INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Therapy Services

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Original version can be accessed at Indiana Health Coverage Program

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Aug. 25, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: Aug. 1, 2017	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of Dec. 1, 2019 Published: July 16, 2020	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of Oct. 1, 2020 Published: Jan. 7, 2021	Scheduled update	FSSA and Gainwell
6.0	Policies and procedures as of April 1, 2022 Published: Jan. 26, 2023	Scheduled update: • Reorganized and edited text as needed for clarity • Updated web links • Updated the *PA for Therapy Services* section • Updated the *Billing and Reimbursement of Therapy Services* section to revise billing guidance and add information about including ordering provider information on the claim • Added a note about substance use disorder and behavioral health in the *Occupational Therapy Services* section • Updated the *Occupational Therapy Services and Modifier GO* and *Physical Therapy Services and Modifier GP* sections to indicate that the information applied to both professional and outpatient claims • Updated the *Billing and Reimbursement for TBI Services* section	FSSA and Gainwell

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> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*
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> *For updates to information in this module, see IHCP Banner Pages and IHCP Bulletins at in.gov/medicaid/providers.*

Introduction

The Indiana Health Coverage Programs (IHCP) covers therapy services for eligible members. This module outlines IHCP prior authorization (PA), billing and reimbursement policies for occupational therapy, physical therapy, respiratory therapy and speech pathology services. Information about cognitive rehabilitation therapy for the treatment of traumatic brain injury (TBI), hyperbaric oxygen therapy, pulmonary rehabilitation programs, cardiac rehabilitation programs, TBI programs and comprehensive outpatient rehabilitation facility (CORF) services is also included.

For information about audiology services, see the *Hearing Services* module. For information about behavioral therapy, including applied behavior analysis (ABA) therapy, see the *Behavioral Health Services* module.

The IHCP reimburses for therapy services provided outside Indiana, subject to PA, as provided by *Indiana Administrative Code 405 IAC 5-5-2*. However, the IHCP does **not** cover home health agency services outside Indiana. See the *Home Health Services* module for billing and PA guidelines related to provision of therapy by home health agencies.

Occupational Therapy, Physical Therapy, Respiratory Therapy and Speech Pathology Services

The following sections provide information about occupational therapy, physical therapy, respiratory therapy and speech pathology services.

> *Note: The IHCP covers robotic therapy as a tool used within other therapy services. Robotic therapy can be performed while providing therapy services, but a provider must bill the most appropriate procedure code for the therapy service rendered rather than specifically for robotic therapy. All PA requirements for covered therapy services apply.*

PA for Therapy Services

In accordance with *405 IAC 5-22-6(a),* the IHCP requires PA for all occupational therapy, physical therapy, respiratory therapy and speech pathology services, with the following **exceptions**:

- Initial evaluations
- Emergency respiratory therapy

- Any combination of therapy services ordered in writing before a member's release or discharge from an inpatient hospital, continuing for a period not to exceed 30 units in 30 calendar days
- Deductible and copay or coinsurance for services covered by Medicare Part B
- Oxygen equipment and supplies necessary for the delivery of oxygen, with the exception of concentrators
- Therapy services provided by a nursing facility or large private or small intermediate care facility for individuals with intellectual disabilities (ICF/IID), which are included in the facility's per diem rate
- Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis or upper respiratory infection (not to exceed 14 hours or 14 calendar days without PA)

In accordance with *405 IAC 5-22-6(b)*, the following PA criteria apply to occupational therapy, physical therapy, respiratory therapy and speech pathology services:

- The IHCP requires written evidence of physician involvement and personal patient evaluation to document acute medical needs.
  - The therapy must be ordered by a qualifying provider, as indicated in the subsections of this module for each type of therapy.
  - Providers must attach a current plan of treatment and progress notes indicating the necessity and effectiveness of therapy to the PA request and make this documentation available for audit.

