

## **Title 23: Division of Medicaid**

### **Part 213: Therapy Services**

#### **Chapter 1: Physical Therapy**

##### *Rule 1.3: Covered Physical Therapy Services*

- A. The Division of Medicaid covers physical therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity to treat a beneficiary's illness, condition, or injury and the following requirements are met:
1. The services require the knowledge, skill and judgment of a state-licensed physical therapist.
  2. The Certificate of Medical Necessity (CMN) for the initial referral/order is completed by the prescribing provider prior to the physical therapy evaluation.
  3. The plan of care (POC) is developed by a state-licensed physical therapist.
  4. The prescribing provider approves the initial/revised POC with a signature and date:
    - a) Before the initiation of treatment or change in treatment, or
    - b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.
  5. The services are rendered as individualized therapy consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.
  6. The services do not duplicate another provider's services including those services provided in a school-based setting.
- B. The Division of Medicaid reimburses for covered physical therapy services provided by:
1. A state-licensed physical therapist.
  2. A state-licensed physical therapist assisted by a state-licensed physical therapist assistant under direct, on-site supervision by a state-licensed physical therapist.
    - a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed physical therapist at regular intervals, as prescribed in regulations adopted by the Mississippi State Board of Physical Therapy and does not include:
      - 1) Contacts by telephone,

- 2) Contacts by pager,
  - 3) Video conferencing, and/or
  - 4) Any method not approved by the Division of Medicaid.
- b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed physical therapist.
3. A state-licensed physical therapist assisted by a physical therapy student who is enrolled in an accredited physical therapy program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed physical therapist, referred to as student assisted physical therapy services.
- a) The Division of Medicaid defines direct, on-site supervision of a physical therapy student as the face-to-face oversight by a state-licensed physical therapist.
  - b) The state-licensed physical therapist must be physically present and engaged in student oversight during the entirety of a physical therapy session such that the state-licensed physical therapist is considered to be providing the physical therapy service.
- C. The state-licensed physical therapist cannot supervise at the same time during the work day more than:
1. One (1) physical therapy student,
  2. A total of four (4) state-licensed physical therapist assistants, or
  3. One (1) physical therapy student and three (3) state-licensed physical therapist assistants.

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

History: Revised eff. 01/01/2016.

*Rule 1.4: Non-Covered Physical Therapy Services*

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

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

- C. Services do not meet medical necessity criteria,
- D. Services do not require the knowledge, skill, and judgment of a state-licensed physical therapist,
- E. Documentation supports that the beneficiary has attained the physical therapy goals or has reached the point where no further significant improvement can be expected,
- F. Documentation supports that the beneficiary has not reached physical therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the physical therapy regimen,
- G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,
- H. Services duplicate other concurrent therapy,
- I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed physical therapist,
- J. Conditions could be reasonably expected to improve spontaneously without therapy,
- K. Services are ordered daily or multiple times per day from the initiation of therapy through discharge,
- L. Services are normally considered part of nursing care,
- M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),
- N. Services are billed as separate fees for self-care/home-management training,
- O. Services are related solely to employment opportunities or the purpose is vocationally based,
- P. Services are for general wellness, exercise, and/or recreational programs,
- Q. Services are provided by physical therapy aides,
- R. Services are delivered in a group therapy or co-therapy session,
- S. Services are investigational or experimental,
- T. Services consist of acupuncture or biofeedback,
- U. Services are outside the scope/and or authority of the state-licensed physical therapist's specialty and/or area of practice,

- V. The provider has not met the prior authorization/pre-certification requirements,
- W. Services are provided in the home setting, or
- X. Services are not specifically listed as covered by the Division of Medicaid.

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

History: Revised eff. 01/01/2016.

*Rule 1.5: Reserved*

## **Part 213 Chapter 2: Occupational Therapy**

### *Rule 2.3 Covered Occupational Therapy Services*

- A. The Division of Medicaid covers occupational therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity to treat a beneficiary's illness, condition, or injury and the following requirements are met:
  - 1. The services require the knowledge, skill and judgment of a state-licensed occupational therapist.
  - 2. The Certificate of Medical Necessity (CMN) for initial referral/order is completed by the prescribing provider prior to the occupational therapy evaluation.
  - 3. The plan of care (POC) is developed by a state-licensed occupational therapist.
  - 4. The prescribing provider approves the initial/revised POC with a signature and date:
    - a) Before the initiation of treatment or change in treatment, or
    - b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.
  - 5. The services are rendered as individualized therapy, consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.
  - 6. The services do not duplicate another provider's services including those services provided in a school-based setting.
- B. The Division of Medicaid reimburses for covered occupational therapy services provided by:
  - 1. A state-licensed occupational therapist.

