



# Florida Medicaid

## **THERAPY SERVICES COVERAGE AND LIMITATIONS HANDBOOK**

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Agency for Health Care Administration



# UPDATE LOG

## THERAPY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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### ***How to Use the Update Log***

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#### **Introduction**

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update will be issued as a completely revised handbook.

It is very important that the provider read the updated material in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

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#### **Explanation of the Update Log**

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

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#### **Instructions**

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
Replacement Pages	December 1999
Revised Handbook	October 2003
Replacement Pages	July 2008
Revised Handbook	October 2011

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# THERAPY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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# CHAPTER 1 THERAPY SERVICES PROVIDER QUALIFICATIONS AND REQUIREMENTS

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**Overview**

**Introduction**

This chapter describes the Florida Medicaid Therapy Services Program, who is an eligible provider, and the requirements for enrollment.

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**Legal Authority**

Therapy services are governed by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Part 440.110. The program was implemented through Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code.

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**Exceptions to Service Limits for Children**

According to 42 USC 1396d(r)(5) Medicaid is required to cover for children "such other necessary healthcare, diagnostic services, treatment, and other measures described in section 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan." There are no limitations of amount, duration, and scope on medically necessary services for Medicaid-eligible children. The process to request, for a child under 21, a service that is not covered or to exceed service limits see the Provider General Handbook.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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**In This Chapter**

This chapter contains:

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**Purpose and Definitions**

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**Purpose**

The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services to recipients ~~from birth through age 20~~ **under the age of 21**. The therapy services program also provides services to recipients age 21 and older for SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings. These are the only services in the therapy program that Medicaid reimburses for adults.

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**Purpose and Definitions**, continued

**Purpose of This Handbook**

This handbook is intended for use by providers who provide therapy services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C., and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

**Adaptive Behavior**

Adaptive behavior refers to the skills that people need to function independently. <sup>JL1</sup>

**Authorization Period**

The date span determined by the therapist and approved by the primary care providers, Advanced Registered Nurse Practitioners (ARNP) or Physician Assistant (PA) designees, or designated physician specialist.

**General Supervision**

General supervision of a physical therapy assistant shall not require on-site supervision by the physical therapist. The physical therapist shall be accessible by two-way communication, which enables the physical therapist to respond to an inquiry when made and to be readily available for consultation during the delivery of care and must be within five miles of the on-site location.

**Occupational Therapy**

Occupational therapy is the provision of services that addresses the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development.

Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits, minimize the disabling effect of these deficits, maintain a level of function, acquire a skill set or restore a skill set. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

**Purpose and Definitions**, continued

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**On-Site  
Supervision**

Supervision of subordinate personnel performing actions subject to licensure pursuant to Chapter 486, F.S., while the licensed supervisor is immediately physically available.

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**Physical Therapy**

Physical therapy is a specifically prescribed program to develop, maintain, improve or restore neuro-muscular or sensory-motor function, relieve pain, acquire a skill set, restore a skill set, or control postural deviations to attain maximum performance.

Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.

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**Purpose and Definitions**, continued

**Occupational Therapy**

Occupational therapy is the provision of services that addresses the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development.

Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits, or to minimize the disabling effect of these deficits, or maintain a level of function. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

**Place of Residence**

Place of residence is the location in which a recipient resides for an extended or a permanent period of time and is considered his home.

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**Respiratory Therapy**

Respiratory therapy is treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system.

Respiratory therapy services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilatory support; therapeutic and diagnostic use of medical gases; respiratory rehabilitation; management of life support systems and bronchopulmonary drainage; breathing exercises and chest physiotherapy.

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**Speech-Language Pathology**

Speech-language pathology services involve the evaluation and treatment of speech-language disorders.

Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

Examples are techniques and instrumentation to evaluate the recipient's condition, remedial procedures to maximize the recipient's oral motor functions and communication via augmentative and alternative communication (AAC) systems.

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**Unit of Service**

A unit of service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

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***Purpose and Definitions***, continued

***Prepaid Therapies Program***

**Introduction** Certain eligibility categories of recipients under the age of 21 will be enrolled in the Prepaid Therapies Program for the provision of their therapy services. The Agency for Health Care Administration (AHCA), Division of Medicaid, contracts with vendors to administer the provision of therapy services to Medicaid recipients who are enrolled in the Prepaid Therapies Program.

**Eligible Recipients** Upon full implementation of the Prepaid Therapies Program, recipients under the age of 21 who are eligible for Medicaid under the Temporary Assistance for Needy Families (TANF) Program or the Supplemental Security Income (SSI) Program and who are not enrolled in a managed care program, except for MediPass and the Children's Medical Services Network, will be enrolled in the Prepaid Therapies Program.

**Ineligible Recipients** The following Medicaid recipients are not eligible to enroll in the Prepaid Therapies Program:

- Recipients 21 years of age and older.
- Recipients who are dually eligible for Medicaid and Medicare.
- Recipients who are eligible for Medicaid under the Medically Needy Program.
- Recipients who are enrolled in a managed care program, except for MediPass and the Children's Medical Services Network.
- Recipients who are excluded from enrolling in managed care.
- Recipients who are enrolled in the Pediatric Emergency Room Diversion Project.
- Recipients who reside in institutions.

***Prepaid Therapies Program***, continued

**Services Exempt from Authorization by the Prepaid Therapies Program**

The following therapy services are exempt from authorization by the Prepaid Therapies Program:

- Therapy services provided to recipients who are enrolled in a Medicaid waiver program that requires therapy authorization;
- Therapy services provided in an inpatient or outpatient hospital setting; and
- Therapy services provided in a public or private school.

**Fee-for-Service Billing**

Recipients who are not eligible for the Prepaid Therapies Program receive therapy services through the Medicaid Therapy Program, which is described in this handbook. Services provided under the Medicaid Therapy Program are reimbursed through fee-for-service billing.

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**Provider Qualifications**

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**Introduction**

Medicaid enrolls physical, occupational and respiratory therapists, speech-language pathologists, and home health agencies as therapy providers.

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**Provider Qualifications For Individual Therapists**

To enroll as a Medicaid provider, the individual therapist must be currently licensed as a physical, occupational or respiratory therapist or speech-language pathologist under Chapter 468 or 486, Florida Statutes [\(F.S.\)](#).

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**Provisionally Licensed Speech-Language Pathologists**

[A provisionally licensed speech-language pathologist may enroll as a Medicaid provider if he or she is:](#)

- [Provisionally licensed under the Florida Administrative Code;](#)
- [In the process of meeting the qualifications for a certificate of clinical competence \(CCC\) from the American Speech and Hearing Association; and](#)
- [Supervised by a Medicaid enrolled licensed speech-language pathologist in accordance with Chapter 468 \[Florida Statutes F.S.\]\(#\) and Chapter 64B20 of the Florida Administrative Code \(F.A.C.\).](#)

[A provisionally licensed speech-language pathologist must be enrolled as a Florida Medicaid provider to be reimbursed by Medicaid.](#)

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**Provider Qualifications**, continued

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**Home Health Agencies**

Medicaid reimburses home health agencies for occupational therapy, physical therapy, and speech-language pathology services through their home health agency provider numbers.

Medicaid does not reimburse home health agencies for respiratory therapy services through their home health agency provider number. Home health agencies may enroll as group therapy providers with a specialty in respiratory therapy. The home health agency must have at least two licensed registered respiratory therapists in the group that are enrolled as individual providers in Medicaid.

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**Provider Qualifications for Home Health Agencies**

To enroll as a Medicaid provider, a home health agency must be licensed in accordance with Chapter 400, Part IV, Florida Statutes (F.S.), and Chapter 59A-8, Florida Administrative Code (F.A.C.) or the applicable laws of the state in which the services are furnished.

~~Providers certified as a rehabilitation agency or comprehensive rehabilitation and provide more than one type of therapy (occupation, speech, physical, respiratory) can be exempt from home health licensure under title 18 of the Social Security Act.~~

The home health agency must:

- Meet the Medicare Conditions of Participation as determined through a survey conducted by the Agency for Health Care Administration, Division of Health Quality Assurance (HQA); or
- Be accredited and deemed by the Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP) as meeting the Medicare Conditions of Participation; and
- Employ or contract with occupational therapists, physical therapists, registered respiratory therapists or speech-language pathologists who are currently licensed under Chapter 468 or 486, F.S.; and
- ~~Be certified as a rehabilitation agency or comprehensive rehabilitation facility under Title XVIII of the Social Security Act to be exempt from home health licensure or licensed under Chapter 400, F.S. as a home health agency providing two or more types of therapy.~~

Home Health agencies receiving accreditation and deemed status by JCAHO or CHAP are responsible for providing accreditation documentation to HQA.

