SECTION 13 - BENEFITS AND LIMITATIONS

SECTION 13-BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

The Healthy Children and Youth (HCY) Program (also known as Early Periodic Screening, Diagnosis, and Treatment, EPSDT) ensures a comprehensive, preventive health care program for MO HealthNet eligible children under the age of 21 years.

The HCY Program is designed to link the child and family to an ongoing health care delivery system. The program provides early and periodic medical and dental screening and diagnosis to eligible children to determine physical and mental defects. It also provides treatment to correct or reduce the severity of defects and chronic conditions found as a result of a screening. Refer to Section 9 of the Therapy Provider Manual for complete information concerning the HCY Program.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid covered services be provided, based on medical necessity as identified in a HCY (EPSDT) screening. These services include physical, occupational, and speech/language therapy services.

13.2 DEFINITIONS

Physical Therapy—Physical therapy (PT) is a specifically prescribed program directed toward the development, improvement, or restoration of neuro-muscular or sensory-motor function, relief of pain, or control of postural deviations to attain maximum performance. PT services include the evaluation and treatment related to range of motion, muscle strength, functional abilities, and the use of adaptive/therapeutic equipment. Activities include, but are *not* limited to, rehabilitation through exercise, massage, the use of equipment, and therapeutic activities.

Occupational Therapy—Occupational therapy (OT) is the provision of services that address the developmental or functional needs of a child related to the performance of self-help skills, adaptive behavior, and sensory, motor, and postural development. Evaluation and treatment services are available to correct or ameliorate physical and/or emotional deficits. Typical activities related to OT are: perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment, and other techniques related to improving motor development.

Speech/Language Therapy—Speech/language therapy (ST) is the evaluation and provision of treatment for the remediation and development of age appropriate speech, expressive and receptive languages, oral motor and communication skills. ST includes activities that stimulate and facilitate the use of effective communication skills. Speech/language therapy includes treatment in one or

more of the following areas: articulation, language development, oral motor/feeding, auditory rehabilitation, voice disorders, and augmentative communication modes.

13.3 THERAPIST PROVIDER PARTICIPATION REQUIREMENTS

To participate in the MO HealthNet Therapy Program, the therapy provider *must* satisfy the following requirements:

- Physical Therapist—a person currently licensed by the state of Missouri as a physical therapist.
- Occupational Therapist—a person currently licensed by the state of Missouri as an occupational therapist.
- Speech Pathologist—a person currently licensed by the state of Missouri as a speech pathologist.
- Speech/language therapist providing services as an employee of a public school—a person certified by the state Department of Elementary and Secondary Education.

A speech/language therapist qualifying as a provider due to certification from the Department of Elementary and Secondary Education (*not* licensed by the state of Missouri) may provide services only to children that are served by the school district.

Practitioners who are located outside of Missouri *must* submit the following additional information applicable to their discipline:

- a copy of his/her current license in that state; and
- proof that physical therapists, occupational therapists, or speech pathologists are legally authorized under that state's law to practice their discipline. Proof of active participation in that state's Medicaid Program as a physical therapist, occupational therapist, or speech pathologist is acceptable documentation.

Additional information on provider conditions of participation can be found in Section 2 of the Therapy Provider Manual.

13.4 SPECIAL DOCUMENTATION REQUIREMENTS

For physical, occupational and speech therapy services, the MO HealthNet Division requires that the following documentation be included in the participant's medical record:

- Participant's complete name;
- Participant's date of birth;
- Date service was provided;

- actual treatment provided for the participant (more than “treatment given”) on the specific date of service;
- individual or group therapy;
- the setting in which the service was rendered;
- time service was delivered (e.g., 4:00-4:15 p.m.);
- The name, title, and signature of the therapist who provided the service;
- the plan of care including treatment, evaluation(s), test(s), findings, results, and prescription(s)/referrals;
- documentation for the need of the service(s) in relationship to the participant's treatment plan;
- the participant's progress toward the goals stated in the treatment plan; and
- official Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) when billing therapy services documented in an IEP or IFSP.

