

**Division of Medicaid /HealthSystems of Mississippi
Outpatient Physical Therapy, Occupational Therapy, and Speech-Language
Pathology (Speech Therapy)**

Frequently Asked Questions (FAQs)

Sections A through I of the FAQs are applicable to all outpatient therapy services/providers. Additional FAQs specific to school health-related providers may be found at the end of this document.

A. Pre-certification Requirements

- 1. Why did the Division of Medicaid (DOM) implement pre-certification requirements for outpatient physical, occupational, and speech-language pathology (speech therapy) services?**

It is DOM's responsibility to be a prudent purchaser of quality health care and to ensure that benefits are provided for medically necessary services.

- 2. What is the role of HealthSystems of Mississippi (HSM)?**

HealthSystems of Mississippi is the Utilization Management and Quality Improvement Organization for DOM. DOM contracted with HSM to perform pre-certification and quality review for outpatient physical therapy, occupational therapy, and speech-language pathology services.

- 3. Does DOM require pre-certification for all therapy codes?**

No. To obtain a list of codes that require pre-certification, providers should refer to the HSM website <http://www.hsom.org/>. Follow the provider manual link. The codes requiring pre-certification are listed in the *Outpatient and School Health Related Occupational, Physical and Speech Therapy Provider Manual*.

- 4. Can a provider bill for a therapy code not on the list if the service is covered under Mississippi Medicaid?**

Yes, if it is medically necessary and is covered by DOM.

- 5. How can the provider find out if a code that does not require pre-certification is covered?**

Providers may contact the ACS Call Center at 1-800-884-3222 or their respective provider representative. Providers may also access the Mississippi Envision web portal at <https://msmedicaid.acs-inc.com/msenvision/>. Select the provider drop-down, go to fee schedules and select the interactive fee schedule.

6. If the number of approved units for a pre-certified period of time is not used, can the therapy provider carry over the unused units to another time period?

No, units cannot be carried over from one period of time to another. The provider must submit a concurrent request if additional therapy is required. Providers should submit documentation explaining why previously approved units were not utilized (e.g., child is ill and unable to participate in therapy). The information will assist HSM in making determinations for further coverage

B. Review Process

1. Who reviews the pre-certification requests?

The review process is handled through the Utilization Management and Quality Improvement Organization (UM/QIO), HealthSystems of Mississippi (HSM). Reviews are based on information provided by the prescribing providers and therapists, medical necessity criteria, and DOM policies. When conducting reviews, HSM utilizes a professional staff consisting of registered nurses, therapists, and physicians.

2. What criteria are used for medical necessity?

DOM has authorized use of the Milliman *Care Guidelines* as a tool to be used in the review of medical necessity. The *Care Guidelines* are evidence-based tools that reflect current best practices for the actual working environment of today's healthcare organization.

3. Are the Milliman *Care Guidelines* applicable to only adults?

No, the *Care Guidelines* are not specific to adults only. Each review is carefully and individually evaluated in accordance with standards and the growth and development process for children. Both DOM and HSM are focused on ensuring children receive medically necessary services.

4. Are Milliman *Care Guidelines* available to providers?

DOM and HSM do not provide copies of the Milliman *Care Guidelines* to providers. The guidelines are a commercially available product. For additional information, go to www.careguidelines.com.

5. Is HSM authorized to reduce frequency and length of services without getting the prescribing physician's approval?

Yes. This is consistent with the role of utilization management companies who are contracted to approve services based on documented medical necessity and application of criteria and policies.

6. What are the timelines for HSM providing a response to a request?

For pre-certification and concurrent requests, HSM will complete the review within two (2) business days of receipt of all necessary information. For example, if a pre-

certification/concurrent request is received on Monday, the provider will have a response by close of business Wednesday (day 2).

For retrospective requests, HSM will complete the review within twenty (20) business days of receipt of all necessary information. For example, if a retrospective request is received on April 3, 2009, the provider will have a response by close of business May 1, 2009.

If a pre-certification request is pended for additional administrative information (intake level) or additional information (first level review), the provider has three (3) business days to submit the information. The receipt date of the request is updated when the information is received.

If a concurrent request is pended for additional administrative information (intake level), the provider has three (3) business days to submit the information. If a concurrent request is pended for additional information (first level review), the provider has one (1) business day to submit the information. The receipt date of the request is updated when the information is received.

If a pre-certification/concurrent request is pended by the physician review team, the provider has one (1) business day to submit the information. The receipt date of the request is updated when the information is received.

If a retrospective request is pended for additional information (first level review), the provider has ten (10) business days to submit the information. The receipt date of the request is updated when the information is received.

If a review is pended at multiple levels, such as intake, (nurse first level review), physician, the timeframe is extended accordingly.

