

The Office of Vermont Health Access Medical Policy

Subject: Physical, Occupational, and Speech Therapy Services

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Description of Service or Procedure

Medicaid covers the provision of Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) services when performed in the treatment of a medical condition. The OT and SLP services must be performed under a physician's order. The PT practice act does not require an MD order for therapists to evaluate and treat in the state of Vermont; however it is currently in Medicaid policy that an MD order is required for Medicaid coverage to apply.

All services must be performed by state licensed therapists. The treatment must be covered under the discipline's state practice act. All services billed as PT, OT or SLP services must be performed by individuals who are licensed to perform physical, occupational or speech therapy services by their state practice act; there is no "incident to" billing for therapy services. (Provider Manual, page 42).

Therapists treat beneficiaries with a full range of medical diagnoses, including neurological, musculoskeletal, integumentary, cardiopulmonary, developmental, and psychological disorders, providing that the treatment of the diagnosis falls within their practice act. The documentation must evidence clear, medical diagnoses/signs/symptoms in order to receive coverage for therapy services. ([7103](#), medical necessity)

The following diagnosis codes are considered **not reimbursable when used as a primary diagnosis** because they are not clearly medical in nature and may be resulting from other, non-medical, issues. [They may be used as secondary diagnoses.]

- 30900-3094
- 31200-3129
- 3131-3133
- 31382-3139
- 31500
- 31509-31539
- 3155-3159
- 71950-71959
- 78079
- 78340
- 78342
- 78440
- 78449
- 78460
- 7992-7993
- 79981-7999
- V600-V629
- V690-V699

Coverage Position

Coverage of therapy services is subject to the terms, conditions and limitations of the beneficiary's Medicaid benefits.

Therapy services are considered *medically necessary* if the **Medical Appropriateness Criteria** are met. The coverage of therapy services is considered **medically appropriate** if **all** of the following criteria are met:

- Directly related to an active treatment of a medical condition designed by the MD; and
- Of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required; and
- Reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition. (Medicaid Rule [7401.3](#))

Services provided by each discipline are covered for up to 4 months based on a physician's order. Provision of these services beyond the initial 4 month period requires prior authorization.

To receive prior authorization for these services during the eight month period immediately following the initial 4 month period, a physician must submit a written request to the OVHA with pertinent clinical data showing the need for continued treatment, projected goals and estimated length of time. Prior authorization for therapy services beyond one year from the onset of treatment will be granted **only if**:

- the service may not be reasonably provided by the patient's support person(s), and
- the patient undergoes another acute care episode or injury, or
- the patient experiences increased loss of function, or
- deterioration of the patient's condition that requires therapy is imminent and predictable.

Medically necessary treatment for children covered under federal EPSDT regulation may continue for more than one year provided the treatment continues to be medically necessary.

In making its prior authorization decision, the OVHA will obtain and take into consideration a qualified therapist's assessment when determining whether the service may be reasonably provided by the support person(s). In addition, when the department has determined that therapy services may be reasonably provided by the patient's support person(s) and the patient otherwise meets the criteria for authorization of therapy services beyond one year, professional oversight of the support person's provision of services is covered, provided such oversight is medically necessary. (Medicaid Rule [7401.4](#); also see 7203 for outpatient services.)

A request for prior authorization of a covered health service will be approved if the health service is:

1. medically necessary (see 7103),
2. appropriate and effective to the medical needs of the beneficiary,
3. timely, considering the nature and present state of the beneficiary's medical condition,
4. the least expensive, medically appropriate health service available,
5. not a preliminary procedure or treatment leading to a service that is not covered,
9. not experimental or investigational, and
10. furnished by a provider with appropriate credentials. (7102.2)

Additional Information

Therapy evaluations are expected to be comprehensive. Evaluations must be physician-prescribed and performed by an appropriate therapist.

Therapy goals should be functionally based, beneficiary oriented, measurable and objective, and age appropriate.

Therapy plans of treatment, including frequency, should be research based, comprehensive, and have a focus on beneficiary/family education and personal responsibility. There should be a discharge plan in place at the onset of treatment.

