Mississippi Medicaid

Provider Reference Guide

For Part 213

Therapy Services

This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.

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PHYSICAL THERAPY INTRODUCTION

Medicaid, as authorized by Title XlX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. DOM initiates Medicaid policy as it relates to these factors.

PRIOR AUTHORIZATION/ RECERTIFICATION

A complete list of CPT codes that require pre-certification may be obtained from the UM/QIO.

PRIOR AUTHORIZATION REQUEST

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

Certification/recertification acknowledges the medical necessity and appropriateness of services. It does not guarantee payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Therapy providers can use standardized forms provided by the UM/QIO. Required forms include the following:

- Pre-certification Review Request
- Certification of Medical Necessity for Initial Referral/Orders

- Outpatient Therapy Evaluation/Re-Evaluation (specific to the therapy requested)

- Outpatient Therapy Plan of Care (specific to the therapy requested)

The initial evaluation and the first therapy session should not be done on the same day to allow time to develop a plan of care and obtain pre-certification from the UM/QIO. However, the UM/QIO is authorized to accept retrospective requests for the following exceptions:

URGENT SERVICES

In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services 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. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

SAME DAY/NON-URGENT SERVICES

In rare instances where same day/non-urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Same day/ non-urgent outpatient physical, occupational, or speech therapy services 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 (example: therapeutic activities, such as the use of crutches, on the same day as diagnosis/treatment of leg fracture). If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

REVIEW OUTCOMES

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for therapy, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the criteria are not met or the review outcome results in a denial, written notification will be sent to the beneficiary/representative, therapy provider, and prescribing provider.

RECONSIDERATION PROCESS

The beneficiary, therapy provider, or prescribing provider may appeal a utilization review denial to the UM/QIO through the reconsideration process outlined in the UM/QIO manual.

ADMINISTRATIVE APPEAL

Disagreement with the UM/QIO reconsideration determination may be appealed 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 review determination notice. The process for requesting an administrative appeal is included in the denial notice that is sent to the beneficiary/representative.

PRESCRIBING PROVIDER ORDERS AND RESPONSIBILITIES

PRESCRIBING PROVIDER

The Division of Medicaid provides benefits for therapy services that are medically necessary, as certified by the prescribing provider. For the purpose of this policy, prescribing provider is defined as a state licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

CERTIFICATE OF MEDICAL NECESSITY FOR INITIAL REFERRAL/ORDERS

The prescribing provider has a major role in determining the utilization of services provided by therapy providers. 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. The form is available through the UM/QIO.

THERAPY PLAN OF CARE

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. For the purpose of this policy, approved means that 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, i.e., only a speech therapist may develop a speech therapy evaluation, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. Providers must use the standardized outpatient therapy plan of care form specific to the therapy requested. Forms are available through the UM/QIO.

The POC may be developed to cover a period of treatment up to six 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 acceptable.

The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO. Based on medical necessity, the UM/QIO may approve certification periods for less

than OR up to six (6) months. Approved certification periods will not exceed the period of treatment indicated on the POC.

EVALUATION AND RE-EVALUATION

Evaluation is an integral component of physical therapy services. The initial evaluation establishes the baseline data necessary for setting realistic goals, measuring progress, and assessing rehabilitation potential. Periodic re-evaluation is used to assess the beneficiary's progress in relationship to treatment goals. All evaluations must be performed by a therapist in the discipline, i.e., only a physical therapist may perform a physical therapy evaluation, etc. Therapy providers must use the standardized outpatient therapy evaluation/re-evaluation form specific to the therapy requested. Forms are available through the UM/QIO.

The initial evaluation must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapist assistant. 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.

The initial evaluation and the first therapy session should not be done on the same day to allow time to develop a plan of care and, if necessary for the applicable CPT code(s), obtain pre-certification from the UM/QIO.

RE-EVALUATION

The Division of Medicaid will cover 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.

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.

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

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

PLAN OF CARE

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. For the purpose of this policy, approved means that 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, i.e., only a physical therapist may develop a physical therapy plan of care, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. Providers must use the standardized outpatient therapy plan of care form specific to the therapy requested. Forms are available through the UM/QIO.

