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1. Section Modifications

Version	Section	Update	Publish Date	SME
19.0	All	Published version	1/1/20	TQD
18.6	2.3.1 Overview	Deleted section header. Text remains in section 2.2. Updated therapy caps for 2020.	12/20/19	W Deseron E Garibovic
18.5	2.2 Independent Physical Therapists (PT)	Updated therapy caps for 2020.	12/20/19	W Deseron E Garibovic
18.4	2.1.13. Covered Services Overview	Added reference to Independent Therapy Fee Schedule.	12/20/19	W Deseron E Garibovic
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17.2	2.2.6. Reimbursement 2.2.16 Excluded Services 2.3.15 Excluded Services	Removed Infant Toddler reference	7/2/18	E Garibovic W Deseron
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15.2	2.3.12 Limitations	Updated documentation timeframe and requirements	10/20/17	S Scheuerer D Baker E Garibovic
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13.1	2.3.1 Overview	Updated annual service limit amount effective 1/1/2017	2/1/17	D Baker E Garibovic
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12.4	2.3.5.1 Evaluation	Added information about new CPT® codes	1/17/17	T Lombard D Baker E Garibovic

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12.1	2.2.5.1 Evaluation	Added information about new CPT® codes	1/17/17	T Lombard D Baker E Garibovic
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11.1	2.2.1 Overview	Updated annual service limit amount effective 1/1/2017	12/30/16	D Baker
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10.4	2.3.17 Post Payment Review	Specified MCU selects sample of claims	11/3/16	K Eidemiller D Baker
10.3	2.3.12 Limitations	Added information for utilization review; updated documentation information	11/3/16	K Eidemiller D Baker
10.2	2.2.18 Post Payment Review	Specified MCU selects sample of claims	11/3/16	K Eidemiller D Baker
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9.36	2.3.16 Experimental and Investigational Services	New section	7/1/16	J Siroky D Baker
9.35	2.3.15 Excluded Services	Updated bulleted list	7/1/16	J Siroky D Baker
9.34	2.3.14 Documentation	Updated duration of the session bullet	7/1/16	J Siroky D Baker
9.33	2.3.13.1 Modalities	Added reference to fee schedule	7/1/16	J Siroky D Baker
9.32	2.3.13 Covered Services	Updated section heading and bulleted list	7/1/16	J Siroky D Baker
9.31	2.3.28 Prior Authorization	Removed section	7/1/16	J Siroky D Baker
9.30	2.3.11 Plan of Care	New section	7/1/16	J Siroky D Baker
9.28	2.3.10 Telehealth	New section	7/1/16	J Siroky D Baker
9.27	2.3.9 Maintenance Therapy	New section	7/1/16	J Siroky D Baker
9.26	2.3.6 Reimbursement	Removed developmental disability agencies	7/1/16	J Siroky D Baker
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9.24	2.3.5 Evaluation and Assessment	Added "aides"	7/1/16	J Siroky D Baker
9.23	2.3.4 Supervision of Physical Therapy Assistants	Updated requirements for reimbursement	7/1/16	J Siroky D Baker
9.22	2.3.5 Detailed Written Orders	Removed section	7/1/16	J Siroky D Baker
9.21	2.3.4 Verbal Preliminary Order	Removed section	7/1/16	J Siroky D Baker
9.20	2.3.3 Physician Orders	Major content updates	7/1/16	J Siroky D Baker
9.19	2.3.2 Independent Therapist Qualifications	Removed Medicare Certification information; added paragraph regarding location of services provided	7/1/16	J Siroky D Baker

