



Administrative Code

Title 23: Medicaid Part 213 Therapy Services

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Title 23: Division of Medicaid

Part 213: Therapy Services

Part 213 Chapter 1: Physical Therapy

Rule 1.1: Provider Enrollment Requirements for Physical Therapist

Providers of physical therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the provider specific requirements outlined below:

- A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
- B. Copy of licensure card or letter from the appropriate board stating current certification and must be from state of servicing location, and
- C. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 1.2: Definitions

- A. Medicaid defines physical therapy services as 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 rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease.
- B. Medicaid defines a physical therapist as an individual who meets the state and federal licensing and/or certification requirements to perform physical therapy services.
- C. Medicaid defines a physical therapy assistant as an individual who meets 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.
- D. Medicaid defines a physical therapy aide as an individual who assists the physical therapist and the physical therapist assist in the practice of physical therapy. The physical therapy aide performs services under the supervision of the licensed physical therapist or licensed physical therapist assistant.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110

Rule 1.3: Covered Services

Medicaid covers outpatient physical therapy services as follows:

- A. Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury.
- B. 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 must be completed by the prescribing provider prior to the therapy evaluation.
- C. Services must be provided by a state-licensed physical therapist. Services may be provided by a state-licensed physical therapist assistant under the direct supervision of a state-licensed physical therapist in the outpatient department of a hospital.
- D. Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated by the prescribing provider's signature and date signed.
 - 1. The prescribing provider must sign and date the POC before initiation of treatment or within thirty (30) calendar days of the verbal order approving the treatment plan.
 - 2. This applies to both the initial and revised plans of care.
- E. The discipline in which the therapist is licensed must match the order for therapy services. Only a state-licensed physical therapist may evaluate, plan care, and deliver physical therapy services.
- F. Services must be conducted one-on-one between the beneficiary and therapist. Group physical therapy is non-covered.
- G. Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- H. Services must not duplicate another provider's services.
- I. Services must be authorized by the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.60 – 410.61; 42 CFR 440.110

Rule 1.4: Non-Covered Services

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

- A. Services not certified/ordered by a physician, physician assistant, or nurse practitioner,

- B. Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes,
- C. Services that do not meet medical necessity criteria,
- D. Services that do not require the skills of a licensed therapist,
- E. 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,
- F. Services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen,
- G. Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members,
- H. Services that duplicate other concurrent therapy,
- I. 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,
- J. Services for conditions that could be reasonably expected to improve spontaneously without therapy,
- K. Services ordered daily, or multiple times per day, from the initiation of therapy through discharge. The frequency of services should decrease as the beneficiary's condition improves,
- L. Services provided in multiple settings for the same beneficiary,
- M. Services normally considered part of nursing care,
- N. Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),
- O. Separate fees for self-care/home management training. Beneficiary and caregiver education is inclusive in covered therapy services,
- P. Services which are related solely to employment opportunities,
- Q. General wellness, exercise, and/or recreational programs,
- R. Services provided by students or physical therapy aides,
- S. Services provided by physical therapy assistants except in the outpatient department of a

hospital,

- T. Group therapy or co-therapy,
- U. Services that are investigative or experimental,
- V. Acupuncture or biofeedback,
- W. Services outside the scope/and or authority of the therapist's specialty and/or area of practice,
- X. Services and items requiring pre-certification, if the precertification has not been requested and/or denied, or the precertification requirements have not been satisfied by the provider,
- Y. Home health physical therapy services for adult beneficiaries, or
- Z. Services not specifically listed as covered by Medicaid.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.60

Rule 1.5: Assistants, Aides and Students

- A. Medicaid covers services provided by state-licensed physical therapist assistants only in the outpatient department of a hospital.
- B. Therapist assistants must be under the direct supervision of a state-licensed therapist of the same discipline. Medicaid defines direct supervision as a state-licensed therapist physically on the premises where services are rendered and, if needed, is available for immediate assistance during the entire time services are rendered.
 - 1. The licensed therapist may not supervise more than two (2) assistants at a time.
 - 2. Medicaid does not cover contacts by telephone, pager, and/or video conferencing as any type of or substitution for direct supervision.
- C. The initial evaluation, plan of care, and discharge summary must be completed by a state-licensed therapist. Medicaid does not cover this if these services are performed by a therapist assistant.
- D. Medicaid does not cover services provided by physical therapist aides, regardless of the level of supervision.
- E. Medicaid does not cover services provided by physical therapy students regardless of the level of supervision.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 42 CFR 410.60

Rule 1.6: Prior Authorization/Precertification

- A. Medicaid requires prior authorization/precertification for certain outpatient therapy services.
1. Prior authorization/precertification for therapy services is conducted through the Utilization Management and Quality Improvement Organization (UM/QIO).
 2. Failure to obtain prior authorization/precertification will result in denial of payment to the providers billing for services.
 3. The UM/QIO must determine medical necessity for the types of therapy services and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the physician.
- B. Prior Authorization/Precertification for outpatient therapy services is only required for certain codes when the services fall into one (1) of the following categories:
1. Therapy services provided to beneficiaries in individual therapist offices or in therapy clinics,
 2. Therapy services provided to adult beneficiaries in the outpatient department of hospitals,
 3. Therapy services provided to beneficiaries in physician offices/clinics,
 4. Therapy services provided to beneficiaries in nursing facilities,
 5. Therapy services covered under regular benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program,
 6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid, if Medicare benefits have exhausted, or
 7. Therapy services billed by school providers.
- C. Prior Authorization/Precertification is not required, when the services fall into one (1) of the following categories:
1. Therapy services provided to beneficiaries in an ICF/MR,
 2. Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),
 3. Therapy services provided to beneficiaries enrolled in a hospice program, or
 4. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not exhausted,

D. Medicaid will cover the initial evaluation and first (1st) therapy session on the same day if the following criteria are met:

1. Medicaid covers urgent physical therapy which 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.
2. Medicaid covers same day/non-urgent outpatient physical therapy services which is defined as the delivery of therapy services that do not meet the definition of urgent, but completion of services on the same day as the evaluation significantly impacts the beneficiary's treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Prescribing Provider Orders and Responsibilities

Medicaid covers therapy services that are medically necessary, as certified by the prescribing provider.

