

Therapy Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

The Electronic Publishing Unit makes every attempt to publish accurate and current information, however, we disclaim any liability or responsibility for any typographical errors, out of date information and/or other inaccuracies that may appear in this document.

To receive eMail notifications of policy updates, go to the **ODM Email List Sign-up site** (<http://www.medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>) and subscribe to the type of communications in which you are interested. eMail notifications are sent as updates are posted to the eManuals site.

eManual Contents

Please send comments to ePubs_updates@jfs.ohio.gov

[Medicaid Handbook Transmittal Letters](#)

[Miscellaneous Medicaid Handbook Transmittal Letters](#)

[Medical Assistance Letters](#)

[Therapy Services Program Rules](#)

[Billing Instructions](#)

Medical Assistance Letters

MAL 589 (Implementation of Administrative Rule Changes Related to Skilled Therapy)

Medical Assistance Letter (MAL) 589

December 20, 2013

TO: Eligible Medicaid Providers of Skilled Therapy Services
Chief Executive Officers, Managed Care Plans
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: Implementation of Administrative Rule Changes Related to Skilled Therapy

Provider Notice

With the establishment of the Ohio Department of Medicaid as an independent entity, administrative rules affecting providers have been renumbered: Rule numbers formerly beginning with *5101:3* now begin with *5160*. It is likely, however, that these rules will continue to be referred to for some time by their old *5101:3* numbers, especially in online sources.

Policy Update

Changes have been made to the Medicaid policy governing the provision of skilled therapy services (physical therapy, occupational therapy, speech-language pathology, and audiology) in non-institutional settings. This policy is currently set forth in eight rules located in three separate chapters of the Ohio Administrative Code: 5160-4, 5160-8, and 5160-34.

All eight of these rules are being rescinded and replaced by five new rules:

- Rule 5160-8-30, "Skilled therapy: scope and definitions"
- Rule 5160-8-31, "Skilled therapy: providers"
- Rule 5160-8-32, "Skilled therapy: coverage"
- Rule 5160-8-33, "Skilled therapy: documentation of services"
- Rule 5160-8-34, "Skilled therapy: payment"

A new version of rule 5160-4-26, "Physical medicine and rehabilitation services," is also being adopted to address physical medicine and rehabilitation services furnished by a physician or by a licensed individual under the supervision of a physician.

Unless otherwise specified, these changes become effective for dates of service January 1, 2014, and after.

The purpose of this MAL is to provide supplementary guidance about these changes and how to implement them.

Results of the Changes

New skilled therapy provider types

New Medicaid provider types are being created for speech-language pathologists and audiologists. These skilled therapists will be able to enroll as "eligible providers" and to submit claims for Medicaid services provided.

Until now, participation in Medicare has been a requirement for physical therapists and occupational therapists enrolled as Medicaid providers. This requirement has been extended to all independently practicing skilled therapists, and an exception has been added: Physical therapists, occupational therapists, speech-language pathologists, and audiologists may be exempted from the Medicare participation requirement if they limit their practice to pediatric treatment (i.e., they do not serve Medicare beneficiaries) and they meet all other requirements for Medicare participation. Skilled therapy providers will be able to apply for the Medicare exemption in the enrollment section of the web portal.

The enrollment process for speech-language pathologists and audiologists and the Medicare exemption for all skilled therapists will not be available through the web portal until March 1, 2014. However, approval of applications submitted on or after that date may be made retroactive to January 1, 2014.

Prescriptions

The Medicaid requirement that skilled therapy services be provided only by prescription is being eliminated, and all references to a "Medicaid-authorized prescriber" are being removed. Providers will continue to be bound by any licensing requirements that concern prescribing or prescriptions, but Medicaid will no longer superimpose additional prescription requirements not found in licensure law.

New program limits and program limit calculation

A defined benefit year replaces the rolling calendar year as the period within which service limits apply. For the foreseeable future, the benefit year will be the calendar year. On January 1 of each year, everyone's therapy utilization history will be reset to zero.

The limit of thirty dates of service per year for any combination of physical therapy and occupational therapy is being changed. The new program limits are thirty dates of service for physical therapy and thirty dates of service for occupational therapy. The limit for speech-language pathology and audiology services remains thirty dates of service.

Additional medically necessary skilled therapy services beyond program limits may be prior-authorized.

Prior authorization

The process for requesting prior authorization for skilled therapy services that exceed program limits will not change. However, all currently approved or pending prior authorizations will end on December 31, 2013, because the service limits and utilization history for all individuals will start over with the new benefit year on January 1, 2014.