C. Standard Form Requirements

1. Why does DOM/HSM require that prescribing providers/therapists utilize their standard forms to submit pre-certification requests to HSM?

DOM made the decision to develop and require use of the standard forms to: (1) ensure consistency in reporting, (2) respond to provider requests to define the information needed for the pre-certification request, (3) assist in provider education, and (4) expedite review process at HSM. The development of the forms was a joint effort between DOM and HSM with input from therapists working with HSM.

2. Does DOM/HSM plan to develop an electronic process for submitting the requests?

Yes. It is anticipated that this technology can be adapted for pre-certification of therapy services. HSM/DOM plans to run a pilot program first followed by full implementation of the technology in 2010.

3. Are providers allowed to add attachments to the standard forms?

Providers must complete the standard forms. If the provider uses all the space provided on a form and needs to continue, the provider may write “see attachment” and add the *Additional Medical Information Form*. The provider may not add attachments in lieu of completing the forms.

D. DOM Coverage/Noncoverage

1. Does DOM cover therapy aides and assistants?

DOM will cover services provided by physical therapy assistants (PTA’s) and certified occupational therapy assistants (COTA’s) **only** in the outpatient department of a hospital. PTA’s and COTA’s must be under direct supervision of a state-licensed therapist of the same discipline. Services provided by physical and/or occupational therapy aides are not covered. Refer to Provider Policy Manual Sections 47.06 and 48.06.

DOM does not cover services provided by speech-language pathology assistants and/or aides regardless of the level of supervision. Refer to Provider Policy Manual Section 49.06.

2. Does DOM policy provide coverage for maintenance therapy?

No. Maintenance therapy consists of activities that preserve the patient’s present level of function and prevent regression of that function. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by DOM. Refer to DOM Provider Policy Manual Sections 47.13, 48.13, and 49.13.

3. How does DOM define medical necessity?

Refer to Provider Policy Manual Section 53.22 for Medically Necessary policy and Section 73.09 for Expanded EPSDT Services policy.

4. Does DOM cover group therapy?

No. It is DOM’s position that beneficiaries should receive individual treatment. Outpatient therapy services are reimbursed for one-on-one services. Refer to Provider Policy Manual Sections 47.07, 48.07, and 49.07.

5. Does DOM cover co-therapy?

No. It is DOM’s position that beneficiaries should receive individual treatment by one provider at a time. Refer to Provider Policy Manual Sections 47.03, 48.03, and 49.04.

6. Does DOM reimburse hospitals for therapy services provided by salaried/ contracted therapists at an offsite location?

According to **current** DOM policy, if contracted or employed hospital employees provide services offsite and outside of the outpatient hospital departments, the hospital may not bill a

charge on the UB04 claim format as an outpatient hospital service. This includes, but is not limited to, sites such as the beneficiary's home, daycare centers, schools, skilled nursing facilities, physician clinics, or therapy clinics. Such places of service are not in the hospital's outpatient departments and do not qualify as an outpatient hospital service. Refer to Provider Policy Manual Section 26.17.

7. Does DOM cover outpatient physical therapy, occupational therapy, and/or speech-language pathology services in multiple settings?

Beneficiaries under age twenty-one (21) may receive medically necessary outpatient therapy services in more than one setting if the services are coordinated and not duplicate in nature. The following information must be submitted with the pre-certification request:

- Goals and objectives from both therapists
- A written statement signed and dated by the **original/initial** therapy provider confirming the coordination of services

It is the responsibility of the second therapy provider to contact the original/initial therapy provider, obtain the information listed above, and submit it to HSM.

This information is necessary to ensure that:

- Duplicate services are not being provided by multiple providers
- The services are medically necessary
- The beneficiary's care is coordinated between providers
- The beneficiary is receiving quality care

8. Does DOM cover therapy services provided in a Head Start Center?

Yes. The same DOM policy/pre-certification requirements apply when the provider delivers therapy services in a Head Start center. The therapy provider should bill for services using place of service 03 (school).

E. Prescribing Provider

What is the role of the prescribing provider (physician, nurse practitioner, physician assistant)?

DOM provides benefits for therapy services that are medically necessary, as certified by the prescribing provider. The prescribing provider must (1) complete a *Certificate of Medical Necessity Form for Initial Referral/Orders* prior to the therapy evaluation, (2) approve the initial *Plan of Care* before treatment is begun, (3) approve all revised plans of care, and (4) conduct a face-to-face-visit with the beneficiary at least every six (6) months. Refer to DOM Provider Policy Manual Sections 47.10, 48.10, and 49.10.

F. Certificate of Medical Necessity for Initial Referral/Orders (CMN)

1. What is the purpose of the Certificate of Medical Necessity for Initial Referral/Orders (CMN)? Is the prescribing provider required to complete the CMN form?