**Note:** See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information. The handbook is available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

**Provider Qualifications**, continued

**Expired License**

A therapy services provider whose license has expired is, after written notice, automatically excluded from participation in the Medicaid program. If the provider's license is reinstated, he may reapply to be a Medicaid provider.

**Therapists with Temporary Licenses**

Medicaid recognizes occupational therapists with temporary licenses who have applied for licensure according to Chapter 468, F.S.

Occupational therapists (OT) who hold temporary licenses cannot enroll as Medicaid providers. However, a licensed, Medicaid enrolled OT may supervise services rendered by professionals who have temporary licenses. The supervision must be in accordance with [Florida Statutes Chapter 468, F.S.](#) and the [Chapter 64B11, F.A.C.](#) ~~Florida Administrative Code.~~

[The Medicaid enrolled OT will be reimbursed for supervising services provided by a temporary licensed OT according to the codes and rates in the Therapy Services Procedure Codes and Maximum Fee Schedule.](#)

All documentation must be signed by both the temporary licensed OT and the supervising Medicaid enrolled OT.

[Note: See Chapter 3, Appendix A, of this handbook for the Therapy Services Procedure Codes and Maximum Fee Schedule](#)

**Therapy Assistants**

Physical therapy assistants, occupational therapy assistants, and speech-language pathology assistants cannot enroll as providers. The physical therapist, occupational therapist, speech-language pathologist who supervises, or home health agency that employs the therapy assistant may be reimbursed for the therapy assistant's visits.

**Therapy Assistant Requirements**

In order for a therapy assistant's services to be reimbursed by Medicaid, the therapy assistant must meet the following requirements:

Physical therapy assistants must be licensed under Chapter 486, F.S., and meet all the requirements that pertain to physical therapy assistants in the Florida Administrative Code (F.A.C.).

Occupational therapy assistants must be licensed under Chapter 468, F.S., and meet all the requirements that pertain to occupational therapy assistants in the F.A.C.

Speech-language pathology assistants must be certified under Chapter 468, F.S., and meet all the requirements that pertain to speech-language pathology assistants in the F.A.C.

**Provider Qualifications**, continued

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**General Enrollment Requirements**

Therapy providers must meet the general Medicaid provider enrollment requirements ~~that are~~ contained in ~~Chapter 2 of~~ the Florida Medicaid Provider General Handbook. In addition, they must follow the specific enrollment requirements ~~that are~~ listed in this section.

~~Note: See Prepaid Therapies Program in this chapter for information on enrolling in a Prepaid Therapies Program vendor's provider network.~~

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**Qualified at the Time of Enrollment**

Therapy providers must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

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**Group Providers**

Two or more providers practicing together must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

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**Provider Responsibilities**

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**General Requirements**

In addition to the general provider requirements and responsibilities ~~that are~~ contained in ~~Chapter 2 of~~ the Florida Medicaid Provider General Handbook, therapy providers are also responsible for complying with the provisions contained in this section.

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**Provider Responsibility and HIPAA**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbook contains the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 1 the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For more information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent help desk at 800-289-7799, select Option 3.

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**Solicitation**

~~In accordance with s. 456.054(2), F.S., it is unlawful for any health care provider or any provider of health care services to offer, pay, solicit, or receive kickbacks, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients. Any violations by a provider shall be considered patient brokering and shall be punishable as provided in s. 817.505, F.S.~~

~~In accordance with s. 409.920(2)(e), F.S., it is unlawful to knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.~~

~~A person who violates this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.~~

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**Provider Responsibilities, continued**

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**Record Keeping Requirements**

Therapy providers must follow the record keeping requirements listed in the Florida Medicaid Provider General Handbook.

Note: See the [Chapter 2 of the Florida Medicaid Provider General Handbook](#) for additional information. The handbook is available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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**Non-Compliance**

Therapy providers found non-compliant with the rules contained in this handbook are subject to the following actions:

- [Recoupment of funds; and](#)
- [Termination as a provider of Medicaid Therapies; and](#)
- [Sanctions or other penalties afforded by law.](#)

Note: See the Florida Medicaid Provider General Handbook for information on Medicaid fraud and abuse. The handbook is available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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## CHAPTER 2 THERAPY SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

**Overview**

**Introduction**

This chapter describes the services covered under the Florida Medicaid Therapy Services Program, the requirements for service provision, and the service limitations and exclusions.

**In This Chapter**

This chapter contains:

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Splints and Casts	<a href="#">2-21</a>
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**Requirements to Receive Services**

**Introduction**

Medicaid reimburses for the physical therapy (PT), occupational therapy (OT), respiratory therapy (RT), and speech-language pathology (SLP) services described in this handbook. **The Florida Medicaid Therapy Services Program covers-reimburses only for the therapy services that are listed on the Procedure Codes and Maximum Fee Schedule in Chapter 3, Appendix A of this handbook.**

**Who Can Receive Therapy Services**

Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21. Medicaid also reimburses SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings to recipient's age 21 and older. These are the only services in the therapy program that Medicaid reimburses for adults.

**Requirements to Receive Services**, continued

**Service Requirements**

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Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. ~~In addition~~Additionally, the services must meet the following criteria:

- ~~• The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;[11]~~
- ~~• The services cannot be experimental or investigational;~~
- ~~• The services must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and~~
- ~~• The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.~~

~~The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.~~

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**Medically Necessary Definition Chapter 59G-1.010 (166), Florida Administrative Code**

Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary as follows:

- (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
- (a) Meet the following conditions:
    - 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
    - 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
    - 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
    - 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
    - 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
  - (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
  - (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
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**Requirements to Receive Services**, continued

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**Prior Authorization**

Effective November 1, 2011 PT, OT, and SLP treatment visits must be authorized by Medicaid's contracted Quality Improvement Organization (QIO) prior to the provision of services. This program fulfills 409.912 (42), F.S.

For recipients whose Medicaid eligibility is established with a retroactive effective date, the QIO performs a retrospective review of the therapy services provided before Medicaid payment can be made.

Evaluations do not require prior authorization.

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**General Requirements for Prior Authorization**

The following general requirements apply to prior authorizations for therapy services:

- The request must be submitted to the Medicaid QIO via its Web-based Internet system.
  - All required documentation to support the request must be submitted directly to the QIO at the time of the request.
  - When requesting prior authorization, each therapy provider is responsible for informing the QIO of other therapy providers also providing services to the recipient.
  - Before submitting a request for prior authorization, orders to initiate or continue therapy services must be signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist.
  - All plans of care submitted must contain current information concerning the recipient. Photocopies of previous plans of care are not acceptable and will result in denials of prior authorization requests.
- 

**Documentation Required for Prior Authorization**

Prior authorization requests must include:

- Recipient's name, address, date of birth, and Medicaid ID number;
  - Requesting provider's Medicaid provider number, name, and address;
  - Ordering provider's Medicaid provider number, National Provider Identifier, or Florida Medical License number, name, and address;
  - Procedure code(s), with modifier(s) if applicable, matching the services reflected in the plan of care;
  - The complete evaluation and plan of care, reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist;
  - Hospital discharge information, if services are being requested as a result of a hospitalization;
  - Units of service requested; and
  - A prescription for the therapy service in accordance with the prescription requirements described in this chapter.
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**Review Criteria**

The QIO may use a national standardized set of criteria, approved by the Agency for Health Care Administration (AHCA), as a guide to establish medical necessity for prior authorization of therapy services.

AHCA may modify these criteria based upon Medicaid policy or the clinical judgment or recommendation of the QIO physician reviewer.

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**Requirements to Receive Services, continued**

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**Approval Process**

The QIO will review each prior authorization request and approve, deny or request additional information to support the request.

The QIO will post the status of the request on its Internet system. Providers must check the Internet system for the status of submitted prior authorization requests.

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**Approved Request**

If a request is approved, the approval will contain a prior authorization number for billing and reference. Only one prior authorization number will be issued per certification period.

The QIO will authorize services for up to a six month period.

Approved authorizations do not guarantee payment, but are contingent upon recipient and provider being eligible on the date of service, and the service not exceeding any applicable service limits.

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**Content of Approved Requests**

The approval of services is accessed via the Internet system and specifies:

- 10-digit prior authorization number;
  - Procedure code;
  - Units of service;
  - Service authorized;
  - Authorized dates of service;
  - The discipline authorized to provide the service; and
  - The number of days for which the prior authorization is valid.
- 

**Changes to Approved Requests**

For any requested change, the therapy provider must submit via the Internet, additional new information, not previously submitted, documenting the need for change.

