



Colorado Medicaid Benefit Coverage Standard

OUTPATIENT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES

Brief Coverage Statement

Individuals with disabilities have two components that must be considered when addressing function. Impairments in body structures and functions limit activities and participation related to functioning and disability. There are also contextual, environmental and personal factors that determine the overall function of the individual.

Physical Therapy (PT) and Occupational Therapy (OT) are health care disciplines that use evidence-based interventions, including specially designed exercises and equipment, to help clients regain or improve function through the processes of habilitation and rehabilitation.

1. Colorado Medicaid covers PT services when they are necessary to alleviate or prevent physical disability, remediate movement, address impairment in body structure or function, or compensate for environmental and personal factors associated with injury and disease.
2. Colorado Medicaid covers OT services when they are necessary to develop or restore physical, cognitive, sensory, or performance skills required for everyday life. Services include assessment, remediation, and restoration of skills and capabilities.

For clients, age 20 and younger, physical therapy and occupational therapy may be used to ensure that the client achieves developmental milestones and maximizes goals of functional independence and participation in home, school, and community settings. Services include examination, treatment and client instruction. Following an initial evaluation, services must be prescribed by a physician, advanced practice nurse, or physician's assistant.

Therapies offered by the Colorado Medicaid may be offered through a number of programs, such as the Department's waiver programs, Early Intervention, School Health Services and the Home Health benefit. This policy does not describe the benefits or regulations for any of these programs. **This policy describes Medicaid outpatient therapy benefits only.** Medicaid fee-for service physical and occupational therapies do not supersede the policies of other programs, such as Early Intervention that may utilize Medicaid therapy services.



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Eligible Providers

PRESCRIBING PROVIDER

- Physician
- Physician Assistant
- Advanced Practice Nurse

RENDERING PROVIDER

1. Physical Therapists

1.1. Must be licensed by the Colorado Department of Regulatory Agencies (DORA) pursuant to Title 12 Article 41.106 and may supervise up to four individuals at one time who are not physical therapists, including certified nurse aides, to assist in the therapist's clinical practice (§12-41-113(1) C.R.S.).

2. Physical Therapist Assistant

2.1. Must be certified by the DORA pursuant to Title 12 Article 41.204 and must work under the supervision of a licensed physical therapist as defined in the Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) and accompanying rules as promulgated by the State Board of Physical Therapy.

3. Occupational Therapist

3.1. Must be registered by the DORA pursuant to Title 12 Article 40.5.

4. Occupational Therapy Assistant

4.1. Must practice under the general supervision of a Colorado registered occupational therapist.

Note: A provider must be enrolled as a Colorado Medicaid provider in order to be eligible to bill for procedures, products and services in treating a Colorado Medicaid client. The prescribing provider is the practitioner who orders the service. The rendering provider is the practitioner who can render the service within the scope of their practice, certifications, and licensure. The rendering provider may or may not be the rendering provider on the claim form, as not all provider types are able to enroll as a Colorado Medicaid provider.

Eligible providers may be individual practitioners or may be employed by certified or licensed home health agencies, therapy home care, children's developmental service agencies, health departments, federally qualified health centers (FQHC), or hospital outpatient services. The provider agency or the individual provider must verify that therapists are regulated by DORA and that the license or registration is current, active and unrestricted to practice.



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PROVIDER AGENCY REQUIREMENTS

Colorado legislation passed in 2008 requires providers of in-home health services who employ therapists to apply for licensing through the Colorado Department of Public Health and Environment (CDPHE). (§25-27.5-103(1) C.R.S. and 6 CCR 1011-1, Chapter XXVI, Section 5.1) as a home **care** agency on or before January 1, 2010. This differs from the credentials necessary to be considered a home **health** agency and bill revenue codes through long-term care. The link to obtain additional information regarding certification is <http://www.cdphe.state.co.us/hf/homecareagencies/index.html>

Eligible Places of Service

- Office
- Outpatient Rehabilitation Facility
- Outpatient Hospital
- Home
- Federally Qualified Health Center
- Rural Health Clinic

Eligible Clients

1. Clients age 20 and younger, and
2. Medicaid-eligible adults in limited circumstances qualify for medically necessary services.