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9.13	2.2.14 Covered Services Overview	Updated bulleted list	7/1/16	J Siroky D Baker
9.12	2.2.12 Plan of Care	New section	7/1/16	J Siroky D Baker
9.11	2.2.11 Telehealth	New section	7/1/16	J Siroky D Baker
9.10	2.2.10 Maintenance Therapy	New section	7/1/16	J Siroky D Baker
9.9	2.2.8 Participants with Feeding Disorders	New section	7/1/16	J Siroky D Baker
9.9	2.2.6 Reimbursement	Removed developmental disability agency	7/1/16	J Siroky D Baker
9.8	2.2.5.1 Evaluation	Clarified "long and short-term" goals	7/1/16	J Siroky D Baker
9.7	2.2.5 Evaluation and Assessment	Added "aides"	7/1/16	J Siroky D Baker
9.6	2.2.4 Supervision of Occupational Therapy Assistants	Updated requirements for reimbursement	7/1/16	J Siroky D Baker
9.5	2.2.5 Detailed Written Orders	Removed section	7/1/16	J Siroky D Baker
9.4	2.2.4 Verbal Preliminary Order	Removed section	7/1/16	J Siroky D Baker
9.3	2.2.3 Physician Orders	Changed PCP to physician/midlevel practitioner; added information for orders to evaluate and treat	7/1/16	J Siroky D Baker
9.2	2.2.2 Independent Therapist Qualifications	Minor updates for clarity; removed developmental disability agency, added public and charter school	7/1/16	J Siroky D Baker
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5.1	2.2.3, 2.3.3 Physician Orders	Updated for clarity	2/12/2015	J Siroky C Taylor D Baker
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2.2	4.9 PA	Removed statement for maximum reimbursement	10/20/2011	J Siroky
2.1	3.9 PA Procedure Codes	Removed statement for maximum reimbursement	10/20/2011	J Siroky
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1.4	All	Replaced member with participant	8/30/2010	TQD
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1.2	3.9.1	Added: as shown in IDAPA 16.03.09.730 - .739 and 16.03.10.215	8/30/2010	C Taylor
1.1	All	Updated all sections to accommodate Section Modifications	8/30/2010	TQD
1.0	All	Initial document – Published version	5/7/2010	TQD

2. Therapy Services – Occupational and Physical

This section covers all Medicaid services provided by occupational therapists and physical therapists as deemed appropriate by the Idaho Department of Health and Welfare (IDHW). It addresses prior authorization (PA), covered and non-covered services, limitations, and other Medicaid requirements for occupational therapists and physical therapists.

2.1. Independent Occupational Therapists (OT)

Medicaid covers physician-ordered OT rendered by therapists who are licensed as occupational therapists, as defined in *IDAPA 24.06.01 Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants*, and who are enrolled as Medicaid providers.

OT services are limited to \$2,080 annually. Additional services may be covered when medically necessary.

2.1.1. Independent Therapist Qualifications

Medicaid will only reimburse for OT services rendered by or under the supervision of a licensed OT who is:

- Identified by Medicare as an independent practitioner and
- Enrolled as an Idaho Medicaid provider.

OT providers whose practice is limited to the treatment of children may be allowed to enroll without Medicare Certification. However, Medicaid will not reimburse those providers for services provided to Medicare beneficiaries. Medicare is the primary payer and must be billed prior to billing Medicaid.

A therapy assistant/aide cannot bill Medicaid directly. Services provided by a licensed assistant can be billed by the supervising OT. Any services provided by an aide are not reimbursable by Medicaid.

A therapist who treats participants in a hospital (inpatient or outpatient), nursing facility, home health agency, intermediate care facility, public school, or charter school is not considered to be an independent therapist. Services provided at those locations must be billed by that enrolled Medicaid provider.

2.1.2. Physician Orders

For reimbursement by Medicaid, the OT must have an order from a physician or midlevel practitioner (nurse practitioner, clinical nurse specialist, or physician assistant). Services must be part of a plan of care (POC) based on that order. The participant's progress must be reviewed and the POC updated and reordered every 90 days by the physician or midlevel practitioner with the following exceptions:

- A home health agency plan of care must be reordered at least every sixty (60) days, and
- If there is supporting documentation from the participant's physician/midlevel practitioner indicating that the participant has a long-term medical condition for which therapy is necessary for more than 90 days, then an order for continued care is required at least every 365 days.

The written physician/midlevel practitioner's order must stipulate:

- Type of services needed
- Frequency of treatment
- When applicable, the expected length of need for which the therapy will be medically necessary.

If the initial order is to evaluate and treat, but does not specify the services, frequency, and length of need, then:

- The OT performs a therapy evaluation based on the initial physician/midlevel practitioner order to evaluate and treat
- The OT develops a plan of care based on that evaluation and sends the plan to the physician/midlevel practitioner
- The OT may begin therapy
- The physician/midlevel practitioner must sign the plan of care specifying the service to be provided, the frequency, and the expected duration plan of care

No claims may be billed until the completed plan of care is signed by the physician/midlevel practitioner.

2.1.3. Supervision of Occupational Therapy Assistants

Certain Therapeutic procedures and treatment modalities, as described in the Current Procedural Terminology® (CPT) Manual, may be performed by a licensed OT assistant when under the supervision of the appropriate therapist, as defined in *IDAPA 24.06.01 Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants*.