When requesting additional units of service within a certification period, the provider should indicate that the request:

- Is for additional visits or a change to an already requested certification period.
  - Include the attending physician approved plan of care, new orders, and a reason for adjustment.
- 

**Denied Requests or Partial Denials**

In a partial denial, a portion of the requested units of service may be denied due to lack of medical necessity. If the QIO denies a request or issues a partial denial, the QIO will post the decision on its Internet system.

If the QIO physician determines that services are not medically necessary, the recipient, ordering provider and therapy provider will be notified in writing that the services will be denied or reduced. The notification letter will include information regarding the recipient's appeal rights.

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**Reauthorization Requests**

Reauthorization requests should be submitted within the timeframe specified by the QIO.

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**Requirements to Receive Services**, continued

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**Reconsideration Review**

A provider or recipient who receives a denial may request reconsideration. If reconsideration is requested, the provider must submit additional information to facilitate the review process.

A reconsideration review of the denial decision must be requested via the Medicaid QIO's Internet system within 40 ten business days of the date of the final denial or partial denial determination.

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**Termination of Services**

The discharge date must be submitted to the Medicaid QIO when a therapy provider terminates services.

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**Fair Hearing**

A recipient has the right to appeal any action taken by the Agency for Health Care Administration (AHCA) or its contracted QIO that adversely affects the recipient's receipt of services.

Hearing requests must be sent to:

DCF, Office of Hearing Appeals  
1317 Winewood Boulevard, Building 5, Room 205  
Tallahassee, Florida 32399-0700

The telephone number is (850) 488-1429.

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**Recipients Exempt from Prior Authorization**

Therapy services for the following recipients are exempt from prior authorization by the QIO:

- Recipients who are members of a Medicaid Health Maintenance Organization (HMOs);
  - Recipients who are members of a Medicaid Provider Service Network (PSNs); and
  - Recipients who have other coverage for therapy services through a third party liability source such as Medicare or commercial insurance.
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**Medically-Needy Eligibility**

A Medically-Needy recipient is an individual who would qualify for Medicaid except that the individual's income or resources exceed Medicaid's income or resource limits.

On a month-by-month basis, the individual's medical expenses are subtracted from his income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the month or for part of the month, depending on the date the medical expenses were incurred.

Providers must ensure that Medically-Needy recipients who are approved for services are eligible for services at the time services are rendered.

Note: See the Florida Medicaid Provider General Handbook for additional information on Medically-Needy eligibility. See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for billing information on Medically-Needy recipients.

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### **Medically-Needy Prior Authorization**

The Medicaid QIO cannot provide a prior authorization number for a Medically-Needy individual who is in a period of ineligibility. If the individual becomes eligible for the dates that the services were rendered, the provider must notify the QIO via its Internet system that the recipient is a Medically-Needy individual and state the recipient's dates of eligibility for each month prior authorization is being requested.

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### **Prescription for Services**

To be reimbursed by Medicaid, all therapy services, including evaluations, PT, OT, RT and SLP, must be prescribed by the recipient's primary care provider, an advanced registered nurse practitioner (ARNP), or a designated physician assistant (PA), or a designated physician specialist.

The prescription should be as specific as possible, and must include:

- The recipient's diagnosis contributing to the need of therapy;
- Signature of the prescribing provider;
- Name, address and telephone number of the prescribing provider;
- Date of prescription;
- The specific type of evaluation requested or the specific type of service;
- For therapy services, the duration and frequency of the therapy treatment period; and
- The physician's MediPass authorization number, if applicable.

If the prescription has not been received before the service is rendered, Medicaid will not reimburse for the service.

Prescriptions to evaluate recipients are valid for up to 60 days.

The plan of care may suffice as a prescription for treatment visits if the signed plan of care indicates that the plan of care is to serve as a prescription and satisfies the above requirements.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies' provision of therapy services. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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### **Prescription for the Reauthorization of Services**

The primary care provider must review the recipient's renewed plan of care every one to six months depending on the authorization period for which the services were approved. If the services continue to be medically necessary, the primary care provider can prescribe the reauthorization of services. The plan of care, with the primary care provider's, ARNP's or PA designee's, or designated physician specialist's signature authorizing requesting the continuation of services, must be submitted to the QIO with all other required documentation and the approval must be received prior to beginning services for the next authorization period.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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## Requirements to Receive Services, continued

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### Documentation for Authorization

— Documentation for authorization must include:

- The evaluation and plan of care, reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist; and
- A prescription for the therapy service that is in accordance with the prescription requirements described in this chapter.

*Note:* See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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## Evaluations

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### Description

Evaluations determine the recipient's level of function and competencies through therapeutic observation and **standardized testing measures appropriate to the language, speech, or physical limitations specific to the therapeutic services required.**

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**Evaluation results are** should be used to develop baseline data to identify the need for early intervention **or therapeutic services;** and to address the recipient's functional abilities, capabilities, activity **ies level performance,** deficits and limitations.

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### Provider Requirements

Medicaid reimburses the following **Medicaid enrolled** providers for evaluations:

- Licensed physical, **and** occupational **therapists;**
- **Certified certified** and registered respiratory therapists;
- Licensed and provisionally licensed speech-language pathologists; and
- Home health agencies that employ or contract with licensed physical and occupational therapists and speech-language pathologists.

Medicaid does not reimburse for evaluations performed by therapy assistants.

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### Temporary Licensed Therapists

A Medicaid enrolled supervising occupational therapist or home health agency may be reimbursed for evaluations performed by an occupational therapist with a temporary license. To receive reimbursement, both the supervising therapist and the therapist with the temporary license must sign and date the evaluation.

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**Evaluations**, continued

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**Evaluations Tests to be Used**

Tests ~~may~~ **should be**:

- **Standardized for a specific disorder identified; or**
- **Consist of a standardized caregiver report format; or**
- ~~may be c~~Composed of ~~the~~ professionally acceptable **therapeutic observational** techniques.

**Age equivalent score reporting does not report a standard score and is not an acceptable evaluation test.**

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**Plan of Care**

The therapist or speech-language pathologist must write the recipient's **therapy** plan of care based on the results of the evaluation. Reimbursement for writing the **initial** plan of care is included in the reimbursement for the evaluation.

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**Reimbursement Limitations**

Medicaid reimburses ~~one~~ initial evaluation per recipient, per ~~discipline~~ **provider type, per year. A Recipient who has received therapy services within six months (180 days) and whose diagnosis has not changed is not eligible for an initial evaluation and must receive a re-evaluation.**

**Medicaid reimburses one re-evaluation per recipient, per discipline, every 150 days, beginning 150 days after the initial evaluation. and one re-evaluation per recipient every six months, per provider type. Re-evaluations rendered within 150 days of a previous evaluation are not reimbursable by Medicaid.**

~~An exception is that the first re-evaluation may be done at four months to allow time to obtain authorization to ensure continuum of services.~~

**Therapy visits performed on the same day as evaluations are not reimbursable.**

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**Codes and Fees**

See Chapter 3, Appendix A, in this handbook for a list and description of procedure codes and fees.

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## Plan of Care

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### Description

A **therapy** plan of care is an individualized **and specific** written program developed by health care professionals for a recipient. The plan of care is designed to meet the medical, health and rehabilitative needs of the recipient.

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### Plan of Care Requirements

After the therapist or speech-language pathologist performs the initial evaluation of a recipient, and before providing services, the therapist or speech language pathologist must write an initial plan of care for the recipient based on the results of the therapist's evaluation. All therapy services must be included in the therapy plan of care, except for evaluations, wheelchair evaluations and fittings, and augmentative and alternative communication (AAC) systems. AAC systems require a specific plan of care.

The therapist must make necessary amendments to the plan of care. If any amendments are made to the plan of care, those amendments must be reviewed, approved and signed by the primary care provider before service is provided.

The therapist must review the plan of care every one to six months and make necessary revisions.

The therapist and the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy must retain a copy of the plan of care in his or her records for the recipient.

The plan of care may suffice as a prescription if the signed plan of care indicates that the plan of care is to serve as a prescription and all prescription requirements are met.

### Plan of Care Requirement

After the therapist or speech-language pathologist performs the initial evaluation of a recipient, the therapist or speech language pathologist must write an initial plan of care for the recipient based on the results of the therapist's evaluation. All therapy services must be included in the general **therapy** plan of care, except for evaluations, wheelchair evaluations and fittings, and augmentative and alternative communication (AAC) systems. AAC systems require a specific plan of care. The therapist may make necessary amendments to the plan of care. If amendments are made to the plan of care, those amendments must be reviewed, approved and signed by the primary care provider before service is provided. The therapist must review the plan of care at least every six months and make necessary revisions.