13.5 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030. For services documented in an Individualized Education Plan (IEP), the state share is the responsibility of the school district originating the IEP and *cannot* be billed to the participant.

For questions regarding the HCY Therapy Program, call the MO HealthNet Provider Communication Unit at (573) 751-2896.

13.6 REIMBURSEMENT

Reimbursement for physical, occupational, or speech/language therapy services is made on a fee-for-service basis. The MO HealthNet maximum allowable fee for a unit of service has been determined by the MO HealthNet Division to be a reasonable fee, consistent with efficiency, economy, and quality of care. MO HealthNet payment for covered services is the lower of the provider’s actual billed charge, based on his/her usual and customary charge to the general public for the service, or the MO HealthNet maximum allowable amount. Services provided as documented in an Individualized Education Plan (IEP) are reimbursed at the Federal Financial Participation Rate (FFP). The remainder of the allowed amount is the responsibility of the school district originating the IEP. Refer to Section 12 of the Therapy Provider Manual for more information.

13.7 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet coverage for each date a service is rendered for reimbursement to be made to a provider.

The participant *must* be under the age of 21 years and eligible for EPSDT services.

All services rendered to a child *must* be billed under the child's individual MO HealthNet identification number.

Refer to Section 1 of the Therapy Provider Manual for more detailed information concerning participant eligibility.

13.8 PLACE OF SERVICE

MO HealthNet requires the two (2)-digit place of service code when filing claims. A complete list of place of service codes can be found in Section 15.8 of the Therapy Provider Manual. The requirements of certification and/or licensure may restrict the place of service in which services may be provided.

The following guidelines are to be used to determine the appropriate place of service code.

- The place of service (11) *must* be used if the provider is employed by or contracted with the entity where the therapy services are performed.
- The place of service school (3) *must* be used for services provided in the school or on the school grounds.
- The place of service comprehensive outpatient rehabilitation facility (62) *must* be used for services provided in a rehabilitation center.
- The place of service other (99) *must* only be used if no other appropriate place of service code is available.

13.8.A Natural Environment

Individual therapy evaluation and treatment services provided in a child's natural environment have a higher MO HealthNet maximum allowable amount when billed with the place of service 12 (home) or 99 (other). Records *must* document services were provided in the natural environment.

13.9 PRIOR AUTHORIZATION

Prior authorization is *not* required for physical, occupational, and speech/language therapy treatment services. Providers may provide services in accordance with the plan of care; however, limits apply.

Intensive therapy may be provided when medically necessary. Refer to Section 13.19 of the Therapy Provider Manual for more information about Intensive Therapy.

13.10 PRESCRIPTION FOR PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

A MO HealthNet-enrolled primary care provider *must* prescribe physical and occupational therapy evaluations and therapy treatment services. The prescription *must* include the primary care provider's National Provider Identifier (NPI) number.

The prescription is valid for a maximum period of one (1) year. A new prescription for physical therapy or occupational therapy services *must* be obtained from the provider each year if services are to continue.

13.11 REFERRAL FOR SPEECH THERAPY SERVICES

Speech/language evaluations and therapy treatment services require a referral by a MO HealthNet-enrolled primary care provider. A referral *must* be provided in written format and signed by the provider. The referral *must* include the primary care provider's National Provider Identifier (NPI) number.

The written referral is valid for a maximum period of one (1) year. A new written referral for speech therapy services *must* be obtained from the provider each year if services are to continue. Letters or prescriptions signed by the primary care provider that include the primary care provider's NPI number are examples of acceptable written referral for speech/language services.

13.12 PLAN OF CARE

A provider-signed plan of care *must* be maintained at the facility where services are performed and *must* be made available for audit purposes at anytime. The MO HealthNet Division does *not* require a specific form for the plan of care.

The Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or other comprehensive treatment plan developed for a specific child may serve as a plan of care for a child receiving physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services under the HCY Program. PT, OT and ST services are considered IEP or IFSP therapy when they are:

- included in an Individual Education Plan (IEP) as defined by the Individuals with Disabilities Education Act, Part B (34 CFR 300 and 301); or

- included in an Individualized Family Service Plan (IFSP) as defined by the Individuals with Disabilities Education, Part H (34 CFR 303) Early Intervention Program for Infants and Toddlers with Disabilities.

Services *must* be provided as indicated in the plan of care.

A participant's plan of care *must* be evaluated at regular intervals within standard medical practice guidelines.

The plan of care *must* specify:

- diagnosis;
- desired outcome;
- nature of the treatment;
- frequency of treatment (number of minutes per day/per week/per month); and
- duration (weeks or months) of services.

The participant may *not* be charged for development of the plan of care. MO HealthNet does *not* reimburse the provider to participate in IEP or IFSP meetings when developing a plan of care for a child.

13.12.A Individual Education Plan (IEP)/Individualized Family Service Plan (IFSP)

Providers billing for PT, OT or ST services for an IEP are required to maintain a copy of the official public school generated IEP in the participant's record to document the service as an IEP service. Only PT, OT and ST services identified on an official IEP generated by the public school, regardless of whether the child attends a public or private school, are reimbursed by MO HealthNet.

Providers billing for PT, OT or ST services for an IFSP *must* maintain a copy of the IFSP (or those portions of the IFSP that identify the PT, OT and ST therapy needs) in the participant's record to document the service as an IFSP service. Only PT, OT and ST services identified on an official IFSP are reimbursed by MO HealthNet. All IFSP services *must* be provided through the First Steps program. Providers *must* be enrolled as a First Steps provider through the administering entity contracted with the Department of Elementary and Secondary Education. Inquiries regarding participation in the First Steps program may be directed to the Central Finance Office Provider Enrollment, P.O. Box 29134, Shawnee Mission, KS 66201-9134, (866) 711-2573, Ext. 2.

When billing for PT, OT and ST services that are identified in an official IEP, providers are required to bill the current five (5)-digit procedure code with a **TM** or **TR** modifier. The **TM** modifier is used for IEP services for both non-MO HealthNet managed care participants and

for MO HealthNet managed care participants when the public school district originates the IEP. The **TR** modifier is used for IEP services for both non-MO HealthNet managed care participants and for MO HealthNet managed care participants when the services are being provided by or for a school district outside the school district originating the IEP (e.g., private school).

Only PT, OT and ST services identified with a **TM** or **TR** modifier may be billed for a MO HealthNet managed care participant.

Rehabilitation Center Services which are *not* related to an IEP/IFSP do *not* require a modifier.

13.12.A(1) Individual Education Plan (IEP)/Individualized Family Service Plan (IFSP) Services for MO HealthNet Managed Care Participants

MO HealthNet managed care participants may receive PT, OT and ST services that are identified in an IEP or IFSP on a fee-for-service basis outside of the MO HealthNet managed care benefit package.

Reviews are conducted by the Missouri Medicaid Audit and Compliance Division or other state and federal auditors to ensure that the therapy services reimbursed by MO HealthNet for MO HealthNet managed care participants were actually those identified on the IEP or IFSP. Therapy services for MO HealthNet managed care participants billed as IEP or IFSP services are recouped by the Missouri Medicaid Audit and Compliance Division if the provider does *not* maintain adequate documentation (the IEP or IFSP) in the record.

Reference Section 13.31 of the Therapy Provider Manual for further information regarding IEP and IFSP services for MO HealthNet managed care participants.

13.13 SCREENING SERVICES

Physical, occupational, and speech/language therapy providers may provide partial or interperiodic screening services for developmental and hearing assessments. One purpose of the interperiodic or partial screening services is to increase access to care for all children. The interperiodic screen may serve as the Healthy Children & Youth (HCY) screen used to provide entry to expanded HCY services. Provision of the interperiodic or partial screening service does *not* eliminate the need for full medical HCY screening services at established intervals based on the child's age. The provider of an interperiodic or partial screen should have a patient referral source for the remaining components of the full medical screen.

