Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. DOM initiates Medicaid policy as it relates to these factors.

~~Effective for dates of services on and after July 1, 2005, pre-certification of outpatient physical therapy is required by the Division of Medicaid. Providers must pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.~~

~~This requirement is applicable to~~:

~~(1) Therapy services provided to beneficiaries under age 21 through the EPSDT Expanded Services program by individual therapists in offices or therapy clinics. Services provided to adult beneficiaries age 21 and over are not covered in individual therapists offices or clinics.~~

~~(2) Therapy services provided to beneficiaries (adult or children) in the outpatient department of hospitals.~~

~~(3) Therapy services provided to beneficiaries under age 21in physician offices/clinics. Services provided to adult beneficiaries age 21 and over are not covered in physician offices/clinics.~~

~~(4) Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted.~~

~~This requirement is not applicable to therapy services~~:

~~(1) Therapy services provided to beneficiaries under age 21and billed by school providers.~~

~~(2) Therapy services provided to beneficiaries in nursing facilities.~~

~~(3) Therapy services provided to beneficiaries in ICF/MR's.~~

~~(4) Therapy services provided to beneficiaries who have been admitted to Hospice.~~

~~(5) Therapy services provided to beneficiaries in Home and Community Based Services (HCBS) waiver programs.~~

~~(6) Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.~~

~~(7) Therapy services provided by non-covered providers under the Medicaid Program (such as CORF's). Services provided by non-covered providers are not covered.~~

Refer to Beneficiary Information, Section 3.08 in this manual.

Outpatient therapy services **not** covered/reimbursed by the Division of Medicaid include, but are not limited to, the following:

- Services not certified/ordered by a physician, physician assistant, or nurse practitioner
- Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes
- Services that do not meet medical necessity criteria
- Services that do not require the skills of a licensed therapist
- Services when documentation supports that the beneficiary has attained the therapy goals or has reached the point where no further significant practical improvement can be expected
- Services when documentation supports that the beneficiary has not reached therapy goals but is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen
- Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members
- Services that duplicate other concurrent therapy/rehabilitation services
- Maintenance and/or palliative services which maintain function and generally do not involve complex procedures or the professional skill, judgment, or supervision of a licensed therapist
- Services for conditions that could be reasonably expected to improve spontaneously without therapy
- Services ordered daily or multiple times per day from the initiation of therapy through discharge, i.e., frequency should decrease as the beneficiary's condition improves
- Services provided in multiple settings for the same beneficiary (example: school and outpatient clinic)
- Services normally considered part of nursing care
- Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF)
- Separate fees for self care/home management training (beneficiary and caregiver education is inclusive in covered therapy services)
- Services which are related solely to employment opportunities (i.e., on-the-job training, work skills, or work settings)
- General wellness, exercise, and/or recreational programs

- Services provided by students
- Services provided by physical therapy assistants **except** in the outpatient department of a hospital
- Services provided by physical therapy aides
- Group therapy
- Co-therapy
- Services that are investigative or experimental
- Acupuncture or biofeedback
- Services outside the scope/and or authority of the therapist's specialty and/or area of practice
- Services and items requiring pre-certification if the pre-certification has not been requested and/or denied, or the pre-certification requirements have not been satisfied by the provider
- Services not specifically listed as covered by the Division of Medicaid
- Exclusions listed elsewhere in the Mississippi Medicaid Provider Manual, bulletins, or other Mississippi Medicaid publications

Outpatient physical therapy services must meet general coverage criteria as follows:

- Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- The beneficiary must be under the care of and referred for therapy services by a state-licensed physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)
- Services must be provided by a state-licensed physical therapist. Exception: services may be provided by a state-licensed physical therapy assistant under the direct supervision of a state-licensed physical therapist in the outpatient department of a hospital. Refer to Section 47.06 of this manual.
- Services must be provided according to a plan of care (POC) developed by the therapy provider and certified (signed and dated) by the prescribing provider within fourteen (14) calendar days of the initiation of treatment. The plan must be re-certified by the prescribing provider at least every sixty (60) calendar days from the date of the initial evaluation or most recent re-evaluation.
- The discipline in which the therapist is licensed must match the order for therapy services, i.e., only a state-licensed physical therapist may evaluate, plan care, and deliver physical therapy services.
- Services must be conducted one-on-one (beneficiary and therapist). Group physical therapy is not covered.
- Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Services must not duplicate another provider's services.