The plan must at a minimum include the following:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Dates of service (from/to)
- Diagnosis/symptomatology/conditions and related ICD-9 codes
- Reason for referral
- Specific diagnostic and treatment procedures/modalities and related CPT codes
- Frequency of therapeutic encounters (visits per week, day, month)
- Units/minutes required per visit
- Duration of therapy (weeks, days, months)
- Precautions (if applicable)
- Clinical update for concurrent plan of care only (general summary of attendance, progress, setbacks, changes since last plan of care
- Short and long term goals (specific, measurable, age appropriate, and current baseline status for each goal
- Home program
- Discharge plan

- Therapist's signature (name and title) and date

The POC may be developed to cover a period of treatment up to six 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 acceptable.

The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO. Based on medical necessity, the UM/QIO may approve certification periods for less than OR up to six (6) months. Approved certification periods will not exceed the period of treatment indicated on the POC.

DOM requires a revised POC in the following situations:

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

- 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. In either case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

- 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. In this situation, the UM/QIO is authorized by DOM to request that the therapy provider submit a revised POC. The therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

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.

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

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.

The initial plan of care and all revised plans of care must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapist assistant.

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

BENEFICIARY NONCOMPLIANCE

DOM will 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:

- Failure to attend scheduled therapy sessions (i.e., 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, illness/death in the family)
- Failure to perform home exercise program as instructed by the therapist
- Failure to fully participate in therapy sessions (i.e., refusing to perform activities directed by therapist; late for scheduled therapy sessions or leaving before the session is completed)
- Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance
- Failure to properly use special equipment or adaptive devices (e.g., beneficiary requires the use of ankle-foot orthoses (AFOs) but does not wear them or bring them to therapy sessions)
- Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record

OCCUPATIONAL THERAPY INTRODUCTION

Medicaid, as authorized by Title XlX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. DOM initiates Medicaid policy as it relates to these factors.

THERAPY ASSISTANTS AIDES AND STUDENTS

THERAPY ASSISTANTS

The Division of Medicaid will cover services provided by state-licensed occupational therapy assistants only in the outpatient department of a hospital. Therapy assistants must be under the direct supervision of a state-licensed therapist of the same discipline, i.e., a state-licensed occupational therapist must directly supervise a state-licensed occupational therapy assistant.

For the purposes of this policy, direct supervision means that the state-licensed therapist is physically on the premises where services are rendered and, if needed, 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. Under no circumstances will the Division of Medicaid recognize contacts by telephone, pager, video conferencing, etc. as any type of or substitution for direct supervision.

The initial evaluation, plan of care, and discharge summary must be completed by a state- licensed therapist. DOM will not reimburse for these services if they are performed by a therapy assistant.

THERAPY AIDES

Services provided by occupational therapy aides, regardless of the level of supervision, are not covered by the Division of Medicaid.

THERAPY STUDENTS

Services provided by occupational therapy students, regardless of the level of supervision, are not covered by the Division of Medicaid.

PRIOR AUTHORIZATION/PRE-CERTIFICATION

Prior authorization or pre-certification serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit DOM to require authorization for any service where it is anticipated or known that the services could either be abused by providers or beneficiaries or could easily result in excessive, uncontrollable Medicaid costs. Certification as referred to in this policy is synonymous with prior authorization.

Pre-certification of certain outpatient therapy services is required by the Division of Medicaid. Providers must prior authorize/pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. Failure to obtain prior authorization will result in denial of payment to the providers billing for services.

A complete list of CPT codes that require pre-certification may be obtained from the UM/QIO.

EXCLUSIONS TO PRIOR AUTHORIZATION/PRE-CERTIFICATION

Pre-certification is not required, regardless of the CPT codes used, when the services fall into one of the following categories:

- Therapy services provided to beneficiaries in an ICF/MR
- Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD)
- Therapy services provided to beneficiaries enrolled in a hospice program
- Therapy services provided to beneficiaries covered under both Medicare and Medicaid if
  Medicare benefits have not been exhausted

PRIOR AUTHORIZATION REQUEST

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

Certification/recertification acknowledges the medical necessity and appropriateness of services. It does not guarantee payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Therapy providers must use standardized forms provided by the UM/QIO. Required forms include the following:

- Pre-certification Review Request
- Certification of Medical Necessity for Initial Referral/Orders
- Outpatient Therapy Evaluation/Re-Evaluation (specific to the therapy requested)
- Outpatient Therapy Plan of Care (specific to the therapy requested)

The initial evaluation and the first therapy session should **not** be done on the same day to allow time to develop a plan of care and obtain pre-certification from the UM/QIO. However, the UM/QIO is authorized to accept retrospective requests for the following exceptions:

URGENT SERVICES

In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services 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. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

SAME DAY/NON-URGENT SERVICES

In rare instances where same day/non-urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Same day/ non-urgent outpatient physical, occupational, or speech therapy services 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 (example: therapeutic activities, such as the use of crutches, on the same day as diagnosis/treatment of leg fracture). If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

REVIEW OUTCOMES

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for therapy, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the criteria are not met or the review outcome results in a denial, written notification will be sent to the beneficiary/representative, therapy provider, and prescribing provider.

