MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 213
Therapy Services

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Title 23: Division of Medicaid

Part 213: Therapy Services

Part 213 Chapter 1: Physical Therapy

Rule 1.1: Provider Enrollment Requirements for Physical Therapist

Providers of physical therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the provider specific requirements outlined below:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System **(**NPPES),

B. Copy of licensure card or letter from the appropriate board stating current certification and must be from state of servicing location, and

C. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 1.2: Definitions

A. Medicaid defines physical therapy services as medically prescribed services designed to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations. Services are concerned with the prevention of disability, and rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease.

B. Medicaid defines a physical therapist as an individual who meets the state and federal licensing and/or certification requirements to perform physical therapy services.

C. Medicaid defines a physical therapy assistant as an individual who meets state and federal licensing and/or certification requirements to assist in the practice of physical therapy services under the supervision of a licensed physical therapist.

D. Medicaid defines a physical therapy aide as an individual who assists the physical therapist and the physical therapist assist in the practice of physical therapy. The physical therapy aide performs services under the supervision of the licensed physical therapist or licensed physical therapist assistant.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110

Rule 1.3: Covered Physical Therapy Services

A. The Division of Medicaid covers physical therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity to treat a beneficiary's illness, condition, or injury and the following requirements are met:

   1. The services require the knowledge, skill and judgment of a state-licensed physical therapist.

   2. The Certificate of Medical Necessity (CMN) for the initial referral/order is completed by the prescribing provider prior to the physical therapy evaluation.

   3. The plan of care (POC) is developed by a state-licensed physical therapist.

   4. The prescribing provider approves the initial/revised POC with a signature and date:

      a) Before the initiation of treatment or change in treatment, or

      b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

   5. The services are rendered as individualized therapy consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.

   6. The services do not duplicate another provider's services including those services provided in a school-based setting.

B. The Division of Medicaid reimburses for covered physical therapy services provided by:

   1. A state-licensed physical therapist.

   2. A state-licensed physical therapist assisted by a state-licensed physical therapist assistant under direct, on-site supervision by a state-licensed physical therapist.

      a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed physical therapist at regular intervals, as prescribed in regulations adopted by the Mississippi State Board of Physical Therapy and does not include:

         1) Contacts by telephone,

         2) Contacts by pager,

         3) Video conferencing, and/or

4) Any method not approved by the Division of Medicaid.

b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed physical therapist.

3. A state-licensed physical therapist assisted by a physical therapy student who is enrolled in an accredited physical therapy program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed physical therapist, referred to as student assisted physical therapy services.

   a) The Division of Medicaid defines direct, on-site supervision of a physical therapy student as the face-to-face oversight by a state-licensed physical therapist.

   b) The state-licensed physical therapist must be physically present and engaged in student oversight during the entirety of a physical therapy session such that the state-licensed physical therapist is considered to be providing the physical therapy service.

C. The state-licensed physical therapist cannot supervise at the same time during the work day more than:

   1. One (1) physical therapy student,

   2. A total of four (4) state-licensed physical therapist assistants, or

   3. One (1) physical therapy student and three (3) state-licensed physical therapist assistants.

Source: 42 CFR §§ 410.60-61, 440.110; Miss. Code Ann. §§ 43-13-121, 73-23-31, et seq.

History: Revised eff. 01/01/2016.

Rule 1.4: Non-Covered Physical Therapy Services

The Division of Medicaid does not cover or reimburse for physical therapy services in the outpatient setting when:

A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,

B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 1.3.A.4.],

C. Services do not meet medical necessity criteria,

D. Services do not require the knowledge, skill, and judgment of a state-licensed physical therapist,

E. Documentation supports that the beneficiary has attained the physical therapy goals or has reached the point where no further significant improvement can be expected,

F. Documentation supports that the beneficiary has not reached physical therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the physical therapy regimen,

G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,

H. Services duplicate other concurrent therapy,

I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed physical therapist,

J. Conditions could be reasonably expected to improve spontaneously without therapy,

K. Services are ordered daily or multiple times per day from the initiation of therapy through discharge,

L. Services are normally considered part of nursing care,

M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),

N. Services are billed as separate fees for self-care/home-management training,

O. Services are related solely to employment opportunities or the purpose is vocationally based,

P. Services are for general wellness, exercise, and/or recreational programs,

Q. Services are provided by physical therapy aides,

R. Services are delivered in a group therapy or co-therapy session,

S. Services are investigational or experimental,

T. Services consist of acupuncture or biofeedback,

U. Services are outside the scope/and or authority of the state-licensed physical therapist's specialty and/or area of practice,

V. The provider has not met the prior authorization/pre-certification requirements,

W. Services are provided in the home setting, or

X. Services are not specifically listed as covered by the Division of Medicaid.

Source: 42 CFR § 410.60; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 1.5: Reserved

Rule 1.6: Prior Authorization/Precertification

A. Medicaid requires prior authorization/precertification for certain outpatient therapy services.

   1. Prior authorization/precertification for therapy services is conducted through the Utilization Management and Quality Improvement Organization (UM/QIO).

   2. Failure to obtain prior authorization/precertification will result in denial of payment to the providers billing for services.

   3. The UM/QIO must determine medical necessity for the types of therapy services and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the physician.