2. A state-licensed occupational therapist assisted by a state-licensed occupational therapist assistant under direct, on-site supervision by a state-licensed occupational therapist.
  - a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed occupational therapist at regular intervals, as prescribed by the standards of the Accreditation Council of Occupational Therapy Education (ACOTE) and does not include:
    - 1) Contacts by telephone,
    - 2) Contacts by pager,
    - 3) Video conferencing, and/or
    - 4) Any method not approved by the Division of Medicaid.
  - b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed occupational therapist.
3. A state-licensed occupational therapist assisted by an occupational therapy student who is enrolled in an accredited occupational therapy program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed occupational therapist, referred to as student assisted occupational therapy services.
  - a) The Division of Medicaid defines direct, on-site supervision of an occupational therapy student as the face-to-face oversight by a state-licensed occupational therapist.
  - b) The state-licensed occupational therapist must be physically present and engaged in student oversight during the entirety of a therapy session such that the state-licensed occupational therapist is considered to be providing the occupational therapy service.
- C. The state-licensed occupational therapist cannot supervise at the same time during the work day more than:
  1. One (1) occupational therapy student,
  2. A total of four (4) state-licensed occupational therapist assistants, or
  3. One (1) occupational therapy student and three (3) state-licensed occupational therapist assistants.

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

History: Revised eff. 01/01/2016.

*Rule 2.4: Non-Covered Occupational Therapy Services*

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

- A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,
- B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 2.3.A.4],
- C. Services do not meet medical necessity criteria,
- D. Services do not require the knowledge, skills, and judgment of a state-licensed occupational therapist,
- E. Documentation supports that the beneficiary has attained the occupational therapy goals or has reached the point where no further significant improvement can be expected,
- F. Documentation supports that the beneficiary has not reached occupational therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the occupational therapy regimen,
- G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,
- H. Services duplicate other concurrent therapy,
- I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed occupational therapist,
- J. Conditions could be reasonably expected to improve spontaneously without therapy,
- K. Services are ordered daily or multiple times per day from the initiation of therapy through discharge,
- L. Services are normally considered part of nursing care,
- M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),
- N. Services are billed as separate fees for self-care/home-management training,
- O. Services are related solely to employment opportunities or the purpose is vocationally based,

- P. Services are for general wellness, exercise, and/or recreational programs,
- Q. Services are provided by occupational therapy aides,
- R. Services are delivered in a group therapy or co-therapy session,
- S. Services are investigational or experimental,
- T. Services consist of acupuncture or biofeedback,
- U. Services are outside the scope/and or authority of the state-licensed occupational therapist's specialty and/or area of practice,
- V. The provider has not met the prior authorization/pre-certification requirements,
- W. Services are provided in the home setting, or
- X. Services are not specifically listed as covered by the Division of Medicaid.

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

History: Revised eff. 01/01/2016.

### **Part 213 Chapter 3: Speech-Language Pathology and Audiology Services**

#### *Rule 3.3: Covered Speech-Language Pathology and Audiology Services*

- A. The Division of Medicaid covers speech-language pathology and audiology services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, for the diagnosis and treatment of a communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity and the following requirements are met:
  1. The services require the knowledge, skill and judgment of a state-licensed speech-language pathologist or audiologist.
  2. The Certificate of Medical Necessity (CMN) for initial referral/order is completed by the prescribing provider prior to the speech-language pathology or audiology evaluation.
  3. The plan of care (POC) is developed by a state-licensed speech-language pathologist or audiologist.
  4. The prescribing provider approves the initial/revised POC with a signature and date:
    - a) Before the initiation of treatment or change in treatment, or

- b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.
5. The services are rendered as individualized speech language pathology or audiology services consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.
  6. The services do not duplicate another provider's services including those services provided in a school-based setting.
  7. The beneficiary presents with one (1) or more of the following:
    - a) Aphagia defined as an inability to swallow,
    - b) Aphasia defined as an absence/impairment of the ability to communicate through speech, writing, or signs caused by focal damage to the language dominant hemisphere of the brain,
    - c) Aphonia defined as an inability to produce sounds from the larynx due to excessive muscle tension, paralysis, or disease of the laryngeal nerves,
    - d) Apraxia defined as an inability to form words to speak despite an ability to use facial and oral muscles to make sounds,
    - e) Dysarthria defined as defective or difficult speech that involves disturbances in muscular control like weakness, lack of coordination, or paralysis of the speech mechanism, either oral, lingual, respiratory or pharyngeal muscles, resulting from damage to the peripheral or central nervous system,
    - f) Dysphagia defined as difficulty swallowing,
    - g) Dysphasia defined as language impairment from neurodevelopmental disorder or brain lesion,
    - h) Dysphonia defined as difficulty speaking due to impairment of the muscles involving vocal production, and/or
    - i) Vocal cord dysfunction defined as impairment of vocal cord mobility due to functional or structural abnormalities resulting from organic or neurological diseases.
  8. Risk factors have been identified and documented including, but are not limited to:
    - a) Neurological disorders/dysfunctions, such as hearing loss or cerebral palsy,
    - b) Surgical procedures, such as partial/comprehensive/radical laryngectomy, repaired

