11. Physical Therapy and related services.

a. Physical Therapy

Reimbursement for physical therapy services requires that the services be prescribed by a Medicaid authorized prescriber, who is either a physician, podiatrist, or dentist, licensed by the state and working within his or her scope of practice as defined by Ohio law. A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a Medicaid School Program (MSP) provider, as defined in Ohio Administrative Code (OAC), if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA). All other reimbursement principles detailed below apply to MSP providers in the same manner they apply to community providers.

At a minimum, a qualified physical therapist will be a licensed physical therapist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified physical therapist assistant will be a licensed physical therapist assistant, licensed in accordance with Ohio law, who has completed a two-year program of education. The licensed physical therapist assistant can provide physical therapy only under the supervision of a qualified physical therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current level of physical functioning of the patient and to identify appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.

Independent practitioners of physical therapy must also be certified under the Medicare program and must maintain an independent practice as defined and determined under Medicare.

Physical therapy services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

A physician or licensed physical therapist must develop and forward to the Medicaid authorized prescriber a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific therapeutic procedures to be used, specific functional goals, the prescription for services, and updates to the plan of care. For the MSP provider, the plan of care will be included in the IEP and maintained by the MSP provider.

A physician, licensed physical therapist, or licensed physical therapist assistant working within his or her scope of practice as defined by state law must furnish the physical therapy services in accordance with the patient's plan of care that has been approved by the Medicaid authorized prescriber or included in the IEP.

The physician or licensed physical therapist must conduct, document, and forward to the Medicaid authorized prescriber a therapy progress summary/progress report at the conclusion of each period of treatment.

Physical therapy services provided to long term care facility residents are included as long term care facility services. Long term care facilities are responsible for ensuring that their recipient-residents obtain necessary physical therapy services.

Limitations

In non-institutional settings, other than schools, a combined maximum of thirty dates of service are allowed per twelve month period for physical therapy and occupational therapy services. In accordance with the EPSDT program, children may receive services beyond established limits, when medically necessary and approved through the prior authorization process.

Maintenance services are non-covered services.

11. Physical Therapy and related services.

b. Occupational Therapy

Reimbursement for occupational therapy services requires that the services be prescribed by a Medicaid authorized prescriber, who is either a physician, podiatrist, or dentist, licensed by the state and working within his or her scope of practice as defined by Ohio law. A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a Medicaid School Program (MSP) provider, as defined in Ohio Administrative Code (OAC), if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA). All other reimbursement principles detailed below apply to MSP providers in the same manner they apply to community providers.

At a minimum, a qualified occupational therapist will be a licensed occupational therapist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified occupational therapy assistant will be a licensed occupational therapy assistant, licensed in accordance with Ohio law, who has completed a two-year program of education. The licensed occupational therapy assistant can provide occupational therapy only under the supervision of a qualified occupational therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current sensory motor functional level of the patient and identifying appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.

Independent practitioners of occupational therapy must also be certified under the Medicare program and must maintain an independent practice as defined and determined under Medicare.

Occupational therapy services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

A physician or licensed occupational therapist must develop and forward to the Medicaid authorized prescriber a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific therapeutic procedures to be used, specific functional goals, the prescription for services, and updates to the plan of care.

For the MSP provider, the plan of care will be included in the IEP and maintained by the MSP provider.

A physician, licensed occupational therapist, or licensed occupational therapy assistant working within his or her scope of practice as defined by state law must furnish the occupational therapy services in accordance with the patient's plan of care that has been approved by the Medicaid authorized prescriber or included in the IEP.

The physician or licensed occupational therapist must conduct, document, and forward to the Medicaid authorized prescriber a therapy progress summary/progress report at the conclusion of each period of treatment.

Occupational therapy services provided to long term care facility residents are included as long term care facility services. Long term care facilities are responsible for ensuring that their recipient-residents obtain necessary occupational therapy services.

Limitations

In non-institutional settings, other than schools, a combined maximum of thirty dates of service are allowed per twelve month period for physical therapy and occupational therapy services. In accordance with the EPSDT program, children may receive services beyond established limits, when medically necessary and approved through the prior authorization process.