Multiple-procedure payment reduction

A new payment-reduction provision has been incorporated into the Medicaid administrative rules governing skilled therapy services. It applies when more than one skilled therapy procedure is performed by the same provider or provider group for an individual patient on the same date. Payment will be made, as it is under Medicare, at 100% for the primary procedure and at 50% for each additional procedure. (The procedure having the greatest Medicaid maximum payment amount is considered to be primary.)

Units of service per claim detail

How these services appear on claims will also be changing. To enable the claim-payment system to determine which procedure is primary, a quantity restriction of one unit will be imposed on skilled therapy procedure codes subject to the multiple-procedure reduction. Providers will no longer be able to report more than one unit for a single claim detail. Instead, they will report multiple claim details of one unit each.

Procedure code modifiers

Two-character procedure code modifiers will be used on claims to identify which skilled therapy services are provided. Certain skilled therapy services that are considered to be "always therapy" will always have to be reported with a modifier. Other skilled therapy services that are considered to be "sometimes therapy" will require a modifier only when the service is provided under a therapy plan of care. All audiology services are considered to be "sometimes therapy."

GP - Physical therapy

GO - Occupational therapy

GN - Speech-language pathology or audiology

Access to Rules and Related Material

The main web page of the Ohio Department of Medicaid (ODM) includes links to valuable information about its services and programs; the address is <http://medicaid.ohio.gov/>.

ODJFS maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule 5160-1-60 or in Appendix DD to that rule. (This rule was formerly numbered 5101:3-1-60.) Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then select the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS and ODM transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by transmittal letter number and subject, and it provides a link to a PDF copy of each document.

To receive automatic notification by e-mail when new Medicaid transmittal letters are published, interested parties may sign up at <http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>.

Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516

MAL 527

Medical Assistance Letter No 527 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Chiropractic Services e-book.

[Click here to view MAL 527, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 526

Medical Assistance Letter No 526 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Chiropractic Services e-book.

[Click here to view MAL 526, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 516

Medical Assistance Letter No 516 (Date - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

MAL 430

Medical Assistance Letter (MAL) No. 430

May 24, 2002

TO: All Physical Therapy/Medicine Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas Hayes, Director

SUBJECT: Proposed Physical Therapy/Medicine Policies

SCHEDULED TO BE EFFECTIVE JULY 1, 2002

The purpose of this Medical Assistance Letter (MAL) is to announce the implementation of new rules pertaining to physical therapy/physical medicine and rehabilitation services. Please note that these rules have been proposed and are pending approval by the Joint Committee on Agency Rule Review (JCARR) in early June. They are scheduled to be effective for services provided on and after July 1, 2002. Should there be a change in the effective date, we will notify all affected providers via a message on a Remittance Advice.

Please note that **all** policies pertaining to physical therapy/ physical medicine are new and should be reviewed carefully. The new policies will be described in detail when the handbooks or handbook updates are issued. The proposed new rules will be available on the Department's policy web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> by the end of May. Once these rules have been approved, the Department will be finalizing a physical therapy handbook for physical therapists and will also be updating the physical medicine section of the physician handbook and will be forwarding those documents to you at a later time.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-state toll free telephone number 1-800-686-6108
Out-of-state telephone number 1-614-728-3288

Medicaid Handbook Transmittal Letters

MHTL 3340-14-01 (Revision of Administrative Rule Governing the Payment of Skilled Therapy 5160-8-34)

Medicaid Handbook Transmittal Letter (MHTL) No. 3340-14-01

August 13, 2014

TO: Eligible Medicaid Providers of Skilled Therapy
Chief Executive Officers, Managed Care Plans
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: Revision of Administrative Rule Governing the Payment of Skilled Therapy 5160-8-34

Modifications are being made to one administrative rule that affect payments made for services rendered by Medicaid providers.

Rule [5160-8-34](#), titled "Skilled Therapy Payment," sets forth provisions for coverage and payment of skilled therapy services performed by eligible non-institutional providers. This rule is being proposed for amendment.

The multiple procedure reduction for therapy services is being revised. The changes are that the first unit or procedure will be reimbursed at 100 per cent of the Medicaid maximum. For each additional unit or procedure therapy providers will be reimbursed eighty per cent of the Medicaid maximum. This revision allows Medicaid to more closely align with Medicare's provision of the multiple therapy reduction. The other change is the multiple procedure payment reduction will only apply to skilled therapies within the same discipline (e.g. physical therapy).