- cleft palate, or glossectomy,
- c) Cognitive impairments that affect communication functions, or
  - d) Medical conditions resulting in communication disorders that require restorative therapy including, but not limited to:
    - 1) Laryngeal carcinoma requiring partial/total laryngectomy that results in dysphonia or aphonia,
    - 2) Traumatic brain injury that may exhibit inadequate respiratory volume, apraxia, dysphagia, or dysarthria,
    - 3) Progressive/static neurological conditions, such as amyotrophic lateral sclerosis, Parkinson's disease, myasthenia gravis, multiple sclerosis, or Huntington's disease,
    - 4) Intellectual disability with disorders of dysarthria, dysphagia, apraxia, or aphagia, and/or
    - 5) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria.
9. The type of service requested includes one (1) or more of the following:
- a) Diagnostic and evaluation services:
    - 1) To determine the type, causal factors, severity of speech-language or swallowing disorders, and the extent of service required to restore functions of speech, language, voice fluency, and swallowing, or
    - 2) The beneficiary demonstrates changes in functional speech or remission of a medical condition that previously contradicted speech-language therapy.
  - b) Therapeutic services defined as services requiring active corrective/restorative therapy, for communication disorders that result from:
    - 1) Laryngeal carcinoma requiring partial/total laryngectomy that results in aphonia so the beneficiary can develop new communication skills through esophageal speech or the use of an electrolarynx,
    - 2) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria, or
    - 3) Medical and neurological conditions, like traumatic brain injury, Parkinson's disease, or multiple sclerosis, exhibiting inadequate respiratory volume/control,

aphonia, dysphagia, dysarthria, or dysphonia.

- B. The Division of Medicaid reimburses for covered speech-language pathology or audiology services provided by:
1. A state-licensed speech-language pathologist or audiologist.
  2. A state-licensed speech-language pathologist or audiologist assisted by a state-licensed speech-language pathologist or audiologist assistant under direct, on-site supervision by a state-licensed speech-language pathologist or audiologist.
    - a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed speech-language pathologist or audiologist at regular intervals, congruent with the standards of the American Speech-Language-Hearing Association (ASHA) and does not include:
      - 1) Contacts by telephone,
      - 2) Contacts by pager,
      - 3) Video conferencing, and/or
      - 4) Any method not approved by the Division of Medicaid.
    - b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed speech-language pathologist or audiologist.
  3. A state-licensed speech-language pathologist or audiologist assisted by a speech-language pathology or audiology student who is enrolled in an accredited speech-language pathology or audiology program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed speech-language pathologist or audiologist, referred to as student assisted speech-language pathology or audiology services.
    - a) The Division of Medicaid defines direct, on-site supervision of a speech-language pathology or audiology student as the face-to-face oversight by a state-licensed speech-language pathologist or audiologist.
    - b) The state-licensed speech-language pathologist or audiologist must be physically present and engaged in student oversight during the entirety of a therapy session such that the state-licensed speech-language pathologist or audiologist is considered to be providing the speech-language pathology or audiology service.
- C. The state-licensed speech-language pathologist or audiologist cannot supervise at the same time during the work day more than:

1. One (1) speech-language pathology or audiology student,
2. A total of four (4) state-licensed speech-language pathologist or audiologist assistants, or
3. One (1) speech-language pathology or audiology student and three (3) state-licensed speech-language pathologist or audiologist assistants.

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

History: Revised eff. 01/01/2016.