Covered Services

Physical and Occupational Therapy services are covered if they are medically necessary as defined in 10 CCR 2505-10 Section 8.076.1.8 and meet the following criteria:

1. Treatment services must be ordered by an eligible prescribing provider (Physician, Physician Assistant, or Advanced Practice Nurse), and be started within 28 days of the date ordered.
2. Therapy services must be provided under a written treatment plan stating with specificity the client's condition, functional level, treatment objectives, the physicians order, plans for continuing care, modifications to the plan, and the plans for discharge from treatment.
3. In a manner consistent with accepted standards of medical practice, the service is found to be equally effective for a diagnosis or treatment compared to other less conservative or more costly treatment options,
4. The service has a base of evidence (including peer-reviewed literature and/or clinical experience and judgment) to support the clinical reasoning and selection of interventions, and
5. The service is consistent with the client's confirmed diagnosis, and not in excess of the client's needs.



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SPECIAL PROVISION: EXCEPTION TO POLICY LIMITATIONS FOR CLIENTS AGES 20 AND YOUNGER

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid program that requires the state Medicaid agency to cover services, products, or procedures for Medicaid clients ages 20 and younger if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Therefore, under EPSDT, children ages 20 and younger are eligible for PT and OT with less restrictive limitations than adults ages 21 and older. The specific differences in service limitations are described throughout this policy.

COVERED PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES

1. One physical therapy evaluation is covered per client, per provider, per new episode of care, per calendar year. This is an initial evaluation, used to establish a plan of care.
2. Four physical therapy re-evaluations are covered per client, per provider, per calendar year. This is used to re-assess the client's condition during treatment, and revise the plan of care if needed.
3. There is a daily limit of five units of therapy services allowed for physical therapy. Some specific daily limits per procedure code do apply. Please see the September 1, 2012 Provider Bulletin for more information.
4. One occupational therapy evaluation is covered per client, per provider, per new episode of care, per calendar year. This is an initial evaluation, used to establish a plan of care.
5. Four occupational therapy re-evaluations are covered per client, per provider, per calendar year. This is used to re-assess the client's condition during treatment, and revise the plan of care if needed.
6. There is a daily limit of five units of therapy services allowed for occupational therapy. Some specific daily limits per procedure code do apply. Please see the September 1, 2012 Provider Bulletin for more information.

INITIAL EVALUATION AND RE-EVALUATIONS MAY INCLUDE ANY OF THE FOLLOWING SERVICES:

1. Neuromuscular or Musculoskeletal Evaluation

- 1.1. Assessment of range of motion, joint integrity, and flexibility
- 1.2. Strength assessment
- 1.3. Soft tissue assessment
- 1.4. Cognitive Assessment (normal covered service, not just for initial evaluation)
- 1.5. Assessment of muscle tone and spasticity
- 1.6. Cranial nerve assessment
- 1.7. Assessment of reflex integrity



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- 1.8. Gait assessment
- 1.9. Assessment of balance in sitting or standing
- 1.10. Assessment of movement and coordination
- 1.11. Assessment of posture in standing, sitting or lying
- 1.12. Assessment of nerve and muscle tissue, structures, and function (clinical electromyography and nerve conduction testing)

2. Cardiovascular/Pulmonary Evaluation

- 2.1. Heart rate and blood pressure
- 2.2. Cardiovascular measures
- 2.3. Respiratory/pulmonary measures

3. Integumentary System Evaluation

- 3.1. Integrity of skin
- 3.2. Limb girth

4. Pain Evaluation

- 4.1. Impact on movement and function
- 4.2. Pain scale

5. Functional Evaluation

- 5.1. Assessment of individual's level of functioning and participation in everyday life activities including activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs)
- 5.2. Functional mobility assessment
- 5.3. Fine and gross motor assessment
- 5.4. Feeding/oral motor assessment
- 5.5. Assessment of assistive technology device use and/or need
- 5.6. Assessment of orthotic/prosthetic device use and/or need

6. Sensory/Perceptual Evaluation

- 6.1. Sensorimotor assessment
- 6.2. Perceptual motor development assessment
- 6.3. Visual perceptual assessment

INTERPRETATION OF TESTS AND MEASURES (INTERVENTION MAY INCLUDE ANY OF THE FOLLOWING SERVICES):