For Medicaid reimbursement:

- All supervision must be done in accordance with the requirements in the Idaho State Occupational Therapy Licensure Board regulations.
- The therapist is required to co-sign any documentation written by the therapy assistant. Therapy services provided by an aide are not reimbursable by Medicaid.

2.1.4. Evaluation and Assessment

Evaluations and re-evaluations may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. Therapy assistants and aides may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service.

2.1.4.1. Evaluation

Effective January 1, 2017, three new evaluation CPT® codes are introduced for occupational therapy (OT) services, 97165, 97166, and 97167. The new codes are based on patient complexity and level of clinical decision-making of low, medium, and high complexity. One new re-evaluation CPT® code is introduced for OT 97168. Codes in current use for 2016 will be discontinued as of December 31, 2016.

Providers must use the detailed long description of each new evaluation code to correctly code claims and ensure accurate reporting of services rendered, based on documentation in the participant's file. The therapist performing the evaluation or re-evaluation must ensure that all components of the billed code are accomplished. While there is a usual time component for each of the codes, to bill a specific code, all listed components must be completed and documented.

Evaluation is a separately payable comprehensive service provided by a licensed OT that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. These evaluative judgments are essential to development of the plan of care, including long and short-term goals and the selection of interventions. The procedure code for evaluation is not a time-based code. If components of that evaluation are divided into separate sessions or separate days, it is still one evaluation, and providers may not bill multiple evaluations for the additional sessions.

2.1.4.2. Re-Evaluation

One new re-evaluation CPT® code is introduced for OT, 97168. The code in current use for 2016 will be discontinued as of December 31, 2016.

Re-evaluation provides additional objective information not included in other documentation, such as progress notes. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care.

Any evaluation or re-evaluation includes an updated POC with revised interventions and treatment goals. Re-evaluation should include general health status and diagnosis, medical/surgical history, and current conditions. The evaluation should include a standardized, norm referencing assessment. If a standardized evaluation is not appropriate for the participant, the evaluation should include therapist's observations, parental/caregiver's observations, description of the participant's deficiencies and strengths, and the medical necessity for skilled therapy services. The evaluation must be completed annually and must be signed and dated by the therapist administering the assessment.

2.1.4.3. Assessment

The assessment is separate from evaluation. It is ongoing, and is included in services or procedures provided. It is not separately payable. Based on the assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.

2.1.5. Reimbursement

Independent OTs are reimbursed on a fee-for-service basis for services provided in the participant's home or in the provider's office. The maximum fee is based upon Medicaid's fee schedule.

The office is defined as the location(s) where the practice is operated during the hours that the therapist engages in the practice at that location. Idaho Medicaid used the Medicare definition and criteria for an office. The office space must be owned, leased, or rented by the therapist/group and used for the exclusive purpose of operating the practice during those hours.

Exceptions to billing services provided outside the home or office setting include:

- "Interdisciplinary Training" as part of the children's developmental disabilities program may bill for that service (99368) in the community setting. That service is not covered except for children enrolled in the children's developmental disabilities program as part

of their budget. The therapist must review the child's plan of service to see if interdisciplinary training is covered and to what extent.

Therapists who treat participants in a nursing home or hospital (inpatient or outpatient), a home health agency, or in the school setting are not considered to be independent therapists. Services provided at those locations should be billed by that entity.

Therapeutic equipment utilized by occupational therapists to provide therapeutic services to Medicaid participants is included in the fee-for-service payment and may not be charged separately (*IDAPA 16.03.09.735.01*).

2.1.6. Healthy Connections (HC)

Effective 2/1/16, a Healthy Connections referral is no longer required for occupational therapy. See [General Information and Requirements for Providers, Healthy Connections \(HC\)](#), for more information.

2.1.7. Participants with Feeding Disorders

Feeding therapy is a service necessary for the treatment of feeding disorders including problems gathering food and getting ready to suck, chew, or swallow. A child who cannot pick up food and get it to his/her mouth or one who cannot completely close their lips to keep food from falling out of their mouth may have a feeding disorder.

Feeding services are covered when a physician/midlevel practitioner has diagnosed a child with a feeding disorder that has caused a clinically significant deviation from normal childhood development. Children who are below 5% on the standard growth chart and who are unable to meet their daily nutritional requirements may meet this criteria. The service must be provided by a licensed occupational therapist with training specific to feeding therapy.