RECONSIDERATION PROCESS

The beneficiary, therapy provider, or prescribing provider may appeal a utilization review denial of services to the UM/QIO through the reconsideration process outlined in the UM/QIO manual.

ADMINISTRATIVE APPEAL

Disagreement with the UM/QIO reconsideration determination may be appealed 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 review determination notice. The process for requesting an administrative appeal is included in the denial notice that is sent to the beneficiary/representative.

MAINTENANCE THERAPY

Maintenance therapy consists of 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 DOM. Such services include but are not limited to the following:

- Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments
- 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
- Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress
- Exercises and range of motion exercises not related to the restoration of a specific loss of function

DOCUMENTATION

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and, upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

NONSUBSTANTIATED SERVICES

DOM, the UM/QIO, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the therapy services provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments

may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

DUAL ELIGIBLE

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible.

Therapy providers may submit a pre-certification request to the UM/QIO for therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The six (6) month timely limitation for filing crossover claims is applicable with no exceptions.

Beneficiaries may not receive services under both programs simultaneously.

OUTPATIENT SPEECH LANGUAGE PATHOLOGY INTRODUCTION

Medicaid, as authorized by Title XlX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. DOM initiates Medicaid policy as it relates to these factors.

BENEFICIARY COST SHARING

Refer to Administrative Code Part 200, Chapter 3.

DEFINITIONS

SPEECH-LANGUAGE PATHOLOGY (SPEECH THERAPY)

Speech-language pathology (speech therapy) services are 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.

SPEECH-LANGUAGE PATHOLOGIST (SPEECH THERAPIST)

A speech-language pathologist (speech therapist) is an individual who meets the state and federal licensing and/or certification requirements to perform speech-language pathology services.

SPEECH-LANGUAGE PATHOLOGY ASSISTANT (SPEECH THERAPY ASSISTANT)

A speech-language pathology assistant is 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.

SPEECH-LANGUAGE PATHOLOGY AIDE (SPEECH THERAPY AIDE)

A speech-language pathology aide is 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.

THERAPY ASSISTANTS, AIDES AND STUDENTS

THERAPY ASSISTANTS

Services provided by speech-language therapy assistants, regardless of the level of supervision, are not covered by the Division of Medicaid.

THERAPY AIDES

Services provided by speech-language therapy aides, regardless of the level of supervision, are not covered by the Division of Medicaid.

THERAPY STUDENTS

Services provided by speech-language therapy students, regardless of the level of supervision, are not covered by the Division of Medicaid.

PRIOR AUTHORIZATION/PRE-CERTIFICATION

Prior authorization or pre-certification serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit DOM to require authorization for any service where it is anticipated or known that the services could either be abused by providers or beneficiaries or could easily result in excessive, uncontrollable Medicaid costs. Certification as referred to in this policy is synonymous with prior authorization.

Pre-certification of certain outpatient therapy services is required by the Division of Medicaid. Providers must prior authorize/pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. Failure to obtain prior authorization will result in denial of payment to the providers billing for services.

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. Providers should be aware that the frequency of visits provided by the therapist must match the Plan of Care signed by the physician. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

Therapy providers must use standardized forms provided by the UM/QIO. Required forms include the following:

- Pre-certification Review Request
- Certification of Medical Necessity for Initial Referral/Orders
- Outpatient Therapy Evaluation/Re-Evaluation (specific to the therapy requested)
- Outpatient Therapy Plan of Care (specific to the therapy requested)

The initial evaluation and the first therapy session should **not** be done on the same day to allow time to develop a plan of care and obtain pre-certification from the UM/QIO. However, the UM/QIO is authorized to accept retrospective requests for the following exceptions:

URGENT SERVICES

In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services 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. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

SAME DAY/NON-URGENT SERVICES

In rare instances where same day/non-urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Same day/ non-urgent outpatient physical, occupational, or speech therapy services 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 (example: therapeutic activities, such as the use of crutches, on the same day as diagnosis/treatment of leg fracture). If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

REVIEW OUTCOMES

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for therapy, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the criteria are not met or the review outcome results in a denial, written notification will be sent to the beneficiary/representative, therapy provider, and prescribing provider.

