referral
- Frequency of therapeutic encounters (visits per week, day, month)
- Units/minutes required per visit
- Duration of therapy (weeks, days, months)
- Precautions (if applicable)

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- Short and long term goals that are specific, measurable, and age appropriate
  - Home program
  - Discharge plan
  - Therapist's signature (name and title) and date

The ~~initial~~ therapy plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of the initiation of treatment. The plan must be reviewed/revise~~d~~d by the prescribing provider as the beneficiary's condition requires, but at least every sixty (60) calendar days from the date of the initial evaluation or most recent re-evaluation. The revised plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of initiation. DOM accepts the signature on the revised plan of care as a new order.

The POC may be developed to cover a period of treatment up to six months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. A POC for a projected period of treatment beyond six (6) months is not acceptable.

The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO. Based on medical necessity, the UM/QIO may approve certification periods for less than **OR** up to six (6) months. Approved certification periods will not exceed the period of treatment indicated on the POC.

**DOM requires a revised POC in the following situations:**

- The projected period of treatment is complete and additional services are required.
- A significant change in the beneficiary's condition and the proposed treatment plan requires that (1) a therapy provider propose a revised POC to the prescribing provider, or (2) the prescribing provider requests a revision to the POC. In either case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.
- Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates. In this situation, the UM/QIO is authorized by DOM to request that the therapy provider submit a revised POC. The therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

All therapy plans of care (initial and revised) must be authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

DOM accepts the signature on the revised plan of care as a new order.

The prescribing provider may make changes to the plan established by the therapist, but the therapist cannot unilaterally alter the plan of care established by the prescribing provider.

**Continuing Medical Oversight**

The prescribing provider is expected to participate in the delivery of care by communicating with the treating therapist, and by assessing the effectiveness of the prescribed care. It is **mandatory** that the prescribing provider has a face-to-face visit with the beneficiary at least every six (6) months, and that the encounter is documented.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X Revised: X Current:</b>	<b>Date: 02/01/06 Date: 07/01/06</b>
<b>Section: Outpatient Physical Therapy</b>	<b>Section: 47.12 Pages: 2</b>	
<b>Subject: Plan of Care</b>	<b>Cross Reference:</b>	

Therapy services must be furnished according to a written plan of care (POC). The plan of care must be **approved** by the prescribing provider **before** treatment is begun. For the purpose of this policy, approved means that the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline, i.e., only a ~~speech~~ physical therapist may develop a ~~speech~~ physical therapy evaluation, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. **Providers must use the standardized outpatient therapy plan of care form specific to the therapy requested.** Forms are available through the UM/QIO.

The plan must at a minimum include the following:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Dates of service (from/to)
- Diagnosis/symptomatology/conditions and related ICD-9 codes
- Reason for referral
- Specific diagnostic and treatment procedures/modalities and related CPT codes
- Frequency of therapeutic encounters (visits per week, day, month)
- Units/minutes required per visit
- Duration of therapy (weeks, days, months)
- Precautions (if applicable)
- Clinical update for concurrent plan of care only (general summary of attendance, progress, setbacks, changes since last plan of care)
- Short and long term goals (specific, measurable, age appropriate, and current baseline status for each goal)
- Home program
- Discharge plan
- Therapist's signature (name and title) and date

~~The initial therapy plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of the initiation of treatment. The plan must be reviewed/revised by the prescribing provider as the beneficiary's condition requires, but at least every sixty (60) calendar days from the date of the initial evaluation or most recent re-evaluation. The revised plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of initiation. DOM accepts the signature on the revised plan of care as a new order.~~

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**DOM requires a revised POC in the following situations:**

- The projected period of treatment is complete and additional services are required.
- A significant change in the beneficiary's condition and the proposed treatment plan requires that (1) a therapy provider propose a revised POC to the prescribing provider, or (2) the prescribing provider requests a revision to the POC. In either case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.
- Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates. In this situation, the UM/QIO is authorized by DOM to request that the therapy provider submit a revised POC. The therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

All therapy plans of care (initial and revised) must be authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

DOM accepts the signature on the revised plan of care as a new order.

The prescribing provider may make changes to the plan established by the therapist, but the therapist cannot unilaterally alter the plan of care established by the prescribing provider.

**The initial plan of care must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapy assistant.**

The servicing provider (licensed therapist) is responsible for providing a copy of the initial plan of care and all revisions to the prescribing provider.