2.1.8. Participants with Developmental Disabilities (DD)

Therapy services for adults with developmental disabilities must be discussed as prioritized needs through the person centered planning process, and be included on the individualized service (ISP) as part of the total cost coming out of the participant's annual budget. The person centered planning team should evaluate the therapy needs of the participant for an entire year and reflect these needs on the ISP.

When a need for additional therapy services is greater than what is indicated on the ISP, an addendum must be submitted to the regional DD care manager to evaluate budget and assessed need. Please submit this addendum to the regional DD care manager. This addendum must show goals for the remaining plan year and proposed start and end dates.

2.1.9. Maintenance Therapy

A maintenance program is one that is ordered by a physician and established by a therapist. To be medically necessary, it must be a service that requires the skills of a therapist to perform the therapy and where the service cannot safely and effectively be done by unskilled personnel. It consists of therapeutic activities and mechanisms to assist a participant in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness. Maintenance therapy often includes a therapeutic home program with periodic assessments of progress.

2.1.10. Telehealth

See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for telehealth covered services and requirements for reimbursement.

Covered telehealth services are real-time communication through interactive technology that enables a provider and a patient at two locations separated by distance to interact simultaneously through two-way video and audio transmission. The evaluation must be provided in person and not by telehealth. The occupational therapist (OT) must certify that the services can safely and effectively be done with telehealth. The physician order must specifically allow the services to be provided by telehealth, and the OT must adhere to all requirements of the licensing board. Additional requirements will be found in the Telehealth Policy.

Reimbursement for telehealth therapy is according to the fee schedule. There is no additional fee for either the originating or the distant site.

2.1.11. Plan of Care

All therapy is provided under a plan of care that is established prior to beginning treatment. The plan must be signed by the therapist who established the plan and the physician. It must be consistent with the therapy evaluation, and must contain at a minimum:

- The diagnoses.
- Measurable treatment goals that pertain to the functional impairment identified in the evaluation.
- Type, frequency, and duration of the therapy services.

2.1.12. Limitations

Once Medicaid has reimbursed the cap amount for OT services, providers should assess the participant to determine if the services continue to be medically necessary and that the skills of a therapist are required. If the services continue to be necessary, the provider may continue to bill for additional services by appending a “KX” modifier to all subsequent claims in that calendar year. The KX modifier is the provider’s attestation that the services are medically necessary.

Beginning November 1, 2016, the utilization review process for therapy services will be primarily targeting claims which indicate high utilization, high dollars, adults transitioning to maintenance, feeding therapies, and other claims with unusual circumstances. In order to ensure an effective and efficient review process, we are requesting for therapy providers to only submit supporting documents once requested by the Department. Please do not submit supporting documentation unless requested by the Department. Providers must submit the required documentation within ten days of the receipt of the Department’s request. Failure to provide the supporting documentation within this timeframe will result in denial of the claim.

The required documentation includes:

- Therapy Service Documentation Coversheet
- Physician order (signed and dated)
- Evaluation
- Current plan of care signed and dated by the physician or mid-level. (Reordered every 90 days for acute conditions and at least 365 days for chronic conditions.) It must specify:
 - Diagnosis
 - Modalities

- Anticipated short and long-term goals that are outcome-based with measurable objectives
- Frequency of treatment
- Expected duration of treatment
- Home follow-through program
- Discharge plan
- Current progress report
- Last 5 sessions of treatment notes

The Department may deny the claim if, at the time of the review, the documentation requested is outdated or missing.

Fax or mail PA requests to the address below, which is the same location as the one used for PA submission.

Fax: 1 (877) 314-8779

Mail to:

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009

The Department will select a number of claims billed with the “KX” modifier to review. All other claims will continue through the claims process. If, after the review, it is determined that a service does not meet criteria for coverage, the claim will be denied and all future OT claims submitted in that calendar year for that participant will be denied. If the participant has a setback, has a new condition, or if there is new information available, the provider can submit a prior authorization request to the Department.

See the [Independent Therapy fee schedule](#) for a list of covered OT services.

2.1.13. Covered Services Overview

Idaho Medicaid covers OT modalities, treatments, and testing as described in the Physical Medicine and Rehabilitation section of the Current Procedural Terminology® (CPT) Manual. The services must:

- Be medically necessary as defined in *IDAPA 13.03.09.011.14*
- Require the skills of an occupational therapist
- Be within the therapist’s scope of practice according to the recognized standards of practice
- Be performed by a therapist who has received adequate training
- Be in accordance with all other Medicaid requirements

See the [Independent Therapy fee schedule](#) for covered OT services.