Maintenance services are non-covered services.

11. Physical Therapy and related services.

c. Services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist).

Reimbursement for speech-language pathology and audiology (SLPA) services requires that the services be prescribed by a Medicaid authorized prescriber, who is either a physician or dentist licensed by the state and working within his or her scope of practice as defined by Ohio law. A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a Medicaid School Program (MSP) provider, as defined in Ohio Administrative Code (OAC), if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA). All other reimbursement principles detailed below apply to MSP providers in the same manner they apply to community providers.

At a minimum, a qualified speech-language pathologist (SLP) will be a licensed SLP, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified audiologist will be a licensed audiologist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, qualified speech-language pathology and audiology (SLPA) aides will be licensed SLPA aides, licensed in accordance with Ohio law, who have completed training requirements as outlined in the approved application and specific to assigned tasks. The licensed speech-language pathologist or audiologist who signs the application for the aide shall supervise that particular aide. The aide may provide services only under the supervision of the speech-language pathology or audiology supervisor of record for that applicant who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current level of speech-language of the patient and to identify the appropriate speech-language treatment to address the findings of the evaluation/re-evaluation.

SLPA services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

A physician, licensed speech-language pathologist or licensed audiologist must develop and forward to the Medicaid authorized prescriber a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific

therapeutic procedures to be used, specific functional goals, the prescription for services, and updates to the plan of care. For the MSP provider, the plan of care will be included in the IEP and maintained by the MSP provider.

A physician, licensed speech-language pathologist or audiologist, or licensed SLPA aide working within his or her scope of practice as defined by state law must furnish the SLPA services in accordance with the patient's plan of care that has been approved by the Medicaid authorized prescriber or included in the IEP.

The physician, licensed speech-language pathologist, or licensed audiologist must conduct, document, and forward to the Medicaid authorized prescriber a therapy progress summary/progress report at the conclusion of each period of treatment.

SLPA services provided to long term care facility residents are included as long term care facility services. Long term care facilities are responsible for ensuring that their recipient-residents obtain necessary SLPA services.

Limitations

In non-institutional settings, other than schools, a combined maximum of thirty dates of service are allowed per twelve month period for SLPA services. In accordance with the EPSDT program, children may receive services beyond established limits, when medically necessary and approved through the prior authorization process.

Maintenance services are non-covered services.

11. Physical Therapy and related services.

a. Physical Therapy

Physical therapy services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

~~Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physical therapy services.~~ Payment for physical therapy services provided by outpatient hospitals, physicians, limited practitioners, or clinics is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed, as specified in the appropriate fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule. The agency's fee schedule was set as of July 1, 2008, and is effective for services provided on or after that date. Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

~~The fee schedule for physical therapy services provided by physicians, limited practitioners, or clinics and any annual/periodic adjustments to this fee schedule are found in Appendix DD to rule 5101:3-1-60 on the web at: http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/3160APXDD.PDF. The rates in this rule were set as of 01/01/10 and are effective for services on or after that date.~~

Payment for physical therapy services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG-exempt.

~~The fee schedule for physical therapy services provided by outpatient hospitals and any annual/periodic adjustments to this fee schedule are found in Appendix F to rule 5101:3-2-21 on the web at: http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/3-2-21APPXF.PDF. The rates in this rule were set as of 01/01/10 and are effective for services on or after that date.~~

Payment for physical therapy services provided to residents of intermediate care facilities for the mentally retarded (ICFs-MR) is included in the facility per diem.

For residents of nursing facilities (NFs), physical therapy services are billed by NFs on a fee-for-service basis and reimbursed at ~~85% of~~ the lesser of the billed charges or 85% of the Medicaid maximum. ~~set forth in Appendix DD to rule 5101:3-1-60 for outpatient hospital services. The reimbursement rates set at 85% are set forth on the web at: http://jfs.ohio.gov/OHP/bltcf/pdf/Therapy%20Fee%20Schedule%20Jan%201%202008.pdf. The rates in this rule were set as of 7/01/07 and are effective for services on or after that date through 7/31/09.~~ For dates of service on or after 8/1/09, payment for physical therapy services provided to residents of NFs is included in the facility per diem.