> *Note: When a member is enrolled in therapy, physician progress notes as to the necessity and effectiveness of therapy and ongoing evaluations to assess progress and redefine goals must be a part of the therapy documentation. The following information and documentation are to be included in the medical record:*
>
> - *Location (place of service code) at which services were rendered*
> - *Documentation of referrals and consultations*
> - *Documentation of test orders*
> - *Documentation of all services performed and billed*
> - *Documentation of medical necessity*
> - *Treatment plan*

- The therapy must be provided by a qualified therapist, or a qualified assistant under the direct supervision of the therapist, as appropriate.
- The level of complexity and sophistication of the therapy and the condition of the member must be such that the judgment, knowledge and skills of a qualified therapist are required.
- The therapy must be medically necessary.
- The IHCP does not cover therapy rendered for diversional, recreational, vocational or avocational purposes; for the remediation of learning disabilities; or for developmental activities that can be conducted by nonmedical personnel.
- The IHCP covers **rehabilitative** therapy services for members under 21 years of age when determined medically necessary. For members 21 years of age and older, the IHCP covers rehabilitative therapy services for no longer than two years from the initiation of the therapy, unless a significant change in medical condition requires longer therapy. Providers can prior authorize respiratory therapy services for a longer period on a case-by-case basis.
- The IHCP covers **habilitative** therapy services for members under 21 years of age on a case-by-case basis, subject to prior authorization. (Educational services, including, but not limited to, the remediation of learning disabilities, are not considered habilitative therapy and are not covered.) Habilitative therapy is not a covered service for members 21 years of age and older.

> *Note: Habilitative therapy refers to therapy addressing chronic medical conditions where further progress is not expected. Habilitative therapy services include physical therapy, occupational therapy, respiratory therapy, speech pathology and audiology services provided to members for the purpose of maintaining their level of functionality, but not the improvement of functionality. Although the development of a habilitation therapy plan is considered part of rehabilitative services, the services furnished under a habilitation therapy plan are not skilled therapy. Educational services, including but not limited to the remediation of learning disabilities, are not considered habilitative therapy services and remain noncovered by the IHCP.*

- When a member is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. The IHCP does not separately reimburse for ongoing evaluations.
- One hour of billed therapy must include a minimum of 45 minutes of direct member care, with the balance of the hour spent in related patient services.
- The IHCP does not reimburse therapy services for more than one hour per day per type of therapy; additional therapy services require prior authorization and must be medically necessary.
- The IHCP does not authorize requests for therapy that would duplicate other services provided to a member.

Prior authorization requests for therapy services must include applicable procedure codes for the services to be rendered, along with appropriate modifiers, when required (see the *Occupational Therapy Services and Modifier GO* and *Physical Therapy Services and Modifier GP* sections for details). This guidance includes PA requests from outpatient facilities, which must submit the request for applicable procedure codes (and modifiers, when indicated) rather than for the relevant revenue code, even though outpatient therapy claims are reimbursed based on revenue code only.

Billing and Reimbursement of Therapy Services

The following billing and reimbursement guidance applies for occupational therapy, physical therapy, respiratory therapy and speech pathology services:

- When the service is rendered in an **outpatient facility setting**, providers bill occupational therapy, physical therapy, respiratory therapy and speech pathology on the institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [Portal] institutional claim or 837I electronic transaction), using the applicable revenue code along with any prior-authorized procedure codes (including modifiers, when appropriate; see the *Occupational Therapy Services and Modifier GO* and *Physical Therapy Services and Modifier GP* sections). The IHCP reimburses outpatient therapy services at a flat, statewide fee based on the revenue code only. For rate information, see the Revenue Codes tab of the Outpatient Fee Schedule, available from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. (Note that procedure codes and applicable modifiers are required on the outpatient claim to confirm prior authorization; separate reimbursement based on procedure code is not available; only the revenue code is reimbursable.)
- When the service is rendered in an office or other **professional setting**, providers bill occupational therapy, physical therapy, respiratory therapy and speech pathology on the professional claim (*CMS-1500* claim form, Portal professional claim or 837P electronic transaction), using applicable procedure codes (including modifiers, when appropriate; see the *Occupational Therapy Services and Modifier GO* and *Physical Therapy Services and Modifier GP* sections). The IHCP reimburses professional therapy services on a per-hour basis or per unit billed. Providers cannot bill for fractional units for less than one hour. Providers must accumulate and report time in one-hour increments. For rate information, see the Professional Fee Schedule, available from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. Reimbursement cutbacks are applied, when applicable, for services rendered by qualifying practitioners that are not eligible for IHCP enrollment, such as physical therapist assistants and speech-language pathologist aides.

> *Note: For billing purposes, the IHCP treats CORFs as a professional setting rather than an outpatient facility setting. CORFs must use the professional claim type when submitting claims to the IHCP. See the Comprehensive Outpatient Rehabilitation Facilities section for more information.*

For IHCP reimbursement, claims for services rendered by provider specialties 170–173 (Physical Therapist, Occupational Therapist, Speech/Hearing Therapist) must include the National Provider Identifier (NPI) of the provider that **ordered** the services, and the ordering provider must be enrolled in the IHCP. For more information, see *Ordering, Prescribing and Referring Provider Requirements* in the *Claim Submission and Processing* module.