13.13.A INTERPERIODIC SCREENS

Medically necessary screens outside the periodicity schedule that do *not* require the completion of all components of a full screen may be provided as an interperiodic screen or as a partial screen.

An interperiodic screen has been defined by the Centers for Medicare & Medicaid Services (CMS) as any encounter with a health care professional acting within his or her scope of practice. Providers who perform interperiodic screens may use the appropriate level of office visit (CPT) procedure code, the appropriate partial HCY screening procedure code, or the procedure code appropriate for the professional's discipline as defined in their provider manual or provider bulletins to bill for the interperiodic screening service.

13.13.B HCY/EPSDT PARTIAL SCREENS

Partial HCY/EPSDT screens for developmental assessment may be performed by a physical, occupational, or speech/language therapist. For more information on the partial HCY/EPSDT developmental assessment screens, refer to Section 9.7.A of the Therapy Provider Manual. Partial HCY/EPSDT screens for hearing assessment may be performed by a speech pathologist (speech/language therapist). For more information on the partial HCY/EPSDT hearing assessment screens, refer to Section 9.7.D of the Therapy Provider Manual. The diagnosis code of V20.0 *must* appear as the primary diagnosis on the claim form when billing for partial HCY screening services.

13.13.C ALL PARTIAL SCREENERS

The provider of a partial medical screen *must* have a referral source to send the participant for the remaining required components of the full medical screen and is expected to help make arrangements for this service.

13.14 THERAPY SERVICES BY INDEPENDENT THERAPIST

Therapy services are available for participants under the age of 21 years through the Healthy Children and Youth (HCY) Program as set forth in this manual. This manual contains information relative to the provision of therapy services by independent therapists (speech/language therapists, occupational therapists, and physical therapists) only.

Physical, occupational, and speech/language services are covered for persons under age 21 years when medically necessary and when the need for treatment is found during a HCY screening service (full, partial, or interperiodic) or Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) as stated in Section 13.17 of the Therapy Program Manual.

Physical, occupational, and speech/language services that are covered in the Therapy Program include evaluation, treatment, splinting or casting supplies, and evaluation/fitting of appropriate equipment such as wheelchairs. Providers may *not* charge for charting time. Each unit billed *must* be spent face-to face with the participant for the majority of each unit and the remainder of the unit *must* be directed to the benefit of the participant. Reimbursement for a service is *not* increased for after hours (including Saturday or Sunday) or holiday visits or for home visits or mileage. Services are to be provided on an individualized basis for physical and occupational therapy services as MO HealthNet does *not* provide coverage for group therapy sessions for physical and occupational therapy. Intensive therapy treatment exists when six (6) or more units of therapy per day or 21 or more units of therapy per week are required. The medical necessity of these services shall be documented and kept in the medical records and shall be provided to the MO HealthNet Division upon request. Reference Section 13.19.E of the Therapy Program Manual for instructions regarding appropriate documentation and billing of intensive therapy services.

Multiple dates of service *cannot* be billed on the same line of the claim form. Only a single date of service with the number of units of service for that service date can be billed per line.

Services provided through the Individual Therapy Program may only be provided and billed by MO HealthNet enrolled therapists or MO HealthNet enrolled school district. Services *must* be billed using the National Provider Identifier (NPI) number issued to the provider who performed the service.

13.14.A PHYSICAL THERAPY (PT)

Physical therapy includes evaluation and treatment services. Physical therapy services *must* be prescribed by a MO HealthNet-enrolled primary care provider. The prescription *must* include the primary care provider's NPI number. Physical therapy, under this program, is only a covered service when:

- the need is discovered during the course of an HCY/EPSDT screen; and
- the service regimen is incorporated into a plan of care.

13.14.B OCCUPATIONAL THERAPY (OT)

Occupational therapy includes evaluation and treatment services. Occupational therapy services *must* be prescribed by a MO HealthNet-enrolled primary care provider. The prescription *must* include the primary care provider's NPI number. Occupational therapy other than for adaptation to the use of an orthotic or prosthetic device is only a covered service when:

- the need is discovered during the course of an HCY/EPSDT screen; and
- the service regimen is incorporated into a plan of care.