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The beneficiary, therapy provider, or prescribing provider may appeal a utilization review denial to the UM/QIO through the reconsideration process outlined in the UM/QIO manual.

ADMINISTRATIVE APPEAL

Disagreement with the UM/QIO reconsideration determination may be appealed 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 review determination notice. The process for requesting an administrative appeal is included in the denial notice that is sent to the beneficiary/representative.

EVALUATION/RE-EVALUATION

Evaluation is an integral component of speech-language pathology services. The initial evaluation establishes the baseline data necessary for setting realistic goals, measuring progress, and assessing rehabilitation potential. Periodic re-evaluation is used to assess the beneficiary's progress in relationship to treatment goals. All evaluations must be performed by a therapist in the discipline, i.e., only a speech-language pathologist may perform a speech-language pathology evaluation, etc. Therapy providers must use the standardized outpatient therapy evaluation/re- evaluation form specific to the therapy requested. Forms are available through the UM/QIO.

The initial evaluation and the first therapy session should not be done on the same day to allow time to develop a plan of care and, if necessary for the applicable CPT code(s), obtain precertification from the UM/QIO.

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.

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

The initial evaluation and all re-evaluations must be completed by a state-licensed therapist. DOM does not recognize and will not reimburse speech-language pathology services performed by a therapy assistant.

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

PLAN OF CARE

A POC for a projected period of treatment beyond six (6) months is not acceptable. The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO.

Based on medical necessity, the UM/QIO may approve certification periods for less than or up to six (6) months. Approved certification periods will not exceed the period of treatment indicated on the POC.

The initial plan of care and all revised plans of care must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapy assistant.

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

BENEFICIARY NONCOMPLIANCE

DOM will 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:

- Failure to attend scheduled therapy sessions (i.e., 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, illness/death in the family)
- Failure to perform home exercise program as instructed by the therapist
- Failure to fully participate in therapy sessions (i.e., refusing to perform activities directed by therapist; late for scheduled therapy sessions or leaving before the session is completed)
- Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance
- Failure to properly use special equipment or adaptive devices (e.g., beneficiary requires the use of ankle-foot orthoses (AFOs) but does not wear them or bring them to therapy sessions)
- Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record

LONG TERM THERAPY

Long term therapy is defined as therapy services that extend beyond six (6) consecutive months. DOM and the UM/QIO will monitor all long term therapy closely to ensure that continuation of services is medically necessary.

DOCUMENTATION

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and, upon request, make these records available to representatives of

DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

The servicing provider (licensed therapist) is responsible for providing a copy of all required therapy documentation as noted above to the prescribing provider.

DOM requires that all x-ray images (films, digital images, etc.) be accessible at all times for review. In addition, DOM requires that the films or images be of such quality that they can be clearly interpreted.

TIMED AND UNTIMED CODES

1. Timed Codes

    - CPT codes that reference a time per unit are 'timed codes.' Providers must bill units of timed codes based upon the total time actually spent in the delivery of the service, i.e., the time spent working directly with the beneficiary. The total treatment time (including the actual beginning and ending time of treatment) must be recorded for services described by time codes. All of the times, as well as the description of the treatment modalities/procedures that were provided must be recorded for each visit. The therapist rendering treatment must sign (signature and title) and date each entry. Documentation may be recorded in the Progress Notes or on a treatment log. If a treatment log is used, it must be retained as part of the beneficiary's medical record.

    Activities that are not considered part of the total treatment time include but are not limited to the following:

    - Pre and post-delivery services (The beneficiary should be in the treatment area and prepared to start treatment.)

    - Time the beneficiary spends not being treated (Examples include but are not limited to the need for toileting or resting.)

    - Time waiting for equipment or for treatment to begin

2. Untimed Codes

- 'Untimed' CPT codes are not defined by a specific time frame. DOM does not require documentation of the treatment time for untimed codes. Whether the service took 10 minutes or 2 hours to complete, only one unit can be billed because only one service was provided. The name and title of the person supervising the treatment/modality must be recorded for all CPT codes requiring direct supervision.

NONSUBSTANTIATED SERVICES

DOM, the UM/QIO, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the therapy services provider.

If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

DUAL ELIGIBLES

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible. Refer to Third Party Recovery, Part 306, Chapter 1 in the Administrative Code for additional information.

Therapy providers may submit a pre-certification request to the UM/QIO for therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The six (6) month timely limitation for filing crossover claims is applicable with no exceptions.

Beneficiaries may not receive services under both programs simultaneously.