Title 23: Division of Medicaid

Part 213: Therapy Services

Part 213 Chapter 1: Physical Therapy

Rule 1.7: Prescribing Provider Orders and Responsibilities

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

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

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

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

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

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

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

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

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

    a) Beneficiary demographic information,

    b) Name of the prescribing provider,

    c) Dates of service,

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

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

    f) Reason for referral,

    g) Frequency of therapeutic encounters,

h) Duration of therapy,

i) Precautions, if applicable,

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

k) Plan for the home program,

l) Discharge plan, and

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

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

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

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

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

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

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

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

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

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

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

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

six (6) months with the encounter documented.

Source: 42 C.F.R. § 410.61; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2021.

Rule 1.8: Evaluation and Re-Evaluation

A. Medicaid requires a Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation. The evaluation does not require prior authorization.

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

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

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

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

a) Beneficiary demographic information,

b) Name of the prescribing provider,

c) Date of the evaluation,

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

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

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

g) Level of function, prior and current

h) Clinical status including cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance by sitting and standing, transfer ability, ambulation on level and elevated surfaces, gait analysis, assistive/adaptive devices which are

currently in use or required, activity tolerance, presence of wounds including description and incision status, assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children such as chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,

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

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

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

l) Impression/interpretation of findings, and

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

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

1. Re-evaluations do not require prior authorization through the UM/QIO.

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

Source: 42 C.F.R. § 410.60; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2021.

Part 213 Chapter 2: Occupational Therapy

Rule 2.6: Prescribing Provider Orders/Responsibilities

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

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

C. Therapy services must be furnished according to a written plan of care (POC). The plan of care must be approved by the prescribing provider before treatment is begun. Medicaid defines approval as the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has

agreed to it. The plan of care must be developed by a therapist in the discipline. A separate plan of care is required for each type of therapy ordered by the prescribing provider. The plan must, at a minimum, include the following:

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Dates of service,

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

5. Reason for referral,

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

7. Frequency of therapeutic encounters,

8. Duration of therapy,

9. Precautions, if applicable,

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

11. Plan for the home program,

12. Discharge plan, and

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

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

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

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

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

3. Information/documentation submitted to the UM/QIO indicates the POC needs further review/revision by the therapist/prescribing provider at intervals different from the

proposed treatment dates. The therapy provider must submit a revised POC to the UM/QIO for authorization/certification prior to rendering services,

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

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

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

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

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

1. Failure to attend scheduled therapy sessions,

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

3. Failure to fully participate in therapy sessions,

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

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

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

Source: 42 C.F.R. §§ 410.59, 410.61; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2021.

Rule 2.7: Evaluation/Re-Evaluation

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

evaluation. The evaluation does not require prior authorization.

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

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

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Date of the evaluation,

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

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

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

7. Level of function, prior and current,

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

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

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

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

12. Impression/interpretation of findings, and

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

D. Medicaid covers re-evaluations based on medical necessity. Re-evaluations do not require prior authorization through the UM/QIO. Documentation must reflect significant change in the beneficiary's condition or functional status. Significant change is defined as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

E. The components of the re-evaluation and the documentation requirements are the same as the initial evaluation, but are focused on assessing significant changes from the initial evaluation or progress toward treatment goals and making a professional judgment about continued care, modifying goals and/or treatment, or termination of therapy services. Documentation should include improvements and setbacks, as well as, interventions required to treat any medical complications. When expected progress has not been realized and continued therapy is planned, the re-evaluation needs to include valid indications to support the expectation that significant improvement will occur in a reasonable and predictable time frame.

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

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

Source: 42 C.F.R. §§ 410.59, 410.61; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2021.

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

Rule 3.6: Prescribing Provider Orders/Responsibilities

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

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

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

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

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

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

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

1. The projected period of treatment is complete and additional services are required, or
2. A significant change in the beneficiary's condition and the proposed treatment plan requires that:
   a) A therapy provider propose a revised POC to the prescribing provider, or
   b) The prescribing provider requests a revision to the POC. Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates.

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

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

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

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

Source: 42 C.F.R. §§ 410.61, 410.62; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2021.

Rule 3.7: Evaluation/ Re-Evaluation

A. Medicaid requires a Certificate of Medical Necessity for Initial Referral/Orders must be completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation. The evaluation does not require prior authorization.

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

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

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Date of the evaluation,

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

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

precautionary information,

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

7. Level of function, prior and current,

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

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

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

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

12. Impression/interpretation of findings, and

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

D. Medicaid covers re-evaluations based on medical necessity. Re-evaluations do not require prior authorization through the UM/QIO. Documentation must reflect significant change in the beneficiary's condition or functional status. Medicaid defines significant change as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

Source: 42 C.F.R. §§ 410.61, 410.62; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2021.