13.14.C SPEECH/LANGUAGE THERAPY (ST)

Speech/language therapy includes evaluation and treatment services. Speech therapy services require a written referral from a MO HealthNet-enrolled primary care provider. The provider may provide the written referral in letter form, on a prescription, etc. The referral *must* include the primary care provider's NPI number. Speech/language therapy, other than for adaptation to the use of an artificial larynx, is a covered service only when:

- the need is discovered during the course of an HCY/EPSDT screen; and
- the service regimen is incorporated into a plan of care.

13.14.D THERAPY EVALUATION SERVICES

Evaluations for physical, occupational, and speech therapy do *not* require prior authorization.

Four (4) hours of evaluation per discipline for a child (per provider) are covered within a 12-month period.

13.14.E THERAPY TREATMENT SERVICES

Therapy treatment services that may be billed to MO HealthNet are treatment services provided directly to the patient by the therapist.

Physical, occupational and speech therapy treatment services that exceed one (1) hour and 15 minutes or five (5) hours weekly are intensive therapy treatment services and require that the provider document the medical necessity of the intensive therapy treatment service(s).

When billing one (1) hour and 30 minutes (6 units) or more of therapy per day or more than five (5) hours (21 or more units) of therapy per week, the provider *must* have documentation that justifies the need for intensive therapy services. The following documentation must be available for each date of service that exceeds the limitations:

- the therapy current evaluation;
- the treatment plan (plan of care), specify frequency and duration; and
- for physical or occupational therapy, a MO HealthNet-enrolled primary care provider's prescription; or
- for speech/language therapy, a MO HealthNet-enrolled primary care provider's written referral.

All documentation for intensive therapy treatment services are not required to be submitted with the claim. The documentation as outlined in the Therapy Provider Manual must be kept in the medical record and shall be provided to the MO HealthNet Division upon request. The

MO HealthNet participant or participant's family *cannot* be billed for the units of service that are ***NOT*** considered medically necessary.

13.14.F COVERAGE OF AUGMENTATIVE COMMUNICATION DEVICES (ACDs)

The General Assembly approved funding for Augmentative Communication Devices (ACDs) and evaluations for ACDs for MO HealthNet participants 21 years and older.

The MO HealthNet Division (MHD) has added coverage for evaluations, ACDs and training for all MO HealthNet participants regardless of their age. Pre-certification is required for all ACDs.

13.14.F(1) Augmentative Communication Devices—Definition

Augmentative Communication Devices (also known as speech-generating devices) are defined as speech aids that provide an individual who has a severe speech impairment with the ability to meet their functional speaking needs. These devices are characterized by:

- Being a dedicated speech device, used solely by the individual who has a severe speech impairment.
- May have digitized speech output, using pre-recorded messages, less than or equal to 8 minutes recording time.
- May have digitized speech output, using pre-recorded messages, greater than 8 minutes recording time.
- May have synthesized speech output, which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques.
- May have synthesized speech output, which permits multiple methods of message formulation and multiple methods of device access.
- May be software that allows a laptop computer, desktop computer or Personal Digital Assistant (PDA) to function as a speech-generating device.

Devices that would not meet the definition of speech-generating devices are characterized by:

- Devices that are not dedicated speech devices, but are devices that are capable of running software for purposes other than for speech generation,

e.g., devices that can also run a word processing package, an accounting program, or perform other non-medical functions.

- Laptop computers, desktop computers, or PDAs, which may be programmed to perform the same function as a speech-generating device, are non-covered since they are not primarily medical in nature and do not meet the definition of Durable Medical Equipment (DME). For this reason, they cannot be considered speech-generating devices for MO HealthNet coverage purposes.
- A device that is useful to someone without severe speech impairment is not considered a speech-generating device for MO HealthNet coverage purposes.