B. Prior Authorization/Precertification for outpatient therapy services is only required for certain codes when the services fall into one (1) of the following categories:

   1. Therapy services provided to beneficiaries in individual therapist offices or in therapy clinics,

   2. Therapy services provided to adult beneficiaries in the outpatient department of hospitals,

   3. Therapy services provided to beneficiaries in physician offices/clinics,

   4. Therapy services provided to beneficiaries in nursing facilities,

   5. Therapy services covered under regular benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program,

   6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid, if Medicare benefits have exhausted, or

   7. Therapy services billed by school providers.

C. Prior Authorization/Precertification is not required, when the services fall into one (1) of the following categories:

   1. Therapy services provided to beneficiaries in an ICF/MR,

2. Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),

3. Therapy services provided to beneficiaries enrolled in a hospice program, or

4. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not exhausted,

D. Medicaid will cover the initial evaluation and first (1st) therapy session on the same day if the following criteria are met:

1. Medicaid covers urgent physical therapy which is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences.

2. Medicaid covers same day/non-urgent outpatient physical therapy services which is defined as the delivery of therapy services that do not meet the definition of urgent, but completion of services on the same day as the evaluation significantly impacts the beneficiary's treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Prescribing Provider Orders and Responsibilities

Medicaid covers therapy services that are medically necessary, as certified by the prescribing provider.

A. The prescribing provider must complete a Certificate of Medical Necessity for Initial Referral/Orders and submit it to the therapist prior to the therapy evaluation. Medicaid defines prescribing provider as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

B. Therapy services must be furnished according to a written plan of care (POC).

1. The POC must be approved by the prescribing provider before treatment is begun.

a) An approved POC does not mean that the prescribing provider has signed the POC prior to implementation, but only has agreed to it.

b) Medicaid covers for the review to be done in person, by telephone, or facsimile.

2. The POC must be developed by a therapist in the discipline.

3. A separate POC is required for each type of therapy ordered by the prescribing provider.

4. Medicaid requires that the POC must, at a minimum, include the following:

   a) Beneficiary demographic information,

   b) Name of the prescribing provider,

   c) Dates of service,

   d) Diagnosis/symptomatology/conditions and related diagnosis codes,

   e) Specific diagnostic and treatment procedures/modalities and related procedure codes,

   f) Reason for referral,

   g) Frequency of therapeutic encounters,

   h) Units/minutes required per visit,

   i) Duration of therapy,

   j) Precautions,

   k) Short and long term goals that are specific, measurable, and age appropriate,

   l) Home program,

   m) Discharge plan, and

   n) Therapist's signature including name, title, and the date of the therapy session.

5. Medicaid requires the POC to be developed to cover a period of treatment not to exceed six (6) months.

   a) The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC.

   b) A POC for a projected period of treatment beyond six (6) months is not covered by Medicaid.

6. Medicaid requires a revised POC in the following situations:

   a) The projected period of treatment is complete and additional services are required,

   b) A significant change in the beneficiary's condition and the proposed treatment plan

requires that:

1) A therapy provider propose a revised POC to the prescribing provider, or

2) The prescribing provider requests a revision to the POC. Information and documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates.

7. All therapy plans of care, both initial and revised, must be authenticated by the prescribing provider's signature and date signed. The prescribing provider must sign the POC before initiation of treatment or within thirty (30) calendar days of the verbal order approving the treatment plan. Medicaid accepts the signature on the revised POC as a new order.

8. The prescribing provider may make changes to the POC established by the therapist, but the therapist cannot unilaterally alter the POC established by the prescribing provider.

C. Medicaid requires the prescribing provider to participate in the delivery of care by communicating with the treating therapist and by assessing the effectiveness of the prescribed care. The prescribing provider must have a face-to-face visit with the beneficiary at least every six (6) months with the encounter documented.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.60

Rule 1.8: Evaluation and Re-Evaluation

A. Medicaid requires a Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation.

B. Medicaid requires a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning before therapy is initiated. A comprehensive evaluation must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan.

1. Medicaid requires the evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators.

2. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

3. Initial evaluations should, at a minimum contain, the following information:

a) Beneficiary demographic information,

b) Name of the prescribing provider,

c) Date of the evaluation,

d) Diagnosis/functional condition or limitation being treated and onset date,

e) Applicable medical history including mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, comorbidities, either complicating or precautionary information,

f) Prior therapy history for same diagnosis/condition and response to therapy,

g) Level of function, prior and current

h) Clinical status including cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance by sitting and standing, transfer ability, ambulation on level and elevated surfaces, gait analysis, assistive/adaptive devices which are currently in use or required, activity tolerance, presence of wounds including description and incision status, assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children such as chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,

i) Special/standardized tests including the name, scores/results, and dates administered,

j) Social history including effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy,

k) Discharge plan including requirements to return to home, school, and/or job,

l) Impression/interpretation of findings, and

m) Physical therapist's signature, including name, title, and date of service.

C. Medicaid covers re-evaluations based on medical necessity.

1. All re-evaluations must be precertified through the UM/QIO.

2. Documentation must reflect a significant change in the beneficiary's condition or functional status. Medicaid defines significant change as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Beneficiary Non-Compliance

Medicaid does not cover therapy services when documentation supports that the beneficiary:

A. Has not reached therapy goals and is unable to participate and/or benefit from skilled intervention,

B. Refuses to participate, or

C. Is otherwise noncompliant with the therapy regimen. Medicaid defines noncompliance as failure to follow therapeutic recommendations which may include any or all of the following:

1. Failure to attend scheduled therapy sessions, which is defined by Medicaid as cancellation or 'no show' to three (3) consecutive therapy sessions and/or missing half or more of the scheduled visits without documentation of valid reasons such as personal illness/hospitalization or illness/death in the family,

2. Failure to perform home exercise program as instructed by the therapist,

3. Failure to fully participate in therapy sessions,

4. Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance,

5. Failure to properly use special equipment or adaptive devices, or

6. Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Maintenance Therapy

Medicaid defines maintenance therapy as activities that preserve the patient's present level of function and prevent regression of that function. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid. Such services include but are not limited to the following:

A. Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments,

B. Repetitive services that are performed to maintain function, maintain gait, maintain strength and endurance that do not require the professional skills of a licensed therapy provider,

C. Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress, or

D. Exercises and range of motion exercises not related to the restoration of a specific loss of function.

Source: Miss. Code Ann. § 43-13-121

Rule 1.11: Documentation

A. Physical therapy provider records must document and maintain records in accordance with requirements set forth in Miss. Admin. Code Part 200, Rule 1.3.