The following sections include additional information specific to each type of therapy service.

Occupational Therapy Services

In accordance with *405 IAC 5-22-6(b)(1)(B)*, for IHCP reimbursement, occupational therapy services must be **ordered** by one of the following IHCP-enrolled providers:

- Physician (doctor of medicine or doctor of osteopathy)
- Podiatrist
- Advanced practice registered nurse
- Optometrist
- Physician assistant
- Chiropractor
- Psychologist

In accordance with *405 IAC 5-22-11*, occupational therapy services must be **performed** by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist. For IHCP reimbursement to be made, a licensed occupational therapist must perform an evaluation.

The IHCP limits evaluations and reevaluations to three hours of service per evaluation.

The IHCP does **not** cover the following occupational therapy services:

- General strengthening exercise programs for recuperative purposes
- Passive range-of-motion services (as the only or primary mode of therapy)
- Occupational therapy psychiatric services

> *Note: The IHCP supports including occupational therapists on a substance use disorder (SUD) or behavioral health treatment team, when the occupational therapists provide services within their scope of licensure. The scope of occupational therapy practice allows the provision of psychosocial interventions, and the IHCP supports including occupational therapy in the treatment plan of members receiving behavioral health treatment services.*

The IHCP does not reimburse separately for occupational therapy services provided by a nursing facility or a large private or small ICF/IID. These services are included in the facility's established per diem rate and do not require PA.

Occupational Therapy Services and Modifier GO

Certain procedure codes require that both the PA request and the claim include the appropriate modifier to indicate that the service was delivered under an occupational therapy plan of care, if applicable. If the PA request for one of these services includes modifier GO – *Services delivered under an occupational therapy plan of care*, then modifier GO must be billed on the claim.

The IHCP compares the way these codes are *billed* (with or without modifier GO) to the way they are *authorized*. If the modifier usage on the claim does not match the usage on the PA, the claim will deny with explanation of benefits (EOB) 3001 – *Dates of service not on the P.A. master file*. This guidance applies to both professional and outpatient claims; if the procedure code and modifier usage on the outpatient claim does not match what was prior authorized, both the procedure code and the associated revenue code will deny for lack of PA.

For applicable codes, see the *Physical and Occupational Therapy Codes That Require a Modifier Match (GO or GP) on the Authorization Request and Claim* table in *Therapy Services Codes* on the *Code Sets* page at in.gov/medicaid/providers.

Physical Therapy Services

In accordance with *405 IAC 5-22-6(b)(1)(A)*, for IHCP reimbursement, physical therapy services must be **ordered** by one of the following IHCP-enrolled providers:

- Physician (doctor of medicine or doctor of osteopathy)
- Podiatrist
- Psychologist
- Chiropractor
- Dentist
- Advanced practice registered nurse
- Physician assistant

In accordance with *405 IAC 5-22-8*, for IHCP reimbursement, physical therapy services must be **performed** by a licensed physical therapist or a certified physical therapist assistant (PTA) under the direct supervision of a licensed physical therapist or physician as defined in *842 IAC 1-1-1(g)*.

> *Note: The PTA is precluded from performing or interpreting tests, conducting initial or subsequent assessments, or developing treatment plans. See the Covered Procedures for Physical Therapist Assistants section for details. The PTA is required to meet with the supervising physical therapist each working day to review treatment, unless the physical therapist or physician is on the premises to provide constant supervision. The consultation can be either face-to-face or by telephone.*

Only the following activities related to the therapy can be performed by someone other than a licensed therapist or a certified PTA under the direct supervision of a licensed physical therapist. The IHCP allowance for the modality provided by the licensed therapist includes payment for the following services, and providers may not bill the IHCP separately for these services:

- Assisting members in preparation for treatment and, as necessary, during and at the conclusion of treatment
- Assembling and disassembling equipment
- Assisting a physical therapist in the performance of appropriate activities related to the treatment of the individual patient

- Following established procedures pertaining to the care of equipment and supplies
- Preparing, maintaining and cleaning treatment areas and maintaining supportive areas
- Transporting patients, records, equipment and supplies in accordance with established policies and procedures
- Performing established clerical procedures

The IHCP limits evaluations and reevaluations to three hours of service per member evaluation.