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

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

- A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,
- B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 3.3.A.4.],
- C. Services do not meet medical necessity criteria,
- D. Services do not require the knowledge, skill, and judgment of a state-licensed speech-language pathologist or audiologist,
- E. Documentation supports that the beneficiary has attained the speech-language pathology or audiology goals or has reached the point where no further significant improvement can be expected,
- F. Documentation supports that the beneficiary has not reached the speech-language pathology or audiology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the speech-language pathology or audiology regimen,
- G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,
- H. Services duplicate other concurrent therapy,
- I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed speech-language pathologist or audiologist,
- J. Conditions could be reasonably expected to improve spontaneously without therapy,

- K. Services are ordered daily, or multiple times per day, from the initiation of therapy through discharge,
- L. Services are normally considered part of nursing care,
- M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),
- N. Services are billed as separate fees for self-care/home-management training,
- O. Services are related solely to employment opportunities or the purpose is vocationally based,
- P. Services are for general wellness, exercise, and/or recreational programs,
- Q. Services are provided by speech-language pathology or audiology aides,
- R. Services are delivered in a group therapy or co-therapy session,
- S. Services are investigational or experimental,
- T. Services consist of acupuncture or biofeedback,
- U. Services are outside the scope/and or authority of the state-licensed speech-language pathologist's or audiologist's specialty and/or area of practice,
- V. The provider has not met the prior authorization/pre-certification requirements,
- W. Services are provided in the home setting, or
- X. Services are not specifically listed as covered by the Division of Medicaid.

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

History: Revised eff. 01/01/2016.

## Title 23: Division of Medicaid

### Part 213: Therapy Services

#### Chapter 1: Physical Therapy

##### *Rule 1.3: Covered Physical Therapy Services*

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

~~A. Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.~~

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

~~2. B. The beneficiary must be under the care of and referred for therapy services by a state-licensed physician, physician assistant, or nurse practitioner. The Certificate of Medical Necessity (CMN) for the Initial Referral/Orders must be is completed by the prescribing provider prior to the physical therapy evaluation.~~

~~C. Services must be provided by a state-licensed physical therapist. Services may be provided by a state-licensed physical therapist assistant under the direct supervision of a state-licensed physical therapist in the outpatient department of a hospital.~~

~~3. D. Services must be provided according to a The plan of care (POC) is developed by the a state-licensed physical therapist, y provider and authenticated by the prescribing provider's signature and date signed.~~

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

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

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

~~2. This applies to both the initial and revised plans of care.~~

~~E. The discipline in which the therapist is licensed must match the order for therapy services. Only a state-licensed physical therapist may evaluate, plan care, and deliver physical therapy services.~~

~~F. Services must be conducted one-on-one between the beneficiary and therapist. Group physical therapy is non-covered.~~

~~5.G. The services are rendered~~ Services must be as individualized therapy, consistent with the symptomatology/diagnosis, and do not in exceedss of the beneficiary's needs.

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

~~I. Services must be authorized by the UM/QIO.~~

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

1. A state-licensed physical therapist.

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

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

1) Contacts by telephone,

2) Contacts by pager,

3) Video conferencing, or

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

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

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

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

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

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

1. One (1) physical therapy student,
2. A total of four (4) state-licensed physical therapist assistants, or
3. One (1) physical therapy student and three (3) physical therapist assistants.

Source: 42 CFR §§ 410.60-61, 440.110; Miss. Code Ann. §§ 43-13-121, 73-23-31, et seq.; 42 CFR 410.60—410.61; 42 CFR 440.110

History: Revised eff. 01/01/2016.

*Rule 1.4: Non-Covered Physical Therapy Services*

The Division of Medicaid does not cover or reimburse for Outpatient physical therapy services in the outpatient setting when: not covered/reimbursed by Medicaid include, but are not limited to, the following:

- A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,
- B. Services when ~~the~~ The plan of care (POC) has not been approved, and signed, and dated by the physician, physician assistant, or nurse practitioner; within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 1.3.A.4.],
- C. Services that do not meet medical necessity criteria,
- D. Services that do not require the ~~knowledge, skills~~ skill, and judgment of a state-licensed physical therapist,
- E. Services when ~~d~~ Documentation supports that the beneficiary has attained the physical therapy goals or has reached the point where no further significant ~~practical~~ improvement can be expected,
- F. Services when ~~d~~ Documentation supports that the beneficiary has not reached physical therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the physical therapy regimen,
- G. Services that ~~t~~ The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,
- H. Services that duplicate other concurrent therapy,
- I. Services are for ~~M~~ maintenance and/or palliative therapy services which maintains function and generally does not involve complex procedures or the professional skill, judgment, or

supervision of a state-licensed physical therapist,

J. ~~Services for e~~Conditions that could be reasonably expected to improve spontaneously without therapy,

K. Services are ordered daily, or multiple times per day, from the initiation of therapy through discharge. ~~The frequency of services should decrease as the beneficiary's condition improves,~~

~~L. Services provided in multiple settings for the same beneficiary,~~

ML. Services are normally considered part of nursing care,

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

ON. Services are billed as Separate fees for self-care/home-management training. ~~Beneficiary and caregiver education is inclusive in covered therapy services,~~

PO. Services ~~which~~ are related solely to employment opportunities or the purpose is vocationally based,