- A. The prescribing provider must complete a Certificate of Medical Necessity for Initial Referral/Orders and submit it to the therapist prior to the therapy evaluation. Medicaid defines prescribing provider as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.
- B. Therapy services must be furnished according to a written plan of care (POC).
 1. The POC must be approved by the prescribing provider before treatment is begun.
 - a) An approved POC does not mean that the prescribing provider has signed the POC prior to implementation, but only has agreed to it.
 - b) Medicaid covers for the review to be done in person, by telephone, or facsimile.
 2. The POC must be developed by a therapist in the discipline.
 3. A separate POC is required for each type of therapy ordered by the prescribing provider.
 4. Medicaid requires that the POC must, at a minimum, include the following:
 - a) Beneficiary demographic information,
 - b) Name of the prescribing provider,

- c) Dates of service,
 - d) Diagnosis/symptomatology/conditions and related diagnosis codes,
 - e) Specific diagnostic and treatment procedures/modalities and related procedure codes,
 - f) Reason for referral,
 - g) Frequency of therapeutic encounters,
 - h) Units/minutes required per visit,
 - i) Duration of therapy,
 - j) Precautions,
 - k) Short and long term goals that are specific, measurable, and age appropriate,
 - l) Home program,
 - m) Discharge plan, and
 - n) Therapist's signature including name, title, and the date of the therapy session.
5. Medicaid requires the POC to be developed to cover a period of treatment not to exceed six (6) months.
- a) The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC.
 - b) A POC for a projected period of treatment beyond six (6) months is not covered by Medicaid.
6. Medicaid requires a revised POC in the following situations:
- a) The projected period of treatment is complete and additional services are required,
 - b) A significant change in the beneficiary's condition and the proposed treatment plan requires that:
 - 1) A therapy provider propose a revised POC to the prescribing provider, or
 - 2) The prescribing provider requests a revision to the POC. Information and documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from

the proposed treatment dates.

7. All therapy plans of care, both initial and revised, must be authenticated by the prescribing provider's signature and date signed. 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. Medicaid accepts the signature on the revised POC as a new order.
 8. The prescribing provider may make changes to the POC established by the therapist, but the therapist cannot unilaterally alter the POC established by the prescribing provider.
- C. Medicaid requires the prescribing provider to participate in the delivery of care by communicating with the treating therapist and by assessing the effectiveness of the prescribed care. The prescribing provider must have a face-to-face visit with the beneficiary at least every six (6) months with the encounter documented.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.60

Rule 1.8: Evaluation and Re-Evaluation

- A. Medicaid requires a Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation.
- B. Medicaid requires a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning before therapy is initiated. A comprehensive evaluation must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan.
 1. Medicaid requires the evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators.
 2. 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.
 3. Initial evaluations should, at a minimum contain, the following information:
 - a) Beneficiary demographic information,
 - b) Name of the prescribing provider,
 - c) Date of the evaluation,
 - d) Diagnosis/functional condition or limitation being treated and onset date,

- e) Applicable medical history including mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, comorbidities, either complicating or precautionary information,
- f) Prior therapy history for same diagnosis/condition and response to therapy,
- g) Level of function, prior and current
- h) Clinical status including cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance by sitting and standing, transfer ability, ambulation on level and elevated surfaces, gait analysis, assistive/adaptive devices which are 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 such as chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,
- i) Special/standardized tests including the name, scores/results, and dates administered,
- j) Social history including 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,
- k) Discharge plan including requirements to return to home, school, and/or job,
- l) Impression/interpretation of findings, and
- m) Physical therapist's signature, including name, title, and date of service.

C. Medicaid covers re-evaluations based on medical necessity.

1. All re-evaluations must be precertified through the UM/QIO.
2. Documentation must reflect a significant change in the beneficiary's condition or functional status. Medicaid defines significant change 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.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Beneficiary Non-Compliance

Medicaid does not cover therapy services when documentation supports that the beneficiary:

- A. Has not reached therapy goals and is unable to participate and/or benefit from skilled intervention,
- B. Refuses to participate, or
- C. Is otherwise noncompliant with the therapy regimen. Medicaid defines noncompliance as failure to follow therapeutic recommendations which may include any or all of the following:
 - 1. Failure to attend scheduled therapy sessions, which is defined by Medicaid as cancellation or 'no show' to three (3) consecutive therapy sessions and/or missing half or more of the scheduled visits without documentation of valid reasons such as personal illness/hospitalization or illness/death in the family,
 - 2. Failure to perform home exercise program as instructed by the therapist,
 - 3. Failure to fully participate in therapy sessions,
 - 4. Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance,
 - 5. Failure to properly use special equipment or adaptive devices, or
 - 6. Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Maintenance Therapy

Medicaid defines maintenance therapy as 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 Medicaid. Such services include but are not limited to the following:

- A. Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments,
- B. 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,
- C. Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress, or
- D. Exercises and range of motion exercises not related to the restoration of a specific loss of function.