B. Required documentation by a servicing physical therapy provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment,

4. Original copies of all Outpatient Therapy Evaluation/Re-Evaluation specific to the therapy ordered,

5. The original copies of all Outpatient Therapy Plan of Care specific to the therapy requested,

6. The original copies of all tests performed or a list of all tests performed, test results, and the written evaluation reports,

7. Treatment log if treatment times are not documented in the progress notes including all requirements for timed codes as follows:

    a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

    b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

    c) The Division of Medicaid considers the following activities as not part of the total treatment time:

        1) Pre and post-delivery of services,

2) Time the beneficiary spends not being treated, and

3) Time waiting for equipment or for treatment to begin.

d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress notes:

a) Must be documented at least weekly,

b) Must include:

1) Date/time of service,

2) Specific treatment modalities/procedures performed,

3) Beneficiary's response to treatment,

4) Functional progress,

5) Problems interfering with progress,

6) Education/teaching activities and results,

7) Conferences,

8) Progress toward discharge goals/home program activities, and

9) The signature and title of the therapist providing the service(s).

c) If treatment times are documented in the progress notes in lieu of a treatment log, all requirements for timed codes must be met as follows:

1) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

2) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

3) The Division of Medicaid considers the following activities as not part of the total treatment time:

(a) Pre and post-delivery of services. ,

(b) Time the beneficiary spends not being treated, and

(c) Time waiting for equipment or for treatment to begin.

4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

9. Discharge summary, if applicable, and

10. A copy of the completed prior approval authorization form with prior approval, if applicable.

C. Required documentation by prescribing providers must include, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders,

12. Evidence that the beneficiary was seen face-to-face and evaluated/re-evaluated every six (6) months at a minimum.

D. In addition, the prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

Source: 42 C.F.R. §§ 422.504, 485.713; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/20.

Rule 1.12: Dual Eligibles

A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy services must be pre-certified through the UM/QIO.

B. Beneficiaries cannot receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 1.13: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 2: Occupational Therapy

Rule 2.1: Provider Enrollment Requirements for Occupational Therapist

Providers of occupational therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the provider specific requirements outlined below:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration

System **(**NPPES),

B. Copy of licensure card or letter from the appropriate board stating current certification and must be from state of servicing location, and

C. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 2.2: Definitions

A. Medicaid defines occupational therapy services as medically prescribed services that address developmental and/or functional needs related to the performance of self-help skills, adaptive behavior, and/or sensory, motor and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and Activities of Daily Living (ADL) functions when such functions have been impaired due to congenital and/or developmental abnormalities, illness or injury.

B. Medicaid defines an occupational therapist as an individual who meets the state and federal licensing and/or certification requirements to perform occupational therapy services.

C. Medicaid defines an occupational therapy assistant as an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of occupational therapy services under the supervision of a licensed occupational therapist.

D. Medicaid defines an occupational therapy aide as an unlicensed individual who assists the occupational therapist and the occupational therapy assistant in the practice of occupational therapy. The occupational therapy aide performs services under the supervision of the licensed occupational therapist or licensed occupational therapy assistant.

E. Medicaid defines direct supervision as a state licensed therapist physically being on the premises where services are rendered and is available for immediate assistance during the entire time services are rendered**.** The licensed therapist may not supervise more than two (2) assistants at a time. Medicaid does not cover contacts by telephone, pager, video conferencing, etc. as any type of or substitution for direct supervision.

F. Medicaid defines prescribing provider as a state licensed physician, nurse practitioner, or physician assistant who refers a beneficiary for therapy services.

G. Medicaid defines maintenance therapy as activities that preserve the patient's present level of function and prevent regression of that function.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 410.59

Rule 2.3 Covered Occupational Therapy Services

A. The Division of Medicaid covers occupational therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity to treat a beneficiary's illness, condition, or injury and the following requirements are met:

   1. The services require the knowledge, skill and judgment of a state-licensed occupational therapist.

   2. The Certificate of Medical Necessity (CMN) for initial referral/order is completed by the prescribing provider prior to the occupational therapy evaluation.

   3. The plan of care (POC) is developed by a state-licensed occupational therapist.

   4. The prescribing provider approves the initial/revised POC with a signature and date:

      a) Before the initiation of treatment or change in treatment, or

      b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

   5. The services are rendered as individualized therapy, consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.

   6. The services do not duplicate another provider's services including those services provided in a school-based setting.

B. The Division of Medicaid reimburses for covered occupational therapy services provided by:

   1. A state-licensed occupational therapist.

   2. A state-licensed occupational therapist assisted by a state-licensed occupational therapist assistant under direct, on-site supervision by a state-licensed occupational therapist.

      a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed occupational therapist at regular intervals, as prescribed by the standards of the Accreditation Council of Occupational Therapy Education (ACOTE) and does not include:

         1) Contacts by telephone,

         2) Contacts by pager,

3) Video conferencing, and/or

4) Any method not approved by the Division of Medicaid.

b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed occupational therapist.