QP. Services are for General wellness, exercise, and/or recreational programs,

RQ. Services are provided by ~~students or~~ physical therapy aides,

~~S. Services provided by physical therapy assistants except in the outpatient department of a hospital,~~

TR. Services are delivered in a Group therapy or co-therapy session,

US. Services ~~that~~ are ~~investigative~~ investigational or experimental,

VT. Services consist of Acupuncture or biofeedback,

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

XV. ~~Services and items requiring pre-certification, if the precertification has not been requested and/or denied, or~~ The provider has not met the prior authorization/pre-certification requirements, ~~have not been satisfied by the provider,~~

YW. Services are provided in the home setting. ~~Home health physical therapy services for adult beneficiaries, or~~

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

Source: ~~42 CFR § 410.60; Miss. Code Ann. § 43-13-121; 42 CFR 410.60~~  
History: Revised eff. 01/01/2016.

~~Rule 1.5: Assistants, Aides and Students Reserved [Deleted and Moved to Miss. Admin. Code Part 213, Rule 1.3 and 1.4.]~~

- ~~A. Medicaid covers services provided by state-licensed physical therapist assistants only in the outpatient department of a hospital.~~
- ~~B. Therapist assistants must be under the direct supervision of a state-licensed therapist of the same discipline. Medicaid defines direct supervision as a state-licensed therapist physically on the premises where services are rendered and, if needed, is available for immediate assistance during the entire time services are rendered.
  - ~~1. The licensed therapist may not supervise more than two (2) assistants at a time.~~
  - ~~2. Medicaid does not cover contacts by telephone, pager, and/or video conferencing as any type of or substitution for direct supervision.~~~~
- ~~C. The initial evaluation, plan of care, and discharge summary must be completed by a state-licensed therapist. Medicaid does not cover this if these services are performed by a therapist assistant.~~
- ~~D. Medicaid does not cover services provided by physical therapist aides, regardless of the level of supervision.~~
- ~~E. Medicaid does not cover services provided by physical therapy students regardless of the level of supervision.~~

Source: ~~Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 42 CFR 410.60~~

## **Part 213 Chapter 2: Occupational Therapy**

~~Rule 2.3 Covered Occupational Therapy Services~~

- ~~A. The Division of Medicaid covers outpatient occupational therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity to treat a beneficiary's illness, condition, or injury and the following requirements are met:
  - ~~1. Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury,~~
  - ~~1. The services require the knowledge, skill and judgment of a state-licensed occupational therapist.~~~~

~~2. The beneficiary must be under the care of and referred for therapy services by a state-licensed physician, physician assistant, or nurse practitioner. The Certificate of Medical Necessity (CMN) for Initial Referral/Orders form must be is completed by the prescribing provider prior to the occupational therapy evaluation.~~

~~3. Services must be provided by a state-licensed occupational therapist or a state-licensed occupational therapy assistant under the direct supervision of a state-licensed occupational therapist in the outpatient department of a hospital.~~

~~4.3. Services must be provided according to a The plan of care (POC) is developed by the a state-licensed occupational therapist. y provider and authenticated, signed and dated, by the prescribing provider.~~

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

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

~~b) w) Within thirty (30) calendar days of the verbal order approving for the initial treatment plan or change in treatment. This applies to both initial and revised plans of care.~~

~~5. The discipline in which the therapist is licensed must match the order for therapy services, for instance, only a state-licensed occupational therapist may evaluate, plan care, and deliver occupational therapy services.~~

~~6. Services must be conducted one-on-one between the beneficiary and therapist.~~

~~7.5. The services are rendered Services must be as individualized therapy, consistent with the symptomatology/diagnosis, and do not in exceedss of the beneficiary's needs, and~~

~~8.6. The Sservices do cannot duplicate another provider's services including those services provided in a school-based setting.~~

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

1. A state-licensed occupational therapist.

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

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

- 1) Contacts by telephone.
  - 2) Contacts by pager.
  - 3) Video conferencing, and/or
  - 4) Any method not approved by the Division of Medicaid.
- b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed occupational therapist.
3. A state-licensed occupational therapist assisted by an occupational therapy student who is enrolled in an accredited occupational therapy program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed occupational therapist, referred to as student assisted occupational therapy services.
- a) The Division of Medicaid defines direct, on-site supervision of an occupational therapy student as the face-to-face oversight by a state-licensed occupational therapist.
  - b) The state-licensed occupational therapist must be physically present and engaged in student oversight during the entirety of a therapy session such that the state-licensed occupational therapist is considered to be providing the occupational therapy service.

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

1. One (1) occupational therapy student,
2. A total of four (4) state-licensed occupational therapist assistants, or
3. One (1) occupational therapy student and three (3) state-licensed occupational therapist assistants.

