

# 2017 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary  
KanCare Program  
Chapter 14: Rehabilitative Therapy

## Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at [UHCprovider.com](http://UHCprovider.com).

Click the following links to access different manuals:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual-go to [UHCCommunityPlan.com](http://UHCCommunityPlan.com), click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in this manual using the following steps:

1. Press CTRL+F.
2. Type in the keyword.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF.

If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our members.

## Important Information about the use of this manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

We amend the manual as policies change.

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# Chapter 14: Rehabilitative Therapy

## 14.1 Introduction

This chapter was designed to provide information and instructions specific to physical therapy, occupational therapy and speech/language pathology providers.

Coverage is available for rehabilitative physical therapy, occupational therapy and speech/language therapy services. Rehabilitative therapy services may be billed by providers such as rehabilitation agencies, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), hospices, outpatient departments of hospitals and suppliers (such as physicians, NNPs, physical, occupational and speech/language therapists in private practice). Providers are limited to performing services within their scope of practice.

The **Benefits and Limitations** subsection defines specific aspects of the scope of physical therapy, occupational therapy and speech/language services allowed within the KanCare Plan. Each practitioner or certified assistant must remain within his or her scope of practice.

### HIPAA Compliance

As a participant in the KanCare Plan, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by K.S.A. 21-3853 and amendments thereto. A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider must not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

## 14.2 Rehabilitative Therapy Billing Instructions

Please see “Chapter 15: Claims” for billing instructions.

### Procedure Codes

Physical, speech and occupational therapists must bill their services using appropriate Current Procedural Terminology (CPT®) codes. Therapists will not be reimbursed for services provided outside their scope of practice. When a CPT® code is not available, the service is not covered by KanCare. Unlisted procedure codes are not covered. Claims only describing a service without the proper CPT® procedure code will be denied.

### Prior Authorization

To view a list of codes requiring Prior Authorization, please go to [UHCCcommunityplan.com](http://UHCCcommunityplan.com) > For Health Care Professionals > Kansas > Provider Information > Prior Authorization.

## 14.3 Benefits and Limitations

### Benefit Plans

Please see “Chapter 3: Member Benefits” for information on KanCare beneficiaries and their benefits.

## 14.4 Medicaid

All therapy services must be prescribed by a physician.

**Habilitative** – Habilitative therapy is covered only for participants zero to under 21 years of age. Therapy must be medically necessary. Therapy is covered for any birth defects and/or developmental delays (habilitative diagnoses) only when approved and provided by an Early Childhood Intervention (ECI), Head Start or LEA program. Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. The purpose of this therapy is to achieve and maintain maximum possible functioning for children.

**Developmental** – Developmental physical, occupational, and speech/language therapy services are covered for children under 21 years of age. Individuals may receive developmental therapy services to treat Autism Spectrum Disorders (ASDs), birth defects, and other developmental delays in any appropriate community setting and from any qualified provider with prior authorization and medical necessity documentation.

Developmental therapy services can be billed using the following range of diagnosis codes:

- F84.0 - F84.9 Autism Spectrum Disorder
- F80.1 - F80.9 Developmental Speech and Language Disorder
- H93.25 Central Auditory Processing Disorder
- F70 - F79 Intellectual Disabilities
- G80.0 - G80.9 Infantile Cerebral Palsy
- Q00.0 - Q89.9 Congenital Anomalies

ASD coverage is available for the diagnosis and treatment of ASD. A licensed medical provider must diagnosis ASD with an appropriate assessment. Services must be preapproved and may include developmental speech therapy, developmental occupational therapy, or developmental physical therapy. An initial comprehensive assessment to establish a baseline must be completed. Periodic re-evaluations and assessments are required at least every six months. Continuous improvement must be shown in order to qualify for continued treatment.

The provision of services for all children with birth defects and developmental delays, which include ASD, is allowed by any qualified provider in any appropriate place of service. The services include developmental physical therapy, developmental occupational therapy, and developmental speech/language pathology services as documented in a comprehensive treatment plan.

**Treatment plan** means a submission by a provider or group of providers and signed by both the provider(s) and parent(s)/caregiver(s) that includes:

- The type of therapy to be administered and methods of intervention
- The goals including specific problems or behaviors requiring treatment

- Frequency of services to be provided
- Frequency of parent or caregiver participation at therapy sessions
- Description of supervision
- Periodic measures for the therapy, including the frequency at which goals will be reviewed and updated
- Who will administer the therapy and the patient's current ability to perform the desired results of therapy

**Note:** An acceptable ICD-10 diagnosis will be required on the treatment plan. Diagnosis codes R68.89 (Other general symptoms and signs), R62.50 (Unspecified lack of expected normal physiologic development in childhood), and R62.59 (Other lack of expected normal physiologic development in childhood) will not be accepted as a primary diagnosis.