3. A state-licensed occupational therapist assisted by an occupational therapy student who is enrolled in an accredited occupational therapy program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed occupational therapist, referred to as student assisted occupational therapy services.

a) The Division of Medicaid defines direct, on-site supervision of an occupational therapy student as the face-to-face oversight by a state-licensed occupational therapist.

b) The state-licensed occupational therapist must be physically present and engaged in student oversight during the entirety of a therapy session such that the state-licensed occupational therapist is considered to be providing the occupational therapy service.

C. The state-licensed occupational therapist cannot supervise at the same time during the work day more than:

1. One (1) occupational therapy student,

2. A total of four (4) state-licensed occupational therapist assistants, or

3. One (1) occupational therapy student and three (3) state-licensed occupational therapist assistants.

Source: 42 CFR § 410. 59, 410.61; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 2.4: Non-Covered Occupational Therapy Services

The Division of Medicaid does not cover or reimburse for occupational therapy services in the outpatient setting when:

A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,

B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 2.3.A.4],

C. Services do not meet medical necessity criteria,

D. Services do not require the knowledge, skills, and judgment of a state-licensed occupational therapist,

E. Documentation supports that the beneficiary has attained the occupational therapy goals or has reached the point where no further significant improvement can be expected,

F. Documentation supports that the beneficiary has not reached occupational therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the occupational therapy regimen,

G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,

H. Services duplicate other concurrent therapy,

I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed occupational therapist,

J. Conditions could be reasonably expected to improve spontaneously without therapy,

K. Services are ordered daily or multiple times per day from the initiation of therapy through discharge,

L. Services are normally considered part of nursing care,

M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),

N. Services are billed as separate fees for self-care/home-management training,

O. Services are related solely to employment opportunities or the purpose is vocationally based,

P. Services are for general wellness, exercise, and/or recreational programs,

Q. Services are provided by occupational therapy aides,

R. Services are delivered in a group therapy or co-therapy session,

S. Services are investigational or experimental,

T. Services consist of acupuncture or biofeedback,

U. Services are outside the scope/and or authority of the state-licensed occupational therapist's specialty and/or area of practice,

V. The provider has not met the prior authorization/pre-certification requirements,

W. Services are provided in the home setting, or

X. Services are not specifically listed as covered by the Division of Medicaid.

Source: 42 CFR § 410.59; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 2.5: Prior Authorization/ Precertification

A. The UM/QIO will determine medical necessity, the types of therapy services, and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the prescribing provider.

B. Prior Authorization/Pre-certification for outpatient therapy services is only required for certain procedure codes when the services fall into one (1) of the following categories:

1. Therapy services provided to beneficiaries, adult and/or children in individual therapist offices or in therapy clinics,

2. Therapy services provided to beneficiaries, adult and/or children, in the outpatient department of hospitals,

3. Therapy services provided to beneficiaries, adult and/or children, in physician offices/clinics,

4. Therapy services provided to beneficiaries in nursing facilities,

5. Therapy services covered under regular State Plan benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program, and

6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted.

C. Exclusions to Prior Authorization/Precertification

1. Prior Authorization/Precertification is not required, regardless of procedure codes used, when the services fall into one (1) of the following categories:

a) Therapy services provided to beneficiaries in an ICF/MR,

b) Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),

c) Therapy services provided to beneficiaries enrolled in a hospice program, or

d) Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

D. Prior Authorization/Pre-certification Request - Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth by the UM/QIO. Medicaid does not cover the initial evaluation and the first therapy session on the same day. The UM/QIO is authorized to accept retrospective requests for urgent services and same day/non-urgent services as defined and outlined in Part 213, Chapter 1.

Source: Miss. Code Ann. § 43-13-121

Rule 2.6: Prescribing Provider Orders/Responsibilities

A. Medicaid provides benefits for therapy services that are medically necessary, as certified by the prescribing provider.

B. The prescribing provider must complete a Certificate of Medical Necessity for Initial Referral/Orders form and submit it to the therapist prior to therapy evaluation.

C. Therapy services must be furnished according to a written plan of care (POC). The plan of care must be approved by the prescribing provider before treatment is begun. Medicaid defines approval as the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline. A separate plan of care is required for each type of therapy ordered by the prescribing provider. The plan must, at a minimum, include the following:

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Dates of service,

4. Diagnosis/symptomatology/conditions and related diagnosis codes,

5. Reason for referral,

6. Specific diagnostic and treatment procedures/modalities and related procedure codes,

7. Frequency of therapeutic encounters,

8. Units/minutes required per visit,

9. Duration of therapy,

10. Precautions, if applicable,

11. Short and long term goals that are specific, measurable, and age appropriate,

12. Home program,

13. Discharge plan, and

14. Therapist's signature, name and title, and date.

D. Medicaid requires the POC to cover a period of treatment up to six (6) months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. Medicaid does not cover a POC for a projected period of treatment beyond six (6) months.