~~B. Prior Authorization/Precertification~~

- ~~1. Certain procedure codes require prior authorization from the Division of Medicaid Utilization Management and Quality Improvement Organization (UM/QIO).~~
- ~~2. Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program rules.~~

Source: 42 CFR § 410. 59, 410.61; Miss. Code Ann. § 43-13-121.5; ~~42 CFR 410.61; 42 CFR 410.59~~

| History: Revised eff. 01/01/2016.

| *Rule 2.4: Non-Covered Occupational Therapy Services*

| The Division of Medicaid does not cover or reimburse for Outpatient occupational therapy services in the outpatient setting when: not covered/reimbursed by Medicaid include, but are not limited to, the following:

- | A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,
- | B. ~~When~~ †The plan of care (POC) has not been approved, and signed, and dated by the physician, physician assistant, or nurse practitioner, within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 2.3.A.4],
- | C. Services ~~that~~ do not meet medical necessity criteria,
- | D. Services ~~that~~ do not require the knowledge, skills, and judgment of a state-licensed occupational therapist,
- | E. ~~Services when~~ dDocumentation supports that the beneficiary has attained the occupational therapy goals or has reached the point where no further significant ~~practical~~ improvement can be expected,
- | F. ~~Services when~~ dDocumentation supports that the beneficiary has not reached occupational therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the occupational therapy regimen,
- | G. ~~Services that~~ †The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,
- | H. Services ~~that~~ duplicate other concurrent therapy,
- | I. Services are for Maintenance and/or palliative ~~services~~ therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed occupational therapist,
- | J. ~~Services for~~ eConditions ~~that~~ could be reasonably expected to improve spontaneously without therapy,
- | K. Services are ordered daily, or multiple times per day, from the initiation of therapy through discharge, ~~since frequency should decrease as the beneficiary's condition improves,~~
- | L. ~~Services provided in multiple settings for the same beneficiary,~~
- | ML. Services are normally considered part of nursing care,

- ~~NM.~~ Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),
- ~~ON.~~ Services are billed as separate fees for self-care/home-management training,
- ~~PO.~~ Services ~~which~~ are related solely to employment opportunities or the purpose is vocationally based,
- ~~QP.~~ Services are for general wellness, exercise, and/or recreational programs,
- ~~RQ.~~ Services are provided by occupational therapy aides, ~~or provided by students,~~
- ~~S.~~ Services provided by occupational therapy assistants, ~~except in the outpatient department of a hospital,~~
- ~~TR.~~ Services are delivered in a group therapy or co-therapy session,
- ~~US.~~ Services ~~that is~~ are ~~investigative~~ investigational or experimental,
- ~~VT.~~ Services ~~consisting of~~ Acupuncture or biofeedback,
- ~~WU.~~ Services are outside the scope/and or authority of the state-licensed occupational therapist's specialty and/or area of practice,
- ~~XV.~~ Services ~~and items requiring prior authorization/pre-certification if prior authorization/pre-certification has not been requested and/or denied, or~~ The provider has not met the prior authorization/pre-certification requirements, ~~have not been satisfied by the provider,~~
- ~~W.~~ Services are provided in the home setting, or
- ~~YX.~~ Services are not specifically listed as covered by the Division of Medicaid, ~~or~~

~~Z.~~ Services provided in the home setting.

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

History: Revised eff. 01/01/2016.

**Part 213 Chapter 3: ~~Outpatient~~ Speech-Language Pathology and Audiology Services (Speech Therapy)**

*Rule 3.3: Covered Speech-Language Pathology and Audiology Services*

A. The Division of Medicaid covers ~~outpatient~~ speech-language pathology and audiology services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, for the diagnosis and treatment of a communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly and

prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity and the following requirements are met: if all the following general coverage criteria is met:

- ~~1. The services must be medically necessary and appropriate for the diagnosis and treatment of communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly;~~
1. The services require the knowledge, skill and judgment of a state-licensed speech-language pathologist or audiologist.
- ~~2. The beneficiary must be under the care of and referred for speech language pathology services by a state licensed physician, physician assistant, or nurse practitioner. The Certificate of Medical Necessity (CMN) for Initial Referral/Orders form must be is completed by the prescribing provider prior to the speech-language pathology or audiology therapy evaluation;~~
- ~~3. The services must require the knowledge, skill and judgment of a speech language pathologist;~~
- ~~43. The services must be provided according to a The plan of care (POC) is developed by the a state-licensed speech-language pathologist or audiologist, and authenticated, signed and dated, by the prescribing provider.~~
4. The prescribing provider must approves sign and date the initial/revised POC with a signature and date:
  - a) b)Before the initiation of treatment or change in treatment, or
  - b) w)Within thirty (30) calendar days of the verbal order approving for the initial treatment plan or change in treatment. This applies to both initial and revised plans of care;
- ~~5. The POC must include specific diagnosis related goals and there must be a reasonable expectation that the beneficiary can achieve measurable improvement in a reasonable period of time, generally four (4) to six (6) months;~~
- ~~6. The discipline in which the speech language pathologist is licensed must match the order for speech language pathology services, for instance only a state licensed speech-language pathologist may evaluate, plan care, and deliver speech language pathology services;~~
75. The services must be are rendered as individualized speech language pathology or audiology services; consistent with the symptomatology/diagnosis; and do not in excess exceed of the beneficiary's needs,