Exclusions

A list of therapy services **not** covered/reimbursed by the Division of Medicaid may be found in Section 47.03 of this manual.

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to therapy providers and are approved by the Division of Medicaid. Refer to Section 47.09 of this manual.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program policies.

Physical Therapy

Physical therapy services are medically prescribed services designed to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations. Services are concerned with the prevention of disability, and the rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease.

Physical Therapist

Physical therapist is an individual who meets the state and federal licensing and/or certification requirements to perform physical therapy services.

Physical Therapy Assistant

A physical therapy assistant is an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of physical therapy services under the supervision of a licensed physical therapist.

Physical Therapy Aide

A physical therapy aide is an unlicensed individual who assists the physical therapist and the physical therapy assistant in the practice of physical therapy. The physical therapy aide performs services under the supervision of the licensed physical therapist or licensed physical therapy assistant.

Therapy Assistants

The Division of Medicaid will cover services provided by state-licensed physical therapy assistants **only** in the outpatient department of a hospital. Therapy assistants must be under the direct supervision of a state-licensed therapist of the same discipline, i.e., a state-licensed physical therapist must directly supervise a state-licensed physical therapy assistant.

For the purposes of this policy, direct supervision means that the state-licensed therapist is physically on the premises where services are rendered and, if needed, is available for immediate assistance during the entire time services are rendered. The licensed therapist may not supervise more than two (2) assistants at a time. Under no circumstances will the Division of Medicaid recognize contacts by telephone, pager, video conferencing, etc. as any type of or substitution for direct supervision.

The initial evaluation, plan of care, and discharge summary must be completed by a state-licensed therapist. DOM will not reimburse for these services if they are performed by a therapy assistant.

Therapy Aides

Services provided by physical therapy aides, regardless of the level of supervision, are not covered by the Division of Medicaid.

Therapy Students

Services provided by physical therapy students regardless of the level of supervision, are not covered by the Division of Medicaid.

Group therapy is defined as the simultaneous treatment of two (2) or more beneficiaries. Group therapy is **not** covered under the outpatient physical therapy program.

Therapy services may be available through the Home Health program for beneficiaries under the age of twenty-one (21). Services are not available for adult beneficiaries.

Therapy providers should refer to Home Health, Section 40 in this manual.

Prior authorization or pre-certification serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit DOM to require authorization for any service where it is anticipated or known that the services could either be abused by providers or beneficiaries or could easily result in excessive, uncontrollable Medicaid costs. Certification as referred to in this policy is synonymous with prior authorization.

Effective for dates of services on and after July 1, 2005, pre-certification of certain outpatient therapy services is required by the Division of Medicaid. Providers must prior authorize/pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. Failure to obtain prior authorization will result in denial of payment to the providers billing for services.

The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

Pre-certification for outpatient therapy services is only required for certain CPT codes when the services fall into one of the following categories:

- Therapy services provided to beneficiaries under age twenty-one (21) through the EPSDT Expanded Services program by individual therapists in offices or therapy clinics. Services provided to adult beneficiaries age twenty-one (21) and over are not covered in individual therapist's offices or clinics.
- Therapy services provided to beneficiaries (adult and/or children) in the outpatient department of hospitals.
- Therapy services provided to beneficiaries under age twenty-one (21) in physician offices/clinics. Services provided to adult beneficiaries age twenty-one (21) and over are not covered in physician offices/clinics.
- Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted.
- Therapy services provided to beneficiaries under age twenty-one through the following providers: Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and State Department of Health.

A complete list of CPT codes that require pre-certification may be obtained from the UM/QIO.