E. Medicaid requires a revised POC in the following situations:

1. The projected period of treatment is complete and additional services are required,

2. A significant change in the beneficiary's condition and the proposed treatment plan requires that a therapy provider propose a revised POC to the prescribing provider, or the prescribing provider requests a revision to the POC. In either case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services, and

3. Information/documentation submitted to the UM/QIO indicates the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates. The therapy provider must submit a revised POC to the UM/QIO for authorization/certification prior to rendering services,

F. All therapy plans of care, initial and revised, must be authenticated, with signature and date, by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment or within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

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

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

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

J. Medicaid does not cover therapy services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen. Noncompliance is defined as failure to follow therapeutic recommendations which may include any or all of the following:

1. Failure to attend scheduled therapy sessions,

2. Failure to perform home exercise program as instructed by the therapist,

3. Failure to fully participate in therapy sessions,

4. Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance, and

5. Failure to properly use special equipment or adaptive devices. Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.

K. Medicaid requires a mandatory face-to-face visit with the beneficiary by the prescribing provider at least every six (6) months and, requires the encounter is documented.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.59; 42 CFR 410.61

Rule 2.7: Evaluation/Re-Evaluation

A. A Certificate of Medical Necessity for Initial Referral/Orders must be completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation.

B. Before therapy is initiated, a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan. The initial evaluation must be completed by a state-licensed therapist. The evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

C. Initial evaluations should, at a minimum, contain the following information:

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Date of the evaluation,

4. Diagnosis/functional condition or limitation being treated and onset date,

5. Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, co-morbidities, with complicating or precautionary information,

6. Prior therapy history for same diagnosis/condition and response to therapy,

7. Level of function, prior and current,

8. Clinical status including cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance, while sitting and standing, transfer ability, ambulation at level and elevated surfaces, gait analysis, assistive/adaptive devices either currently in use or required, activity tolerance, presence of wounds including description and incision status, assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children by chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,

9. Special/standardized tests including the name, scores/results, and dates administered,

10. Social history including effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy,

11. Discharge plan including requirements to return to home, school, and/or job,

12. Impression/interpretation of findings, and

13. Occupational therapist's signature, with name and title and date.

D. Medicaid covers re-evaluations based on medical necessity. All re-evaluations must be pre-certified through the UM/QIO. Documentation must reflect significant change in the beneficiary's condition or functional status. Significant change is defined as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

E. The components of the re-evaluation and the documentation requirements are the same as the initial evaluation, but are focused on assessing significant changes from the initial evaluation or progress toward treatment goals and making a professional judgment about continued care, modifying goals and/or treatment, or termination of therapy services. Documentation should include improvements and setbacks, as well as, interventions required to treat any medical complications. When expected progress has not been realized and continued therapy

is planned, the re-evaluation needs to include valid indications to support the expectation that significant improvement will occur in a reasonable and predictable time frame.

F. In all cases, other than termination of therapy services, re-evaluation findings must be reflected in revisions to the therapy plan of care.

G. The servicing provider, or licensed therapist, is responsible for providing a copy of the initial evaluation and all re-evaluations to the prescribing provider.

Source: Miss. Code Ann. § 43-13-121

Rule 2.8: Maintenance Therapy

A. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid.

B. Maintenance programs must be planned and taught before the end of active therapy treatment so that the beneficiary, family members, or other unskilled caregivers can carry out the program. If the maintenance program is not established until after the rehabilitative program has been completed, the skills of a therapist for development of a maintenance program are not considered medically necessary and are covered.

Source: Miss. Code Ann. § 43-13-121

Rule 2.9: Documentation

A. Occupational therapy providers must document and maintain records in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3.

B. Required documentation by an occupational therapy servicing provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment,

4. Original copies of all Outpatient Therapy Evaluation/Re-Evaluation forms specific to the therapy ordered,

5. Original copies of all Outpatient Therapy Plan of Care forms specific to the therapy ordered,

6. Original copies of all tests performed or a list of all tests performed, test results, and the written evaluation reports,

7. Treatment log if treatment times are not documented in the progress notes including all requirements of timed codes as follows:

    a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

    b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

    c) The Division of Medicaid considers the following activities as not part of the total treatment time:

        1) Pre and post-delivery of services,

        2) Time the beneficiary spends not being treated, and

        3) Time waiting for equipment or for treatment to begin.

    d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

    e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

    f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress notes:

    a) Must be documented at least weekly.

    b) Must include:

        1) Date/time of service,

        2) Specific treatment modalities/procedures performed,

        3) Beneficiary's response to treatment, functional progress,

        4) Problems interfering with progress,

        5) Education/teaching activities and results,

6) Conferences,

7) Progress toward discharge goals/home program activities, and

8) The signature and title of the therapist providing the service(s).

c.) If treatment times are documented in the progress notes in lieu of a treatment log, all requirements for timed codes must be met, Refer to timed and untimed codes in this Part.

9. Discharge Summary, if applicable, and

10. A copy of the completed prior approval form with prior approval authorization, if applicable.

C. Required documentation by a prescribing occupational therapy provider includes, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen, face-to-face, and evaluated/re-evaluated every six (6) months, at a minimum.

D. The prescribing occupational therapy provider must retain copies of the rendering provider's/ therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

Source: 42 C.F.R. §§ 422.504, 485.715; Miss. Code Ann. §§ 43-13-117, 43-13-121,.

History: Revised eff. 01/01/20.

Rule 2.10: Dual Eligibles

A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy services must be prior authorized/ precertified through the UM/QIO.

B. Beneficiaries may not receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 2.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 3: Outpatient Speech-Language Pathology (Speech Therapy)

Rule 3.1: Provider Enrollment Requirements

Providers of speech-language pathology must comply with the requirements set forth in Part 200, Rule 4.8 in addition the provider type specific requirements outlined below. Therapy providers wishing to enroll as group providers must adhere to the enrollment requirements in Part 200, Rule 4.9.

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Copy of current licensure card or permit.