All therapy services rendered by a therapist or therapist group to one individual on the same date should be reported on a single claim. Reporting such services on separate claims may cause incorrect payment of the first claim submitted and denial of subsequent claims. Providers may adjust an incorrectly paid claim by adding the denied services and resubmitting it.

The effective date for these changes in our claims payment system will be for dates of service July 1, 2014 forward. However the implementation date for these changes will be in December. ODM will discuss with HP the possibility of adjusting any affected claims due to the implementation date.

Access to Rules and Related Material

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, <http://www.medicaid.ohio.gov/>.

Some information about provider payment is listed by provider type on the 'Fee Schedule and Rates' web page, which may be accessed through the main ODM web page (Providers > Fee Schedule and Rates).

The Ohio Department of Job and Family Services (ODJFS) maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule 5160-1-60 (formerly 5101:3-1-60) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select 'General Information for Medicaid Providers'.

- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select the rule number and title from the 'Table of Contents' pull-down menu.
- (5) Scroll down and select the link to Appendix DD.

The Legal/Policy Central web site includes a calendar of documents that have recently been published, <http://www.odjfs.state.oh.us/lpc/calendar/>. It also displays a listing of ODJFS and Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>, categorized by letter number and subject, with links to PDF copies of the documents.

To receive automatic electronic notification when new Medicaid transmittal letters are published, interested parties may sign up at <http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>.

Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516

MHTL 3340-09-02 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3340-09-02

January 8, 2010

TO: All Eligible Occupational Therapists
All Eligible Physical Therapists
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3340-09-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3340-09-01

October 30, 2009

TO: All Providers of Physical Therapy and Occupational Therapy Services
All Providers of Speech-language Pathology/Audiology Services
Directors, Departments of Job and Family Service

FROM: Douglas E. Lumpkin, Director

SUBJECT: Changes in Medicaid Reimbursement of Physical Therapy, Occupational Therapy and Speech-Language Pathology/Audiology Services for Residents of Nursing Facilities (NFs).

Rule Change

Rule change effective August 1, 2009

Rule [5101:3-34-01.3](#), entitled Physical Therapy, Occupational Therapy and Speech-language Pathology/Audiology Services: Provider Claims, Billing, Payment and Reimbursement, has been amended to set forth that the provision of therapy services to residents of a nursing facility (NF) is the responsibility of the NF and reimbursable through the nursing facility per diem.

Amended Substitute House Bill 1 changed how Medicaid will reimburse some services provided to nursing facility (NF) residents. These services, which include physical, occupational and speech language pathology/audiology therapy, were previously provided by, and reimbursed to, fee-for-service providers. Amended Substitute House Bill 1 changed this arrangement by making NFs responsible for providing these services to Medicaid NF residents and by reimbursing NFs for the services through the nursing facility per diem. Making the NFs responsible for providing physical, occupational and speech language pathology/audiology therapy to the Medicaid nursing facility residents provides opportunities for improved coordination of services received by nursing facility residents and creates incentives for more effective utilization of health care expenditures.

Webpage:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>. Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this MHTL should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MHTL 3340-08-03

Medicaid Handbook Transmittal Letter (MHTL) 3340-08-03

July 17, 2008

To: All Providers of Physical Therapy and Occupational Therapy Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Medicaid Program Fee Increases

Effective July 1, 2008

Medicaid Reimbursement-OAC 5101:3-1- 60

The Department is pleased to announce that the Medicaid maximums for certain codes will be increased as part of the Governor's biennium budget. An aggregate 3% increase is being implemented for claims with dates of service on and after July 1, 2008.

The Medicaid maximums for selected CPT codes have been raised. If the Medicaid maximum was over the Medicare price, the Medicaid maximum was lowered to the 2007 Medicare fee. For many codes, the Medicaid maximum remains unchanged.

These Medicaid maximum changes are applicable to claims for consumers remaining in traditional Medicaid (fee-for-service) who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule 5101:3-1- 60 will affect their MCP reimbursement. Contracting questions should be directed to the applicable MCP.

Web Page and Paper Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>.

The full text of this rule amendment and the accompanying appendix DD to this rule can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Physical Therapy Services handbook.

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "Physical Therapy Services"; and,
- (3) Selecting this MHTL number from the "Table of Contents" pull-down menu

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar/>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3340-08-01

Medicaid Handbook Transmittal Letter (MHTL) 3340-08-01

January 9, 2008

TO: All Eligible Providers of Physician Services
All Eligible Providers of Physical Therapy Services
All Eligible Providers of Occupational Therapy Services
All Eligible Fee-for-Service Ambulatory Health Care Clinics
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Coverage of Physical Therapy, Occupational Therapy, and Speech-Language Pathology/Audiology Services in Non-Institutional Settings

The following rules and program changes are effective January 1, 2008.