Exclusions

Pre-certification is **not required**, regardless of the CPT codes used, when the services fall into one of the following categories:

- Therapy services billed by school providers
- Therapy services provided to beneficiaries in nursing facilities

- Therapy services provided to beneficiaries in an ICF/MR
- Therapy services provided to beneficiaries in a hospice
- Therapy services provided to beneficiaries in Home and Community Based Services (HCBS) waiver programs
- Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted

Prior Authorization Request

Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth in the UM/QIO therapy manual.

Certification/recertification acknowledges the medical necessity and appropriateness of services. It does not guarantee payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Therapy providers must use standardized forms provided by the UM/QIO. Required forms include the following:

- Pre-certification Review Request
- Certification of Medical Necessity for Initial Referral/Orders
- Outpatient Therapy Evaluation/Re-Evaluation (specific to the therapy requested)
- Outpatient Therapy Plan of Care (specific to the therapy requested)

The initial evaluation and the first therapy session should **not** be done on the same day to allow time to develop a plan of care and obtain pre-certification from the UM/QIO. In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

Review Outcomes

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. If the criteria are met for therapy, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the criteria are not met or the review outcome results in a denial, written notification will be sent to the beneficiary/representative, therapy provider, and prescribing provider.

Reconsideration Process

The beneficiary, therapy provider, or prescribing provider may appeal a utilization review denial to the UM/QIO through the reconsideration process outlined in the UM/QIO manual.

Administrative Appeal

Disagreement with the UM/QIO reconsideration determination may be appealed by the beneficiary/legal representative. The beneficiary/legal representative must submit a written request for administrative appeal within thirty (30) calendar days of the UM/QIO reconsideration review determination notice. The process for requesting an administrative appeal is included in the denial notice that is sent to the beneficiary/representative.

Prescribing Provider

The Division of Medicaid provides benefits for therapy services that are medically necessary, as certified by the prescribing provider. For the purpose of this policy, prescribing provider is defined as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

Certificate of Medical Necessity for Initial Referral/Orders

The prescribing provider has a major role in determining the utilization of services provided by therapy providers. The prescribing provider **must** complete a Certificate of Medical Necessity for Initial Referral/Orders form and submit it to the therapist **prior** to therapy evaluation. The form is available through the UM/QIO.

Therapy Plan of Care

Therapy services must be furnished according to a written plan of care (POC). The plan of care must be **approved** by the prescribing provider **before** treatment is begun. For the purpose of this policy, 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. The plan of care must be developed by a therapist in the discipline, i.e., only a speech therapist may develop a speech therapy evaluation, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. **Providers must use the standardized outpatient therapy plan of care form specific to the therapy requested.** Forms are available through the UM/QIO.

The plan must at a minimum include the following:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Dates of service (from/to)
- Diagnosis/symptomatology/conditions and related ICD-9 codes
- Specific diagnostic and treatment procedures/modalities and related CPT codes
- Reason for referral
- Frequency of therapeutic encounters (visits per week, day, month)
- Units/minutes required per visit
- Duration of therapy (weeks, days, months)
- Precautions (if applicable)

- Short and long term goals that are specific, measurable, and age appropriate
- Home program
- Discharge plan
- Therapist's signature (name and title) and date

The **initial** therapy plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of the initiation of treatment. The plan must be reviewed/revised by the prescribing provider as the beneficiary's condition requires, but at least every sixty (60) calendar days from the date of the initial evaluation or most recent re-evaluation. The revised plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of initiation. DOM accepts the signature on the revised plan of care as a new order.

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

Continuing Medical Oversight

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

Evaluation is an integral component of physical therapy services. The initial evaluation establishes the baseline data necessary for setting realistic goals, measuring progress, and assessing rehabilitation potential. Periodic re-evaluation is used to assess the beneficiary's progress in relationship to treatment goals. **All evaluations must be performed by a therapist in the discipline, i.e., only a physical therapist may perform a physical therapy evaluation, etc. Therapy providers must use the standardized outpatient therapy evaluation/re-evaluation form specific to the therapy requested.** Forms are available through the UM/QIO.