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

~~8. Treatments must result in significant, practical improvement in the level of functioning within a reasonable period of time or must be necessary for establishment of a maintenance program. The improvement potential must be significant in relationship to the extent and duration of the therapy requested,~~

~~9. The services must require one to one intervention and supervision of a speech language pathologist. Group therapy is not covered,~~

~~10. The services must not duplicate another provider's services, for instance, an occupational therapist and speech language pathologist performing the same services on the same day or two (2) speech language pathologists performing the same services, and~~

~~11. The services, when provided by multiple providers, must be coordinated by the providers to ensure that:~~

~~a) Therapy services are coordinated,~~

~~b) Duplicate services are not being provided,~~

~~c) Services are medically necessary, and~~

~~d) Beneficiary is receiving quality care.~~

~~B. Clinical Criteria:~~

~~1. Medicaid covers medically necessary speech language pathology services and requires prior authorization through the Utilization Management and Quality Improvement Organization (UM/QIO).~~

~~7.2. Medicaid covers if (1) The beneficiary presents with one (1) or more of the following signs/symptoms or neurological developmental disorders:~~

~~a) Aphagia defined as an inability to swallow,~~

~~b) Aphasia defined as an absence/impairment of the ability to communicate through speech, writing, or signs caused by focal damage to the language dominant hemisphere of the brain. It is considered total/complete when both sensory and motor areas are involved,~~

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

- d) Apraxia defined as an inability to form words to speak despite an ability to use facial and oral muscles to make sounds,
- e) Dysarthria defined as defective or difficult speech that involves disturbances in muscular control like weakness, lack of coordination, or paralysis of the speech mechanism, either oral, lingual, respiratory or pharyngeal muscles, resulting from damage to the peripheral or central nervous system,
- f) Dysphagia defined as difficulty swallowing,
- g) Dysphasia defined as language impairment from neurodevelopmental disorder or brain lesion,
- h) Dysphonia defined as difficulty speaking due to impairment of the muscles involving vocal production, and/or
- i) Vocal cord dysfunction defined as impairment of vocal cord mobility due to functional or structural abnormalities resulting from organic or neurological diseases.

~~3. The Certificate of Medical Necessity for Initial Referral/Orders.~~

~~48. Risk factors that have been identified and documented. Such factors can include~~ge, but are not limited to: ~~the following:~~

- a) Neurological disorders/dysfunctions, such as hearing loss or cerebral palsy,
- b) Surgical procedures, such as partial/comprehensive/radical laryngectomy, repaired cleft palate, or glossectomy,
- c) Cognitive impairments that affect communication functions,or
- d) Medical conditions resulting in communication disorders that ~~may~~ require restorative therapy including, but not limited to: ~~Examples are as follows:~~
  - 1) Laryngeal carcinoma requiring partial/total laryngectomy that results in dysphonia or aphonia,-
  - 2) Traumatic brain injury that may exhibit inadequate respiratory volume, apraxia, dysphagia, or dysarthria,
  - 3) Progressive/static neurological conditions, such as amyotrophic lateral sclerosis, Parkinson's disease, myasthenia gravis, multiple sclerosis, or Huntington's disease,
  - 4) ~~Mental retardation~~ Intellectual disability with disorders of dysarthria, dysphagia, apraxia, or aphagia, and/or

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

~~5. A comprehensive evaluation is conducted to determine the beneficiary's current medical status, level of functioning, disability, health/psychosocial state, and need for treatment.~~

~~6. A comprehensive written treatment plan is completed to treat the speech language pathology disorder.~~

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

a) Diagnostic and evaluation services:

- 1) To determine the type, causal factors, severity of speech-language or swallowing disorders, and the extent of service required to restore functions of speech, language, voice fluency, and swallowing, or
- 2) The beneficiary demonstrates changes in functional speech or remission of a medical condition that previously contradicted speech-language therapy.