Note: Therapy treatment should be focused on self-management of the condition and on increasing beneficiary independence. It is expected that therapists will instruct beneficiaries in techniques to manage their condition. Long term use of passive modalities to control a condition is not considered efficacious treatment.

Note: When a beneficiary presents with multiple referrals for treatment of multiple conditions simultaneously or contiguously, it is the expectation of Medicaid that the therapist will discuss the multiple referrals with the physician and recommend evaluation for a systemic condition or recommend a comprehensive treatment approach. It is inefficacious to provide long term treatment for multiple areas of discomfort without looking toward a systemic ailment or the need for a comprehensive approach.

Note: **CAUTIONS:** All therapy evaluation and treatment must be research-based and not investigational or experimental in nature. If there is any doubt, the providing therapist must provide substantive, current, peer-reviewed literature to support the therapy. All treatment must demonstrate progress toward measurable goals with a focus on function and a progression toward beneficiary/caregiver independence.

Note: **REQUIRED DOCUMENTATION:** The request for prior authorization for extended therapy services must be received by the Office of Vermont Health Access on or prior to the date of the provision of services. ([7102](#))

Each prior authorization request must include the following documentation: [[Therapy Extension Form](#)]

- beneficiary name
- birth date
- beneficiary's Medicaid number
- supplying provider name and Medicaid number(s)
- attending physician name and number(s)
- diagnoses
- information on the dates/events complicating therapy
- the date of initial therapy for the acute episode/condition
- treatment frequency
- patient-oriented goals with objective and measurable parameter
- a research-based treatment plan that includes beneficiary/caregiver education and a discharge plan
- objective, measurable results of previous treatment goals
- the professional signature of both the therapist and prescribing physician

The therapy office/department must have physician approval of the treatment plan on file.

“Additional information that may be required” includes:

- the patient's complete medical record,
- a response to clinical questions posed by the department,
- the practitioner's detailed and reasoned opinion in support of medical necessity,
- a statement of the alternatives considered and the provider's reasons for rejecting them, and
- a statement of the practitioner's evaluation of alternatives suggested by the department and the provider's reasons for rejecting them.” (7102.2)

Codes/Billing Information

PT/OT/ST Services and Medicare Cap: Due to the Deficit Reduction Act 03, Medicare took the unusual step of limiting benefits for physical, occupational and speech therapy services provided by independent therapists. When a patient reaches the payment cap imposed by Medicare on independent therapists, therapy is still covered by Medicare through hospital outpatient departments and home health agencies. Therefore, Medicaid does **NOT** become the primary payer and the independent therapist should refer the patient to the hospital or

home health agency. Vermont Medicaid will continue to reimburse coinsurance and deductible on approved crossover claims.

Note: Regarding Other Insurance: “Prior Authorization for physical, occupational, and speech therapies is required for services lasting longer than 4 months from the start of the service. Once a beneficiary’s other insurance benefit exhausts, the OVHA becomes the primary insurer and PA rules apply, as necessary. The PA rules provide a 30-day transition period to assure continuity of service. Effective 9/01/06, the OVHA will not pay claims beyond the transition period unless the service has received prior authorization. If the primary insurance is indicated on your prior authorization notice, the provider is not obligated to attach that insurance denial to each submission. This will enable electronic billing of the claims covered in the PA period.” (RA letter: 8/25/06).

Note: Incident To Billing: There is no “incident to” billing for therapy services. Only licensed therapists and licensed therapist assistants will be covered for the provision of therapy services for Medicaid beneficiaries. There is no coverage for other individuals who are being supervised by therapists. This includes aides, athletic trainers, massage therapists, kinesiotherapists, personal trainers, and exercise physiologists.

Note: Certification periods are 4 months in length, and are based on the date of the first outpatient therapy service for the specific therapy discipline for the acute episode/condition. It is the responsibility of the therapy provider to determine if the beneficiary was seen elsewhere for the acute episode/condition, and to determine the first date of treatment at any outpatient facility, regardless of coverage source. A new acute episode/condition results in a new initial date of treatment, with certification period dates determined from the new initial date of treatment. For individuals with chronic conditions, it is imperative that providers ask the beneficiary, EDS Provider Services, and/or the prescribing physician about previous coverage and initial date of therapy service.