Initial Evaluation

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

Before therapy is initiated, a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan. **The initial evaluation must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapy assistant**. The evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

Initial evaluations should at minimum contain the following information:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Date of the evaluation
- Diagnosis/functional condition or limitation being treated and onset date
- Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, comorbidities (complicating or precautionary information)
- Prior therapy history for same diagnosis/condition and response to therapy
- Level of function (prior and current)
- Clinical status: cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance (sitting and standing), transfer ability, ambulation (level and elevated surfaces), gait analysis, assistive/adaptive devices (currently in use or required), activity tolerance, presence of wounds (including description and incision status), assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children (e.g., chronological age/corrected age), motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy

- Special/standardized tests including the name, scores/results, and dates administered
- Social history: effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy
- Discharge plan including requirements to return to home, school, and/or job
- Impression/interpretation of findings
- Physical therapist's signature (name and title) and date

The initial evaluation and the first therapy session should not be done on the same day to allow time to develop a plan of care and, if necessary for the applicable CPT code(s), obtain pre-certification from the UM/QIO.

Re-Evaluation

The Division of Medicaid will cover re-evaluations based on medical necessity. All re-evaluations must be pre-certified through the UM/QIO. Documentation **must reflect significant change** in the beneficiary's condition or functional status. Significant change is defined as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

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

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

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

Therapy services must be furnished according to a written plan of care (POC). The plan of care must be **approved** by the prescribing provider **before** treatment is begun. For the purpose of this policy, 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. The plan of care must be developed by a therapist in the discipline, i.e., only a speech therapist may develop a speech therapy evaluation, etc. A separate plan of care is required for each type of therapy ordered by the prescribing provider. **Providers must use the standardized outpatient therapy plan of care form specific to the therapy requested.** Forms are available through the UM/QIO.

The plan must at a minimum include the following:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Name of the prescribing provider
- Dates of service (from/to)
- Diagnosis/symptomatology/conditions and related ICD-9 codes
- Reason for referral
- Specific diagnostic and treatment procedures/modalities and related CPT codes
- Frequency of therapeutic encounters (visits per week, day, month)
- Units/minutes required per visit
- Duration of therapy (weeks, days, months)
- Precautions (if applicable)
- Clinical update for concurrent plan of care only (general summary of attendance, progress, setbacks, changes since last plan of care
- Short and long term goals (specific, measurable, age appropriate, and current baseline status for each goal
- Home program
- Discharge plan
- Therapist's signature (name and title) and date

The **initial** therapy plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of the initiation of treatment. The plan must be reviewed/revised by the prescribing provider as the beneficiary's condition requires, but at least every sixty (60) calendar days from the date of the initial evaluation or most recent re-evaluation. The revised plan of care must be authenticated (signed and dated) by the prescribing provider within fourteen (14) calendar days of initiation. DOM accepts the signature on the revised plan of care as a new order.

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

The initial plan of care must be completed by a state-licensed therapist. DOM will not reimburse for this service if it is performed by a therapy assistant.

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

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**. Such services include but are not limited to the following:

- Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments
- Repetitive services that are performed to maintain function, maintain gait, maintain strength and endurance that do not require the professional skills of a licensed therapy provider
- Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress
- Exercises and range of motion exercises not related to the restoration of a specific loss of function

Maintenance programs should be planned and taught **before** the end of active therapy treatment so that the beneficiary, family members, or other unskilled caregivers can carry out the program. If the maintenance program is not established until after the rehabilitative program has been completed, the skills of a therapist for development of a maintenance program are not considered medically necessary and will not be covered.

Long term therapy is defined as therapy services that extend beyond six (6) consecutive months. DOM and the UM/QIO will monitor all long term therapy closely to ensure that continuation of services is medically necessary.