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce policy changes and clarifications regarding Medicaid coverage of physical therapy, occupational therapy, and speech-language pathology/audiology services in non-institutional settings. These policy changes are implemented by:

- The amendment of:
 - Rule **5101:3-4-26** of the Administrative Code, entitled "Covered physical medicine services and rehabilitation services"; and
 - Rule **5101:3-8-01** entitled "Eligible providers of limited practitioner services";
- The rescission of and re-issuance of:
 - **5101:3-8-02** of the Administrative Code, entitled "Covered physical therapy and rehabilitation services and limitations" (to be renamed "Covered physical therapy services and limitations");
- The adoption of new:
 - Rule **5101:3-8-03** of the Administrative Code, entitled "Covered occupational therapy services and limitations";
 - Rule **5101:3-34-01** of the Administrative Code, entitled "Physical therapy, occupational therapy and speech-language pathology/audiology services: general provisions";
 - Rule **5101:3-34-01.1** of the Administrative Code, entitled "Physical therapy, occupational therapy and speech-language pathology/audiology services: definitions";
 - Rule **5101:3-34-01.2** of the Administrative Code, entitled "Physical therapy, occupational therapy and speech-language pathology/audiology services: coverage and limitations"; and
 - Rule **5101:3-34-01.3** of the Administrative Code, entitled "Physical therapy, occupational therapy and speech-language pathology/audiology services: provider claims, billing, payment and reimbursement."

Introduction

These new policies address physical therapy, occupational therapy, and speech-language pathology/audiology services. Mental health, behavioral health, and addiction services are addressed under separate policy.

Skilled Therapy Services:

Physical Therapy

Coverage of physical therapy services does not change with these policies. Currently, physical therapy is covered in a variety of settings. Independently practicing physical therapists are currently a Medicaid provider type. Physical therapy services are proposed to be subject to limits in combination with occupational therapy.

Occupational Therapy

Coverage of occupational therapy services changes with these policies. Currently, occupational therapy is covered only in institutional settings. Independently practicing occupational therapists are not currently a Medicaid provider type. Occupational therapy services are proposed to be covered in non-institutional settings by independently practicing occupational therapists and fee-for-service ambulatory health care clinics. Occupational therapy services are proposed to be subject to limits in combination with physical therapy. Independently practicing occupational therapists are proposed to become a Medicaid provider type.

Speech-Language Pathology and Audiology Services

Coverage of speech-language pathology and audiology services changes with these policies. Speech-language pathology and audiology services are proposed to be subject to limits comparable to limits for physical therapy and occupational therapy.

Purpose of Skilled Therapy Services:

Developmental

Coverage of skilled therapy services for the purpose of developmental delays changes with these policies. Currently, physical therapy and speech language pathology services are covered only if the purpose of the service is to restore the patient to a level of functioning that was lost, such as through injury or illness.

Inclusion of developmental is important for preschool-aged children. "Developmental" describes physical therapy, occupational therapy, and/or speech-language pathology/audiology services provided to individuals aged birth through six years for the purpose of gaining a new level of functionality that the child has not yet achieved, but is expected to achieve, based on age, in accordance with developmental milestones established by the American Academy of Pediatrics. Such services constitute skilled therapy. Skilled therapy does not include services provided by non-licensed persons. Although the development of a maintenance plan is considered part of developmental and rehabilitation therapy services, the services furnished under a maintenance plan are not skilled therapy.

The proposed definition of developmental delay is consistent with the definition proposed by Early Intervention programs, to be effective in 2007. "Developmental delay" is a 1.5 standard deviation or twenty-five percent delay based on the use of an evidence-based tool in one or more areas of development (cognitive, physical communication, social or emotional, and/or adaptive) and/or through informed clinical opinion.

The proposed definition of "developmental milestones" references standards established by the American Academy of Pediatrics. "Developmental milestones," for the purposes of this rule, means the general developmental trends in patients aged birth through six years of age, as developed by the American Academy of Pediatrics (Caring for Baby and Young Child: Birth to Age 5; 4th Edition, American Academy of Pediatrics).