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

- 1) Laryngeal carcinoma requiring partial/total laryngectomy that results in aphonia so the beneficiary can develop new communication skills through esophageal speech or the use of an electrolarynx,
- 2) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria, or
- 3) Medical and neurological conditions, like traumatic brain injury, Parkinson's disease, or multiple sclerosis, exhibiting inadequate respiratory volume/control, aphonia, dysphagia, or dysarthria, or dysphonia.

~~8. Facilities who are Medicaid providers and who contract with an individual or group to provide speech language pathology services must ensure compliance with all speech language pathology program rules.~~

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

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

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

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

1) Contacts by telephone.

2) Contacts by pager, and/or

3) Video conferencing.

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

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

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

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

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

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

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

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

Source: 42 CFR § 410.61-62; Miss. Code Ann. § 43-13-121,; 42 CFR 410.61; 42 CFR 410.62

History: Revised eff. 01/01/2016.

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

~~A. The Division of Medicaid does not cover or reimburse for The following Outpatient speech-language pathology or audiology services in the outpatient setting when:~~ are not covered:

~~1A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,~~

~~2B. Services when~~ †The plan of care (POC) has not been approved, and signed, and dated by the physician, physician assistant, or nurse practitioner; within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 3.3.A.4.],

~~3C. Services that do not meet the general coverage~~ medical necessity criteria,

~~4D. Services that do not require the knowledge, skill, and judgment of a state-licensed speech-language pathologist or audiologist,~~

~~5E. Services when~~ †Documentation supports that the beneficiary has attained the speech-language pathology or audiology goals or has reached the point where no further significant functional improvement is apparent and/or can be expected to occur,

~~6F. Services when~~ †Documentation supports that the beneficiary has not reached the speech-language pathology or audiology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise non-compliant with the speech-language pathology or audiology regimen,

~~7G. Services that~~ †The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,

~~8H. Services that duplicate other concurrent therapy,~~

~~9I. Services are for~~ †Maintenance and/or palliative therapy services that which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed speech-language pathologist or audiologist,

~~10J. Services for~~ †Conditions that could be reasonably expected to improve spontaneously without therapy,

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

~~11L. Services are normally considered part of nursing care,~~

~~12M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility~~

(CORF),

~~13N. Services are billed as Sseparate fees for self-care/home-management training,~~

~~14O. Services which are related solely to employment opportunities or the purpose is vocationally based,~~

~~15P. Services that are primarily are for general wellness, exercise, and/or recreational programs,~~

~~16. Services when the purpose is vocationally based,~~

~~17. Services provided by student,~~

~~18. Services provided by speech-language assistants,~~

~~19Q. Services are provided by speech-language pathology or audiology aides,~~

~~20R. Services are delivered in a Ggroup therapy or co-therapy session,~~

~~21. Co-therapy,~~

~~22S. Services that is are investigative investigational or experimental,~~

~~23T. Services consist of Aacupuncture or biofeedback,~~

~~23U. Services are outside the scope/and or authority of the state-licensed speech-language pathologist's or audiologist's therapist's specialty and/or area of practice, including, but not limited to:~~

~~a)V. Services and items requiring prior authorization/precertification if the prior authorization/precertification has not been requested and/or denied, or The provider has not met the prior authorization/pre-certification requirements, have not been satisfied by the provider,~~

~~b) Speech-language pathology services that is educational in nature, not medical,~~

~~c) Consultation services between speech-language pathologists or other providers,~~

~~d) Services when clinical documentation and/or plan of care do not support the need for or the continuation of the services,~~

~~e) Services when the treatment is for a dysfunction that is self-correcting, or~~

~~f)W. Services are provided in the Hhome setting, or health therapy services.~~

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

~~B. Beneficiary Noncompliance:~~

- ~~1. Medicaid does not cover therapy services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen.~~
- ~~2. Non-compliance is defined as failure to follow therapeutic recommendations which may include any or all of the following:~~
  - ~~a) Failure to attend scheduled therapy sessions, either by cancellation or 'no show' to three (3) consecutive therapy sessions and/or missing half (1/2) or more of the scheduled visits without documentation of valid reasons such as personal illness/hospitalization or illness/death in the family,~~
  - ~~b) Failure to perform home exercise program as instructed by the therapist,~~
  - ~~c) Failure to fully participate in therapy sessions,~~
  - ~~d) Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance,~~
  - ~~e) Failure to properly use special equipment or adaptive devices, or~~
  - ~~f) Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.~~

Source: 42 CFR § 410.61-62; Miss. Code Ann. § 43-13-121.; ~~42 CFR 410.61; 42 CFR 410.62~~

History: Revised eff. 01/01/2016.