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and, upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

General Documentation Requirements

1. Servicing Provider

The provider rendering therapy services must retain documentation supporting medical necessity in the medical record for a minimum of five (5) years. Required documentation includes but is not limited to the following:

- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider
- Signed consent for treatment, if applicable
- The original copies of all Outpatient Therapy Evaluation/Re-Evaluation forms specific to the therapy requested (Refer to Section 47.11)
- The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy requested. (Refer to Section 47.12)
- The original copies of all tests performed or a list of all tests and test results, and the written evaluation reports
- Specific documentation for timed CPT codes. If a treatment log is used, it must be retained as part of the beneficiary's medical record. Refer to the section of this policy on timed and untimed codes
- Progress Notes:

  If the beneficiary is receiving therapy one or more times per week, progress notes must be documented at least weekly. If treatment intervals exceed weekly (e.g., every other week), progress notes must be documented following each therapy session.

  Progress notes should include date/time of service, specific treatment modalities/procedures performed, beneficiary's response to treatment, functional progress, problems interfering with progress, education/teaching activities and results, conferences (i.e., family, caregivers,

physicians, etc.), progress toward discharge goals/home program activities, and the signature and title of the therapist providing the service(s). If treatment times are documented in the Progress Notes in lieu of a Treatment Log, all requirements for timed codes must be met. Refer to the section of this policy on timed and untimed codes

- Discharge Summary, if applicable
- A copy of the completed prior approval form with prior approval authorization, if applicable

2. Prescribing Provider

The prescribing provider must retain documentation supporting medical necessity in the medical record for a minimum of five (5) years. Required documentation includes but is not limited to the following:

- Date(s) of service
- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Signed consent for treatment, if applicable
- Medical history /chief complaint
- Diagnosis
- Specific name/type of all diagnostic studies and results/findings of the studies
- Treatment rendered and response to treatment
- Medications prescribed including name, strength, dosage, and route
- Orders that are signed and dated for all medications, treatments, and procedures rendered
- Discharge planning and beneficiary instructions
- Copy of the Certificate of Medical Necessity for Initial Referral/Orders
- Evidence that the beneficiary was seen (face-to-face) and evaluated/re-evaluated every six (6) months at a minimum

In addition, the prescribing provider must retain copies of the rendering provider's (therapist's) documentation as follows:

- Initial therapy evaluation and all re-evaluations
- Initial plan of care and all revisions
- Written evaluation reports for all tests
- Discharge summary, if applicable

The servicing provider (licensed therapist) is responsible for providing a copy of all required therapy documentation as noted above to the prescribing provider.

DOM requires that all x-ray images (films, digital images, etc.) be accessible at all times for review. In addition, DOM requires that the films or images be of such quality that they can be clearly interpreted.

Timed and Untimed Codes

1. Timed Codes

CPT codes that reference a time per unit are 'timed codes.' Providers must bill units of timed codes based upon the total time actually spent in the delivery of the service, i.e., the time spent working directly with the beneficiary. The total treatment time (including the actual beginning and ending time of treatment) must be recorded for services described by time codes. All of the times, as well as the description of the treatment modalities/procedures that were provided, must be recorded for each visit. The therapist rendering treatment must sign (signature and title) and date each entry. Documentation may be recorded in the Progress Notes or on a treatment log. If a treatment log is used, it must be retained as part of the beneficiary's medical record.

Activities that are **not** considered part of the total treatment time include but are not limited to the following:

- Pre and post-delivery services (The beneficiary should be in the treatment area and prepared to start treatment.)
- Time the beneficiary spends not being treated (Examples include but are not limited to the need for toileting or resting.)
- Time waiting for equipment or for treatment to begin

2. Untimed Codes

'Untimed' CPT codes are not defined by a specific time frame. DOM does not require documentation of the treatment time for untimed codes. Whether the service took 10 minutes or 2 hours to complete, only one unit can be billed because only one service was provided. The name and title of the person supervising the treatment/modality must be recorded for all CPT codes requiring direct supervision.

Nonsubstantiated Services

DOM, the UM/QIO, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the therapy services provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible. Refer to Third Party Recovery, Section 6.03 in this manual for additional information.

Therapy providers may submit a pre-certification request to the UM/QIO for therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The six (6) month timely limitation for filing crossover claims is applicable with no exceptions.

Beneficiaries may not receive services under both programs simultaneously.