The therapist and the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy must retain a copy of the plan of care in his or her records for the recipient.

**Plan of Care**, continued

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**Provider Requirements**

Only the following providers may initiate, develop, submit or change the plan of care:

- Licensed physical, occupational and respiratory therapists; and
  - Licensed and provisionally licensed speech-language pathologists.
- 

**Initial Plan of Care Components**

The plan of care must include the following information:

- Recipient's name, date of birth, and Medicaid ID number;
  - The specific therapy to be provided;
  - **Specific**, achievable, measurable, time-related long and short term **therapeutic** goals and objectives that are related to the functioning of the recipient and are based on the primary care provider's, ARNP's or PA designee's, or designated physician specialist's prescription;
  - Medications, treatments, and equipment required;
  - Description of medical condition, including the most specific diagnosis codes **within the therapist's scope of practice contributing to the recipient's need of therapy** shown in the current edition of the International Classification of Diseases, Clinical Modification;
  - **Functional limitations;**
  - Frequency, length of each treatment and the duration of the treatment;
  - Therapy methods and monitoring criteria;
  - Methods for monitoring equipment needs and recommendations for equipment needs;
  - Diet as indicated **if applicable;**
  - Methods of demonstrating and teaching the recipient;
  - Methods of demonstrating and teaching the family and other relevant caregivers who are involved with the recipient; and,
  - How the treatment will be coordinated with the other service needs prescribed for the recipient.
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**Plan of Care**, continued

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In addition to the initial plan of care requirements, the renewed view of the plan of care must include:

- A progress report that evaluates the recipient's accomplishments toward a stated goal;
  - A description of the recipient's attitudes and behaviors toward the therapy;
  - An assessment of the effectiveness of services provided;
  - An assessment of the recipient's rehabilitation potential; and
  - Modifications to the plan of care; and
  - If applicable, justification of medical necessity for services provided to maintain functionality.<sup>[12]</sup>
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**Plan of Care Approval**

The plan of care must be reviewed, signed and dated by the therapist and by the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy. The ~~physician's~~ prescriber's signature indicates approval of the plan of care.

The prescriber/physician must review, certify, and re-sign the renewed plan of care, based on the recipient's re-evaluation, every one to six calendar months depending on the approved authorization period. This must be done before the end of the authorization period.

Electronic signatures are permissible as defined by Chapter 668, Part 1, F.S., and CFR Title 45, Part 164.312.

All signatures on the plan of care must be legible and dated.

If the plan of care has not been signed and approved before the service is rendered, Medicaid will not reimburse for the service.

Note: See Chapter 5 in the Florida Medicaid Provider General Handbook for requirements of electronic signatures and electronic record keeping. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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## Therapy and Speech-Language Treatment Visits

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### Description

Therapy and speech-language treatment visits are face-to-face encounters with a recipient for the purpose of providing physical, occupational or respiratory therapy or speech-language pathology services. The treatment visit includes all of the therapist's activities with the recipient, except for **evaluations**; splints and casts; wheelchair evaluations and fittings; and augmentative and alternative communication (AAC) system fittings, adjustments and training.

**Reimbursement for demonstrating and teaching, which include the family and other relevant caregivers who are involved with the recipient, is included in the reimbursement for treatment visits if the recipient is present. Otherwise, these services are not reimbursable by Medicaid.**

Note: See Splints and Casts, Wheelchair Evaluations and Fittings, and Augmentative and Alternative Communication in this chapter for additional information on these procedures.

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### Provider Requirements

Medicaid reimburses the following providers for treatment visits:

- Licensed physical **and** occupational **therapists**;
  - **Certified** and registered respiratory therapists;
  - Licensed speech-language pathologists and provisionally licensed speech-language pathologists; and
  - Home health agencies that employ or contract with licensed physical and occupational therapists, licensed speech-language pathologists, and provisionally licensed speech-language pathologists.
- 

### Temporary Licensed Therapists

A Medicaid enrolled **supervising** occupational therapist or home health agency may be reimbursed for treatment visits performed by an occupational therapist with a temporary license **being supervised under general supervision requirements**. To receive reimbursement, both the supervising therapist and the therapist with the temporary license must sign and date the treatment records.

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## Therapy and Speech-Language Treatment Visits, continued

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### Therapy Assistants

A supervising therapist or home health agency may be reimbursed for treatment visits performed by a physical or occupational therapy assistant or speech-language pathology assistant, if the following requirements are met:

- ~~The s~~Speech-language pathology assistants must provide the services under the direct supervision of a speech-language pathologist.
  - Occupational therapy assistants may provide services **under general supervision** in a different location than the supervising therapist, but the supervising therapist must be ~~in the same geographical area on site~~ and accessible by phone for the therapy assistant providing services. The supervising occupational therapist must conduct an on-site supervisory visit ~~monthly at least every 30 days~~ to the recipient who has been receiving services from a therapy assistant **once every three calendar months or every nine visits, whichever is less.**
  - Physical therapy assistants may provide services under the general supervision of a physical therapist which does not require on-site supervision if the recipient related activities are for a board-certified orthopedic physician or physiatrist licensed pursuant to Chapter 458, F.S., or Chapter 459, F.S., or a practitioner licensed under Chapter 460, F.S. The supervising physical therapist must conduct an on-site supervisory visit ~~at least every 30 days~~ to the recipient who has been receiving services from a therapy assistant **once every three calendar months or every nine visits, whichever is less.**
  - **Patient-related activities not performed for a board-certified orthopedic physician or physiatrist licensed pursuant to Chapter 458, F.S., or Chapter 459, F.S. and patient-related activities performed for practitioners licensed under Chapter 461, F.S. or Chapter 466, F.S., -shall be performed under the onsite supervision of a physical therapist.**
  - **Reimbursement ~~of~~ for supervision ~~for~~ of therapy services is included in the reimbursement for the therapy assistant's services.**
  - **A therapy assistant treatment visit and therapist treatment visit cannot be reimbursed on the same day.**
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**Service Requirements**

To be reimbursed by Medicaid, physical, occupational and respiratory therapy and speech-language pathology treatment visits must be:

- Authorized via a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist; and
- **Included/Authorized** in the recipient's **valid and approved** plan of care.
- **Prior authorized by the Medicaid contracted Quality Improvement Organization.**

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**Prescription for the Reauthorization of Services**

- ~~The primary care provider must review the recipient's renewed plan of care every one to six months depending on the authorization period for which the services were approved. If the services continue to be medically necessary, the primary care provider can prescribe the reauthorization of services. The plan of care, with the primary care provider's, ARNP's or PA designee's, or designated physician specialist's signature authorizing continuation of services, must be received prior to beginning services for the next authorization period.~~
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## Therapy and Speech-Language Treatment Visits, continued

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### Place of Service

Physical, occupational and respiratory therapy and speech language pathology treatment services can be provided in the recipient's home place of residence or other community setting, such as schools, prescribed pediatric extended care centers or day care centers. Reimbursement for services provided in the recipient's home place of residence or other community setting is paid directly to the provider on a fee-for-service basis in accordance with the Therapy Services Procedure Codes and Fee Schedule in Chapter 3.

Place of residence is the location in which a recipient resides for an extended or a permanent period of time and is considered his home. Place of residence is the location where a Medicaid recipient lives and may include:

- Recipient's private home;
- Assisted Living Facility (ALF);
- Developmental ~~services~~ disabilities group home;
- Foster or medical foster care home; or
- Any home where unrelated individuals reside together in a group.

Services can also be provided in a nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), and in an inpatient and outpatient hospital. Payment for these services is included in the facility's per diem. The therapist cannot be reimbursed directly by fee-for-service f or services provided in these locations. Evaluations provided by hospitals are not counted against the recipient's evaluation reimbursement limitations. -Inpatient and outpatient hospital therapy services are reimbursed according to the Florida Medicaid Hospital Services Coverage and Limitations Handbook.

Providers cannot bill the same type of therapy provided in the school setting and community setting in the same day.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

Note: See the Florida Medicaid Hospital Services Coverage and Limitations Handbook for information about hospital services. All Medicaid handbooks are available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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## Therapy and Speech-Language Treatment Visits, continued

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### Reimbursement Limitations

Medicaid reimbursement for therapy services is based on units-of-service. Each unit-of-service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

~~The billing standard for therapy treatment is either one or two units-of-service.~~ The units-of-service may be combined **into one treatment visit to form one 30-minute treatment visit** or provided as ~~two~~ individual treatment visits.

