KANSAS MEDICAL ASSISTANCE PROGRAM
Fee-for-Service Provider Manual

Rehabilitative Therapy Services

Updated 12.2015
## Part II

**Rehabilitative Therapy Services Fee-for-Service Provider Manual**  
(Physical Therapy, Occupational Therapy, Speech/Language Pathology)

### Introduction

<table>
<thead>
<tr>
<th>Section</th>
<th>Billing Instructions</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7000</td>
<td>Rehabilitative Therapy Billing Instructions</td>
<td>7-1</td>
</tr>
</tbody>
</table>

**Benefits and Limitations**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8100</td>
<td>Copayment</td>
<td>8-1</td>
</tr>
<tr>
<td>8300</td>
<td>Benefit Plans</td>
<td>8-2</td>
</tr>
<tr>
<td>8400</td>
<td>Medicaid</td>
<td>8-3</td>
</tr>
</tbody>
</table>

**Appendix**

<table>
<thead>
<tr>
<th>Code</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes</td>
<td>A-1</td>
</tr>
</tbody>
</table>

**Forms**

All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

**Disclaimer:** This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

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PART II
REHABILITATIVE THERAPY SERVICES FEE-FOR-SERVICE PROVIDER MANUAL
Updated 12/15

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to physical therapy, occupational therapy, and speech/language pathology providers. It is divided into two subsections: Billing Instructions and Benefits and Limitations.

The Billing Instructions subsection gives information applicable to physical therapy, occupational therapy and speech/language services for completing and submitting the CMS-1500.

In order to bill KMAP for rehabilitative therapy services, each individual must be enrolled as a private practitioner or be employed in one of the following practice types: an unincorporated solo practice, unincorporated partnership, or unincorporated group practice. Physician and nonphysician practitioner (NPP) group practices may employ physical therapists in private practice (PTPP) and/or occupational therapists in private practice (OTPP) if state and local law permit this employee relationship.

Note: 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; NPPs; 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 KMAP. Each practitioner or certified assistant must remain within his or her scope of practice. KMAP will not reimburse services provided by speech/language therapy assistants.

HIPAA Compliance

As a participant in KMAP, 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.
Introduction to the CMS 1500 Claim Form

Physical, occupational, and speech/language therapy providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website or billed through Provider Electronic Solutions (PES). When a paper form is required, it must be submitted on an original red claim form and completed as indicated. Any claim not submitted on the red claim form will be returned to the provider. The Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

Any of the following billing errors may cause a CMS 1500 claim to deny or be sent back to the provider:

- Sending a CMS 1500 Claim Form carbon copy.
- Sending a KanCare paper claim to KMAP.
- Using a PO Box in the Service Facility Location Information field.

An example of the CMS 1500 Claim Form and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms and Instructions) heading.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers.

SUBMISSION OF CLAIM

Send completed first page of each claim and any necessary attachments to:

KMAP
Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas  66601-3571
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Updated 12/15

Physical, occupational, and speech/language therapy services require a copayment of $1 per date of service. Therapy visits must be provided by an HHA, physician’s office, outpatient hospital department, Local Education Agency (LEA) or independently enrolled therapy practitioner. (Refer to Section 3000 of the General TPL Payment Fee-for-Service Provider Manual for exceptions.)

Bill all services provided on the same date on the same claim form. If multiple claims are submitted for the same date(s) of service, copayment will be deducted for each claim submitted.

Do not reduce charges or balance due by the copayment amount. This reduction is automatically made during claim processing.
BENEFITS AND LIMITATIONS

8300. Benefit Plans  Updated 10/13

KMAP beneficiaries will be assigned to one or more benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the General Benefits Fee-for-Service Provider Manual for information on the plastic State of Kansas Medical Card and eligibility verification.
**BENEFITS AND LIMITATIONS**

**8400. MEDICAID Updated 12/15**

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 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
- 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. Diagnosis must be established using an appropriate assessment instrument and performed by an appropriately licensed medical provider. Services must be preapproved and may include developmental speech therapy, developmental occupational therapy, or developmental physical therapy as appropriate. An initial comprehensive assessment to establish a baseline must be completed. Periodic re-evaluations and assessments are required at least every six months and 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, will be allowed by any qualified provider in any appropriate place of service. The services will 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.

For additional information regarding developmental therapy services, reference General Therapy Guidelines and Requirements in Section 2710 of the General Benefits Fee-for-Service Provider Manual.

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.

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 as noted above.**

**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 the Kansas Medicaid State Plan, speech therapy must be provided by a speech pathologist with a certificate of clinical competence from the American Speech and Hearing Association.

### Procedure Codes

Physical therapists and occupational therapists must bill their services using appropriate *Current Procedural Terminology (CPT®)* codes. Refer to Section 1300 in the *General Introduction Fee-for-Service Provider Manual* for information on how to obtain a *CPT®* codebook.

Therapists will not be reimbursed for services provided outside their scope of practice. Questions regarding specific procedure code coverage can be directed to Customer Service. Refer to Section 1000 of the *General Introduction Fee-for-Service Provider Manual*.

When a *CPT®* code is not available, the service is not covered by KMAP. Not otherwise classified codes are not covered. Unlisted procedure codes are not covered.

Claims only describing a service without the proper *CPT®* procedure code will be denied.

### 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 postpayment 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. However, it must include the following:

- 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
- Beneficiary's response to therapy
- Progress toward goal(s)
- Date and signature of therapist by each entry
Autoauthentication (computerized authentication) of documentation for the medical record is acceptable as long as it meets federal guidelines. Federal regulation 42CFR 482.24 (c) (1) (i) requires 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. This may include, but is not limited to, the registered PT or OT initialing each treatment note written by a certified therapy assistant or the registered PT or OT writing “Treatment was supervised” followed by his or her signature.

**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 postpay 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 will begin at the discretion of the provider. There are no limitations for medically necessary services for EPSDT participants. 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 content of the TBI waiver as outlined in the waiver approved plan of care.

**Vacuum Assisted Wound Closure Therapy**

Vacuum assisted wound closure therapy is covered for specific benefit plans. Prior authorization is required and criteria must be met. Refer to the DME Fee-for-Service Provider Manual for criteria. For questions about service coverage for a given benefit plan, contact KMAP Customer Service at 1-800-933-6593 or 785-274-5990. All prior authorization must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.
Procedure codes billable for developmental physical, occupational, and speech/language therapy services require prior authorization and include, but are not limited to the following CPT codes:

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