Source: Miss. Code Ann. § 43-13-121

Rule 1.11: Documentation

Provider records must be documented and maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3 in addition to the provider specific requirements outlined below:

A. Servicing providers must maintain documentation including, but not limited to, the following:

1. Beneficiary demographic information,
2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,
3. Signed consent for treatment, if applicable,
4. The original copies of all Outpatient Therapy Evaluation/Re-Evaluation specific to the therapy requested,
5. The original copies of all Outpatient Therapy Plan of Care specific to the therapy requested,
6. The original copies of all tests performed or a list of all tests, test results, and the written evaluation reports,
7. Specific documentation for timed procedure codes. If a treatment log is used, it must be retained as part of the beneficiary's medical record,
8. Progress Notes:
 - a) If the beneficiary is receiving therapy one (1) or more times per week, progress notes must be documented at least weekly,
 - b) If treatment intervals exceed weekly, progress notes must be documented following each therapy session,
 - c) Progress notes should include:
 - 1) Date/time of service,
 - 2) Specific treatment modalities/procedures performed,
 - 3) Beneficiary's response to treatment,
 - 4) Functional progress,

- 5) Problems interfering with progress,
 - 6) Education/teaching activities and results,
 - 7) Conferences,
 - 8) Progress toward discharge goals/home program activities, and
 - 9) The signature and title of the therapist providing the service(s).
- d) If treatment times are documented in the Progress Notes in lieu of a Treatment Log, all requirements for timed codes must be met as follows:
- 1) Medicaid defines timed codes as procedure codes that reference a time per unit. Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service. Medicaid considers the following activities as not part of the total treatment time:
 - i) Pre and post-delivery services. The beneficiary must be in the treatment area and prepared to start treatment,
 - ii) Time the beneficiary spends not being treated, and
 - iii) Time waiting for equipment or for treatment to begin.
 - 2) Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.
9. Discharge Summary, if applicable, and
10. A copy of the completed prior approval form with prior approval authorization, if applicable.
- B. Prescribing providers must maintain documentation including, but not limited to, the following:
1. Date(s) of service,
 2. Beneficiary demographic information,
 3. Signed consent for treatment, if applicable,
 4. Medical history /chief complaint,

5. Diagnosis,
6. Specific name/type of all diagnostic studies and results/findings of the studies,
7. Treatment rendered and response to treatment,
8. Medications prescribed including name, strength, dosage, and route,
9. Orders that are signed and dated for all medications, treatments, and procedures rendered,
10. Discharge planning and beneficiary instructions,
11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders,
12. Evidence that the beneficiary was seen face-to-face and evaluated/re-evaluated every six (6) months at a minimum, and
13. Copies of the rendering provider's therapist's documentation as follows:
 - a) Initial therapy evaluation and all re-evaluations,
 - b) Initial plan of care and all revisions,
 - c) Written evaluation reports for all tests, and
 - d) Discharge summary, if applicable.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.12: Dual Eligibles

- A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy services must be pre-certified through the UM/QIO.
- B. Beneficiaries cannot receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 1.13: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 2: Occupational Therapy

Rule 2.1: Provider Enrollment Requirements for Occupational Therapist

Providers of occupational therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the provider specific requirements outlined below:

- A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
- B. Copy of licensure card or letter from the appropriate board stating current certification and must be from state of servicing location, and
- C. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 2.2: Definitions

- A. Medicaid defines occupational therapy services as medically prescribed services that address developmental and/or functional needs related to the performance of self-help skills, adaptive behavior, and/or sensory, motor and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and Activities of Daily Living (ADL) functions when such functions have been impaired due to congenital and/or developmental abnormalities, illness or injury.
- B. Medicaid defines an occupational therapist as an individual who meets the state and federal licensing and/or certification requirements to perform occupational therapy services.
- C. Medicaid defines an occupational therapy assistant as an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of occupational therapy services under the supervision of a licensed occupational therapist.
- D. Medicaid defines an occupational therapy aide as an unlicensed individual who assists the occupational therapist and the occupational therapy assistant in the practice of occupational therapy. The occupational therapy aide performs services under the supervision of the licensed occupational therapist or licensed occupational therapy assistant.
- E. Medicaid defines direct supervision as a state licensed therapist physically being on the premises where services are rendered and 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. Medicaid does not cover contacts by telephone, pager, video conferencing, etc. as any type of or substitution for direct supervision.

- F. Medicaid defines prescribing provider as a state licensed physician, nurse practitioner, or physician assistant who refers a beneficiary for therapy services.
- G. Medicaid defines maintenance therapy as activities that preserve the patient's present level of function and prevent regression of that function.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 410.59

Rule 2.3 Covered Services

A. Medicaid covers outpatient occupational therapy services as follows:

1. Services must be medically necessary for the treatment of the beneficiary's illness, condition, or injury,
2. 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,
3. Services must be provided by a state-licensed occupational therapist or a state-licensed occupational therapy assistant under the direct supervision of a state-licensed occupational therapist in the outpatient department of a hospital,
4. Services must be provided according to a plan of care (POC) developed by the therapy provider and authenticated, signed and dated, by the prescribing provider. The prescribing provider must sign and date 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,
5. The discipline in which the therapist is licensed must match the order for therapy services, for instance, only a state-licensed occupational therapist may evaluate, plan care, and deliver occupational therapy services,
6. Services must be conducted one-on-one between the beneficiary and therapist,
7. Services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs, and
8. Services cannot duplicate another provider's services.