Coding

Hospitals and home health agencies bill using the revenue codes:

- 420 for PT
- 430 for OT
- 440 for ST (speech therapy)

Rehabilitation facilities which are certified and accredited by CARF (The Commission on the Accreditation of Rehabilitation Facilities) **and private practitioners** bill using procedure codes:

64550	92609	95834	97003	97028	97113	97597
92506	92610	95851	97004	97032	97116	97750
92507	92611	95852	97010	97033	97124	99199
92508	92612	96105	97012	97034	97139	GO152
92526	92614	96110	97014	97035	97140	G0153
92609	92616	96111	97016	97036	97150	S9445
92597	95831	96125	97018	97039	97530	
92607	95832	97001	97022	97110	97532	
92608	95833	97002	97026	97112	97542	

Guideline Addendum re: Pediatric Therapy

Because federal law supersedes state law, the Vermont Medicaid rule regarding one year of therapy per acute episode/condition does not apply to children. Also, there are additional issues for children because many school age children are eligible for services through their school system, some of which can be covered by Medicaid as

well. Given these issues, some additional guidelines have been formulated to help clarify therapy coverage for children.

- **All treatment must be medically necessary under federal as well as state law.** It is necessary to demonstrate that a treatment is medically necessary by having a clear medical diagnosis. Diagnoses that are vague or too general do not help demonstrate medical necessity and make it difficult for reviewers to determine if the therapy being requested is medically appropriate for the beneficiary. For example, a diagnosis of ‘disorder of the nervous system, not otherwise specified’ is so vague that a reviewer would not be able to determine if the treatment being requested is appropriate. Another example is ‘muscle weakness’. Many individuals are weak from lack of exercise, but they do not have a medical problem and their weakness does not need treatment by a therapist. Sometimes, families/physicians resist diagnoses, or sometimes a clear diagnosis can not be made. In these circumstances, the therapist must provide information to demonstrate that the problem being treated is clearly medical in nature. *For example, a doctor refers a child with a ‘developmental delay’ and will not provide a more specific diagnosis. The therapist notes that the child has coordination issues and hypotonia. The therapist notes this on the therapy authorization form to demonstrate that the delay is medical in nature.*
- **All treatment, including treatment frequency, should be established by evaluation and be unique to the specific needs of the individual, not the convenience of the provider.** *For example, a therapy provider who sees all clients once a week regardless of their condition is not providing services unique to the needs of the individual.*
- **All treatment must include training for the child’s care providers, to maximize the therapeutic effects of the treatment, and to minimize caregiver dependence on intensive professional level services.** Lay people can be taught therapy concepts and techniques and become competent and confident in following through with the techniques. The therapist’s knowledge is required to evaluate and re-evaluate the therapeutic program, adjusting the program to meet the unique needs of the individual. The expectation is that as caregiver competence and confidence increases, the need for high-intensity professional level services will gradually decrease over time to a level that provides for programmatic upgrades and ongoing family education. *For example, a therapy evaluation is done on a child with cerebral palsy. The family has many needs and questions initially, so the therapist determines that it is appropriate to begin at an intensive frequency of twice per week. As the family and other caregivers (such as daycare personnel, personal care attendants, and early interventionists) participate in the treatment process and learn the concepts and techniques to manage the individual’s needs, the frequency of professional services decreases gradually. The caregivers become more competent and confident, and require less direct support. Gradually, the frequency is decreased to a level of twice per month, to upgrade the goals, ensure that all equipment needed is available and fits well, and provide additional education to the caregivers as circumstances change.*
- **If an individual has a new acute episode/condition, which significantly changes the treatment plan and goals, then a new start of care date is given, and no therapy authorization is needed for the first 4 months of treatment.** *For example, an individual with severe contractures receives tendon lengthening surgery. He had been receiving treatment at a frequency of twice per month for equipment adjustment and caregiver education regarding the home program. After the surgery, there are new precautions, new goals, and a new plan. The change in program is significant. The surgery results in a new Start of Care date. No therapy authorization is needed for the first 4 months of treatment. The therapist determines that an increased frequency of care is warranted, and begins treatment at twice per week. After 4 months, the individual has recovered from the post-op period, caregivers are trained in the new care plan, and the therapist requests a frequency of weekly for 2 months and then twice per week for 2 months, with appropriate goals and plan.*
- **Infants and very young children change rapidly in the first years of life.** Caregivers need a higher intensity of professional assistance initially, both because they need to learn the concepts and techniques of care, but also because of the rapidity of growth and development. **As the changes gradually slow, the frequency of skilled therapy services can decrease as well.** *For example, a child with a*