2.1.13.1. Treatment Modalities

A modality is any physical agent applied to produce therapeutic changes to biologic tissue to include, but not limited to: thermal, acoustic, light, mechanical, or electric energy. Treatment modalities may be performed by the therapist or the directly supervised therapy assistant. Not all modalities are covered by Medicaid. See the Independent Therapy fee schedule on the [Medicaid Fee Schedules](#) website for information about covered procedure codes.

2.1.13.2. Therapeutic Procedures

Therapeutic procedures are the application of clinical skills and/or services that attempt to improve function. All therapeutic procedures require direct, one-on-one participant contact by the therapist or the directly supervised therapy assistant.

2.1.13.3. Tests and Measurements

Tests and measurements require the therapist to have direct one-to-one patient contact.

2.1.13.4. Active Wound Care Management

Wound care management requires that:

- The therapist has the appropriate training
- The therapist has direct, one-to-one, patient contact

2.1.14. Documentation

According to *IDAPA 16.05.07* Section 101, "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five years from the date the item or service was provided."

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries must include at least the following:

- Date and time of service
- Duration of the session (time in and time out – this is the only way to accurately support the amount of time billed)
- Specific treatment provided and the corresponding procedure codes
- Problem(s) treated
- Objective measurement of the participant's response to the services provided during the treatment session
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist

If a scheduled session does not occur as scheduled, the provider must indicate the reason the plan of care was not followed. Missed visits are not a covered service and cannot be billed to Medicaid.

2.1.15. Excluded Services

The following services are excluded from payment.

- Acupuncture (with or without electrical stimulation)
- Biofeedback services (unless provided to treat urinary incontinence)
- Services that address developmentally acceptable error patterns
- Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not require the skills of a therapist to maintain their progress
- Services for participants who have achieved stated goals
- Services that do not require the skills of a therapist or therapy assistant
- Services provided by aides or technicians
- Massage, work hardening, and conditioning
- Services that are not medically necessary as defined in *IDAPA 16.03.09.011*

- Duplicate services
- Services that the Department considers to be experimental or investigational, including, but not limited to, hippotherapy, animal-assisted therapy, and craniosacral therapy
- Skilled therapy for the primary goal of weight management
- Vocational programs
- Group therapy in settings other than School-Based Services
- Vision therapy/eye exercise therapy
- Services provided by athletic trainers

2.1.16. Experimental and Investigational Services

Services that are considered to be experimental or investigational are not covered. Certain types of therapy services lack credible scientific data/clinical evidence for effective treatment, and include but are not limited to: hippotherapy or any animal-assisted therapy, music therapy or sensory integration and auditory integration, and other services not meeting generally accepted and recognized standards of care for medical treatments. These services are considered to be investigational, and must not be billed to Medicaid as therapy services.

2.1.17. Post Payment Review

All orders, evaluations, plans of care, and any other documentation supporting the billed services must be maintained by the provider. The Medical Care Unit may select a random sample of claims for post-payment review.

When a claim is selected for review, the provider will be notified in person or writing by the Department of Health and Welfare or its representative. The therapist must provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity of the billed service including time in and time out. Medicaid may recoup the payment if proper documentation cannot be produced by the provider.

To ensure the integrity of Idaho's Medicaid program, there are a number of federal and state program integrity agencies that may conduct Medicaid payment review. Providers must provide requested documentation to the Department, to the Centers for Medicare and Medicaid Services (CMS), and to any Department or CMS contractor immediately upon request.

2.2. Independent Physical Therapy (PT) Service Policy

Medicaid covers physician-ordered PT rendered by a physical therapist licensed by the Physical Therapy Licensure Board as defined in *IDAPA 24.13.01 Physical Therapy Licensure Board*, and who is enrolled as a Medicaid provider.

Therapy services for speech and physical therapy combined are limited to \$2,080 annually. Additional services may be covered when medically necessary.

2.2.1. Independent Therapist Qualifications

Medicaid will only reimburse for PT services rendered by or under the supervision of a licensed PT who is:

- Identified by Medicare as an independent practitioner, and
- Enrolled as an Idaho Medicaid provider.

A therapy assistant/aide cannot bill Medicaid directly. Services provided by a licensed assistant can be billed by the supervising PT. Any services provided by supportive personnel are not reimbursable by Medicaid.

A therapist who treats participants in a hospital (inpatient or outpatient), nursing facility, home health agency, public school, or charter school is not considered to be an independent therapist. Services provided at those locations must be billed by that enrolled Medicaid Provider.