C. Documentation that the individual meets one (1) of the following requirements:

1. Has a certificate of clinical competence from the American Speech and Hearing Association (ASHA),

2. Has completed the equivalent educational requirements and work experience necessary for the certificate, or

3. Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

D. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: 42 C.F.R. § 440.110; 42 C.F.R. 455, Subpart E; Miss. Code Ann. § 43-13-121.

History: Revised eff. 05/01/2018.

Rule 3.2: Definitions

A. Medicaid defines speech therapy services as medically prescribed services necessary for the diagnosis and treatment of communication impairment and/or swallowing disorder that has occurred due to disease, trauma or congenital anomaly.

B. Medicaid defines a speech-language pathologist (speech therapist) as an individual who meets the state and federal licensing and/or certification requirements to perform speech-language pathology services.

C. Medicaid defines a speech-language pathology assistant or speech therapy assistant as an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of speech-language pathology services under the supervision of a licensed speech-language pathologist.

D. Medicaid defines a speech-language pathology aide as an unlicensed individual who assists the speech-language pathologist and the speech-language pathology assistant in the practice of speech-language pathology. The speech-language pathology aide performs services under the supervision of the licensed speech-language pathologist.

E. Medicaid defines group therapy as the simultaneous treatment of two (2) or more beneficiaries.

F. Medicaid defines a prescribing provider as a state licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

G. Medicaid defines maintenance therapy as activities that preserve the beneficiary's present level of function and prevent regression of that function.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110

Rule 3.3: Covered Speech-Language Pathology and Audiology Services

A. The Division of Medicaid covers speech-language pathology and audiology services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, for the diagnosis and treatment of a communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity and the following requirements are met:

1. The services require the knowledge, skill and judgment of a state-licensed speech-language pathologist or audiologist.

2. The Certificate of Medical Necessity (CMN) for initial referral/order is completed by the prescribing provider prior to the speech-language pathology or audiology evaluation.

3. The plan of care (POC) is developed by a state-licensed speech-language pathologist or audiologist.

4. The prescribing provider approves the initial/revised POC with a signature and date:

   a) Before the initiation of treatment or change in treatment, or

   b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

5. The services are rendered as individualized speech language pathology or audiology services consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.

6. The services do not duplicate another provider's services including those services provided in a school-based setting.

7. The beneficiary presents with one (1) or more of the following:

   a) Aphagia defined as an inability to swallow,

   b) Aphasia defined as an absence/impairment of the ability to communicate through speech, writing, or signs caused by focal damage to the language dominant hemisphere of the brain,

   c) Aphonia defined as an inability to produce sounds from the larynx due to excessive muscle tension, paralysis, or disease of the laryngeal nerves,

d) Apraxia defined as an inability to form words to speak despite an ability to use facial and oral muscles to make sounds,

e) Dysarthria defined as defective or difficult speech that involves disturbances in muscular control like weakness, lack of coordination, or paralysis of the speech mechanism, either oral, lingual, respiratory or pharyngeal muscles, resulting from damage to the peripheral or central nervous system,

f) Dysphagia defined as difficulty swallowing,

g) Dysphasia defined as language impairment from neurodevelopmental disorder or brain lesion,

h) Dysphonia defined as difficulty speaking due to impairment of the muscles involving vocal production, and/or

i) Vocal cord dysfunction defined as impairment of vocal cord mobility due to functional or structural abnormalities resulting from organic or neurological diseases.

8. Risk factors have been identified and documented including, but are not limited to:

a) Neurological disorders/dysfunctions, such as hearing loss or cerebral palsy,

b) Surgical procedures, such as partial/comprehensive/radical laryngectomy, repaired cleft palate, or glossectomy,

c) Cognitive impairments that affect communication functions, or

d) Medical conditions resulting in communication disorders that require restorative therapy including, but not limited to:

1) Laryngeal carcinoma requiring partial/total largyngectomy that results in dysphonia or aphonia,

2) Traumatic brain injury that may exhibit inadequate respiratory volume, apraxia, dysphagia, or dysarthria,

3) Progressive/static neurological conditions, such as amyotrophic lateral sclerosis, Parkinson's disease, myasthenia gravis, multiple sclerosis, or Huntington's disease,

4) Intellectual disability with disorders of dysarthria, dysphagia, apraxia, or aphagia, and/or

5) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria.

9. The type of service requested includes one (1) or more of the following:

    a) Diagnostic and evaluation services:

        1) To determine the type, causal factors, severity of speech-language or swallowing disorders, and the extent of service required to restore functions of speech, language, voice fluency, and swallowing, or

        2) The beneficiary demonstrates changes in functional speech or remission of a medical condition that previously contradicted speech-language therapy.

    b) Therapeutic services defined as services requiring active corrective/restorative therapy, for communication disorders that result from:

        1) Laryngeal carcinoma requiring partial/total largyngectomy that results in aphonia so the beneficiary can develop new communication skills through esophageal speech or the use of an electrolarynx,

        2) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria, or

        3) Medical and neurological conditions, like traumatic brain injury, Parkinson's disease, or multiple sclerosis, exhibiting inadequate respiratory volume/control, aphonia, dysphagia, dysarthria, or dysphonia.

B. The Division of Medicaid reimburses for covered speech-language pathology or audiology services provided by:

    1. A state-licensed speech-language pathologist or audiologist.

    2. A state-licensed speech-language pathologist or audiologist assisted by a state-licensed speech-language pathologist or audiologist assistant under direct, on-site supervision by a state-licensed speech-language pathologist or audiologist.

        a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed speech-language pathologist or audiologist at regular intervals, congruent with the standards of the American Speech-Language-Hearing Association (ASHA) and does not include:

            1) Contacts by telephone,

            2) Contacts by pager,

            3) Video conferencing, and/or

4) Any method not approved by the Division of Medicaid.

b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed speech-language pathologist or audiologist.