B. Prior Authorization/Precertification

1. Certain procedure codes require prior authorization from the Division of Medicaid Utilization Management and Quality Improvement Organization (UM/QIO).
2. Facilities who are Medicaid providers and who contract with an individual or group to provide therapy services must ensure compliance with all therapy program rules.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.61; 42 CFR 410.59

Rule 2.4: Non-Covered Therapy Services

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

- A. Services not certified/ordered by a physician, physician assistant, or nurse practitioner,
- B. Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes,
- C. Services that do not meet medical necessity criteria,
- D. Services that do not require the skills of a licensed therapist,
- E. 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,
- F. Services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen,
- G. Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members,
- H. Services that duplicate other concurrent therapy,
- I. 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,
- J. Services for conditions that could be reasonably expected to improve spontaneously without therapy,
- K. Services ordered daily, or multiple times per day, from the initiation of therapy through discharge, since frequency should decrease as the beneficiary's condition improves,
- L. Services provided in multiple settings for the same beneficiary,
- M. Services normally considered part of nursing care,

- N. Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),
- O. Separate fees for self-care/home management training,
- P. Services which are related solely to employment opportunities,
- Q. General wellness, exercise, and/or recreational programs,
- R. Services provided by occupational therapy aides or provided by students,
- S. Services provided by occupational therapy assistants, except in the outpatient department of a hospital,
- T. Group therapy or co-therapy,
- U. Services that is investigative or experimental,
- V. Acupuncture or biofeedback,
- W. Services outside the scope/and or authority of the therapist's specialty and/or area of practice,
- X. Services and items requiring prior authorization/pre-certification if prior authorization/pre-certification has not been requested and/or denied, or the prior authorization/pre-certification requirements have not been satisfied by the provider,
- Y. Services not specifically listed as covered by Medicaid, or
- Z. Services provided in the home setting.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.59

Rule 2.5: Prior Authorization/ Precertification

- A. The UM/QIO will determine medical necessity, the types of therapy services, and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the prescribing provider.
- B. Prior Authorization/Pre-certification for outpatient therapy services is only required for certain procedure codes when the services fall into one (1) of the following categories:
 1. Therapy services provided to beneficiaries, adult and/or children in individual therapist offices or in therapy clinics,
 2. Therapy services provided to beneficiaries, adult and/or children, in the outpatient department of hospitals,

3. Therapy services provided to beneficiaries, adult and/or children, in physician offices/clinics,
4. Therapy services provided to beneficiaries in nursing facilities,
5. Therapy services covered under regular State Plan benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program, and
6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted.

C. Exclusions to Prior Authorization/Precertification

1. Prior Authorization/Precertification is not required, regardless of procedure codes used, when the services fall into one (1) of the following categories:
 - a) Therapy services provided to beneficiaries in an ICF/MR,
 - b) Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),
 - c) Therapy services provided to beneficiaries enrolled in a hospice program, or
 - d) Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

D. Prior Authorization/Pre-certification Request - Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth by the UM/QIO. Medicaid does not cover the initial evaluation and the first therapy session on the same day. The UM/QIO is authorized to accept retrospective requests for urgent services and same day/non-urgent services as defined and outlined in Part 213, Chapter 1.

Source: Miss. Code Ann. § 43-13-121

Rule 2.6: Prescribing Provider Orders/Responsibilities

- A. Medicaid provides benefits for therapy services that are medically necessary, as certified by the prescribing provider.
- B. 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.
- C. 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. Medicaid

defines approval as 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. A separate plan of care is required for each type of therapy ordered by the prescribing provider. The plan must, at a minimum, include the following:

1. Beneficiary demographic information,
 2. Name of the prescribing provider,
 3. Dates of service,
 4. Diagnosis/symptomatology/conditions and related diagnosis codes,
 5. Reason for referral,
 6. Specific diagnostic and treatment procedures/modalities and related procedure codes,
 7. Frequency of therapeutic encounters,
 8. Units/minutes required per visit,
 9. Duration of therapy,
 10. Precautions, if applicable,
 11. Short and long term goals that are specific, measurable, and age appropriate,
 12. Home program,
 13. Discharge plan, and
 14. Therapist's signature, name and title, and date.
- D. Medicaid requires the POC 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. Medicaid does not cover a POC for a projected period of treatment beyond six (6) months.
- E. Medicaid requires a revised POC in the following situations:
1. The projected period of treatment is complete and additional services are required,
 2. A significant change in the beneficiary's condition and the proposed treatment plan requires that a therapy provider propose a revised POC to the prescribing provider, or the

prescribing provider requests a revision to the POC. In either case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services, and

3. Information/documentation submitted to the UM/QIO indicates the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates. The therapy provider must submit a revised POC to the UM/QIO for authorization/certification prior to rendering services,
- F. All therapy plans of care, initial and revised, must be authenticated, with signature and date, 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.
- G. Medicaid accepts the signature on the revised plan of care as a new order.
- H. 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.
- I. The servicing provider, the licensed therapist, is responsible for providing a copy of the initial plan of care and all revisions to the prescribing provider.
- J. Medicaid does not cover therapy services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen. Noncompliance is defined as failure to follow therapeutic recommendations which may include any or all of the following:
1. Failure to attend scheduled therapy sessions,
 2. Failure to perform home exercise program as instructed by the therapist,
 3. Failure to fully participate in therapy sessions,
 4. Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance, and
 5. Failure to properly use special equipment or adaptive devices. Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.
- K. Medicaid requires a mandatory face-to-face visit with the beneficiary by the prescribing provider at least every six (6) months and, requires the encounter is documented.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.59; 42 CFR 410.61

Rule 2.7: Evaluation/Re-Evaluation

- A. 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.