2.2.2. Physician Orders

For reimbursement by Medicaid, the PT must have an order from a physician or midlevel practitioner (nurse practitioner, clinical nurse specialist, or physician assistant). Services must be a part of a plan of care (POC) based on that order. The participant's progress must be reviewed and the POC updated and reordered every 90 days by a physician or midlevel practitioner with the following exceptions.

- If there is supporting documentation from the participant's physician/midlevel practitioner indicating that the participant has a long-term condition for which therapy is necessary for more than 90 days, an order for continued care is required at least every 365 days.
- A home health agency plan of care must be reordered at least every sixty (60) days.

The written physician/midlevel practitioner order must stipulate:

- Type of services needed
- Frequency of treatment, and
- When applicable, the expected length of need for which the therapy is expected to be medically necessary.

If the initial order is to evaluate and treat, but does not specify the services, frequency, and length of need, then:

1. The PT performs a therapy evaluation based on the initial physician/midlevel practitioner order to evaluate and treat.
2. The PT develops a plan of care based on that evaluation and sends the plan to the physician/midlevel practitioner.
3. The PT may begin therapy.
4. The physician/midlevel practitioner must sign the plan of care specifying the service to be provided, the frequency, and the expected duration.

No claims may be billed until the completed plan of care is signed by the physician/midlevel practitioner.

2.2.3. Supervision of Physical Therapy Assistants

Therapeutic procedures and treatment modalities, as described in the Current Procedural Terminology® (CPT) Manual, may be performed by a licensed PT assistant when under the supervision of the appropriate therapist, as defined in *IDAPA 24.13.01 Rules Governing the Physical Therapy Licensure Board*.

For Medicaid reimbursement:

- All supervision must be done in accordance with the regulations of the Idaho Physical Therapy Licensure Board rules.

- The supervising therapist is required to cosign any documentation completed by the assistant. Therapy services provided by an aide are not reimbursable by Medicaid.

2.2.4. Evaluation and Assessment

Evaluations and re-evaluations may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. Therapy assistants and aides may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service.

2.2.4.1. Evaluation

Effective January 1, 2017, three new evaluation CPT® codes are introduced for physical therapy (PT) services, 97161, 97162, and 97163. The new codes are based on patient complexity and level of clinical decision-making of low, medium, and high complexity. One new re-evaluation CPT® code is introduced for PT 97164. Codes in current use for 2016 will be discontinued as of December 31, 2016.

Providers must use the detailed long description of each new evaluation code to correctly code claims and ensure accurate reporting of services rendered, based on documentation in the participant's file. The therapist performing the evaluation or re-evaluation must ensure that all components of the billed code are accomplished. While there is a usual time component for each of the codes, to bill a specific code, all listed components must be completed and documented.

Evaluation is a separately payable comprehensive service provided by a licensed PT that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. These evaluative judgments are essential to development of the plan of care, including short and long-term goals, and the selection of interventions. The procedure code for evaluation is not a time-based code. If components of that evaluation are divided into separate sessions or separate days, it is still one evaluation and providers may not bill multiple evaluations for the additional sessions.

2.2.4.2. Re-Evaluation

One new re-evaluation CPT® code is introduced for PT, 97164. The code in current use for 2016 will be discontinued as of December 31, 2016.

Re-evaluation provides additional objective information not included in other documentation, such as progress notes. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care.

Any evaluation or re-evaluation includes an updated POC with revised interventions and treatment goals. Re-evaluation should include general health status and diagnosis, medical/surgical history, and current conditions. The evaluation should include a standardized, norm referencing assessment. If a standardized evaluation is not appropriate for the participant, the evaluation should include therapist's observations, parental/caregiver's observations, description of the participant's deficiencies and strengths, and the medical necessity for skilled therapy services. The evaluation must be completed annually and must be signed and dated by the therapist administering the assessment.

2.2.4.3. Assessment

Assessment is separate from evaluation. It is ongoing, and is included in services or procedures provided. It is not separately payable. Based on the assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.

2.2.5. Reimbursement

Independent physical therapists (PT) are reimbursed on a fee-for-service basis for services provided in the participant's home or in the provider's office. The maximum fee paid is based upon Medicaid's fee schedule.

The office is defined as the location(s) where the practice is operated during the hours that the therapist engages in the practice at that location. Idaho Medicaid uses the Medicare definition and criteria for an office. The office space must be owned, leased, or rented by the therapist/group and used for the exclusive purpose of operating the practice during those hours.