**Rehabilitative** – All therapies must be physically rehabilitative. Therapies are covered for adults 21 years of age and over only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or illness.

Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit.

Therapy treatments are not covered for psychiatric diagnoses.

Providers of rehabilitative therapy can submit claims with the following diagnosis code: Z51.89 – Encounter for other specified aftercare. This replaces ICD-9 diagnosis codes V57.0 -V57.9 as the primary diagnosis. Providers are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when Z51.89 is used as the primary diagnosis.

**Wheelchair Seating Assessments** - Effective July 1, 2017, Physical Medicine and Rehabilitation procedure codes 97542, 97755, and 97760 are covered for the management of wheelchair seating assessments.

Reimbursement cannot exceed \$500 per beneficiary per year for seating assessment services.

Reimbursement for wheelchair seating assessments is limited to the following care providers:

- Carney Center Seating Clinic, Wichita, Kansas
- Children's Mercy Hospital Seating Clinic, Kansas City, Missouri
- KU Medical Center Seating Clinic, Kansas City, Kansas

## 14.5 Provider Requirements

**Physical therapy** services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. A qualified physical therapist (PT) is a person who is licensed as a PT by the Kansas Board of Healing Arts or has licensure or certification in the jurisdiction in which the service is provided.

All physical therapy services must be prescribed by a physician and performed by either a registered PT or by a certified physical therapy assistant (PTA) working under the supervision of a registered PT. Supervision must be clearly documented. This may include, but is not limited to, the registered PT initialing each treatment note written by the certified PTA or the registered PT writing "Treatment was supervised" followed by his or her signature.

**Occupational therapy** services are those services provided within the scope of practice of occupational therapists (OTs) and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or where function has been permanently lost or reduced by illness or injury to improve the individual's ability to perform those tasks required for independent functioning. A qualified OT is an individual who is licensed by the Kansas Board of Healing Arts or jurisdiction in which the service is provided. Occupational therapy services may also be provided by an occupational therapy assistant (OTA) working under the supervision of an OT. Supervision must be clearly documented.

**Speech-language pathology (SLP)** services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. According to KanCare, speech therapy must be provided by a speech pathologist with a certificate of clinical competence from the American Speech and Hearing Association.

## 14.6 Documentation

A copy of the physician's order for physical therapy, occupational therapy and speech/language pathology services must be retained with the medical record.

To verify services provided in the course of a post-payment review, documentation in the beneficiary's medical record must support the service billed. Documentation must be legible and complete. Proper documentation does not need to be in any specific format. It must include:

- Pertinent past and present medical history with approximate date of diagnosis
- Identification of expected goals or outcomes
- Description of therapy and length of time spent on treatment
- Member's response to therapy
- Progress toward goal(s)
- Date and signature of therapist by each entry

Auto-authentication (computerized authentication) of documentation for the medical record is acceptable as long as it meets federal guidelines. Regulations require there be a method for determining whether the individual authenticated the document after transcription. All entries must be legible and complete. Entries must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for providing the service. The author of each entry must be identified and authenticate his or her entry. Authentication may include the author's signature, written initials or computer entry. If services were performed by a certified therapy assistant, supervision must be clearly documented.

**Note:** When therapy services are provided due to an acute exacerbation of pain and decline in mobility or function related to an existing condition, documentation must support the provision of the visits. Therapies provided in such a situation are expected to address comfort and mobility and should be of a short duration. Provision of therapies for an extended duration to treat symptoms related to an existing or chronic condition is not acceptable due to lack of rehabilitation potential. These visits are subject to recoupment in a post-pay review.

## Limitations

Therapy services are limited to up to six consecutive months per injury or illness for participants 21 years of age and older. Therapy services begin at the discretion of the provider. Traumatic brain injury (TBI) beneficiaries may receive six months of therapy services as a state plan benefit. When state plan therapy benefits are exhausted, TBI beneficiaries may receive additional rehabilitative therapy services as outlined in the waiver approved plan of care.

## Vacuum Assisted Wound Closure Therapy

This is covered for specific benefit plans. Prior authorization is required. Criteria must be met. For questions about service coverage for a given benefit plan, contact Provider Services at 877-542-9235. All prior authorization must be requested in writing by a participating DME care provider. All medical documentation must be submitted that care provider.