Habilitation

Coverage of skilled therapy services for the purpose of habilitation does not change with these policies. Habilitation services continue to be non-covered services under Medicaid, with the exception of habilitation services provided in an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), or those habilitation services included under a federally approved Home and Community-Based Services (HCBS) waiver that are medically necessary services identified in an enrollee's particular HCBS waiver. "Habilitation" describes the process by which the staff of a facility or agency assists an individual with mental retardation or other developmental disabilities in acquiring those life skills that enable the individual to cope more effectively with the demands of the individual's own person and environment, and in raising the level of the individual's personal, physical, mental, social, and vocational efficiency.

Maintenance

Coverage of skilled therapy services for the purpose of maintenance does not change with these policies. "Maintenance" describes physical therapy, occupational therapy, and/or speech language

pathology/audiology services for the purpose of maintaining a level of functionality. Although the development of a maintenance plan is considered part of developmental and rehabilitation therapy services, the services furnished under a maintenance plan are not skilled therapy.

Rehabilitation

Coverage of skilled therapy services for the purpose of rehabilitation does not change with these policies. "Rehabilitation" means physical therapy, occupational therapy, and/or speech language pathology/audiology services for the purpose of restoring the individual to a level of functionality after a loss of functionality. Such services are considered skilled therapy. Although the development of a maintenance plan is considered part of developmental and rehabilitation therapy services, the services furnished under a maintenance plan are not skilled therapy.

Medical Necessity and Skilled Therapy Services:

Evidence-Based Services

Coverage of evidence-based services is clarified with these policies. Currently, there is no requirement that Medicaid covered services are based on a clearly articulated and empirically-supported theory. A definition for "Evidence-based" is included in this proposed policy.

Licensed Health Care Providers

Coverage of services by licensed and non-licensed health care providers is clarified with these policies. Skilled therapy does not include services provided by non-licensed persons. Services provided by non-licensed persons are not covered by Medicaid.

Providers of Skilled Therapy Services:

Physical Therapists

Inclusion of physical therapists as a Medicaid provider type does not change with these policies. Independently practicing physical therapists are currently recognized as a Medicaid provider type.

Occupational Therapists

Exclusion of occupational therapists as a Medicaid provider type changes with these policies. Independently practicing occupational therapists are proposed to become a Medicaid provider type.

Fee-for-Service Ambulatory Health Care Clinics

Inclusion of fee-for-service ambulatory health care clinics as a Medicaid provider type does not change with these policies. However, these clinics are proposed to be able to submit claims for occupational therapy services.

Access to and Allowable Settings for Skilled Therapy Services:

Non-Institutional Settings

Allowable settings for Medicaid coverage of physical therapy and speech-language pathology/audiology services do not change with these policies. Allowable settings for Medicaid coverage of occupational therapy change with these policies. Currently, occupational therapy is covered only in institutional settings. Occupational therapy services are proposed to be covered in non-institutional settings by independently practicing occupational therapists and fee-for-service ambulatory health care clinics.

Natural Environments

Allowable settings for Medicaid coverage of skilled therapy change with these policies. "Natural environments" is a concept critical to the provision of early intervention services to children aged birth to three. Inclusion of natural environments as an appropriate setting for developmental and rehabilitative services to this age group is critical to care coordination with early intervention providers. "Natural environments," in accordance with part C of the Individuals with Disabilities Education Act (IDEA), Sec. 303.18, means settings that are natural or normal for children, and includes home and community settings in which children without disabilities participate.

Quality Assurance for Skilled Therapy Services:

Requirements for coverage of services are clarified with these policies. For a service to be covered by Medicaid requires the following:

- Prescription for services;
- Patient clinical evaluation and assessment;
- Patient plan of care and treatment, to include specific functional goals and the level/degree of improvement expected (within sixty days for rehabilitative services or within nine months for developmental services);
- Provision of services by or under the direct supervision of a physician or licensed therapist and in accordance with a plan of care and treatment;
- Patient re-evaluation at the conclusion of the period treatment if additional therapy is needed, including development of and instruction regarding a maintenance plan;
- Documentation of all services in the patient 's record; and
- Communication between providers and prescribers, thus promoting continuity of care and establishment of a medical home.

Cost Effectiveness of Skilled Therapy Services:

Requirements for coverage of services are clarified with these policies. For a service to be covered by Medicaid requires the following:

- Services must be provided with the expectation that the patient will attain or make significant progress toward expected milestones (developmental) within a six-month period of treatment or that the patient will be restored to a level of functionality (rehabilitative) within a sixty-day period of treatment. Services will not be covered by Medicaid once a patient demonstrates no progress. If such an expectation does not exist a safe and effective maintenance program may be established.
- Evaluation services cannot be billed more than once per injury or condition. Re-evaluation services cannot be billed more than once per sixty-day period of treatment for rehabilitative services or once per six-month period of treatment for developmental services. The services billed must correspond to the services listed in the documented plan of care and treatment.