Exceptions to billing services provided outside the home or office setting include:

- "Interdisciplinary Training" as part of the children's developmental disabilities program may bill for that service (99368) in the community setting. That service is not covered except for children enrolled in the children's developmental disabilities program as part of their budget. The therapist must review the child's plan of service to see if interdisciplinary training is covered and to what extent.

Therapists who treat participants in a nursing home or hospital (inpatient or outpatient), a home health agency, intermediate care facility, or in the school setting are not considered to be independent therapists. Services provided at those locations must be billed by that entity.

Therapeutic equipment utilized by physical therapists to provide therapeutic services to Medicaid participants is included in the fee-for-service payment and may not be charged separately (*IDAPA 16.03.09.735.01*).

2.2.6. Healthy Connections (HC)

Effective 2/1/16 a Healthy Connections referral is no longer required for physical therapy services. See [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook *Healthy Connections (HC)*, for more information.

2.2.7. Participants with Developmental Disabilities

Therapy services for adults with developmental disabilities must be discussed as prioritized needs through the person centered planning process, and be included on the individualized service (ISP) as part of the total cost coming out of the participant's annual budget. The person centered planning team should evaluate the therapy needs of the participant for an entire year and reflect these needs on the ISP.

When a need for additional therapy services is greater than what is indicated on the ISP, an addendum must be submitted to the regional DD care manager to evaluate budget and assessed need. Please submit this addendum to the regional DD care manager. This addendum must show goals for the remaining plan year and proposed start and end dates.

2.2.8. Maintenance Therapy

A maintenance program is one that is ordered by a physician and established by a therapist. To be covered by Medicaid, it must be a service that requires the skills of a therapist to perform the therapy and it cannot safely and effectively be done by unskilled personnel. It consists of therapeutic activities and mechanisms to assist a participant in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness. Maintenance therapy often includes a therapeutic home program with periodic assessments of progress.

2.2.9. Telehealth

See the [General Information and Requirements for Providers](#), Idaho Medicaid Provider Handbook for telehealth covered services and requirements for reimbursement.

Covered telehealth services are real-time communication through interactive technology that enables a provider and a patient at two locations separated by distance to interact simultaneously through two-way video and audio transmission. The evaluation must be provided in person and not by telehealth. The PT must certify that the services can safely and effectively be done with telehealth. The physician order must specifically allow the services to be provided by telehealth, and the PT must adhere to all requirements of the licensing board. Additional requirements will be found in the Telehealth Policy.

Reimbursement for telehealth therapy is according to the fee schedule. There is no additional fee for either the originating or the distant site.

2.2.10. Plan of Care

All therapy is provided under a plan of care that is established prior to beginning treatment. The plan must be signed by the therapist who established the plan and the physician. It must be consistent with the therapy evaluation, and must contain at a minimum:

- The diagnoses
- Measurable treatment goals that pertain to the functional impairment identified in the evaluation
- Type, frequency, and duration of the therapy services

2.2.11. Limitations

Once Medicaid has reimbursed the cap amount for PT and SLP services combined, providers should assess the participant to determine if the services continue to be medically necessary and that the skills of a therapist are required. If the services continue to be necessary, the provider may continue to bill for services by appending a "KX" modifier to subsequent claims. The "KX" modifier is the provider's attestation that the services are medically necessary.

Beginning November 1, 2016, the utilization review process for therapy services will be primarily targeting claims which indicate high utilization, high dollars, adults transitioning to maintenance, feeding therapies, and other claims with unusual circumstances. In order to ensure an effective and efficient review process, we are requesting for therapy providers to only submit supporting documents once requested by the Department. Please do not submit supporting documentation unless requested by the Department. Providers must submit the required documentation within ten days of the receipt of the Department's request. Failure to provide the supporting documentation within this timeframe will result in denial of the claim.

The required documentation includes:

- Therapy Service Documentation Coversheet
- Physician order (signed and dated)
- Evaluation
- Current plan of care signed and dated by the physician or mid-level. (Reordered every 90 days for acute conditions and at least 365 days for chronic conditions.) It must specify:
 - Diagnosis
 - Modalities
 - Anticipated short and long-term goals that are outcome-based with measurable objectives
 - Frequency of treatment
 - Expected duration of treatment
 - Home follow-through program
 - Discharge plan
- Current progress report
- Last five session of treatment notes

The Department may deny the claims if, at the time of the review, the documentation requested is outdated or missing.