~~If additional medically necessary therapy needs are present in an individual case, u~~ Up to four units-of-service, **per type of therapy**, may be provided on a single date of service. **Daily treatments may not exceed four units-of-service.** No more than 14 units-of-service, per therapy, will be reimbursed per **calendar week from Sunday to Saturday**. **This allows for up to three one-hour treatment visits per week, if medically necessary, and the medical necessity is documented and prescribed in the plan of care.** ~~Daily treatments may not exceed four units-of-service.~~

Only one type of therapy will be reimbursed for a given 15-minute session. ~~Medicaid reimburses only one provider~~**multiple providers**, be it the school district or a community provider, **cannot be reimbursed** for the same procedure (~~as determined by the Medicaid automated payment system comparing procedure codes on claims~~) provided to a recipient on the same day.

~~Providers cannot bill for the same service provided by another provider on the same day.~~

Physical, occupational, and respiratory therapy must be with an individual recipient, not a group of children. Speech therapy may be rendered to a group of children as described in the Group Therapy Treatment Visits for Speech Therapy.

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**Therapy and Speech-Language Treatment Visits**, continued

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**Group Therapy Treatment Visits for Speech Therapy**

To be reimbursed by Medicaid, a group speech therapy session is limited to six children. All the children do not have to be Medicaid recipients.

The group must receive a minimum of 30 minutes of therapy.

Medicaid will not reimburse for both group and individual speech therapy sessions for a recipient on the same day.

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**Documentation**

The therapist must record, **for on a per each treatment basis**, the **time period time services began and the** type of services rendered, the progress achieved, and the change in the recipient's status due to treatment. Each entry must be signed and dated by the Medicaid enrolled treating provider on the date the service is provided.

**Note:** See the Florida Medicaid Provider General Handbook for information on record keeping and documentation requirements.

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**Service Exclusions**

Medicaid reimbursement for the therapy treatment visit does not include telephone responses to questions, conferences with the child's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time.

Medicaid reimbursement for a respiratory therapy visit does not include securing, installing, or maintaining respiratory therapy equipment. Medicaid does not reimburse a respiratory therapy visit that is solely for the purpose of oximetry services.

**Hippotherapy is not a covered service unless it can be demonstrated medically necessary.**

**Medicaid will not reimburse for treatment visits provided the same day as an evaluation of the same type of therapy.**

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**Codes and Fees**

**Note:** See Chapter 3, Appendix A, of this handbook for the therapy treatment visit procedure codes and fee schedule.

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## Augmentative and Alternative Communication (AAC)

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### Description

AACs are designed to allow individuals the capability to communicate. As defined by the American Speech-Language Hearing Association (ASHA), an AAC attempts to compensate for the impairment and disability patterns of individuals with severe, expressive communication disorders, i.e., individuals with severe speech-language and writing impairments.

Dedicated systems are designed specifically for a disabled population.

Non-dedicated systems are commercially available devices such as laptop computers with special software. **Medicaid does not reimburse for non-dedicated systems.**

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for information specific to AACs. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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### Covered Services for Recipients Under the Age of 21

AAC evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for recipients under the age of 21. **Fittings, adjustments, and training are reimbursed for recipient owned AAC devices.**

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### Covered Services for Recipients Age 21 and Older

AAC initial evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for recipients age 21 and older. **Fittings, adjustments, and training are only reimbursed for recipient owned AAC devices.** Medicaid reimburses only speech-language pathologists for AAC **evaluation** services provided to recipients age 21 and older. **~~These are the only services that are reimbursed by the therapy services program for adults.~~**

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### AAC System Reimbursement

AACs are reimbursed through the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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### Who is Eligible to Receive an AAC

For Medicaid to reimburse for an AAC system, the recipient must meet the following criteria:

- ~~Be unable to communicate basic needs without the use of an AAC;~~ **and Demonstrate a severe, expressive communication disorder; and**
  - Have the physical, cognitive and language abilities necessary to use the AAC system **as documented in an evaluation that was performed and dated by a licensed speech-language pathologist within the past six (6) months. -**
-

**Augmentative and Alternative Communication (AAC),** continued

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**Interdisciplinary Team and Evaluation of Recipients Under the Age of 21 Years of Age Enrolled in Public School:**

For recipients under **the age of 21 and enrolled in public school**, an interdisciplinary team (ID team) must be formed to evaluate the recipient, recommend an AAC, and write an individualized action plan **or plan of care.**

The ID team must consist of at least two members and must include a speech-language pathologist who will lead the team. The speech-language pathologist may request the assistance of an occupational therapist and physical therapist. It is expected that most cases will require the need for an occupational therapist to be a part of the ID team. If appropriate, the recipient who will use the AAC should be encouraged to participate on the ID team as well as the recipient's caregivers, teachers, social workers, case managers, and any other members deemed necessary.

**It is the responsibility of the team leader to provide the team members and other appropriate individuals with the necessary documentation to review and make a determination of concurrence. Documentation must include an evaluation and individual action plan or plan of care.**

~~For recipients age 21 and older, a speech language pathologist is responsible for the evaluation, recommending an AAC, and writing an individualized action plan.~~

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**Interdisciplinary Team and Evaluation of Recipients Under 21 Years of Age the Age of 21 Attending Home School**

**For recipients attending home school, a speech-language pathologist is responsible for performing an evaluation, recommending an AAC device and accessories, and for writing an individualized action plan or plan of care.**

**An interdisciplinary team for recipients attending home school must consist of the evaluating speech-language pathologist, the home school teacher, and the recipient's parent or responsible caregiver. If the recipient is currently receiving occupational or physical therapy services, the occupational or physical therapist should be included on the team.**

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**Evaluation for Recipients Age 21 and Older or Recipients Not Enrolled in Public or Home School**

**For recipients age 21 or older or recipients not enrolled in public school or not home schooled, a speech-language pathologist is responsible for performing an evaluation, recommending an AAC device and accessories, and for writing an individualized action plan or plan of care.**

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**Initial Evaluation**

The ID team, led by the speech-language pathologist, must perform an initial evaluation on the recipient for an AAC system that meets, at a minimum, the evaluation documentation requirements listed in the Provider Qualifications for Initial Evaluations.

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## **Augmentative and Alternative Communication (AAC),** continued

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### **Provider Qualifications for Initial Evaluations**

Medicaid reimburses the following provider types for AAC initial evaluations through the therapy services program:

- For recipients under **the age of** 21:
    - Licensed and provisionally licensed speech-language pathologists;
    - Licensed physical therapists;
    - Licensed occupational therapists; and
    - Home health agencies that employ or contract with licensed and provisionally licensed speech-language pathologists, licensed physical therapists, and licensed occupational therapists.
  - For recipients age 21 and older:
    - Licensed and provisionally licensed speech-language pathologists; and
    - Home health agencies that employ or contract with licensed and provisionally licensed speech-language pathologists.
- 

### **Initial Evaluation Reimbursement Limitations**

For recipients under age 21, Medicaid reimburses one speech-language pathologist, one occupational therapist and one physical therapist who are designated members of the ID team for an initial evaluation. Medicaid reimburses for one initial evaluation per recipient, per provider.

AAC evaluations are valid for six ~~(6)~~ months from the date of the initial evaluation.

For recipients age 21 and older, Medicaid reimburses one speech-language pathologist for an initial evaluation, per recipient.

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## **Augmentative and Alternative Communication (AAC), continued**

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### **Speech-Language Pathologist's Evaluation Documentation Requirements**

Once the ID team (or speech-language pathologist for recipients age 21 and older) has evaluated the recipient and recommended an AAC, the speech-language pathologist must document the following information in writing (the first three items are obtained from the recipient's medical record):

- Significant medical diagnosis(es);
- Significant treatment information and medications;
- Medical prognosis;
- Motor skills, i.e., posture or positioning, selection abilities, range and accuracy of movement, wheelchair use (if applicable include make model serial number of wheelchair), etc.;
- Cognitive skills, i.e., alertness, attention span, vigilance, etc.;
- Sensory or perceptual abilities, i.e., hearing, vision, etc.;
- Language comprehension;
- Expressive language capabilities;
- Oral motor speech status;
- Use of communication or present communication abilities;
- Communication needs including the need to enhance conversation, writing and signaling emergency, basic care and related needs;
- Writing impairments, if any;
- Environment, i.e., home, work, etc., with a description of communication barriers; ~~and~~;
- AAC recommendation, which may include symbol selection, encoding method, selection set (physical characteristics of display), type of display, selection technique, message output, literacy assessment, vocabulary selection, and participation patterns; ~~r~~;
- The evaluator's printed name, title, copy of current professional license or Department of Education (DOE) certification, and legible and dated signature; and
- The evaluator's telephone number for contact purposes.

### **Team Approval of the Evaluation**

The evaluation, which includes the individualized action plan, must be signed, titled (credentials), and dated by all contributing ID team members (or the speech-language pathologist for recipients age 21 and older).