The IHCP does not reimburse separately for physical therapy services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's per diem rate and do not require PA.

Covered Procedures for Physical Therapist Assistants

The IHCP has identified certain services that are eligible for reimbursement when performed by a PTA. For a table of applicable procedure codes, see *Therapy Services Codes* on the *Code Sets* page at in.gov/medicaid/providers.

When these services are performed by a PTA, providers must bill them with the modifier **HM** – *Less than a bachelor's degree.* These services, when billed with the HM modifier, are priced to reimburse at 75% of the rate for a physical therapist.

Note that evaluation and testing procedure codes are excluded from the table because PTAs may not administer tests or perform evaluations.

Physical Therapy Services and Modifier GP

Certain procedure codes require that both the PA request and the claim include the appropriate modifier to indicate that the service was delivered under a physical therapy plan of care, if applicable. If the PA request for one of these services includes modifier **GP** – *Services delivered under a physical therapy plan of care*, then modifier GP must be billed on the claim.

The IHCP compares the way these codes are *billed* (with or without modifier GP) to the way the codes are *authorized*. If the modifier usage on the claim does not match the usage on the PA, the claim will deny with EOB 3001 – *Dates of service not on the P.A. master file*. This guidance applies to both professional and outpatient claims; if the procedure code and modifier usage on the outpatient claim does not match what was prior authorized, both the procedure code and the associated revenue code will deny for lack of PA.

For applicable codes, see the *Physical and Occupational Therapy Codes That Require a Modifier Match (GO or GP) on the Authorization Request and Claim* table in *Therapy Services Codes* on the *Code Sets* page at in.gov/medicaid/providers.

Hippotherapy

The IHCP covers hippotherapy for physical therapy. To be covered, the services must be provided by a licensed physical therapist and billed using the appropriate Current Procedural Terminology (CPT®[1]) codes from the following list:

- 97110 – *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility*
- 97112 – *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities*

[1] *CPT copyright 2022 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

- 97530 – *Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes*
- 97533* – *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes.*

  * CPT code 97533 can be used only for patients with a diagnosis of traumatic brain injury (TBI).

> *Note: The IHCP does **not** cover procedure code S8940 – Equestrian/hippotherapy, per session.*

Hippotherapy services must be included in the patient's treatment plan. Existing PA requirements for physical therapy apply to hippotherapy.

Respiratory Therapy Services

In accordance with *405 IAC 5-22-6(b)(1)(C)*, for IHCP reimbursement, respiratory therapy services must be ordered by an IHCP-enrolled physician (doctor of medicine or doctor of osteopathy).

Additionally, in accordance with *405 IAC 5-22-10*, the IHCP reimburses for respiratory therapy services only when performed by a licensed respiratory therapist or certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency or clinic.

The IHCP considers the equipment necessary for rendering respiratory therapy part of the provider's capital equipment.

> *Note: The IHCP does not require PA for respiratory therapy given on an emergency basis. In addition, for a period not to exceed 14 hours or 14 calendar days, providers can perform respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis and upper respiratory infection without PA. If the member requires additional services after that date, the provider must obtain PA.*

The IHCP does not reimburse separately for respiratory therapy services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's established per diem rate.

Speech Pathology Services

Speech pathology services are provided for IHCP members with speech, hearing or language disorders. These services include diagnostic, screening, preventive and corrective services.

In accordance with *405 IAC 5-22-6(b)(1)(C)*, for IHCP reimbursement, speech pathology services must be ordered in writing by an IHCP-enrolled physician (doctor of medicine or doctor of osteopathy).

> *Note: For dates of service on or after Aug. 1, 2022, the following licensed practitioners may order speech pathology services:*
>
> - *Physician*
> - *Nurse practitioner*
> - *Clinical nurse specialist*
> - *Certified nurse midwife*
> - *Physician assistant*

Additionally, in accordance with *405 IAC 5-22-9,* the speech pathology service must be rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. A registered speech-language pathology aide may provide services subject to *880 IAC 1-2.1*. Procedures performed by speech-language pathologist aides must be billed with modifier HM using the supervising practitioner's NPI, and are reimbursed at 75% of the rate paid to a speech-language pathologist.

Evaluations and reevaluations are limited to three hours of service per evaluation.

Group therapy is covered only in conjunction with, not in addition to, regular individual treatment. The IHCP will not reimburse for group therapy as the only or primary means of treatment.

The IHCP does not reimburse separately for speech pathology services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's established per diem rate.