INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Therapy Services

LIBRARY REFERENCE NUMBER: PROMOD00049
PUBLISHED: AUGUST 1, 2017
POLICIES AND PROCEDURES AS OF APRIL 1, 2017
VERSION: 2.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: August 25, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: August 1, 2017	Scheduled update: • Edited and reorganized text as needed for clarity • Updated references in the *Introduction* section • Removed exemptions for physical therapy and occupational therapy services from the *Prior Authorization for Therapy Services* section • Updated information about rehabilitative and habilitative services and added note about HIP limitations in the *Coverage and Limitations for Therapy Services* section • Updated the following in the *Occupational Therapy Services* section: – Expanded provider types that can order occupational therapy – Changed “licensed” and “certified” to “registered” to reflect change in IHCP policy – Removed PA exemption for acute medical condition provided in an outpatient setting • Updated the following in the *Physical Therapy Services* section: – Expanded provider types that can order physical therapy – Removed PA exemption for acute medical condition provided in an outpatient setting	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		• Clarified information about PTAs in the *Physical Therapy Services* section and the *Covered Procedures for Physical Therapist Assistants* subsection • Modified 97530, 97533, and S8940 code descriptions in the *Hippotherapy* section • Updated the *Respiratory Therapy Services* section • Added the *Speech Pathology* section • Added electronic billing options in the *Comprehensive Outpatient Rehabilitation Facilities* section	

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> *Note:* *For policy information regarding coverage of therapy services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

This module outlines the Indiana Health Coverage Programs (IHCP) prior authorization (PA), billing, and coverage criteria for therapy services, including occupational therapy, physical therapy, respiratory therapy, and speech pathology services, as well as cognitive rehabilitation therapy for the treatment of traumatic brain injury. For information on audiology services, see the *Hearing Services* module. For information about behavioral therapy, including applied behavior analysis (ABA) therapy, see the *Mental Health and Addiction Services* module.

> *Note:* *For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.*

The IHCP reimburses for therapy services provided outside Indiana, subject to PA, as provided by *Indiana Administrative Code 405 IAC 5-5-2*. However, the IHCP does **not** cover home health agency (HHA) services outside Indiana. See the *Home Health Services* module for billing guidelines related to provision of therapy by HHAs.

Outpatient providers bill occupational therapy, physical therapy, respiratory therapy, and speech pathology as stand-alone services. For these services, providers bill using the revenue code only and the IHCP reimburses at a flat, statewide fee on a per-hour basis or per unit billed. See the Outpatient Fee Schedule at indianamedicaid.com for rate information. Providers cannot bill for fractional units for less than one hour. Providers must accumulate and report time in one-hour increments.

Prior Authorization for Therapy Services

In accordance with *405 IAC 5-22-6(a)*, the IHCP requires prior review and authorization for all therapy services, with the following exceptions:

- Initial evaluations
- Emergency respiratory therapy
- Any combination of therapy services ordered in writing before a member's release or discharge from an inpatient hospital, continuing for a period not to exceed 30 units, sessions, or visits in 30 calendar days
- Deductible and copay or coinsurance for services covered by Medicare Part B
- Oxygen equipment and supplies necessary for the delivery of oxygen, with the exception of concentrators
- Therapy services provided by a nursing facility or large private or small intermediate care facility for individuals with intellectual disability (ICF/IID), which are included in the facility's *per diem* rate
- Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, or upper respiratory infection (not to exceed 14 hours or 14 calendar days without PA)

Coverage and Limitations for Therapy Services

In accordance with *405 IAC 5-22-6(b)*, the following criteria for PA of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology services:

- The IHCP requires written evidence of physician involvement and personal patient evaluation to document acute medical needs. The therapy must be ordered by a qualifying provider (as noted in the subsections of this module for each service). Providers must attach a current plan of treatment and progress notes indicating the necessity and effectiveness of therapy to the PA request and make this documentation available for audit.
- A qualified therapist, or a qualified assistant under the direct supervision of the therapist, as appropriate, must provide the therapy.
- Therapy must be of such a level of complexity and sophistication, and the condition of the member must be such that they require the judgment, knowledge, and skills of a qualified therapist.
- The IHCP reimburses only for medically reasonable and necessary therapy.
- The IHCP does not cover therapy rendered for diversional, recreational, vocational, or avocational purposes, nor for the remediation of learning disabilities or developmental activities that can be conducted by nonmedical personnel.
- For members 21 years of age and older, the IHCP covers therapy for rehabilitative services for no longer than two years from the initiation of the therapy, unless a significant change in medical condition requires longer therapy. Providers can prior authorize respiratory therapy services for a longer period on a case-by-case basis. Habilitative therapy is not a covered service for members 21 years of age and older.
- For members under 21 years of age, the IHCP covers therapy for rehabilitative services when determined to be medically necessary. Habilitative therapy services for recipients under 21 years of age are covered on a case-by-case basis and are subject to prior authorization. Educational services, including, but not limited to, the remediation of learning disabilities, are not considered habilitative therapy and are not covered.

> *Note: Habilitative therapy refers to therapy addressing chronic medical conditions where further progress is not expected. Habilitative therapy services include physical therapy, occupational therapy, respiratory therapy, speech pathology, and audiology services provided to members for the purpose of maintaining their level of functionality, but not the improvement of functionality. Although the development of a habilitation therapy plan is considered part of rehabilitative services, the services furnished under a habilitation therapy plan are not skilled therapy. Educational services, including but not limited to the remediation of learning disabilities, are not considered habilitative therapy services and remain noncovered by the IHCP.*

- When a member is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. The IHCP does not separately reimburse for ongoing evaluations.
- One hour of billed therapy must include a minimum of 45 minutes of direct patient care, with the balance of the hour spent in related patient services.
- The IHCP does not reimburse therapy services for more than one hour per day, per type of therapy; additional therapy services require prior authorization and must be medically necessary.
- The IHCP does not prior authorize requests for therapy that duplicate other services provided to a patient.

Note:	*HIP Basic members are limited to 60 physical therapy, occupational therapy, speech pathology, and pulmonary rehabilitation combined visits annually. HIP Plus members are limited to 75 physical therapy, occupational therapy, speech pathology, and pulmonary rehabilitation combined visits annually.*

Occupational Therapy Services

For IHCP reimbursement, occupational therapy services must be ordered by a physician or (effective February 1, 2017) by one of the following providers:

- Chiropractor
- Nurse practitioner
- Optometrist
- Physician assistant
- Podiatrist
- Psychologist

In accordance with *405 IAC 5-22-11*, occupational therapy services must be performed by a licensed occupational therapist or a licensed occupational therapy assistant under the direct, on-site supervision of a licensed occupational therapist. A licensed occupational therapist must perform an evaluation for IHCP reimbursement to be made.

The IHCP limits evaluations and reevaluations to three hours of service per evaluation.

The IHCP does not cover the following occupational therapy services:

- General strengthening exercise programs for recuperative purposes
- Passive range-of-motion services as the only or primary mode of therapy
- Occupational therapy psychiatric services

The IHCP does not reimburse separately for occupational therapy services provided by a nursing facility or a large private or small ICF/IID. These services are included in the facility's established *per diem* rate and do not require PA.

Physical Therapy Services

For IHCP reimbursement, physical therapy services must be ordered by a physician or (effective February 1, 2017) by one of the following providers:

- Chiropractor
- Dentist
- Nurse practitioner
- Physician assistant
- Podiatrist
- Psychologist

In accordance with *405 IAC 5-22-8*, physical therapy services must be performed by a licensed physical therapist or a certified physical therapist assistant (PTA) under the direct supervision of a licensed physical therapist or physician.

> *Note: The PTA is precluded from performing or interpreting tests, conducting initial or subsequent assessments, or developing treatment plans. See the Covered Procedures for Physical Therapist Assistants section for details. The PTA is required to meet with the supervising physical therapist each working day to review treatment, unless the physical therapist or physician is on the premises to provide constant supervision. The consultation can be either face-to-face or by telephone.*

The IHCP limits evaluations and reevaluations to three hours of service per member evaluation.

The IHCP allowance for the modality provided by the licensed therapist includes payment for the following services, and providers may not bill the IHCP separately for these services:

- Assisting patients in preparation for treatment and, as necessary, during and at the conclusion of treatment
- Assembling and disassembling equipment
- Assisting a physical therapist in the performance of appropriate activities related to the treatment of the individual patient
- Following established procedures pertaining to the care of equipment and supplies
- Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas
- Transporting patients, records, equipment, and supplies in accordance with established policies and procedures
- Performing established clerical procedures

The IHCP does not reimburse separately for physical therapy services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's *per diem* rate and do not require PA.