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**Augmentative and Alternative Communication (AAC),** continued

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**Individualized  
Action Plan or Plan  
of Care**

The ID team members headed by the speech-language pathologist (or the speech-language pathologist for recipients age 21 and older) are responsible for developing the recipient's individualized action plan or plan of care. Reimbursement for the development of the individualized action plan is included in the reimbursement for the evaluation.

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**Individualized  
Action Plan  
Components**

The ID team members led by the speech-language pathologist (or the speech-language pathologist for recipients age 21 and older) must write the recipient's individualized action plan. The plan must include the following information:

- An explanation of any AAC currently being used or owned by the recipient at home, work or school;
  - The current use of the system(s) and its limitations;
  - The appropriate long and short-term therapy objectives;
  - The recommended AAC (based on cost-effectiveness and the recipient's needs);
  - The recommended length of a trial period, if applicable;
  - A description of any AACs that the recipient has previously tried;
  - The specific benefits of the recommended AAC over other possibilities;
  - An established plan for mounting, if necessary, repairing, and maintaining the AAC;
  - Who is responsible to deliver and program the AAC to operate at the level recommended by the ID team;
  - Who will train the support staff, recipient and primary caregiver in the proper use and programming of the AAC; and
  - Documentation of medical necessity.
- 

**Team Approval of  
the Evaluation**

~~The evaluation, which includes the individualized action plan, must be signed, titled (credentials), and dated by all contributing ID team members (or the speech language pathologist for recipients age 21 and older).~~

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**Augmentative and Alternative Communication (AAC),** continued

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**AAC Systems Reimbursed Through the DME Program**

Medicaid reimburses for only AACs that are dedicated systems. AAC systems must be prior authorized by the Medicaid consultant.

Medicaid will reimburse for one AAC system every five years per recipient, and [aa](#) software upgrade every two years, if needed. Modifications, which may be in the form of replacing the AAC system or upgrading the AAC's software, may be reimbursed only if the new technology will improve communication significantly.

Medicaid will reimburse for replacement of devices, components or accessories when there is irreparable failure or damage not caused by willful abuse or neglect.

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**Trial Period for AACs**

The ID team (or the speech-language pathologist for recipients age 21 and older) may recommend that the recipient have a trial period with the AAC system. The trial period must be prior authorized by Medicaid. All the steps for completion of a prior authorization package and the components of the prior authorization package must be completed for a trial period to be authorized.

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**Rental-Only AAC Systems**

Medicaid reimburses for rental-only AAC systems for trial periods. Rental-only reimbursements can continue past the trial period when the ID team (or the speech-language pathologist for recipients age 21 and older) recommends and Medicaid approves a continued rental-only situation.

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**Concurrence by School Personnel**

If the recipient is in the public school system, school personnel must be given the opportunity to comment and concur with the ID team's recommended device.

School personnel must agree that the recipient's teacher and school therapist are knowledgeable in the use of the AAC or will be trained regarding its use.

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**Concurrence of Home School Teacher**

The home school teacher must concur with the recommendation of the AAC device, by providing his printed name, title, and dated signature on the individualized action plan or plan of care.

As appropriate, the speech-language pathologist must train the home school teacher regarding the AAC device and its use.

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## Augmentative and Alternative Communication (AAC), continued

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### Physician Approval

**If the recipient is enrolled in MediPass, the recipient's MediPass primary care provider must authorize the AAC device prior to the DME provider's submission of a prior authorization request to the Medicaid fiscal agent.**

The speech-language pathologist must send the evaluation, which includes the recommended AAC, the individualized action plan, and the speech-language pathologist's plans for management of the recipient's communicative disorder to the recipient's primary care provider, ARNP or PA designee, or designated physician specialist.

The recipient's primary care provider, ARNP or PA designee, or designated physician specialist must review the evaluation and individualized action plan, and if he or she concurs, sign and date the evaluation and prescribe the AAC. The prescription must include the primary care provider's, ARNP's or PA designee's, or designated physician specialist's name, address, telephone number, medical license number, and MediPass authorization number, if applicable. (If the recipient is in MediPass, the AAC must be authorized by the recipient's MediPass primary care provider.)

**If the recipient is enrolled in MediPass, the recipient's MediPass primary care provider must authorize the AAC device prior to the DME provider's submission of a prior authorization request to the Medicaid fiscal agent.**

The primary care provider, ARNP or PA designee, or designated physician specialist returns the signed and dated evaluation, individualized action plan, and prescription to the speech-language pathologist.

Note: See the Florida Medicaid Provider General Handbook for information on MediPass and Medicaid Health Maintenance Organizations (HMOs).

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### **Conflict of Interest for AAC Device**

**The medical professionals who evaluate the recipient, serve on the ID team, or prescribe the AAC device must not have a financial relationship with or receive any financial gain from the AAC device manufacturer or the DME provider.**

**A signed and dated statement of non-conflict from each member of the ID team must be included in the therapist's documentation and included with the prior authorization request packet.**

**Note:** ~~Note:~~ See Self-Referral and Conflict of Interest in the Provider Requirements section in **Chapter 1** of the Durable Medical Equipment Handbook. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). **Select Public Information for Providers, then Provider Support, and then Provider Handbooks**

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**Augmentative and Alternative Communication (AAC),** continued

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**Referral to the  
DME Provider**

The speech-language pathologist is responsible for submitting the following information to the DME provider:

- The recipient's evaluation, which is completed, signed, titled (credentials) and dated by the interdisciplinary team members (or speech-language pathologist for recipients age 21 and older) and the recipient's primary care provider, ARNP or PA designee, or designated physician specialist;
  - Individualized action plan; and
  - The recipient's primary care provider's, ARNP's or PA designee's, or designated physician specialist's prescription for the AAC system.
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**Prior  
Authorization by  
Medicaid**

AACs must be prior authorized by the Medicaid consultant. The DME provider is responsible for requesting prior authorization.

**Prior authorization (PA) requests for AAC devices, AAC device accessories, and repairs must be reviewed for medical necessity by Medicaid's professional consultant or designated staff member and authorized by the Medicaid DME and Medical Supply Services Program.**

**Current procedure codes used for AAC devices are listed on the DME and Medical Supply Services Provider Fee Schedule.**

**Note: For information regarding the authorization process and where to submit prior authorization requests for AAC devices, accessories and repairs, see Chapter 2 in the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in ~~this chapter~~ Chapter 2 of the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ~~for information regarding the authorization process and where to submit prior authorization requests for AAC devices, accessories and repairs.~~ The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.**

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**Augmentative and Alternative Communication (AAC),** continued

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**Steps for Completion of a PA Package for Recipients Under 21 Years of Age Enrolled in Public or Home School Steps for Completion of a Prior Authorization Package**

The steps below must be followed to obtain Medicaid authorization for an AAC device for recipients who are under 21 years of age and enrolled in public school or attending home school.

Written documentation from each step must be included in the Medicaid prior authorization package.

1. Interdisciplinary team (ID team), led by the speech-language pathologist, evaluates the recipient, recommends an AAC device, and writes an individualized action plan or plan of care.

2. Speech-language pathologist sends the evaluation, which includes the recommended AAC device, the individualized action plan or plan of care, the speech-language pathologist's plans for management of the recipient's communication disorder, and the non-conflict of interest statement to the recipient's physician, treating physician's ARNP or physician assistant, or designated physician specialist.

3. Treating physician, treating physician's prescribing ARNP or physician assistant, or designated physician specialist must review the evaluation and individualized action plan or plan of care; and, if he concurs, sign and date the evaluation and prescribe the AAC device.

4. Recipient's MediPass primary care provider authorizes the AAC device if the recipient is enrolled in MediPass. (The DME provider must obtain MediPass authorization in order to be reimbursed for the claim.)

5. The ID team speech-language pathologist forwards the prior authorization package to the DME provider.

6. The DME provider completes the prior authorization package by attaching an invoice, proof of manufacturer's cost, warranty information, and a Florida Medicaid Authorization Request form, PA-01, and submits the package to the Medicaid fiscal agent.

7. The Medicaid professional consultant reviews the prior authorization package and recommends approval or denial of the authorization request.