13.14.F(2) Eligibility for Augmentative Communication Devices (ACDs)

MHD reimburses for electronic or manual ACDs, regardless of the participant's age, when the device is deemed medically necessary through pre-certification. DME pre-certification criteria documents may be found at http://www.dss.mo.gov/mhd/cs/dmeprecert/pages/dmeprecert.htm. Refer to Section 13.31 of the Durable Medical Equipment Provider Manual for pre-certification guidelines.

13.14.F(3) Augmentative Communication Device (ACD) Evaluation Team/Site

For ACD team/sites currently enrolled as a speech-language pathologist, rehabilitation center or outpatient hospital but *not* previously approved by the Bureau of Special Health Care Needs (BSHCN) that wish to be considered as a MO HealthNet ACD evaluation team/site, contact the Provider Enrollment Unit via e-mail at: mmac.providerenrollment@dss.mo.gov. Providers should state if they are currently enrolled as a MO HealthNet provider. Approval is given to speech-language pathologists, rehabilitation centers or outpatient hospitals that meet the following criteria:

1. The ACD team/site leader *must* be a Missouri licensed speech-language pathologist who has a certificate of clinical competency from the American Speech-Language-Hearing Association;
2. The speech-language pathologist *must* possess, at a minimum, two (2) years experience in the evaluation and selection of ACDs and *must*

have expertise in the determination of which speech and specific ACD and strategies to use to maximize functional communication;

3. In addition to the speech-language pathologist, team membership may include, but is *not* limited to, the following: Missouri licensed audiologist, educator, occupational therapist, physical therapist, physician, manufacturer's representative, social worker, case manager or a second speech pathologist. At least two (2) of these professionals *must* participate in the ACD evaluation. ACD team/site membership may change with each evaluation performed; and

4. The speech pathologist or any of the ACD team members may *not* be a vendor of ACDs or have a financial relationship with a vendor/manufacturer. This excludes the manufacturer's representative.

A description of the ACD team/site evaluation protocol as well as equipment available for an ACD evaluation *must* be submitted to the Provider Enrollment Unit.

Approval is granted based on an ACD team evaluation concept and compliance with the requirements. The provider is notified in writing of any deficiencies. Approval may be granted upon correction of these deficiencies.

Approved speech therapists receive a provider specialty of G1, which allows the provider to bill for the evaluation and training procedures listed in Section 13.19.F(10) of the Therapy Provider Manual.

13.14.F(4) Augmentative Communication Device (ACD) Evaluation

The ACD evaluation *must* be performed by a MO HealthNet-approved evaluation site. The ACD evaluation *must* be submitted in report form and *must* contain the following information:

- medical diagnosis related to communication dysfunction leading to the need for an ACD;
- current communication status and limitations;
- speech and language skills, including prognosis for speech and/or written communication;
- cognitive readiness for use of an ACD;
- interactional/behavioral and social abilities, both verbal and nonverbal;

- cognitive, postural, mobility, sensory (visual and auditory), capabilities and medical status;
- limitations of participant's current communication abilities without an ACD (if a device is currently in use, a description of the limitations of this device);
- motivation to communicate via use of an ACD;
- residential, vocational, educational and other situations requiring communication;
- participant's name, address, date of birth, and MO HealthNet/MO HealthNet managed care ID number (DCN);
- ability to meet projected communication needs: (Does ACD have growth potential? How long will it meet needs?);
- anticipated changes, modifications or upgrades for up to two (2) years;
- training plans;
- plans for parental/caregiver training and support;
- statement as to why prescribed ACD is the most appropriate and cost effective device. Comparison of the advantages, limitations and cost of alternative systems evaluated with the participant *must* be included; and
- complete description of ACD prescribed including all medically necessary accessories or modifications.

13.14.F(5) Augmentative Communication Device (ACD) Training

Up to ten (10) hours of ACD training is approved in a six (6)-month period. In cases where ten (10) hours of training is *not* adequate, an additional Prior Authorization Request is required. The Prior Authorization Request *must* include a detailed explanation of the need for additional hours of training.