1. Neuromuscular / Musculoskeletal and Pain Intervention

- 1.1. Gait and mobility
- 1.2. Posture and body mechanics
- 1.3. Range of motion and flexibility
- 1.4. Strengthening
- 1.5. Therapeutic exercise



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- 1.6. Joint manipulation
 - 1.7. Manual therapy
 - 1.8. Use of thermal agents
 - 1.9. Hydrotherapy
 - 1.10. Neuromuscular training or re-education
 - 1.11. Aquatic therapy
 - 1.12. Electrical stimulation and TENS
 - 1.13. Biofeedback for the treatment of incontinence
- 2. Cardiovascular/Pulmonary Intervention**
- 2.1. Cardiovascular-Pulmonary rehabilitation and endurance training
- 3. Integumentary System Intervention**
- 3.1. Hydrotherapy
 - 3.2. Assess fit of orthotics and prosthetics
- 4. Psychosocial Intervention**
- 5. Functional Intervention**
- 5.1. Fabrication and application of casts, splints, orthotic or prosthetic device
 - 5.2. Facilitation of motor milestones
 - 5.3. Activities of daily living training
 - 5.4. Wheelchair management/propulsion
 - 5.5. Pre-vocational training
 - 5.6. Feeding/oral motor development and skills
 - 5.7. Direct assistance with the assessment, selection, acquisition, fitting, training or use of a Medicaid approved/covered Assistive Technology Device or orthotic/prosthetic devices, including complex rehab technology, if this technology is necessary to improve a client's functional capacity and health.
- 6. Sensory/Perceptual Intervention**
- 6.1. Sensorimotor training
 - 6.2. Visual perceptual training

Documentation

CLIENT'S RECORD OF SERVICE – GENERAL REQUIREMENTS

Rendering providers must document all evaluations, re-evaluations, services provided, client progress, attendance records, and discharge plans. All documentation must be kept in the client's records along with a copy of the referral or prescribing provider's order. Documentation should support both the medical necessity of services and the need for the level of skill provided. Rendering providers must copy the client's primary care provider (PCP), prescribing provider and/or medical home on all relevant records.



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NOTE: Senate Bill 07-004 states that the IFSP “shall qualify as meeting the standard for medically necessary services.” Therefore no physician is required to sign a work order, when an IFSP exists.

All documentation should include the following:

1. The client’s name and date of birth
2. The date and type of service provided to the client
3. A description of each service provided during the encounter including procedure codes and time spent on each
4. The total duration of the encounter
5. The name or names and titles of the persons providing each service and the name and title of the therapist supervising or directing the services.

Colorado Medicaid requires the following types of documentation as a record of services provided within an episode of care: initial evaluation, re-evaluation, visit/encounter notes and a discharge summary.

INITIAL EVALUATION

Written documentation of the initial evaluation must include the following:

1. **Referral Information:** Reason for referral and referral source
2. **History:** Must include diagnoses pertinent to the reason for referral, including date of onset; cognitive, emotional, and/or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses; current functional limitation or disability as a result of the above loss, and the onset of the disability; pre-morbid functional status, including any pre-existing loss or disabilities; review of available test results; review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.
3. **Assessment:** The assessment section should include a summary of the client’s impairments, functional limitations and disabilities, based on a synthesis of all data/findings gathered from the evaluation procedures. Pertinent factors which influence the treatment diagnosis and prognosis should be highlighted, and the inter-relationship between the diagnoses and disabilities for which the referral was made should be discussed.
4. **Plan of Care:** A detailed Plan of Care must be included in the documentation of an initial evaluation. This care plan must include the following:
 - 4.1. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured
 - 4.2. Proposed interventions/treatments to be provided during the episode of care
 - 4.3. Proposed duration and frequency of services to be provided
 - 4.4. Estimated duration of episode of care.



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An episode of outpatient therapy is defined as the period of time from the first day the client is under the care of the clinician for the current condition(s) being treated by one therapy discipline until the last date of service for that plan of care for that discipline in that setting.

The therapist's plan of care must be reviewed, revised if necessary, and signed, as medically necessary by the client's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. The care plan should not cover more than a 90-day period or the time frame documented in the IFSP. A plan of care must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. If the service is a Medicare covered service and is provided to a client who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

Note: the 90 day period is not a 90 day PAR time period, it is just a review/progress report every 90 days.