mitochondrial disorder needs a high frequency of professional level services initially, to obtain equipment, educate the caregivers, and set up the home program. As they grow and change rapidly in the first year, the caregivers have many questions about how to care for the child. Over time, their questions become fewer, the changes become more gradual, and the caregivers become more competent and confident in the care. The frequency of skilled services decreases accordingly.

- Infants and young children with complex medical needs often have multiple professional disciplines providing services simultaneously. **Vermont Medicaid expects that the professionals are communicating with each other, and that their goals demonstrate good communication by avoiding both overlaps and gaps in the treatment and training provided.** This would extend beyond the therapists who work together to all the members of the child’s team, including Early Interventionists, nutritionists, physicians, nurses, personnel from VABVI (Vermont Association for the Blind and Visually Impaired) for the vision impaired, etc. *For example, a child born very prematurely comes home with support from nursing, a neonatologist, a pulmonary specialist, a nutritionist, a PT, an OT, and VABVI personnel. The family gets connected to the Family, Infant, and Toddler program (FITP) and an IFSP (Individualized Family Service Plan) is created. The professional team communicates frequently, with the permission of the parents, to educate each other and exchange information on their goals and plans, to avoid overlaps and gaps in care. The PT and OT note that they have written identical positioning goals and equipment goals on their request for a Medicaid extension. They discuss together who will be the ‘lead’ person in each of these areas, and the lead person writes the goal on their Medicaid extension form. The other discipline provides support, affirmation, and encouragement to supplement the training by the ‘lead’ therapist. In this case, the PT decides to take the lead with positioning issues, while the OT decides to take the lead with equipment issues. There is a specific positioning issue for the child’s hands, which the OT feels she would prefer to address, so after discussion the OT writes a goal and plan specific to hand positioning.*
- **Current medical research supports learning, including motor learning, in the most natural and comfortable environment for the child.** For children, this generally means their home and daycare when very young, with the addition of their school as they get older. Generalizing skills across different environments is very difficult for both children and families. Therefore, Vermont Medicaid supports and encourages treatment in the home and community environment, over the clinical environment. There are times when clinical equipment that can not be brought into the home is necessary for the treatment. If this is not the case, then it is felt that the use of a clinic is often for the convenience of the therapist and not for the benefit of the child. The use of the clinical model should be questioned when it is not apparent that specialized clinical equipment is necessary to provide treatment. *For example, a child with Spina Bifida who has just received new reciprocating gait orthoses needs to use the parallel bars to begin gait training. As these can not be brought to the home, the child comes to a therapy clinic for initial training. As soon as the child advances to the use of a walker or crutches, however, the treatment switches to the home so that the child and the family sees that walking is not just an activity done in a clinic, but is an activity that is done right in the familiar surroundings of the home, with the real obstacles that will be faced such as rugs, pets, and toys on the floor.*
- Vermont schools participate in a ‘child find’ to determine in part if there are children who require special services. Before a child turns 3, the medical model therapist should begin discussing the process of connecting to School Model Services with the family. This will help demystify the process, and smooth the transition. It is important to discuss the differences between an IFSP and an IEP (Individualized Education Program) if this is appropriate to the case. Families should be educated in the differences between school and medical model therapy services. **School model services support the child in accessing their Free and Appropriate Public Education (“FAPE”) in the Least Restrictive Environment (“LRE”). Medical Model services focus on medically necessary treatment specific to the home and community.** Some school based services are high intensity; some are more consultative in nature, depending upon the child’s needs, the support available to the student, and the level of training that school personnel require. It is often the case, just as in the medical model, that frequency starts off

