INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Therapy Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures current as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures current as of April 1, 2016 Published: August 25, 2016	Semiannual update: • Added note box for managed care providers to the *Introduction* section • Added cross-reference to the *Mental Health and Addiction Services* module for information about behavioral therapy • Clarified information about prior authorization exceptions in the *Prior Authorization for Therapy Services* section • Clarified information about unit restrictions in the *Coverage and Limitations for Therapy Services* section and the *Physical Therapy Services* subsection • Removed reference to First Steps in the *Physical Therapy Services* section • Edited the *Respiratory Therapy Services* section for clarity	FSSA and HPE

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

Introduction

This document 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, as well as cognitive rehabilitation therapy for the treatment of traumatic brain injury. For information about behavioral 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 therapy 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 unit billed. 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

Physical therapy, occupational therapy, and respiratory therapy ordered in writing by a physician to treat an acute medical condition require PA, except in the following instances:

- Physical therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 hours, sessions, or visits within 30 calendar days, without PA. This exception includes the provision of splints, crutches, and canes. Providers must obtain PA for additional services.
- Occupational therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 hours, sessions, or visits in 30 calendar days without PA. This exception includes provision of splints, crutches, and canes. Providers must obtain PA for additional services.
- Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection may continue for a period not to exceed 14 hours or 14 calendar days, without PA. If the member requires additional services after that date, the provider must obtain PA.

Coverage and Limitations for Therapy Services

405 IAC 5-22-6(b) provides that, unless specifically indicated otherwise, the following criteria for PA of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology:

- The IHCP requires written evidence of physician involvement and personal patient evaluation to document acute medical needs. A physician must order the therapy. 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.
- The IHCP covers therapy for rehabilitative services for a member 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 habilitative services for a member younger than 18 years old for a longer period on a case-by-case basis. Providers can prior authorize respiratory therapy services for a longer period on a case-by-case basis.
- The IHCP does not cover maintenance therapy.
- 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.

Physical Therapy Services

405 IAC 5-22-8 provides that physical therapy services are subject to the following restrictions:

- A licensed physical therapist, or a certified physical therapist assistant under the direct supervision of a licensed physical therapist or physician, must perform physical therapy service. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified therapist assistant who must be under the direct supervision of a licensed physical therapist.

> *Note: 405 IAC 1-11.5-2(c)(4) allows for the reimbursement of services provided by certified physical therapist assistants (PTAs). This rule amends 405 IAC 5-22-8 regarding supervision requirements for services provided by certified PTAs. The PTA is precluded from performing and interpreting tests, conducting initial or subsequent assessments, or developing treatment plans. Under direct supervision, a PTA is still 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 allowance for the modality provided by the licensed therapist includes payment for the following services, and providers may not bill separately for them:
  - 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 limits evaluations and reevaluations to three hours of service per member evaluation. For the initial evaluation, the IHCP does not require PA. For any additional reevaluations, the IHCP does require PA, unless the evaluations are conducted during the initial 30 days after hospital discharge and the discharge orders include physical therapy orders. The IHCP does not authorize reevaluations more than one time per year unless the provider submits documentation indicating a significant change in the patient's condition. The provider is responsible for determining whether evaluation services have been previously provided.
- Physical therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 hours, sessions, or visits within 30 calendar days, without PA. This exception includes the provision of splints, crutches, and canes. Providers must obtain PA for additional services.
- 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 procedures that can be performed by a PTA and are eligible for reimbursement. Providers must bill these services with the modifier HM – *Less than a bachelor's degree.* Pricing for these services reimburses at 75% of the reimbursement level for a physical therapist. See *Therapy Services Codes* on the *Code Sets* page at indianamedicaid.com for the following table: *Procedure Codes for Services That a Physical Therapist Assistant (PTA) May Perform*.

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 by provider (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 by the provider, each 15 minutes.*

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

Note:	*Procedure code S8940 – Hippotherapy per person, 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

405 IAC 5-22-10 states that respiratory therapy services are subject to the following restrictions:

- 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.
- 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 and do not require PA.

The IHCP does not require PA for respiratory therapy given on an emergency basis.

[1] *CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Occupational Therapy Services

405 IAC 5-22-11 states that occupational therapy services are subject to the following restrictions:

- A registered occupational therapist, or a certified occupational therapy assistant under the direct, on-site supervision of a registered occupational therapist, must perform the occupational therapy service. A registered occupational therapist must perform the evaluation for the IHCP to reimburse the provider.
- The IHCP limits evaluations and reevaluations to three hours of service per evaluation. For the initial evaluation, the IHCP does not require PA. For any additional reevaluations, the IHCP does require PA, unless the evaluations are conducted during the initial 30 days after hospital discharge when the discharge orders include occupational therapy orders. The IHCP does not authorize reevaluations more than one time per year unless the provider submits documentation indicating significant change in the patient's condition. The provider is responsible for determining whether evaluations have been previously provided.
- The IHCP does not cover general strengthening exercise programs for recuperative purposes.
- The IHCP does not cover passive range-of-motion services as the only or primary mode of therapy.
- The IHCP does not reimburse for occupational therapy psychiatric services.
- Occupational therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed 12 hours, sessions, or visits in 30 calendar days without PA. This exception includes provision of splints, crutches, and canes. Providers must obtain PA for additional 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.

Cognitive Rehabilitation 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 (including compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes*
- 97533 – *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, 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 the injured and 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-language therapy
- Occupational therapy

CORF services are to be billed on a *CMS-1500* claim form or the 837P electronic transaction, 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 *UB-04* claim form, it will be processed.