- B. 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. 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.

- C. Initial evaluations should, at a minimum, contain the following information:
 - 1. Beneficiary demographic information,
 - 2. Name of the prescribing provider,
 - 3. Date of the evaluation,
 - 4. Diagnosis/functional condition or limitation being treated and onset date,
 - 5. Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, co-morbidities, with complicating or precautionary information,
 - 6. Prior therapy history for same diagnosis/condition and response to therapy,
 - 7. Level of function, prior and current,
 - 8. Clinical status including cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance, while sitting and standing, transfer ability, ambulation at level and elevated surfaces, gait analysis, assistive/adaptive devices either 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 by chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,
 - 9. Special/standardized tests including the name, scores/results, and dates administered,
 - 10. Social history including 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,

11. Discharge plan including requirements to return to home, school, and/or job,
 12. Impression/interpretation of findings, and
 13. Occupational therapist's signature, with name and title and date.
- D. Medicaid covers 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.
- E. 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.
- F. In all cases, other than termination of therapy services, re-evaluation findings must be reflected in revisions to the therapy plan of care.
- G. The servicing provider, or licensed therapist, is responsible for providing a copy of the initial evaluation and all re-evaluations to the prescribing provider.

Source: Miss. Code Ann. § 43-13-121

Rule 2.8: Maintenance Therapy

- A. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid.
- B. Maintenance programs must 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 are covered.

Source: Miss. Code Ann. § 43-13-121

Rule 2.9: Documentation

A. Therapy providers must document and maintain auditable records that meet the requirement set forth in Part 200, Chapter 1, Rule 1.3 and those outlined:

1. The servicing provider must maintain documentation including, but not limited to, the following:
 - a) Beneficiary demographic information,
 - b) A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,
 - c) Signed consent for treatment, if applicable,
 - d) The original copies of all Outpatient Therapy Evaluation/Re-Evaluation forms specific to the therapy request,
 - e) The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy requested,
 - f) The original copies of all tests performed or a list of all tests and test results, and the written evaluation reports,
 - g) Specific documentation for timed procedure codes. If a treatment log is used, it must be retained as part of the beneficiary's medical record,
 - h) Progress Notes:
 - 1) If the beneficiary is receiving therapy one (1) or more times per week, progress notes must be documented at least weekly. If treatment intervals exceed weekly, progress notes must be documented following each therapy session.
 - 2) 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, 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.
 - i) Discharge Summary, if applicable, and
 - j) A copy of the completed prior approval form with prior approval authorization, if applicable.

- B. The prescribing provider must maintain documentation including, but not limited to, the following:
1. Date(s) of service,
 2. Beneficiary demographic information,
 3. Signed consent for treatment, if applicable,
 4. Medical history/chief complaint,
 5. Diagnosis,
 6. Specific name/type of all diagnostic studies and results/findings of the studies,
 7. Treatment rendered and response to treatment,
 8. Medications prescribed including name, strength, dosage, and route,
 9. Orders that are signed and dated for all medications, treatments, and procedures rendered,
 10. Discharge planning and beneficiary instructions,
 11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and
 12. Evidence that the beneficiary was seen, face-to-face, and evaluated/re-evaluated every six (6) months, at a minimum.
- C. In addition, the prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:
1. Initial therapy evaluation and all re-evaluations,
 2. Initial plan of care and all revisions,
 3. Written evaluation reports for all tests, and
 4. Discharge summary, if applicable.
- D. The servicing provider or licensed therapist is responsible for providing a copy of all required therapy documentation as noted above to the prescribing provider.
- E. Timed Codes:
1. Medicaid defines procedure codes that reference a time per unit as 'timed codes.' Providers must bill units of timed codes based upon the total time actually spent in the

delivery of the service. 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, with 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.

2. Activities that are not considered part of the total treatment time include, but are not limited to, the following:
 - a) Pre and post-delivery services - The beneficiary should be in the treatment area and prepared to start treatment,
 - b) Time the beneficiary spends not being treated, and
 - c) Time waiting for equipment or for treatment to begin.
3. Medicaid defines 'Untimed' procedure codes as no specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Whether the service took ten (10) minutes or two (2) hours to complete, only one (1) unit can be billed because only one (1) service was provided. The name and title of the person supervising the treatment/modality must be recorded for all procedure codes requiring direct supervision.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118, 43-13-129

Rule 2.10: Dual Eligibles

- A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy services must be prior authorized/precertified through the UM/QIO.
- B. Beneficiaries may not receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 2.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 3: Outpatient Speech-Language Pathology (Speech Therapy)

Rule 3.1: Provider Enrollment Requirements

Providers of speech therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition the provider type specific requirements outlined below. Therapy providers wishing to enroll as group providers must adhere to the enrollment requirements in Part 200, Chapter 4, Rule 4.9.