at a higher level, and then as school personnel becomes more confident and competent, and as the child becomes more familiar with the school environment, and as the developmental changes gradually slow, that the frequency of therapy services changes accordingly. **It is the task of the medical model therapist, because their relationship with the child and family are already established, to help prepare and facilitate the introduction of the child and family into the school system.** It is also the task of the medical model therapist to help the family learn to differentiate between the school and medical model services. *For example, a child with high level autism is 2½. The medical model therapists begin to discuss the process of connecting with the school district with the family. They talk about the evaluation process, IEPs, 504s, EST plans, and other ways that a child may access therapy services in the school. They compare the IEP with the IFSP so families understand the difference. They talk with the family about the school model of therapy services and how it differs from the medical model of services. Both medical and school model therapists participate in transition meetings to help smooth the transition. The school and medical model therapists communicate together, with the permission of the parents, to avoid gaps and overlaps in their treatment. The medical model therapists feel that there are many home and community issues that still need to be addressed, so they continue to treat the child after school starts. Although when the child was younger they may have worked on goals that could be considered “pre-academic” (such as scribbling with a crayon), once school begins they focus on home and community issues because the school therapists are now supporting the Special Education team in providing the academic services.*

- Some children do not qualify for an IEP. They may still receive therapy services via a 504 plan, or an EST plan. Also, they may see a therapist for an assessment or an evaluation even if they do not qualify for any plan. **If a medical model therapist feels a child has needs that can impact their school performance, s/he should contact the school therapist, with the permission of the parent, to share the concerns.** The school therapist can then discuss this concern with the appropriate school personnel to see if the school will cover an assessment. *For example, a child with a mild foot deformity is being seen by a medical model therapist. The therapist is concerned that this problem may affect the child’s ability to participate safely in physical education class and at recess. With the parent’s permission, the medical model therapist calls the school model therapist and mentions her concerns. The school model therapist checks with the Special Education Coordinator, who is her contact person. The Coordinator agrees to cover an assessment. The therapist observes the child in physical education class and at recess, and makes recommendations to the PE teacher and the recess personnel. She then calls the medical model therapist to update her about what has occurred. The school model therapist also sends a note home to parents to apprise them of what she has done.*
- Some families decide not to access the school system. **The medical model therapist should then make clear to the family that medical model Medicaid can never take the place of school model services.** The family needs to understand that the medical model therapist can not assist the family with academically related issues and receive coverage from Medicaid for it. Families should be encouraged to work with their school districts to see what might be available for support. *For example, a student with Asperger’s syndrome is home schooled. The family does not want the child to be in school for classes, but after meeting and problem-solving with the school district, they decide that they will bring their child in for school model speech services. The speech language pathologist arranges for a time at the end of the school day, when things are less chaotic, for the child to receive his services.*
- Medical model therapists are not covered by Vermont Medicaid to discuss cases with teachers, paraeducators, or any other school personnel. That is a **consultation**, and should be covered by the school district. The medical model therapist’s **point of contact** under Vermont Medicaid, with family permission, is the school therapist. That is **collaboration**. Collaboration is necessary for quality care, to avoid gaps and duplication of services. Collaboration also helps prevent confusion. *For example, a medical model therapist tries to contact the school model therapist regarding her treatment techniques for a child with autism. The medical model therapist advocates, and is using, Applied Behavioral Analysis and discrete trial learning techniques. The school model therapist does not respond to the*

calls. The school model therapist advocates, and is using, a Floor time model. The child is confused at the different approaches; the parents don't know what they should be doing. The child's progress is delayed because of the confusion.