DME provider is responsible for completing items 6 and 7. The DME provider must complete and submit a prior authorization package to the Medicaid fiscal agent for Medicaid review and approval. For the therapist's information, the following components must be included in the prior authorization package:

1. The AAC evaluation and recommendation signed and dated by the ID team members (or speech-language pathologist for recipients age 21 and older) and the recipient's primary care provider, ARNP or PA designee or designated physician specialist;
2. The individualized action plan;
3. A prescription for the AAC signed and dated by the recipient's primary care provider, ARNP or PA designee or designated physician specialist that includes the provider's name, address, telephone number, and medical license number;
4. The MediPass authorization number, if the recipient is a MediPass participant;
5. A statement of concurrence from school personnel, if the recipient is in the public school system;
6. A completed State of Florida, Florida Medicaid Authorization Request form;
7. An itemized invoice listing retail costs for the equipment; and
8. Manufacturer's catalogue information regarding cost and warranty information.

The DME provider is responsible for completing items 6, 7 and 8.

**Augmentative and Alternative Communication (AAC), continued**

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**Steps for  
Completion of a  
PA Package for  
Recipients 21 or  
Older or for  
Recipients not  
Enrolled in  
Public or Home  
School**

The following steps must be followed to obtain Medicaid authorization for an AAC device for recipients who are age 21 or older or recipients who are not enrolled in public or home school.

The written documentation for each step must be included in the Medicaid prior authorization package:

1. Speech-language pathologist sends the evaluation, which includes the recommended AAC device, the individualized action plan or plan of care, the speech-language pathologist's plans for management of the recipient's communication disorder, and the non-conflict of interest statement to the recipient's physician, treating physician's ARNP or physician assistant, or designated physician specialist.

2. Treating physician, treating physician's prescribing ARNP or physician assistant, or designated physician specialist must review the evaluation and individualized action plan or plan of care; and, if he concurs, sign and date the evaluation and prescribe the AAC device.

3. Recipient's MediPass primary care provider authorizes the AAC device if the recipient is enrolled in MediPass. (The DME provider must obtain MediPass authorization in order to be reimbursed for the claim.)

4. Speech-language pathologist forwards the prior authorization package to the DME provider.

5. DME provider completes the prior authorization package by attaching an invoice, proof of manufacturer's cost, and a Florida Medicaid Authorization Request form, PA-01, and submits the package to the Medicaid fiscal agent.

6. Medicaid professional consultant reviews the prior authorization package and recommends approval or denial of the authorization request.

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**Augmentative and Alternative Communication (AAC),** continued

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**Medicaid Approval of the AAC**

Medicaid's decision for coverage will be based on a medical rationale for the request of a particular system, a comparative analysis of equipment tested, and the individual recipient's ability to use the equipment as it relates to a medical need.

Medicaid will not deny an AAC based solely on the fact that the recipient can communicate in writing.

---

**Additional Evaluation Requested by Medicaid**

Florida Medicaid reserves the right to request an AAC evaluation of a recipient from either another physician or an individual who is board-certified as a neurologist, physiatrist, otolaryngologist, audiologist, optometrist or ophthalmologist.

The Medicaid reviewer can request a videotape of the recipient in different functional communication settings for the evaluation of the prior authorization request.

Florida Medicaid reserves the right to request an evaluation of a recipient from another physician or an individual who is board-certified as a neurologist, physiatrist, otolaryngologist, audiologist, optometrist, or ophthalmologist for the purpose of establishing the appropriateness of the device being recommended.

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**DME Provider Responsibilities**

Prior to billing for an AAC system, the DME provider is responsible to ensure the properly selected system and all components have been delivered to the recipient and are operational in the recipient's home.

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**Augmentative and Alternative Communication (AAC),** continued

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**Follow-up Evaluations**

Medicaid reimburses the speech-language pathologist for one follow-up evaluation per rented or purchased device when the AAC system is delivered in order to ensure that the system is appropriate for meeting the needs of the recipient. Medicaid reimburses follow-up evaluations only for recipients under age 21.

---

**Follow-up Evaluation Documentation**

Documentation for a follow-up evaluation must be a progress note, signed and dated on the date of service, that describes the session with the recipient and AAC, and any alterations made to the initial evaluation and/or the individualized action plan.

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**Re-Evaluations**

Medicaid requires that the recipient be re-evaluated for the appropriateness of the AAC system every six months. The first re-evaluation must take place within six months of the follow-up evaluation. Medicaid reimburses re-evaluations only for recipients under age 21.

---

**Re-Evaluation Documentation**

Documentation for a re-evaluation must consist of the elements of the initial evaluation.

---

**Provider Requirements for Follow-Up and Re-Evaluations and AAC Fitting, Adjusting and Training Sessions**

Medicaid reimburses the following provider types for follow-up evaluation, re-evaluations, and AAC fitting, adjusting and training sessions.

- Licensed and provisionally licensed speech-language pathologists; and
- Home health agencies that employ or contract with licensed or provisionally licensed speech-language pathologists.

Medicaid does not reimburse speech-language pathology assistants for AAC evaluations, fittings, adjustments and training.

---

**Follow-up and Re-Evaluation Reimbursement Limitations**

Medicaid reimburses for one follow-up evaluation per recipient under age 21, per device, per provider.

Medicaid reimburses up to two re-evaluations per recipient under age 21, per device, per provider, per calendar year.

Medicaid will reimburse for only one follow-up evaluation plus one re-evaluation or two re-evaluations per recipient under age 21, per device, per provider, per calendar year.

---

**Augmentative and Alternative Communication (AAC),** continued

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**AAC Fitting, Adjustment and Training Sessions**

Treatment sessions for AAC fitting, adjustment and training are face-to-face encounters with a recipient for the purpose of providing instructions on the use of the AAC device and making minor adjustments on the device as needed. Medicaid reimburses for these sessions for all recipients.

The sessions must be a face-to-face contact with an individual recipient. Medicaid does not reimburse for group AAC fitting, adjustment and training.

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**AAC Fitting, Adjustment and Training Sessions Reimbursement Limitations**

Medicaid reimburses the provider for medically necessary AAC fitting, adjustments, and training sessions. Medicaid reimburses up to a maximum of eight 30-minute sessions per recipient, per device, per year. The provider may be reimbursed for only one session, per recipient, per day.

Providers may also be reimbursed for one treatment session on the same day as a fitting, adjustment and training session for recipients under age 21.

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**Service Exclusions**

Medicaid reimbursement for the AAC fitting, adjustment and training sessions does not include telephone responses to questions, conferences with the child's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time.

---

**Documentation for AAC Fitting, Adjustment and Training**

The therapist must record on a per treatment basis the time period and the type of service rendered, the progress of the recipient in the use of the AAC device, and change in the recipient's status due to the services rendered. Each entry must be signed and dated by the Medicaid enrolled treating provider on the date the service was provided.

Note: See the Florida Medicaid Provider General Handbook, for information on record keeping and documentation requirements.

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**Codes and Fees**

See Chapter 3, Appendix A, of this handbook for the AAC procedure codes and fee schedule.

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***Splints and Casts***

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**Description**

Medicaid reimburses physical and occupational therapists for applying splints and casts that are needed for a recipient's therapy.

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**Provider Requirements**

Only licensed physical and occupational therapists can be reimbursed for applying splints and casts.

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**Service Requirements**

To be reimbursed by Medicaid, the splint or cast service must be:

- Authorized by a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist; and
  - Included in the recipient's plan of care.
- 

**Reimbursement Limitations**

Medicaid reimburses for a maximum of two cast and splint applications per day, per recipient. This is a combined total.

A therapy visit and a cast or splint application may be reimbursed on the same day for the same recipient.

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**Codes and Fees**

See Chapter 3, Appendix A, of this handbook for the splint and cast procedure code and fee schedule.

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## **Wheelchair Evaluations and Fittings**

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### **Description**

Medicaid reimburses physical and occupational therapists for an initial evaluation of a recipient's need for a wheelchair, and follow-up evaluations after it is delivered to make adjustments and to properly fit the wheelchair to the recipient.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for information specific to wheelchairs. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

---

### **Provider Requirements**

Only licensed physical and occupational therapists may be reimbursed for wheelchair evaluations.

The therapist who performed the initial wheelchair evaluation must:

- Be available to the durable medical equipment provider that is supplying the wheelchair; and
  - Be present upon delivery of the wheelchair to perform the follow-up evaluation to make adjustments and properly fit the chair to the recipient.
- 

### **Service Requirements**

To be reimbursed by Medicaid, the following criteria must be met:

- The initial wheelchair evaluation must be prescribed ~~via referral~~ by the primary care provider, ARNP or PA designee, or a designated physician specialist;
  - The therapist must complete, sign and date a wheelchair evaluation report documenting the recipient's need for a wheelchair and the specific type of wheelchair needed; and
  - The primary care provider, ARNP or PA designee, or a designated physician specialist must provide the durable medical equipment provider with a written prescription for the wheelchair repair or replacement.
-

## **Wheelchair Evaluations and Fittings**, continued

### **Wheelchair Evaluation Report**

The wheelchair evaluation report must contain the following information:

- Identification of the recipient's physical conditions that make a wheelchair reasonable and medically necessary;
- If an electric wheelchair is recommended, justification of its appropriateness based on the recipient's capacity and medical condition;
- Justification of all accessories and add-on components based on the recipient's medical needs; and
- Explanation of the medical or health related purpose for each accessory or add-on component, the medical consequences of omitting the item, and why the physical disability of the recipient justifies the inclusion of the item.