Fax or mail supporting documentation to:

Fax: 1 (877) 314-8779

Mail to:

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009

The Department will select a number of claims billed with the “KX” modifier to review. All other claims will continue through the claims process. If, after the review, it is determined that a service does not meet criteria for coverage, the claim will be denied and all future PT claims submitted in that calendar year for that participant will be denied. If the participant has a setback, has a new condition, or if there is new information available, the provider can submit a prior authorization request to the Department.

2.2.12. Covered Services

Idaho Medicaid covers PT evaluation, modalities, treatments, and testing as described in the Physical Medicine and Rehabilitation section of the Current Procedural Terminology® (CPT) Manual. The services must:

- Be medically necessary as defined in *IDAPA 13.03.09.011.14*
- Require the skills of a PT
- Be within the therapist’s scope of practice according to the recognized standards of practice
- Be performed by a therapist who has received adequate training for the service needed
- Be in accordance with all other Medicaid requirements

See the Independent Therapy fee schedule on the [Medicaid Fee Schedules](#) website for information about covered procedure codes.

2.2.12.1. Modalities

A modality is any physical agent applied to produce therapeutic changes to biologic tissue to include, but not limited to: thermal, acoustic, light, mechanical, or electric energy. Treatment

modalities may be performed by the therapist or the directly supervised therapy assistant. Not all modalities are covered by Medicaid. See the Independent Therapy fee schedule on the [Medicaid Fee Schedules](#) website for information about covered procedure codes.

2.2.12.2. Therapeutic Procedures

Therapeutic procedures are the application of clinical skills and/or services that attempt to improve function. All therapeutic procedures require the therapist to have direct one-on-one participant contact by the therapist or directly supervised therapy assistant.

2.2.12.3. Additional Tests or Measurements

Tests and measurements require the therapist to have direct, one-to-one, patient contact.

Wound care management requires that:

- The therapist has the appropriate training
- The therapist has direct one-to-one patient contact

2.2.13. Documentation

According to *IDAPA 16.05.07* Section 101, "Medicaid providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five (5) years from the date the item or service was provided".

Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries must include the following.

- Date and time of service
- Duration of the session (time in and time out – this is the only way to accurately support the amount of time billed)
- Specific treatment provided and the corresponding procedure codes
- Problem(s) treated
- Objective measurement of the participant's response to the services provided during the treatment session
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist

If a scheduled session does not occur as scheduled, the provider must indicate the reason the plan of care was not followed. Missed visits are not a covered service and cannot be billed to Medicaid.

2.2.14. Excluded Services

The following services are excluded from payment by Idaho Medicaid.

- Acupuncture (with or without electrical stimulation)
- Biofeedback services (unless provided to treat urinary incontinence)
- Services that address developmentally acceptable error patterns
- Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not require the skills of a therapist to maintain their progress
- Services for participants who have achieved stated goals
- Services that do not require the skills of a therapist or therapy assistant
- Services provided by aides or technicians
- Massage, work hardening, and conditioning

- Services not medically necessary as defined in *IDAPA 16.03.09.011*
- Duplicate services
- Services that are considered to be experimental or investigational including, but not limited to, hippotherapy, animal-assisted therapy, and craniosacral therapy
- Skilled therapy for the primary goal of weight management
- Group therapy by providers other than school-based services
- Vocational programs
- Vision therapy/eye exercise therapy
- Services by athletic trainers

2.2.15. Experimental and Investigational Services

Services that are considered to be experimental or investigational are not covered. Certain types of therapy services lack credible scientific data/clinical evidence for effective treatment, and include but are not limited to: hippotherapy or any animal-assisted therapy, music therapy or sensory integration and auditory integration, and other services not meeting generally accepted and recognized standards of care for medical treatments. These services are considered to be investigational, and must not be billed to Medicaid as therapy services.

2.2.16. Post Payment Review

All orders, evaluations, plans of care, and any other documentation supporting the billed services must be maintained by the provider. The Medical Care Unit may select a random sample of claims for post-payment review.

When a claim is selected for review, the provider will be notified in person or writing by the Department of Health and Welfare or its representative. The therapist must provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity of the billed service including time in and time out. Medicaid may recoup the payment if proper documentation cannot be produced by the provider.

To ensure the integrity of Idaho's Medicaid program, there are a number of federal and state program integrity agencies that may conduct Medicaid payment review. Providers must provide requested documentation to the Department, to the Centers for Medicare and Medicaid Services (CMS), and to any Department or CMS contractor immediately upon request.