The CMN form is the prescribing provider's initial referral/orders. The prescribing provider must complete, sign, and date the CMN, and submit it to the therapist prior to therapy evaluation. Refer to Provider Policy Manual Sections 47.10, 48.10, and 49.10.

2. Will DOM allow the prescribing provider to provide the information/orders necessary for completion of the CMN through dictation or a verbal order?

No. The prescribing provider must initiate the therapy by completing, signing, and dating the CMN. It is acceptable, however, for a member of the prescribing provider's staff to complete the beneficiary and provider information and diagnoses. The prescribing provider must validate the accuracy of the information and complete the remainder of the form, including the specific order.

3. Does the CMN form replace the prescribing provider's prescription?

Yes.

4. Will the Division of Medicaid policy allow a verbal order in lieu of the CMN?

No.

5. Does the CMN form have to be completed before the therapist conducts the initial evaluation?

Yes.

6. Will DOM reimburse provider charges for completing/signing the CMN?

No.

7. If the beneficiary needs therapy services in more than one therapy discipline, does the provider have to submit a separate CMN for each (e.g., beneficiary needs both occupational and physical therapy)?

No. All disciplines can be addressed on one CMN.

G. Evaluation/Reevaluation

1. Who performs the evaluation and completes the evaluation form?

The evaluation must be performed/completed by a state-licensed therapist of the same discipline as the requested therapy (e.g., physical therapist must perform evaluation for physical therapy). The therapist performing the evaluation must complete the evaluation form. Refer to Provider Policy Manual Sections 47.11, 48.11, and 49.11 of the DOM Provider Policy Manual.

2. Does the therapist delivering therapy service have to be the same therapist who performed the evaluation?

No.

3. Does the evaluation have to be prior authorized?

The initial evaluation does not have to be prior authorized, but a Treatment Authorization Number (TAN) is required. All re-evaluations must be prior authorized/pre-certified. Refer to Provider Policy Manual Sections 47.11, 48.11, and 49.11.

4. What paperwork is required to obtain a TAN for the initial evaluation?

Providers must submit the following HSM forms:

- *CMN Form*-signed by the prescribing provider **prior to** the evaluation
- *Evaluation Form*-completed and signed by the therapist who performed the evaluation. The therapist must be of the same discipline as the requested therapy
- *Certification Review Request Form*

All forms are available on the HMS website at <http://www.hsom.org/>.

5. DOM provides coverage for re-evaluations based on medical necessity. Please clarify this policy.

The process of evaluation/re-evaluation should occur throughout the course of the beneficiary's treatment. This evaluation process is considered *routine*, and the provider may not submit the evaluation/re-evaluation for separate reimbursement.

DOM will only cover re-evaluations based on medical necessity. Refer to Provider Policy Manual Sections 53.22 and 73.09. 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. Refer to Provider Policy Manual Sections 47.11, 48.11, and 49.11.

DOM has also authorized HSM to consider re-evaluations in instances when a physician specializing in rehabilitation requests further evaluation by another therapist to assist in identifying the beneficiary's therapy needs. In this type instance, it is expected that the beneficiary is receiving therapy in his/her local community.

H. Plan of Care (POC)

1. Is the physician required to complete the plan of care form?

Therapy services must be furnished according to a written plan of care (POC). The plan of care must be developed by a therapist in the discipline, i.e., only a speech-language

pathologist may develop a speech-language therapy plan of care, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. The plan of care must be **approved** by the prescribing provider **before** treatment is begun. For DOM purposes, **approved** means that 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. 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. Refer to Provider Policy Manual Sections 47.10, 47.12, 48.10, 48.12, 49.10, and 49.12.

2. What is the difference between short-term goals and long term goals?

Short-term and long-term goals must be specific, measurable, and age appropriate. Short-term is defined as goals to be obtained in one (1) to three (3) months, or goals to be obtained in a short time frame. Long-term is defined as goals to be obtained in three (3) to six (6) months, or goals that are reached once the beneficiary has reached his/her maximum potential.

3. The prescribing provider must sign the plan of care within thirty (30) days. What is the process if the therapist is unable to get the signed plan of care back within the required timeframe?

Concurrent requests cannot be accepted for review until the therapist is able to provide HSM with the prescribing provider's signed plan of care. HSM is authorized to monitor the prescribing provider's compliance with signing the plan of care within the thirty (30) day timeline.

4. Does DOM/HSM require that the therapist involve the family in the plan of care?

Yes. A home program is considered an essential element of the therapy plan. DOM expects that the family/caregiver will be included in the plan, that they will be available for instruction/training, and that they will participate in and be compliant with the home program.

5. Is there a time limit on the Plan of Care?

Yes. The Plan of Care (POC) may be developed 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. A POC for a projected period of treatment beyond six (6) months is not acceptable.