**Send the request directly to the following address for review:**

**Bureau of Medicaid Services  
DME Prior Authorization  
2727 Mahan Drive, Mail Stop 20  
Tallahassee, FL 32308**

**PA requests for custom manual and custom power-operated wheelchairs (K0009 and K0014) must be submitted on either the Custom Wheelchair Evaluation, AHCA-Med Serv Form 015, July 2007, or another document that contains the same information as the form.**

**Note: See the Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook for the AHCA-Med Serv Form 015, July 2007. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.**

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### **Reimbursement Limitations**

Medicaid reimbursement for wheelchair evaluations and fittings is limited to:

- One initial wheelchair evaluation per recipient, per provider, **every five years;**
- One follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the chair to the recipient; and
- One follow-up evaluation six months after the wheelchair is delivered to recommend any additional adjustments.

**The Florida Medicaid Durable Medical Equipment Program reimburses one mobility device every five years.**

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### **Codes and Fees**

See Chapter 3, Appendix A, of this handbook for the wheelchair evaluations and fitting procedure codes and fee schedule.

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## CHAPTER 3

### THERAPY SERVICES

### PROCEDURE CODES

#### **Overview**

#### **Introduction**

This chapter describes the procedure codes for Medicaid reimbursable services that must be used by therapists providing services to eligible recipients.

#### **Procedure and Diagnosis Code Origination**

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. The CPT includes HCPCS descriptive terms and parameters and numeric identifying codes for reporting service and procedures.

~~Effective with dates of service on or after October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.~~

~~All previously used "local codes" can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service on or after October 16, 2003. For dates of services prior to October 16, 2003, the provider must use procedure codes that were payable at that time. Please refer to Appendix A for the valid codes for Florida Medicaid services effective October 16, 2003.~~

A diagnosis code is required on the CMS-1500 claim form for all medical procedures. Use the most specific code available. Fourth and fifth digits are required when available.

#### **In This Chapter**

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-2
How to Read the Therapy Fee Schedule	3-2
Appendix A: Procedure Codes and Maximum Fee Schedule	A-1

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## Reimbursement Information

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### Submission of a Prior Authorization Claim for Payment

Providers submit a claim for payment for a prior authorized procedure after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the 10-digit prior authorization number on the claim form.

Note: For additional information on completing the claim form, see the Florida Medicaid Provider Reimbursement Handbook, CMS 1500. The handbook may be accessed at: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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### Prior Authorization Number

When a prior authorization request is approved, the approval will contain a prior authorization number for billing and reference. Only one prior authorization number will be issued per certification period.

For Medicaid to reimburse the service:

- The 10-digit prior authorization number must be entered in field 23 on the claim form;
  - The authorization period, corresponding to the prior authorization number entered in field 23, must match the dates of service shown on the claim;
  - The Medicaid provider number and Medicaid recipient identification number on the claim form and the plan of care must match; and
  - The Medicaid provider must provide the service before submitting the claim.
- 

### Therapists with Temporary Licenses

Medicaid enrolled, supervising therapists and home health agencies may be reimbursed for services rendered by occupational therapists with temporary licenses. The provider bills the procedure code for the service that the temporary licensed therapist rendered.

Note: See Appendix A in this chapter for the therapy procedure codes and fees.

---

### Therapy Assistants

Medicaid enrolled, supervising therapists and home health agencies may be reimbursed for services rendered by physical therapy assistants, occupational therapy assistants and speech-language pathology assistants. Providers must use the therapy assistant procedure codes to bill for services rendered by therapy assistants. These codes have lower maximum fees than the therapy procedure codes. **Reimbursement for supervision is included in the therapy assistant fee. Providers may not bill an additional charge for the supervision of a therapy assistant.**

Note: See Appendix A in this chapter for the therapy assistant procedure codes and fees.

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**Services Provided  
in Institutions**

Therapy services provided in a nursing home facility, an intermediate care facility for developmental disabilities (ICF/DD), or an inpatient and outpatient hospital are not reimbursed according to the fee schedule in Appendix A. Medicaid reimbursement for therapy services is included in the facility's cost-based reimbursement.

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### ***How to Read the Therapy Fee Schedule***

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**Description**

The therapy fee schedule lists the procedure codes, modifiers, their descriptors and maximum fees. The following information explains the procedure codes and maximum fee schedule columns, reading from left to right.

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**Code**

The five-digit, alpha-numeric code in this column identifies the procedure being billed.

---

**Description of Service**

The information in this column describes the service or procedure associated with the procedure code.

---

**Maximum Fee**

The fee in this column is the maximum amount Medicaid will pay for the procedure. The maximum fee encompasses the professional and technical components of the service.

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**Maximum Allowable Units**

The maximum amount of units reimbursable by Medicaid to a provider for the specified period of time.

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**APPENDIX A  
PROCEDURE CODES AND MAXIMUM FEE SCHEDULE**

**AUGUMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC)**

<b>Code</b>	<b>Modifier</b>	<b>Description of Service</b>	<b>Maximum Fee</b>	<b>Maximum Allowable Units</b>
92597		AAC Initial Evaluation Provided by a Speech-Language Pathologist	\$97.50	1 per 5 years
92597	GP	AAC Initial Evaluation Provided by a Physical Therapist	\$97.50	1 per 5 years
92597	GO	AAC Initial Evaluation Provided by an Occupational Therapist	\$97.50	1 per 5 years
92597	GN	AAC Re-Evaluation Provided by a Speech-Language Pathologist	\$50.00	1 per 6 months
92609		AAC Fitting, Adjustment, and Training Visit	\$40.00	8 per year

**OCCUPATIONAL THERAPY**

<b>Code</b>	<b>Modifier</b>	<b>Description of Service</b>	<b>Maximum Fee</b>	<b>Maximum Allowable Units</b>
97003		Occupational Therapy Evaluation, Initial	\$48.50	1 per year
97004		Occupational Therapy Re-Evaluation, Periodic	\$48.50	1 per 5 months
97530		Physical Medicine Treatment Visit, Therapeutic Exercise Visit	\$16.97	4 per day, 14 per week
29799	HA	Application of Cast or Splint	\$18.58	2 per day

**PHYSICAL THERAPY**

<b>Code</b>	<b>Modifier</b>	<b>Description of Service</b>	<b>Maximum Fee</b>	<b>Maximum Allowable Units</b>
97001		Physical Therapy Evaluation, Initial	\$48.50	1 per year
97002		Physical Therapy Re-Evaluation, Periodic	\$48.50	1 per 5 months
97110		Physical Therapy Treatment Visit	\$16.97	4 per day, 14 per week
29799	HA	Application of Cast or Splint	\$18.58	2 per day

**RESPIRATORY THERAPY**

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
S5180	HA	Initial Evaluation/Re-evaluation - Rendered by a Registered Respiratory Care Practitioner	\$48.50	1 per 6 months
G0238		Respiratory Therapy Visit - Rendered by a Registered Respiratory Care Practitioner	\$16.97	4 per day, 14 per week

**SPEECH THERAPY**

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
92506		Speech Therapy Evaluation/Re-evaluation	\$48.50	1 per 6 months*
92507		Speech Therapy Visit	\$16.97	4 per day, 14 per week
92508		Group Speech Therapy per child in the group per 15 minutes	\$ 3.30	4 per day, 14 per week

**THERAPY ASSISTANTS:  
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY**

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
92507	HM	Speech Therapy Visit Provided by a Speech Therapy Assistant	\$13.58	4 per day, 14 per week
97530	HM	Occupational Therapy Visit Provided by an Occupational Therapy Assistant	\$13.58	4 per day, 14 per week
97110	HM	Physical Therapy Visit Provided by a Physical Therapy Assistant	\$13.58	4 per day, 14 per week

**WHEELCHAIR EVALUATION AND FITTING**

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
97001	TG	Wheelchair Evaluation and Fitting by a Physical Therapist	\$48.50	3 per five years*
97003	TG	Wheelchair Evaluation and Fitting by an Occupational Therapist	\$48.50	3 per five years*

\* See Chapter 2 for More Details

**Your search for  
Health Care Information  
may be over.**

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with Health Care  
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surgery centers,  
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