Specific Changes to Individual Rules of the Ohio Administrative Code:

Rule 5101:3-4-26 of the Administrative Code, entitled "Covered physical medicine and rehabilitation services," is amended to:

- Reference Chapter 5101:3-34 of the Administrative Code, which describes the Medicaid covered skilled therapy services (physical therapy, occupational therapy, and speech-language pathology/audiology services) in non-institutional settings;
- Add coverage of occupational therapy services; and
- Specify that the Department reimburse physician providers only for skilled therapy services delivered by licensed individuals who are under the direct supervision of a physician.

Rule 5101:3-8-01 of the Administrative Code, entitled "Eligible providers of limited practitioner services," is amended to:

- Add occupational therapists as Medicaid providers authorized to be reimbursed by the Department for occupational therapy services;
- Specify all eligible providers of limited practitioner services as defined in the rule; and
- Clarify that individuals licensed under state law to practice a limited branch of medical care or remedial care are eligible to participate in the Medicaid program provided that the individual is authorized by the Department to be a provider for those services.

Rule 5101:3-8-02 of the Administrative Code, entitled "Covered physical therapy and rehabilitation services and limitations," is rescinded and replaced to:

- Define "direct supervision" in the physical therapist's office, physical therapy group practice, or clinic setting; and
- Reference Chapter 5101:3-34 of the Ohio Administrative Code for more information about Medicaid coverage and limitations of physical therapy services.

Rule 5101:3-8-03 of the Administrative Code, entitled "Covered occupational therapy services and limitations," is a new rule created to:

- Define "direct supervision" in the occupational therapist's office, occupational therapy group practice, or clinic setting;
- Allow occupational therapists that are currently licensed under Chapter 4755. of the Ohio Revised Code and who are working within the scope of their practice as defined by state law to be Medicaid-eligible providers of occupational therapy services; and
- Reference Chapter 5101:3-34 of the Ohio Administrative Code for more information about Medicaid coverage and limitations of occupational therapy services.

Rule 5101:3-34-01 of the Administrative Code, entitled "Physical Therapy, Occupational Therapy and Speech-Language Pathology/Audiology Services: general provisions" is a new rule created to provide introduction to Medicaid covered skilled therapy services (physical therapy, occupational therapy, and speech-language pathology/audiology services) in non-institutional settings.

Rule 5101:3-34-01.1 of the Administrative Code, entitled "Physical therapy, occupational therapy and speech-language pathology/audiology services: definitions," is a new rule created to provide definitions of terms used in describing Medicaid covered skilled therapy services (physical therapy, occupational therapy, and speech-language pathology/audiology services) in non-institutional settings.

Rule 5101:3-34-01.2 of the Administrative Code, entitled "Physical therapy, occupational therapy and speech-language pathology/audiology services: coverage and limitations," is a new rule created to provide a description of the coverage and limitations of Medicaid skilled therapy services (physical therapy, occupational therapy, and speech-language pathology/audiology services) in non-institutional settings.

Rule 5101:3-34-01.3 of the Administrative Code, entitled "Physical therapy, occupational therapy and speech-language pathology/audiology services: provider claims, billing, payment and reimbursement," is a new rule created to outline billing, payment, and reimbursement requirements for Medicaid covered skilled therapy services (physical therapy, occupational therapy, and speech-language pathology/audiology services) in non-institutional settings.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Providers may view current reimbursement rates online by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Paper Distribution:

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:**Office of Ohio Health Plans****Provider Services Section****P.O. Box 1461****Columbus, OH 43216-1461****800-686-1516**

MHTL 3340-02-01

Medicaid Handbook Transmittal Letter (MHTL) 3340-02-01

June 13, 2002

TO: All Providers of Physical Therapy and Rehabilitation Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Physical Therapy And Rehabilitation Services Handbook Issuance

ELIGIBLE PHYSICAL THERAPY AND REHABILITATION PROVIDERS AND COVERAGE REVISIONS EFFECTIVE JULY 1, 2002

- **New Physical Therapy and Rehabilitation Ohio Medicaid Provider Handbook, Chapter 3340**
- **Policy updates and changes**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the issuance of a new consolidated Ohio Medicaid Provider Handbook, Chapter 3340 for providers of physical therapy and rehabilitation services. The rules relating to the policies contained in this handbook are in a proposed status but are scheduled to be effective for services provided on and after July 1, 2002.