RE-EVALUATION

A re-evaluation should occur whenever there is an unanticipated change in the client's status, a failure to respond to interventions as expected or there is a need for a new plan of care based on new problems and goals requiring a significant modification of treatment plan. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following:

1. Reason for re-evaluation
2. Client's health and functional status reflecting any changes
3. Findings from any repeated or new examination elements
4. Changes to plan of care

VISIT/ENCOUNTER NOTES:

Written documentation of each encounter must be in the client's record of service. These visit notes document the implementation of the plan of care established by the therapist at the initial evaluation. Each visit note must include the following:

1. The total duration of the encounter
2. The type and scope of treatment provided, including procedure codes and modifiers used.
3. The time spent providing each service. **The number of units billed/requested must match the documentation.**
4. Identification of the short or long term goals being addressed during the encounter.



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Colorado Medicaid recommends but does not require that documentation follow the Subjective, Objective, Assessment and Plan (SOAP) format. In addition to the above required information, the visit note should include:

1. A **subjective** element which includes the reason for the visit, the client/caregiver's report of current status relative to treatment goals, and any changes in client's status since the last visit;
2. An **objective** element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;
3. An **assessment** component which includes the practitioner's assessment of the client's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals, and
4. A **plan** component which states the plan for next visit(s).

DISCHARGE SUMMARY

At the conclusion of therapy services, a discharge summary should be included in the documentation of the final visit in an episode of care. This may include the following:

1. Highlights of a client's progress or lack of progress towards treatment goals.
2. Summary of the outcome of services provided during the episode of care.

RECORD RETENTION

Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Colorado Medical Assistance Program services. Records must substantiate submitted claim information. Such records include but are not limited to:

1. Treatment plans
2. Prior authorization requests
3. Medical records and service reports
4. Records and original invoices for items, including drugs that are prescribed, ordered, or furnished
5. Claims, billings, and records of Colorado Medical Assistance Program payments and amounts received from other payers

Each provider shall retain any other records created in the regular operation of business that relate to the type and extent of goods and services provided (for example, superbills). All records must be legible, verifiable, and must comply with generally accepted accounting principles and auditing standards (10 CCR 2505-10 8.130.2.E). Each entry in a medical record must be signed and dated by the individual providing the medical service. Stamped signatures are not acceptable (10 CCR 2505-10 8.130.2.F). Providers utilizing electronic-record keeping



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may apply computerized signatures and dates to the medical record if their record-keeping systems guarantee the following security measures:

1. Restrict application of an electronic signature to the specific individual identified by the signature. System security must prevent one person from signing another person's name.
2. Prevent alterations to authenticated (signed and dated) reports. If the provider chooses to supplement a previous entry, the system must only allow a new entry that explains the supplement. The provider must not be allowed to change the initial entry.
3. Printed or displayed electronic records must note that signatures and dates have been applied electronically (10 CCR 2505-10 8.130.2.G.).

Requirements

PRESCRIPTION

A prescription is required for all services rendered after the initial evaluation. The prescription can be one of the following:

1. A plan of care signed by the prescribing provider,
2. An order written by the prescribing provider, or
3. A current IEP/IFSP.

NOTIFICATION

1. Providers of adult PT/OT services are required to submit a notification through the ColoradoPAR Program's CareWebQI system in order to provide services. Providers must submit a notification and obtain an MMIS PAR ID prior to rendering services and submitting a claim to the Colorado Medical Assistance Program. A notification must be submitted every time new services are requested up to the 48 unit limit for adults. NOTE: PT/OT services for adults is capped at a 48 unit limit per fiscal year.

PRIOR AUTHORIZATION

1. No prior authorization is required for 0 – 48 units of physical and occupational therapy for adults or children.
2. Prior Authorization is required for physical and occupational therapy greater than 48 units for children 20 and under.
 - 2.1. Claims submitted for 49 or greater units of therapy will not be paid without a prior authorization.
 - 2.2. Prior Authorizations for therapy services greater than 48 units may only be submitted for clients 20 and younger.