- A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
- B. Copy of current licensure card or permit,
- C. Copy of current certificate of clinical competence from the American Speech and Hearing Association (ASHA),
- D. Documentation from the State Department of Health verifying that they have completed one (1) of the following requirements:
 - 1. Has completed the equivalent educational requirements and work experience necessary for the certificate, or
 - 2. Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
- E. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 42 CFR 455, Subpart E

Rule 3.2: Definitions

- A. Medicaid defines speech therapy services as medically prescribed services necessary for the diagnosis and treatment of communication impairment and/or swallowing disorder that has occurred due to disease, trauma or congenital anomaly.
- B. Medicaid defines a speech-language pathologist (speech therapist) as an individual who meets the state and federal licensing and/or certification requirements to perform speech-language pathology services.
- C. Medicaid defines a speech-language pathology assistant or speech therapy assistant as an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of speech-language pathology services under the supervision of a

licensed speech-language pathologist.

- D. Medicaid defines a speech-language pathology aide as an unlicensed individual who assists the speech-language pathologist and the speech-language pathology assistant in the practice of speech-language pathology. The speech-language pathology aide performs services under the supervision of the licensed speech-language pathologist.
- E. Medicaid defines group therapy as the simultaneous treatment of two (2) or more beneficiaries.
- F. Medicaid defines a prescribing provider as a state licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.
- G. Medicaid defines maintenance therapy as activities that preserve the beneficiary's present level of function and prevent regression of that function.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110

Rule 3.3: Covered Services

- A. Medicaid covers outpatient speech-language pathology services if all the following general coverage criteria is met:
 - 1. The services must be medically necessary and appropriate for the diagnosis and treatment of communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly,
 - 2. The beneficiary must be under the care of and referred for speech-language pathology 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,
 - 3. The services must require the knowledge, skill and judgment of a speech-language pathologist,
 - 4. The services must be provided according to a plan of care (POC) developed by the speech-language pathologist and authenticated, signed and dated, by the prescribing provider. The prescribing provider must sign and date 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,
 - 5. The POC must include specific diagnosis-related goals and there must be a reasonable expectation that the beneficiary can achieve measurable improvement in a reasonable period of time, generally four (4) to six (6) months,
 - 6. The discipline in which the speech-language pathologist is licensed must match the order

for speech-language pathology services, for instance only a state-licensed speech-language pathologist may evaluate, plan care, and deliver speech-language pathology services,

7. The services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs,
8. Treatments must result in significant, practical improvement in the level of functioning within a reasonable period of time or must be necessary for establishment of a maintenance program. The improvement potential must be significant in relationship to the extent and duration of the therapy requested,
9. The services must require one-to-one intervention and supervision of a speech-language pathologist. Group therapy is not covered,
10. The services must not duplicate another provider's services, for instance, an occupational therapist and speech-language pathologist performing the same services on the same day or two (2) speech-language pathologists performing the same services, and
11. The services, when provided by multiple providers, must be coordinated by the providers to ensure that:
 - a) Therapy services are coordinated,
 - b) Duplicate services are not being provided,
 - c) Services are medically necessary, and
 - d) Beneficiary is receiving quality care.

B. Clinical Criteria:

1. Medicaid covers medically necessary speech-language pathology services and requires prior authorization through the Utilization Management and Quality Improvement Organization (UM/QIO).
2. Medicaid covers if the beneficiary presents with one (1) or more of the following signs/symptoms or neurological developmental disorders:
 - a) Aphagia defined as an inability to swallow,
 - b) Aphasia defined as an absence/impairment of the ability to communicate through speech, writing, or signs caused by focal damage to the language dominant hemisphere of the brain. It is considered total/complete when both sensory and motor areas are involved,

- c) Aphonia defined as an inability to produce sounds from the larynx due to excessive muscle tension, paralysis, or disease of the laryngeal nerves
 - d) Apraxia defined as an inability to form words to speak despite an ability use facial and oral muscles to make sounds,
 - e) Dysarthria defined as defective or difficult speech that involves disturbances in muscular control like weakness, lack of coordination, or paralysis of the speech mechanism, either oral, lingual, respiratory or pharyngeal muscles, resulting from damage to the peripheral or central nervous system,
 - f) Dysphagia defined as difficulty swallowing,
 - g) Dysphasia defined as language impairment from neurodevelopmental disorder or brain lesion,
 - h) Dysphonia defined as difficulty speaking due to impairment of the muscles involving vocal production, and
 - i) Vocal cord dysfunction defined as impairment of vocal cord mobility due to functional or structural abnormalities resulting from organic or neurological diseases.
3. The Certificate of Medical Necessity for Initial Referral/Orders.
4. Risk factors that have been identified and documented. Such factors can include, but are not limited to, the following:
- a) Neurological disorders/dysfunctions, such as hearing loss or cerebral palsy,
 - b) Surgical procedures, such as partial/comprehensive/radical laryngectomy, repaired cleft palate, or glossectomy,
 - c) Cognitive impairments that affect communication functions,
 - d) Medical conditions resulting in communication disorders that may require restorative therapy. Examples are as follows:
 - 1) Laryngeal carcinoma requiring partial/total laryngectomy that results in dysphonia or aphonia.
 - 2) Traumatic brain injury that may exhibit inadequate respiratory volume, apraxia, dysphagia, or dysarthria,
 - 3) Progressive/static neurological conditions, such as amyotrophic lateral sclerosis, Parkinson's disease, myasthenia gravis, multiple sclerosis, or Huntington's disease,