13.14.F(6) Purchase or Rental of an Augmentative Communication Device (ACD)

Pre-certification *must* be obtained for purchase or rental of an ACD. Rental of an ACD is approved only if the participant's ACD is being repaired, modified or if the participant is undergoing a limited trial period (3 months) to determine appropriateness and ability to use the ACD. If a trial period (3 months) is recommended, the trial period and the subsequent purchase of an ACD require separate pre-certification. The treating speech-language pathologist *must* confirm

the participant is utilizing the selected device daily and accurately in a variety of communication situations and demonstrates the cognitive and physical ability to effectively use the device during the trial period.

In addition to the modifier NU, new equipment, modifier NR, new when rented, will be assigned with the approved pre-certification for the purchase following the required trial period of an ACD.

All rental payments are deducted from the MO HealthNet purchase price should the trial period indicate the need for purchase of the device. The combined reimbursement for each month of the trial period (3 months) and subsequent purchase is complete payment for the device.

13.14.F(7) Modification/Replacement/Repair of Augmentative Communication Devices (ACDs)

The initial prescription for an ACD should attempt to take into account all projected changes in a participant's communication abilities for at least two (2) years. However, if changes occur in participant needs, capabilities or potential for communication, necessary modifications/replacements may be considered.

Supporting documentation for the modification or replacement *must* include:

- re-evaluation of the participant by a MO HealthNet approved ACD evaluation team/site; and
- changes in the participant's communication abilities which support the medical necessity/appropriateness of the requested changes.

If requesting a different ACD from the one currently being used by the participant, a new ACD evaluation by a MO HealthNet approved site *must* be performed. Pre-certification is required.

Replacement of an ACD is considered due to loss, unrepairable damage, or if the ACD is no longer functional. Pre-certification is required.

If requesting replacement with the same ACD, a statement from the speech-language pathologist is required indicating that the participant’s abilities and/or communication needs are unchanged and/or no other ACD currently available is better able to meet the participant's needs. In addition, the cause of loss or damage *must* be documented along with what measures will be taken to prevent reoccurrence.

Routine repairs of an ACD *not* covered by warranty are covered. A Certificate of Medical Necessity *must* be submitted and *must* document the reason for the repair. The participant's physician *must* sign the Certificate of Medical Necessity if the repair is $500.00 and over. Battery replacement is considered a repair.

13.14.F(8) MO HealthNet Managed Care Health Plans Coverage of an Augmentative Communication Device (ACD)

MO HealthNet managed care health plans provide augmentative communication evaluations, devices and training as a benefit to their participants. Providers should contact the participant's MO HealthNet managed care health plan for the health plan's procedure for providing an ACD.

13.14.F(9) Augmentative Communication Device Evaluation and Training Procedure Codes

The following procedure codes are billable by an approved team/site only.

PROC CODE	REQUIRED ATTACHMENT	REIMBURSE AMOUNT
92597	None	$375.00
92606	Prior authorization	$12.50/15 minutes
92609	Prior authorization	$12.50/15 minutes

13.14.F(10) Augmentative Communication Device (ACD) Procedure Codes

ACDs are covered under the Durable Medical Equipment (DME) Program. Covered procedure codes, billable by enrolled DME providers only, are listed in Section 10.2 of the DME Provider Manual.

13.14.G THERAPY SERVICES REGARDLESS OF AGE

MO HealthNet has a limited therapy program available to participants without regard to age. The coverage is limited to physical therapy in a hospital or physician’s office and to adaptive training in connection with the receipt of an orthotic or prosthetic device or an artificial larynx. Adaptive therapy may be provided by rehabilitation center providers, outpatient hospital providers, and home health agencies. Coverage of therapy by other provider types, e.g., hospitals, physicians, rehabilitation centers, home health agencies, is addressed in their respective provider manuals and bulletins. Therapy services are not covered for participants age 21 and over who are in a category of assistance as described in Section 1.5.A of the Therapy Provider Manual.

In addition, any qualified participant may also be evaluated for and receive an ACD when meeting criteria set out in Section 13.19.F of the Therapy Provider Manual.