Covered Procedures for Physical Therapist Assistants

The IHCP has identified services that can be performed by a PTA and are eligible for reimbursement. For a table of applicable procedure codes, see *Therapy Services Codes* on the *Code Sets* page at indianamedicaid.com.

When these services are performed by a PTA, providers must them with the modifier HM – *Less than a bachelor's degree.* These services, when billed with the HM modifier, are priced to reimburse at 75% of the reimbursement level for a physical therapist.

Note that evaluation and testing procedure codes are excluded from the table, because PTAs may not administer tests or perform evaluations.

Hippotherapy

The IHCP covers hippotherapy for physical therapy. To be covered, a licensed physical therapist must provide the services, and providers must bill for the services using the appropriate Current Procedural Terminology (CPT®[1]) code from the following list:

- 97110 – *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility*
- 97112 – *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities*
- 97530 – *Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes*
- 97533* – *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes.*

*CPT code 97533 can be used only for patients with a diagnosis of traumatic brain injury (TBI).

Note:	*Procedure code S8940 – Equestrian/hippotherapy, per session is **not** covered by the IHCP.*

A physician must order the hippotherapy services and include them in the patient's treatment plan. Existing PA requirements for physical therapy apply to hippotherapy.

Respiratory Therapy Services

For IHCP reimbursement, respiratory therapy services must be ordered in writing by a physician. Additionally, in accordance with *405 IAC 5-22-10*, the IHCP reimburses for respiratory therapy service only when performed by a licensed respiratory therapist or a certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic.

The IHCP considers the equipment necessary for rendering respiratory therapy part of the provider's capital equipment.

Note:	*The IHCP does not require PA for respiratory therapy given on an emergency basis. In addition, for a period not to exceed 14 hours or 14 calendar days, providers can perform respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection without PA. If the member requires additional services after that date, the provider must obtain PA.*

The IHCP does not reimburse separately for respiratory therapy services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's established *per diem* rate.

Speech Pathology

Speech pathology services are provided for IHCP members with speech, hearing, or language disorders. These services include diagnostic, screening, preventive, and corrective services.

For IHCP reimbursement, speech pathology services must be ordered in writing by a physician. Additionally, in accordance with *405 IAC 5-22-9*, the speech pathology service must be rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. A registered speech-language pathology aide may provide services subject to *880 IAC 1-2.1*.

Evaluations and reevaluations are limited to three hours of service per evaluation.

Group therapy is covered only in conjunction with, not in addition to, regular individual treatment. The IHCP will not reimburse for group therapy as the only or primary means of treatment.

The IHCP does not reimburse separately for speech pathology services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's established *per diem* rate.

Therapy for Traumatic Brain Injury

405 IAC 5-29-1(25)(I) states that cognitive rehabilitation is a noncovered service, except for the treatment of traumatic brain injury (TBI).

The IHCP limits the following CPT codes to the specific TBI diagnoses:

- 97532 – *Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes*
- 97533 – *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes*.

Comprehensive Outpatient Rehabilitation Facilities

A comprehensive outpatient rehabilitation facility (CORF) is a facility that is primarily engaged in providing outpatient rehabilitation to people who are injured or disabled, or to patients recovering from illness with a plan of treatment under the supervision of a physician. The purpose of a CORF is to permit the member to receive multidisciplinary rehabilitation services per *515 IAC 2-1-3*, at a single location, in a coordinated fashion.

CORF services include the following:

- Outpatient mental health services in accordance with *405 IAC 5-20-8* (required service)
- Physical therapy (required service)
- Physician services (required service)
- Speech pathology
- Occupational therapy

CORF services are to be billed on a professional claim (*CMS-1500* claim form, 837P electronic transaction, or Provider Healthcare Portal professional claim) with place-of-service code 62 – *Comprehensive outpatient rehabilitation facility*. Facility charges are not separately reimbursed.

However, if a crossover claim is transmitted from Medicare on the institutional claim (*UB-04* claim form or 837I electronic transaction), it will be processed.