The physical therapy handbook will be available on the Department's web site at "<http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>" in July of 2002.

Handbook and Policy Update:

Policy updates and changes are contained in this handbook. The handbook addresses eligibility, covered services and limitations, coverage for services provided by physical therapy assistants under the direct supervision of a physical therapist, documentation requirements and non-covered services for providers of physical therapy services. (PTS.1000)

All sections of the handbook are important and should be read carefully. Of particular note is handbook section PTS.1107 titled "Limitations". (PTS.1100)

- Physical medicine services are limited to thirty dates-of-service per recipient per twelve-month period regardless of the number of modalities or procedures the patient may receive during a visit. The number of units, e.g., modalities or procedures, will no longer be the limiting factor.
- This 30-visit limitation is across all providers and provider types that a recipient receives physical medicine from during the rolling twelve-month period.

Additional Handbook Information

Included in the new handbook, Chapter 3340, is the ODJFS Medicaid Telephone Directory, a listing of ODJFS forms, the Top 15 Commonly Asked Questions and billing instructions.

Health Insurance Portability and Accountability Act (H.I.P.P.A.)

To learn more about H.I.P.P.A., there has been a web site created by Ohio's statewide H.I.P.P.A. committee. Please check the following web site address for educational materials including an awareness brochure: * <http://www.state.oh.us/hipaa/educationalmaterials.htm>

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
The Provider Network Management section
P.O. Box 1461
Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

**The URL cited above was corrected, the hard copy contains a minor error (...us.hippa/...).*

MHTL 3340-02-01

Medicaid Handbook Transmittal Letter (MHTL) 3340-02-01

June 13, 2002

TO: All Providers of Physical Therapy and Rehabilitation Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Physical Therapy And Rehabilitation Services Handbook Issuance

ELIGIBLE PHYSICAL THERAPY AND REHABILITATION PROVIDERS AND COVERAGE REVISIONS EFFECTIVE JULY 1, 2002

- **New Physical Therapy and Rehabilitation Ohio Medicaid Provider Handbook, Chapter 3340**
- **Policy updates and changes**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the issuance of a new consolidated Ohio Medicaid Provider Handbook, Chapter 3340 for providers of physical therapy and rehabilitation services. The rules relating to the policies contained in this handbook are in a proposed status but are scheduled to be effective for services provided on and after July 1, 2002.

The physical therapy handbook will be available on the Department's web site at "<http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>" in July of 2002.

Handbook and Policy Update:

Policy updates and changes are contained in this handbook. The handbook addresses eligibility, covered services and limitations, coverage for services provided by physical therapy assistants under the direct supervision of a physical therapist, documentation requirements and non-covered services for providers of physical therapy services. (PTS.1000)

All sections of the handbook are important and should be read carefully. Of particular note is handbook section PTS.1107 titled "Limitations". (PTS.1100)

- Physical medicine services are limited to thirty dates-of-service per recipient per twelve-month period regardless of the number of modalities or procedures the patient may receive during a visit. The number of units, e.g., modalities or procedures, will no longer be the limiting factor.
- This 30-visit limitation is across all providers and provider types that a recipient receives physical medicine from during the rolling twelve-month period.

Additional Handbook Information

Included in the new handbook, Chapter 3340, is the ODJFS Medicaid Telephone Directory, a listing of ODJFS forms, the Top 15 Commonly Asked Questions and billing instructions.

Health Insurance Portability and Accountability Act (H.I.P.P.A.)

To learn more about H.I.P.P.A., there has been a web site created by Ohio's statewide H.I.P.P.A. committee. Please check the following web site address for educational materials including an awareness brochure: * <http://www.state.oh.us/hipaa/educationalmaterials.htm>

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
The Provider Network Management section
P.O. Box 1461
Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

**The URL cited above was corrected, the hard copy contains a minor error (...us.hippa/...).*

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

[Click here to view MHTL 3334-10-02, New 2010 HCPCS and CPT Codes and Policy Updates](#)

MHTL 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01), is maintained in the General Information e-book.