Non-Covered Services



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GENERAL NON-COVERED SERVICES

Outpatient physical and occupational therapies are not covered in these situations:

1. The services do not meet the medical necessity criteria;
2. The services unnecessarily duplicate those of another provider;
3. The services are experimental, investigational, or are provided as part of a clinical trial;
4. The services are maintenance in nature for adults with conditions which are chronic, long-term, and stable;
5. Adult therapy services that exceed 48 units (adults therapy services are capped at 48 units);
or
6. For supplies or for pre-fabricated supplies that can be obtained from a medical supplier.

SPECIFIC NON-COVERED SERVICES

1. A client may receive OT and PT services during the same period and service dates; however, duplicate therapy (the same therapy performed by both an OT and PT) may not be performed on the same dates of service.
2. Services for conditions of chronic pain that do not interfere with the client's functional status and that can be treated by routine nursing measures;
3. Art and craft activities for the purpose of recreation;
4. Hippotherapy/equine therapy;
5. Services not documented in the client's health care record;
6. Services not part of the client's plan of care;
7. Services specified in a plan of care that is not reviewed and revised as medically necessary by the client's attending physician;
8. Services that are designed maintain the functional status of an adult client with a physical impairment or a cognitive deficit;
9. Services by more than one provider of the same type for the same diagnosis and for the same treatment unless the service is provided by the school district as specified in the client's IEP or in an IFSP. Exceptions may be made on a limited case by case basis for complex rehabilitation cases:
10. A therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements;
11. Vocational or educational services, except as provided under IEP-related or waiver services;
12. Psychosocial services;
13. Educational, personal need and comfort therapies are not covered benefits of fee-for-service for any client regardless of age;
14. Record keeping documentation and travel time (the transport and waiting time of a client to and from therapy sessions);



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15. Time spent for preparation, report writing, processing of claims, or documentation regarding billing or service provision.

Definitions

Term	Definition
Assistive Technology Device	Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. – The Individuals with Disabilities Education Act (IDEA) of 2004
Complex Rehab Technology	Products and services include medically necessary individually configured manual and power wheelchair systems, adaptive seating systems, alternative positioning systems, and other mobility devices that require evaluation, fitting, configuration, adjustment or programming. These products and services are designed to meet the specific and unique medical and functional needs of an individual with a primary diagnoses resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from an injury or trauma. (http://www.ncart.us/advocacy/what-is-complex-rehab-technology).
Individualized Family Service Plan (IFSP)	A written plan that documents current levels of development and Early Intervention (EI) services needed by a child eligible for EI services and the child's family. The IFSP clearly designates what EI services are to be provided, who will provide and fund those EI services, when the services will start and end, and the intensity and how frequently they will be provided. Parents (defined as the parent(s) or legal guardian(s) of the child) retain the ultimate decision in determining whether they, their child, or other family members will accept or decline a specific EI service.



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Term	Definition
Individualized Educational Plan (IEP)	The written plan designed to help develop specific educational goals for the child with disabilities. It identifies the disability, describes the child’s strengths and areas of need, lists goals the child should reach in a year’s time, includes short-term instructional objectives that represent a series of skills to master or goals to accomplish and identifies programs and services, including regular education that the child will receive. A new IEP is developed each year. From age 14 on, the IEP will also focus on transition needs and services.

References

10 CCR 2505-10 § 8.200 – Physician Services

42 U.S.C. § 1396d(r) [1905(r) SSA] State Plans for Medical Assistance

10 CCR 2505-10, Section 8.520

12-41-103(5) C.R.S.

12-41-113(1) C.R.S.

Federal definitions of assistive technology (2010). The National Early Childhood Technical Assistance Center. Retrieved on March 2, 2012 from <http://www.nectac.org/topics/atech/definitions.asp>.

Technical Assistance Brief – Individualized Family Service Plan (2011, February). Early Intervention Colorado (Technical Brief Volume IV, Number 3). Retrieved on May 2, 2012 from: http://www.eicolorado.org/Files/TA_Brief_IFSP_FINAL_RevisedFeb2011.pdf

Individualized Education Plan (IEP) Overview (2012). Northwest Colorado BOCES. <http://nwboces.schoolfusion.us/modules/cms/pages.phtml?sessionid=&pageid=177535>

Medicaid Director Signature

Date