11. Physical Therapy and related services.

b. Occupational Therapy

Occupational therapy services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

~~Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of occupational therapy services.~~ Payment for occupational therapy services provided by outpatient hospitals, physicians, limited practitioners, or clinics is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed, as specified in the appropriate fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule. The agency's fee schedule was set as of July 1, 2008, and is effective for services provided on or after that date. Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

~~The fee schedule for occupational therapy services provided by physicians, limited practitioners, or clinics and any annual/periodic adjustments to this fee schedule are found in Appendix DD to rule 5101:3-1-60 on the web at: http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/3160APXDD.PDF. The rates in this rule were set as of 01/01/10 and are effective for services on or after that date.~~

Payment for occupational therapy services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

~~The fee schedule for occupational therapy services provided by outpatient hospitals and any annual/periodic adjustments to this fee schedule are found in Appendix F to rule 5101:3-2-21 on the web at: http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/3-2-21APPXF.PDF. The rates in this rule were set as of 01/01/10 and are effective for services on or after that date.~~

Payment for occupational therapy services provided to residents of intermediate care facilities for the mentally retarded (ICFs-MR) is included in the facility per diem.

For residents of nursing facilities (NFs), occupational therapy services are billed by NFs on a fee-for-service basis and reimbursed at ~~85% of~~ the lesser of the billed charges or 85% of the Medicaid maximum. ~~set forth in Appendix DD to rule 5101:3-1-60 for outpatient hospital services. The reimbursement rates set at 85% are set forth on the web at: http://jfs.ohio.gov/OHP/bltcf/pdf/Therapy%20Fee%20Schedule%20Jan%201%202008.pdf. The rates in this rule were set as of 7/01/07 and are effective for services on or after that date through 7/31/09.~~ For dates of service on or after 8/1/09, payment for occupational therapy services provided to residents of NFs is included in the facility per diem.

11. Physical Therapy and related services.

c. Speech, Hearing, and Language Disorders

Speech-language pathology and audiology (SLPA) services are covered as hospital, home health agency, physician, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (7), and (9) for reimbursement provisions.

~~Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.~~ Payment for SLPA services provided by outpatient hospitals, physicians, limited practitioners, or clinics is the lesser of the billed charge or the Medicaid maximum for the particular service performed, as specified in the appropriate fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule. The agency's fee schedule was set as of July 1, 2008, and is effective for services provided on or after that date. Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

~~The fee schedule for SLPA services provided by physicians, limited practitioners, or clinics and any annual/periodic adjustments to this fee schedule are found in Appendix DD to rule 5101:3-1-60 on the web at: http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/3160APXDD.PDF. The rates in this rule were set as of 01/01/10 and are effective for services on or after that date.~~

Payment for SLPA services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

~~Maximum reimbursement fees for SLPA services provided by outpatient hospitals are found in Appendix F to rule 5101:3-2-21 on the web at: http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_forms/3-2-21APPXF.PDF. The rates in this rule were set as of 01/01/10 and are effective for services on or after that date.~~

Payment for SLPA services provided to residents of intermediate care facilities for the mentally retarded (ICFs-MR) is included in the facility per diem.

For residents of nursing facilities (NFs), SLPA services are billed by NFs on a fee-for-service basis and reimbursed at ~~85% of~~ the lesser of the billed charges or 85% of the Medicaid maximum. ~~set forth in Appendix DD to rule 5101:3-1-60 for outpatient hospital services. The reimbursement rates set at 85% are set forth on the web at: http://jfs.ohio.gov/OHP/bltef/pdf/Therapy%20Fee%20Schedule%20Jan%201%202008.pdf. The rates in this rule were set as of 7/01/07 and are effective for services on or after that date through 7/31/09.~~ For dates of service on or after 8/1/09, payment for SLPA services provided to residents of NFs is included in the facility per diem.