3. A state-licensed speech-language pathologist or audiologist assisted by a speech-language pathology or audiology student who is enrolled in an accredited speech-language pathology or audiology program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed speech-language pathologist or audiologist, referred to as student assisted speech-language pathology or audiology services.

   a) The Division of Medicaid defines direct, on-site supervision of a speech-language pathology or audiology student as the face-to-face oversight by a state-licensed speech-language pathologist or audiologist.

   b) The state-licensed speech-language pathologist or audiologist must be physically present and engaged in student oversight during the entirety of a therapy session such that the state-licensed speech-language pathologist or audiologist is considered to be providing the speech-language pathology or audiology service.

C. The state-licensed speech-language pathologist or audiologist cannot supervise at the same time during the work day more than:

   1. One (1) speech-language pathology or audiology student,

   2. A total of four (4) state-licensed speech-language pathologist or audiologist assistants, or

   3. One (1) speech-language pathology or audiology student and three (3) state-licensed speech-language pathologist or audiologist assistants.

Source: 42 CFR § 410.61-62; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 3.4: Non-Covered Speech-Language Pathology or Audiology Services

The Division of Medicaid does not cover or reimburse for speech-language pathology or audiology services in the outpatient setting when:

A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,

B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 3.3.A.4.],

C. Services do not meet medical necessity criteria,

D. Services do not require the knowledge, skill, and judgment of a state-licensed speech-language pathologist or audiologist,

E. Documentation supports that the beneficiary has attained the speech-language pathology or audiology goals or has reached the point where no further significant improvement can be expected,

F. Documentation supports that the beneficiary has not reached the speech-language pathology or audiology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the speech-language pathology or audiology regimen,

G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,

H. Services duplicate other concurrent therapy,

I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed speech-language pathologist or audiologist,

J. Conditions could be reasonably expected to improve spontaneously without therapy,

K. Services are ordered daily, or multiple times per day, from the initiation of therapy through discharge,

L. Services are normally considered part of nursing care,

M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),

N. Services are billed as separate fees for self-care/home-management training,

O. Services are related solely to employment opportunities or the purpose is vocationally based,

P. Services are for general wellness, exercise, and/or recreational programs,

Q. Services are provided by speech-language pathology or audiology aides,

R. Services are delivered in a group therapy or co-therapy session,

S. Services are investigational or experimental,

T. Services consist of acupuncture or biofeedback,

U. Services are outside the scope/and or authority of the state-licensed speech-language pathologist's or audiologist's specialty and/or area of practice,

V. The provider has not met the prior authorization/pre-certification requirements,

W. Services are provided in the home setting, or

X. Services are not specifically listed as covered by the Division of Medicaid.

Source: 42 CFR § 410.61-62; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 3.5: Prior Authorization/Pre-certification

A. Medicaid requires prior authorization/precertification of certain outpatient therapy services. Prior authorization/precertification for therapy services is conducted through the Utilization Management and Quality Improvement Organization (UM/QIO) Failure to obtain prior authorization/precertification will result in denial of payment to the providers billing for services.

B. Prior Authorization/Pre-certification for outpatient therapy services is only required for certain procedure codes when the services fall into one (1) of the following categories:

1. Therapy services provided to beneficiaries, adult and/or children in individual therapist offices or in therapy clinics,

2. Therapy services provided to beneficiaries, adult and/or children in the outpatient department of hospitals,

3. Therapy services provided to beneficiaries, adult and/or children in physician offices/clinics,

4. Therapy services provided to beneficiaries in nursing facilities,

5. Therapy services covered under regular benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program,

6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted,

7. Therapy services provided to beneficiaries under age twenty-one (21) through the following providers: Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and State Department of Health, or

8. Therapy services billed by school providers.

C. Prior Authorization/Precertification is not required, regardless of the procedure codes used, when the services fall into one (1) of the following categories:

1. Therapy services provided to beneficiaries in an ICF/MR,

2. Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),

3. Therapy services provided to beneficiaries enrolled in a hospice program, or

4. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

D. Prior Authorization/Precertification Request

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

2. Medicaid does not cover the initial evaluation and the first (1st) therapy session on the same day. The UM/QIO is authorized to accept retrospective requests for the following exceptions:

a) Urgent services as defined and outlined in Part 213, Chapter 1, Rule 1.6 D or

b) Same Day/ Non-Urgent Services as defined and outlined in Part 213, Chapter 1, Rule 1.6 D.

Source: Miss. Code Ann. § 43-13-121

Rule 3.6: Prescribing Provider Orders/Responsibilities

A. Medicaid covers therapy services that are medically necessary, as certified by the prescribing provider. Medicaid defines prescribing provider as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

B. The prescribing provider must complete a Certificate of Medical Necessity for Initial Referral/Orders form and submit it to the therapist prior to therapy evaluation.

C. Therapy services must be furnished according to a written plan of care (POC). The plan of care must be approved by the prescribing provider before treatment is begun. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline. A separate plan of care is required for each type of therapy ordered by the prescribing provider.