13.15 PROCEDURE CODES

13.15.A OCCUPATIONAL AND PHYSICAL THERAPY SUPPLY CODES

Casting supplies and services include the cost of supplies and the therapist time when splinting or casting procedures are required for a patient. These services *must* be prescribed by a physician.

The amount of time spent placing the cast/splint is $10 per unit. Each unit billed equals 15 minutes (i.e. 30 minutes=2 units). Provider documentation of time spent must include the starting clock time and ending clock time. Refer to Section 19.2 of the Therapy Provider Manual for the list of appropriate procedure codes to use.

13.15.B EVALUATION AND TREATMENT PROCEDURE CODES

For physical, occupational, and speech/language therapy evaluations and treatment services, reference Section 19 of the Therapy Provider Manual.

13.16 DURABLE MEDICAL EQUIPMENT (DME)

The Durable Medical Equipment Program (DME) provides medical equipment and supplies that are medically necessary in the course of treatment. Prosthetics, orthotics, or equipment that may be used by therapists providing services to MO HealthNet HCY participants may be covered through the DME Program. DME or supplies *must* be prescribed by a physician and obtained from an enrolled DME MO HealthNet provider. Any DME or supplies rented or purchased under the DME Program are provided for a specific participant and may only be used for that particular participant.

DME services are a MO HealthNet managed care health plan benefit for MO HealthNet managed care participants.

13.17 NON-COVERED SERVICES

The following physical, occupational and speech therapy services are *not* covered:

- group physical and occupational therapy; and
- physical, occupational and speech therapy services unrelated to a prosthetic/orthotic device unless provided to a child under the age of 21 in the HCY Program.

13.18 NON-ALLOWABLE SERVICES

The following services are *not* separately allowable or billable to the participant or to the MO HealthNet agency:

- Cancelled or missed ("no show") appointments.

13.19 PARTICIPANT COPAY

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. This amount is referred to as copay. The copay amount is paid by the participant at the time services are rendered. Services of the Therapy program described in this manual are *not* subject to a copay amount.

13.20 MO HEALTHNET MANAGED CARE HEALTH PLANS

MO HealthNet managed care health plans are required to provide medically necessary physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services to children under the age of 21. The only exception is that PT, OT and ST services identified in an Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) are *not* the MO HealthNet managed care health plan's responsibility. PT, OT and ST services are considered IEP or IFSP therapy when they are:

- included in an Individual Education Plan (IEP) as defined by the Individuals with Disabilities Education Act, Part B (34 CFR 300 and 301); or
- included in an Individualized Family Service Plan (IFSP) as defined by the Individuals with Disabilities Education, Part H (34 CFR 303) Early Intervention Program for Infants and Toddlers with Disabilities.

Therapy services continue to be reimbursed on a fee-for-service basis by MO HealthNet when providing IEP or IFSP therapy services to MO HealthNet managed care participants. IEP/IFSP therapy services for MO HealthNet managed care participants *must* be billed with the appropriate modifier. When billing for PT, OT and ST therapy services that are identified in an official IEP, providers are required to bill the current five (5)-digit procedure codes with a TM or TR modifier. The TM modifier is used for IEP services for both the non-MO HealthNet managed care participants and for MO HealthNet managed care participants when the public school district originates the IEP. The TR modifier is used for IEP services for both the non-MO HealthNet managed care participants and for MO HealthNet managed care participants when the services are being provided by or for a school district outside the school district originating the IEP (i.e., private school).

Only PT, OT and ST services identified with a TM or TR modifier may be billed for a MO HealthNet managed care participant.

Medically necessary PT, OT and ST services beyond the scope identified in a child's IEP or IFSP are the responsibility of the MO HealthNet managed care health plans. The provider of IEP or IFSP therapy services should coordinate additional services with the MO HealthNet managed care health plan's providers.

13.21 DIAGNOSIS CODES

Diagnosis code(s) are required when billing MO HealthNet and are contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code book. Refer to Section 18 of the Therapy Provider Manual for further information.

END OF SECTION

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