- 4) Mental retardation with disorders of dysarthria, dysphagia, apraxia, or aphasia, and
 - 5) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria.
5. A comprehensive evaluation is conducted to determine the beneficiary's current medical status, level of functioning, disability, health/psychosocial state, and need for treatment.
 6. A comprehensive written treatment plan is completed to treat the speech-language pathology disorder.
 7. The type of service requested includes one (1) or more of the following:
 - a) Diagnostic and evaluation services:
 - 1) To determine the type, causal factors, severity of speech-language or swallowing disorders, and the extent of service required to restore functions of speech, language, voice fluency, and swallowing, or
 - 2) The beneficiary demonstrates changes in functional speech or remission of a medical condition that previously contradicted speech-language therapy.
 - b) Therapeutic services, services requiring active corrective/restorative therapy, for communication disorders that result from:
 - 1) Laryngeal carcinoma requiring partial/total laryngectomy that results in aphonia so the beneficiary can develop new communication skills through esophageal speech or the use of an electrolarynx,
 - 2) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria, or
 - 3) Medical and neurological conditions, like traumatic brain injury, Parkinson's disease, or multiple sclerosis, exhibiting inadequate respiratory volume/control, aphonia, dysphagia, or dysarthria, or dysphonia.
 8. Facilities who are Medicaid providers and who contract with an individual or group to provide speech-language pathology services must ensure compliance with all speech-language pathology program rules.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.61; 42 CFR 410.62

Rule 3.4: Non-Covered Services

- A. The following Outpatient speech-language pathology services are not covered:
1. Services not certified/ordered by a physician, physician assistant, or nurse practitioner,
 2. Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes,
 3. Services that do not meet the general coverage criteria,
 4. Services that do not require the knowledge, skill, and judgment of a licensed speech-language pathologist,
 5. Services when documentation supports that the beneficiary has attained the speech-language pathology goals or has reached the point where no further significant functional improvement is apparent and/or can be expected to occur,
 6. Services when documentation supports that the beneficiary has not reached speech-language pathology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise non-compliant with the speech-language pathology regimen,
 7. Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members,
 8. Services that duplicate other concurrent therapy,
 9. Maintenance and/or palliative services that maintain function and generally do not involve complex procedures or the professional skill, judgment, or supervision of a licensed speech-language pathologist,
 10. Services for conditions that could be reasonably expected to improve spontaneously without therapy,
 11. Services normally considered part of nursing care,
 12. Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),
 13. Separate fees for self-care/home management training,
 14. Services which are related solely to employment opportunities,
 15. Services that are primarily general wellness, exercise, and/or recreational programs,
 16. Services when the purpose is vocationally based,
 17. Services provided by student,

18. Services provided by speech-language assistants,
19. Services provided by speech-language pathology aides,
20. Group therapy,
21. Co-therapy,
22. Services that is investigative or experimental,
23. Acupuncture or biofeedback,
23. Services outside the scope/and or authority of the therapist's specialty and/or area of practice including, but not limited to:
 - a) Services and items requiring prior authorization/precertification if the prior authorization/precertification has not been requested and/or denied, or the prior authorization/pre-certification requirements have not been satisfied by the provider,
 - b) Speech-language pathology services that is educational in nature, not medical,
 - c) Consultation services between speech-language pathologists or other providers,
 - d) Services when clinical documentation and/or plan of care do not support the need for or the continuation of the services,
 - e) Services when the treatment is for a dysfunction that is self-correcting, or
 - f) Home health therapy services.

B. Beneficiary Noncompliance:

1. Medicaid does not cover therapy services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen.
2. Non-compliance is defined as failure to follow therapeutic recommendations which may include any or all of the following:
 - a) Failure to attend scheduled therapy sessions, either by cancellation or 'no show' to three (3) consecutive therapy sessions and/or missing half (1/2) or more of the scheduled visits without documentation of valid reasons such as personal illness/hospitalization or illness/death in the family,

- b) Failure to perform home exercise program as instructed by the therapist,
- c) Failure to fully participate in therapy sessions,
- d) Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance,
- e) Failure to properly use special equipment or adaptive devices, or
- f) Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.61; 42 CFR 410.62

Rule 3.5: Prior Authorization/Pre-certification

- A. Medicaid requires prior authorization/precertification of certain outpatient therapy services. Prior authorization/precertification for therapy services is conducted through the Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain prior authorization/precertification will result in denial of payment to the providers billing for services.
- B. Prior Authorization/Pre-certification for outpatient therapy services is only required for certain procedure codes when the services fall into one (1) of the following categories:
 - 1. Therapy services provided to beneficiaries, adult and/or children in individual therapist offices or in therapy clinics,
 - 2. Therapy services provided to beneficiaries, adult and/or children in the outpatient department of hospitals,
 - 3. Therapy services provided to beneficiaries, adult and/or children in physician offices/clinics,
 - 4. Therapy services provided to beneficiaries in nursing facilities,
 - 5. Therapy services covered under regular benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program,
 - 6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted,
 - 7. Therapy services provided to beneficiaries under age twenty-one (21) through the following providers: Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and State Department of Health, or

8. Therapy services billed by school providers.
- C. Prior Authorization/Precertification is not required, regardless of the procedure codes used, when the services fall into one (1) of the following categories:
1. Therapy services provided to beneficiaries in an ICF/MR,
 2. Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),
 3. Therapy services provided to beneficiaries enrolled in a hospice program, or
 4. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.
- D. Prior Authorization/Precertification Request
1. Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth by the UM/QIO.
 2. Medicaid does not cover the initial evaluation and the first (1st) therapy session on the same day. The UM/QIO is authorized to accept retrospective requests for the following exceptions:
 - a) Urgent services as defined and outlined in Part 213, Chapter 1, Rule 1.6 D or
 - b) Same Day/ Non-Urgent Services as defined and outlined in Part 213, Chapter 1, Rule 1.6 D.