- Upon collaboration with the school based therapist, **the Medical Model therapist must clearly delineate the distinctions between her program and the school based services provided to the child.** This delineation must demonstrate that communication has occurred so both parties have an awareness of each other's plans and goals. It also must demonstrate that the programs are such that they avoid gaps and overlaps, and avoid significant differences in treatment techniques that might cause confusion and concern to the child, families and caregivers. *For example, a child with rheumatoid arthritis is working on grip issues with her school based occupational therapist. The home based therapist is focusing on ADL (activities of daily living) skills, such as using buttons, zippers, and eating utensils. The therapists clearly communicate to each other so each will know what the other is doing, and can support and affirm each other's program to the child's caregivers.*
- **Medical Model therapists must understand that even though a child may not have a school therapist, children work on skills every day in school that may have a relationship to Therapy, but may not require professional therapy services. They must remember that teachers, school psychologists, and special educators are all highly skilled, highly trained, licensed professionals who are also capable of helping children with learning skills.** *For example, a 6 year old child with ADHD has handwriting issues. The home based Occupational Therapist wants to work intensively with the child on handwriting skills at home. She reports that she needs to work on these skills because the child "doesn't have OT services at school." She does not acknowledge that the child's teacher is a licensed, highly skilled professional who teaches handwriting skills every day in her classroom. The teacher states that if she feels she can not help this child, she will ask for an evaluation by the school Occupational Therapist. Teaching handwriting skills is generally done by classroom teachers, who have resources available to them if they require the assistance.*
- Vermont Medicaid requires that treatment techniques used by therapists are supported by a high standard of current, peer reviewed medical literature and research. **Vermont Medicaid does not cover treatments that are 'experimental and investigational', meaning that they have inadequate research base.** *For example, a therapist goes to a course and learns a new technique. The course instructor provides testimonials and anecdotal evidence, but provides only her own research to support the technique. The instructor's research involved only 9 students, did not have a control group, and the testers were not double blinded. The therapist can not anticipate that Vermont Medicaid will cover this treatment until its efficacy is demonstrated by a higher level of research, and is replicated by other researchers.*
- **Therapists and families should discuss the course of therapy for a child directly upon initial evaluation, and with each re-evaluation.** *For example, a child with a head injury initially receives a high level of therapy services. The caregivers often leave the room during the therapy sessions, feeling that therapy is "someone else's job" and that "this is their time for a break". The caregivers then do not have a clear understanding of the therapy program and do not follow through with it outside of therapy time. The child feels that therapy is something that happens at the clinic, and has no meaning outside of that venue. When the therapist feels that the child has plateaued in her improvements, and wants to begin decreasing the frequency of services, the caregivers are furious and insist that the therapist must continue at the high level of services provided initially. The therapist feels trapped into providing a level of services that is no longer medically necessary. This may have been avoided if the course of therapy is discussed initially and at every re-evaluation.*
- A primary goal of all therapists must be to promote independence for children and their caregivers. **Vermont Medicaid supports therapists in helping children and families reach goals of independence and self-reliance. Vermont Medicaid does not support practices and practice patterns which result in chronic dependence on professional practitioners.** *For example, a child*

with a head injury initially receives a high level of therapy services. The therapists discuss the course of treatment with the family, emphasizing the vital importance of the family in participating in every treatment session and of following through with their program. They discuss the need for frequent services initially, and then a gradual taper as the caregivers become more confident and competent. The child and family do a great job at following through, and therapy progresses well. When the child is re-evaluated, new goals are established, and the therapist finds that the family is doing a great job with the home program and feels confident in their ability to follow the program. They agree to the therapist's plan to decrease the frequency of services. They know that the therapist is available to reassess should the situation change in any way. After a year of high frequency treatment, they are ready for a lower intensity of professional services. They know that this does not mean their child is being deprived of services; they know that this means that the child has progressed nicely, and that they are doing a great job. They know this because the therapist has made this clear to them. A lower level of services demonstrates that the program has successfully helped the child and family reach a greater level of independence and self-reliance!

References

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The Medicaid Rule only lists coverage availability, it does not guarantee individual determinations of medical necessity. Please check with the appropriate department to determine if the service/item in question is a covered service/item under a particular benefit plan. Use of Medicaid rule is not intended to replace independent medical judgment for treatment of individuals.

This document has been classified as public information.