D. Medicaid requires the POC must, at a minimum, include the following:

1. Beneficiary demographic information,
2. Name of the prescribing provider,
3. Dates of service,
4. Diagnosis/symptomatology/conditions and related diagnosis codes,
5. Specific diagnostic and treatment procedures/modalities and related procedure codes,
6. Reason for referral,
7. Frequency of therapeutic encounters,
8. Units/minutes required per visit,
9. Duration of therapy,
10. Precautions short and long term goals that are specific, measurable, and age appropriate,
11. Home program,
12. Discharge plan, and
13. Therapist's signature, including the name and title, and date of the therapy session,

E. The plan of care (POC) must be developed to cover a period of treatment not to exceed six (6) months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. A POC for a projected period of treatment beyond six (6) months is not covered by Medicaid.

F. Medicaid requires a revised POC in the following situations:

1. The projected period of treatment is complete and additional services are required, or

2. A significant change in the beneficiary's condition and the proposed treatment plan requires that:

a) A therapy provider propose a revised POC to the prescribing provider, or

b) The prescribing provider requests a revision to the POC. Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates.

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

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

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

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

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.61; 42 CFR 410.62

Rule 3.7: Evaluation/ Re-Evaluation

A. Medicaid requires a Certificate of Medical Necessity for Initial Referral/Orders must be completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation.

B. Medicaid requires that before therapy is initiated, a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan. Medicaid requires the evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

C. Initial evaluations should, at a minimum, contain the following information:

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Date of the evaluation,

4. Diagnosis/functional condition or limitation being treated and onset date,

5. Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, co-morbidities, complicating or precautionary information,

6. Prior therapy history for same diagnosis/condition and response to therapy,

7. Level of function, prior and current,

8. Clinical status including cognitive function, sensation/proprioception, edema, vision and hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance by sitting and standing, transfer ability, ambulation on level and elevated surfaces, gait analysis, assistive/adaptive devices currently in use or required, activity tolerance, presence of wounds including description and incision status, assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,

9. Special/standardized tests including the name, scores/results, and dates administered,

10. Social history: effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy,

11. Discharge plan including requirements to return to home, school, and/or job,

12. Impression/interpretation of findings, and

13. Physical therapist's signature including name and title and date of service.

D. Medicaid covers re-evaluations based on medical necessity. All re-evaluations must be pre-certified through the UM/QIO. Documentation must reflect significant change in the beneficiary's condition or functional status. Medicaid defines significant change as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 3.8: Maintenance Therapy

A. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid. Such services include, but are not limited to, the following:

1. Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments,

2. Repetitive services that are performed to maintain function, maintain gait, maintain strength and endurance that do not require the professional skills of a licensed therapy provider,

3. Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress, or

4. Exercises and range of motion exercises not related to the restoration of a specific loss of function.

B. Maintenance programs must be planned and taught before the end of active therapy treatment so that the beneficiary, family members, or other unskilled caregivers can carry out the program. Maintenance programs established after the rehabilitative program are not considered medically necessary and will not be covered.

Source: Miss. Code Ann. § 43-13-121

Rule 3.9: Documentation

A. Speech therapy providers must document and maintain records in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3.

B. Required documentation by servicing speech therapy provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment,

4. Original copies of all Outpatient Therapy Evaluation/Re-Evaluations specific to the therapy ordered,

5. The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy ordered,

6. The original copies of all tests performed or a list of all tests performed, test results, and the written evaluation reports,

7. Treatment log if treatment times are not documented in the progress notes including all requirements for timed codes as follows:

   a) The Division of Medicaid defines timed codes as procedure codes that reference a time per unit.

   b) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

c) The Division of Medicaid considers the following activities as not part of the total treatment time:

1) Pre and post-delivery of services,

2) Time the beneficiary spends not being treated, and

3) Time waiting for equipment or for treatment to begin.

d) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

e) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

f) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

8. Progress notes:

a) Must be documented at least weekly.

b) Must include:

1) Date/time of service,

2) Specific treatment modalities/procedures performed,

3) Beneficiary's response to treatment,

4) Functional progress,

5) Problems interfering with progress,

6) Education/teaching activities and results,

7) Conferences,

8) Progress toward discharge goals/home program activities, and

9) The signature and title of the therapist providing the service(s).

c) If treatment times are documented in the progress notes in lieu of a treatment log, all requirements for timed codes must be met as follows:

1) The Division of Medicaid defines timed codes as procedure codes that reference a

time per unit.

2) The Division of Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

3) The Division of Medicaid considers the following activities as not part of the total treatment time:

   (a) Pre and post-delivery of services,

   (b) Time the beneficiary spends not being treated, and

   (c) Time waiting for equipment or for treatment to begin.

4) The Division of Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame.

5) The Division of Medicaid does not require documentation of the treatment time for untimed codes.

6) The Division of Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

9. Discharge summary, if applicable, and

10. A copy of the completed prior authorization form, if applicable.

C. Required documentation by prescribing provider must include, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen (face-to-face) and evaluated/re-evaluated every six (6) months at a minimum.

D. The prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

Source: 42 C.F.R. §§ 422.504, 485.715; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/20.

Rule 3.10: Dual Eligibles

A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy service must be prior authorization/precertified through the UM/QIO.

B. Beneficiaries cannot receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 3.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 4: Administrative Appeals

Rule 4.1: Appeals for Therapy Services

A. Reconsideration Process - The beneficiary, therapy provider, or prescribing provider is afforded the right to appeal a utilization review denial to the UM/QIO through the reconsideration process set forth by the UM/QIO.

B. Administrative Appeal - Disagreement with the UM/QIO reconsideration determination shall be appealed to Medicaid by the beneficiary/legal representative. The beneficiary/legal representative must submit a written request for administrative appeal within thirty (30) calendar days of the UM/QIO reconsideration determination notice.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 42 CFR 441.308