Source: Miss. Code Ann. § 43-13-121

Rule 3.6: Prescribing Provider Orders/Responsibilities

- A. Medicaid covers therapy services that are medically necessary, as certified by the prescribing provider. Medicaid defines prescribing provider as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.
- B. 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.
- C. 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. 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. A separate plan of care is required for each type of therapy ordered by the prescribing provider.

D. Medicaid requires the POC must, at a minimum, include the following:

1. Beneficiary demographic information,
2. Name of the prescribing provider,
3. Dates of service,
4. Diagnosis/symptomatology/conditions and related diagnosis codes,
5. Specific diagnostic and treatment procedures/modalities and related procedure codes,
6. Reason for referral,
7. Frequency of therapeutic encounters,
8. Units/minutes required per visit,
9. Duration of therapy,
10. Precautions short and long term goals that are specific, measurable, and age appropriate,
11. Home program,
12. Discharge plan, and
13. Therapist's signature, including the name and title, and date of the therapy session,

E. The plan of care (POC) must be developed to cover a period of treatment not to exceed 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 covered by Medicaid.

F. Medicaid requires a revised POC in the following situations:

1. The projected period of treatment is complete and additional services are required, or
2. A significant change in the beneficiary's condition and the proposed treatment plan requires that:
 - a) A therapy provider propose a revised POC to the prescribing provider, or
 - b) The prescribing provider requests a revision to the POC. Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates.

- G. 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.
- H. Medicaid accepts the signature on the revised plan of care as a new order.
- I. 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.
- J. Medicaid requires the prescribing provider 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.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.61; 42 CFR 410.62

Rule 3.7: Evaluation/ Re-Evaluation

- A. Medicaid requires 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.
- B. Medicaid requires that 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. Medicaid requires 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.
- C. Initial evaluations should, at a minimum, contain the following information:
 - 1. Beneficiary demographic information,
 - 2. Name of the prescribing provider,
 - 3. Date of the evaluation,
 - 4. Diagnosis/functional condition or limitation being treated and onset date,
 - 5. Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, co-morbidities, complicating or precautionary information,

6. Prior therapy history for same diagnosis/condition and response to therapy,
 7. Level of function, prior and current,
 8. Clinical status including cognitive function, sensation/proprioception, edema, vision and hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance by sitting and standing, transfer ability, ambulation on 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 chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,
 9. Special/standardized tests including the name, scores/results, and dates administered,
 10. 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,
 11. Discharge plan including requirements to return to home, school, and/or job,
 12. Impression/interpretation of findings, and
 13. Physical therapist's signature including name and title and date of service.
- D. Medicaid covers 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. Medicaid defines significant change 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.

Source: Miss. Code Ann. § 43-13-121

Rule 3.8: Maintenance Therapy

- A. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid. Such services include, but are not limited to, the following:
1. Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments,
 2. 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,

3. Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress, or
 4. Exercises and range of motion exercises not related to the restoration of a specific loss of function.
- B. Maintenance programs must 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. Maintenance programs established after the rehabilitative program are not considered medically necessary and will not be covered.

Source: Miss. Code Ann. § 43-13-121

Rule 3.9: Documentation

- A. Speech therapy providers must document and maintain records in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3.
- B. Required documentation by servicing provider includes, but is not limited to, the following:
1. Beneficiary demographic information,
 2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,
 3. Signed consent for treatment, if applicable,
 4. The original copies of all Outpatient Therapy Evaluation/Re-Evaluations specific to the therapy requested,
 5. The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy requested,
 6. The original copies of all tests performed or a list of all tests and test results, and the written evaluation reports,
 7. Specific documentation for timed procedure codes. If a treatment log is used, it must be retained as part of the beneficiary's medical record,
 8. Progress Notes:
 - a) 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, progress notes must be documented following each therapy session.

b) 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, 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 timed and untimed codes in this Part.

9. Discharge Summary, if applicable, and

10. A copy of the completed prior approval form with prior approval authorization, if applicable.

C. Required documentation by prescribing provider includes, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment, if applicable,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen (face-to-face) and evaluated/re-evaluated every six (6) months at a minimum.

D. In addition, the prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and
4. Discharge summary, if applicable.

E. Timed Codes

1. Procedure codes that reference a time per unit are ‘timed codes.’ Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.
2. Medicaid considers the following activities as not part of the total treatment time:
 - a) Pre and post-delivery services. The beneficiary should be in the treatment area and prepared to start treatment,
 - b) Time the beneficiary spends not being treated, or
 - c) Time waiting for equipment or for treatment to begin.

F. Untimed procedure codes are not defined by a specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 3.10: Dual Eligibles

- A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy service must be prior authorization/precertified through the UM/QIO.
- B. Beneficiaries cannot receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 3.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 4: Administrative Appeals

Rule 4.1: Appeals for Therapy Services

- A. Reconsideration Process - The beneficiary, therapy provider, or prescribing provider is afforded the right to appeal a utilization review denial to the UM/QIO through the reconsideration process set forth by the UM/QIO.
- B. Administrative Appeal - Disagreement with the UM/QIO reconsideration determination shall be appealed to Medicaid 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 determination notice.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 42 CFR 441.308