**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 largyngectomy that results in dysphonia or aphonia,

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

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

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

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

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

a) Diagnostic and evaluation services:

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

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

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

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

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

3) Medical and neurological conditions, like traumatic brain injury, Parkinson's

disease, or multiple sclerosis, exhibiting inadequate respiratory volume/control, aphonia, dysphagia, dysarthria, or dysphonia.

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

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

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

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

1) Contacts by telephone,

2) Contacts by pager,

3) Video conferencing, and/or

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

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

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

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

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

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

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

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

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

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

History: Revised eff. 01/01/2016.

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

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

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

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

C. Services do not meet medical necessity criteria,

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

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

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

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

H. Services duplicate other concurrent therapy,

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

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

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

L. Services are normally considered part of nursing care,

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

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

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

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

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

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

S. Services are investigational or experimental,

T. Services consist of acupuncture or biofeedback,

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

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

W. Services are provided in the home setting, or

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

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

History: Revised eff. 01/01/2016.