The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO. Based on medical necessity, the UM/QIO may approve certification periods for less than or up to six (6) months. Approved certification periods will not exceed the period of treatment indicated on the POC. Refer to Provider Policy Manual Sections 47.12, 48.12, and 49.12.

I. Beneficiary Eligibility

1. How can a provider verify eligibility?

Providers can verify eligibility through DOM's fiscal agent:

Phone: 1-800-884-3222 or 601-206-3000

Web: <https://msmedicaid.acs-inc.com/msenvision/index.do>.

2. What does retroactive eligibility mean?

If an individual meets certain financial and need requirements before applying for Medicaid, eligibility for Medicaid is possible during all or part of a three (3) month period before the date of the application. This period is called retroactive eligibility. Refer to Provider Policy Manual Section 3.03.

J. Resources

1. How does a provider access the DOM policies?

Providers can access DOM Provider Policy Manual at <http://www.medicaid.ms.gov/>. The outpatient therapy policies are in Sections 47 (physical therapy), 48 (occupational therapy), and 49 (speech-language pathology). Providers of therapy services in the schools should also refer to Section 76 (EPSDT School Health-Related Services)

2. How does a provider access the HSM provider manuals and standard or online forms?

A provider may access the HSM Provider Manuals at <http://www.hsom.org/>.

3. Does HSM provide training for therapy providers?

HSM periodically conducts workshops for providers. HSM also conducts monthly webinars for therapy providers and encourages therapy providers to incorporate HSM's webinars into their internal training for new staff and/or as a refresher course. In addition, a provider may request training by calling the HSM Education Department at (601) 360-4961.

4. How can a provider contact the HSM Help Line?

The toll free number is (866) 740-2221. The number for the Jackson area is (601) 360-4949.

5. Who does the beneficiary (parent/legal guardian for children) contact if there are questions/complaints?

Providers should direct beneficiary inquiries to DOM's Beneficiary Relations Division. Due to privacy regulations, DOM will communicate only with adult beneficiaries or parents/legal guardians of children. The DOM Beneficiary Relations Division may be contacted as follows:

- Telephone: (601) 359-6133
- Mail: Beneficiary Relations Division, Division of Medicaid, 550 High Street, Suite 1000, Jackson, MS 39201-1399.

****The following FAQs section is specific to school health-related services/providers. However, the FAQs in the previous section are also applicable****

A. Does DOM cover physical therapy, occupational therapy, and speech-language pathology services provided in the school?

Yes, DOM does cover medically necessary therapy services provided to Medicaid eligible children with disabilities as defined in the Individuals with Disabilities Education Act (IDEA). Refer to DOM Provider Policy Manual Section 76.05. Certain codes must be pre-certified through HSM. Refer to the HSM website <http://www.hsom.org/> and follow the provider manual link. The codes requiring pre-certification are listed in the *Outpatient and School Health Related Occupational, Physical and Speech Therapy Provider Manual*.

B. Does DOM cover physical therapy, occupational therapy, and/or speech-language pathology services for children in both the school setting and another setting?

When a provider submits a request for pre-certification of therapy services for a child who is also receiving school based therapy services from a provider of the same discipline, the requesting therapist is required to submit documentation demonstrating coordination of services with the school based therapist.

The following information must be submitted with the pre-certification request:

- Goals and objectives which will be addressed by the requesting therapist
- Goals and objectives which will be addressed by the school based/non-school based therapist
- A written statement signed and dated by the school based/non-school based therapist confirming the coordination of services

This information is necessary to ensure that:

- Duplicate services are not being provided by multiple providers
- The services are medically necessary
- The beneficiary's care is coordinated between providers
- The beneficiary is receiving quality care

C. Will DOM/HSM accept the beneficiary's IEP/IFSP in lieu of a Plan of Care?

No.

D. Does the provider need to submit the Individualized Education Plan (IEP) and/or Individualized Family Services Plan (IFSP) to HSM or DOM?

No. Therapy services must be medically necessary and documented in the beneficiary's IEP/IFSP. The IEP/IFSP does not have to be submitted to HSM or DOM, but must be included in the beneficiary's record. Records must be made available upon request. Refer to Provider Policy Manual Sections 76.03 and 76.05.

E. Is the school required to submit the School Services Checklist to DOM or HSM?

No, the checklist is not required for any outpatient therapy services. DOM does require a checklist for other school health-related services.

F. What does DOM/HSM require when a beneficiary transfers from one school to another?

When a beneficiary transfers schools, HSM requires the following documents: (1) A copy of the initial evaluation, (2) a new/revised Plan of Care, (3) a Certification Review Request Form, and (4) a letter from the parent/legal guardian requesting to change therapy providers. DOM does not require any additional information.