[Click here to view MHTL 3334-09-02, Discontinuing the Disability Medical Assistance \(DMA\) Program and the Rescission of Ohio Administrative Code \(OAC\) Rule 5101:3-23-01](#)

Therapy Services Program Rules

[MHTL 3334-13-11](#)

Effective Date: January 1, 2014

- (A) Rules 5160-8-31 to 5160-8-34 of the Administrative Code set forth provisions governing payment for skilled therapies as non-institutional professional services. Provisions governing payment for skilled therapies as the following service types are set forth in the indicated part of the Administrative Code:
- (1) Hospital services, Chapter 5160-2;
 - (2) Nursing facility services, Chapter 5160-3;
 - (3) Home health services, Chapter 5160-12;
 - (4) Clinic services rendered by the following providers:
 - (a) Fee-for-service ambulatory health care clinics, Chapter 5160-13;
 - (b) Rural health clinics, Chapter 5160-16;
 - (c) Federally qualified health centers, Chapter 5160-28; or
 - (d) Outpatient health facilities, Chapter 5160-29;
 - (5) Medicaid school program services, Chapter 5160-35; and
 - (6) Intermediate care facility services, Chapter 5123:2-7.
- (B) The following definitions apply to rules 5160-8-31 to 5160-8-34 of the Administrative Code:
- (1) "Audiologist" is a person who holds a valid license as an audiologist under Chapter 4753. of the Revised Code.
 - (2) "Audiology aide" is a person who holds a valid license as an audiology aide under Chapter 4753. of the Revised Code.
 - (3) "Developmental services" are skilled therapy services rendered, in accordance with developmental milestones established by the American academy of pediatrics, to enable individuals younger than seven years of age to attain a level of age-appropriate functionality that they have not yet achieved but are expected to achieve.
 - (4) "Developmental disability" has the same meaning as in section 5123.01 of the Revised Code.
 - (5) "Eligible provider" has the same meaning as in rule 5160-1-17 of the Administrative Code.
 - (6) "Maintenance services" are skilled therapy services rendered to individuals for the purpose of maintaining but not improving functionality.
 - (7) "Mechanotherapist" is a person who holds a valid license as a mechanotherapist under Chapter 4731. of the Revised Code and works within the scope of practice defined by state law.
 - (8) "Non-institutional setting" is a location that is not a hospital or long-term care facility and that is appropriate to the delivery of skilled therapy services. Examples include but are not limited to practitioners' offices, clinics, licensed child day care centers, adult day care centers, and public facilities such as community centers.
 - (9) "Occupational therapist" is a person who holds a valid license as an occupational therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.
 - (10) "Occupational therapy" has the same meaning as in section 4755.04 of the Revised Code.
 - (11) "Occupational therapy assistant" is a person who holds a valid license as an occupational therapy assistant under Chapter 4755. of the Revised Code.

- (12) "Physical therapist" is a person who holds a valid license as a physical therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.
- (13) "Physical therapist assistant" is a person who holds a valid license as a physical therapist assistant under Chapter 4755. of the Revised Code.
- (14) "Physical therapy" has the same meaning as in section 4755.40 of the Revised Code.
- (15) "Rehabilitative services" are skilled therapy services rendered to individuals for the purpose of improving functionality.
- (16) "Skilled therapist" is a collective term encompassing physical therapist, occupational therapist, speech-language pathologist, and audiologist.
- (17) "Skilled therapy" is a collective term encompassing physical therapy, occupational therapy, speech-language pathology, and audiology.
- (18) "Speech-language pathologist" is a person who holds a valid license as a speech-language pathologist under Chapter 4753. of the Revised Code.
- (19) "Speech-language pathology aide" is a person who holds a valid license as a speech-language pathology aide under Chapter 4753. of the Revised Code.
- (20) "Standardized test" is a diagnostic tool or procedure that has a standardized administration and scoring process, the results of which can be compared to an appropriate normative sample. Standardized tests must be norm-referenced, age-appropriate, and specific to areas of deficit.
- (21) "Supplemental test" is a non-diagnostic screening or criterion-referenced tool that is used to provide further documentation of deficits and to corroborate the results of a standardized test. A supplemental test may not be used in place of a standardized test.

Replaces: Part of 5160-34-01.1, part of 5160-34-01.2

Effective: 01/01/2014

R.C. 119.032 review dates: 01/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 12/20/2013

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5164.06, 5164.70

Prior Effective Dates: 01/01/2008

[MHTL 3334-13-11](#)

Effective Date: January 1, 2014

(A) Rendering providers.

- (1) Independently practicing skilled therapists either must participate in the medicare program or, if they limit their practice to pediatric treatment and do not serve medicare beneficiaries, must meet all other requirements for medicare participation.
- (2) The following eligible providers may render a physical therapy service:
 - (a) A physical therapist;
 - (b) A physical therapist assistant who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider;
 - (c) A physical therapy student who is completing an internship, if the following conditions are met:
 - (i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy;
 - (ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;
 - (iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and
 - (iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met; or
 - (d) A mechanotherapist.
- (3) The following eligible providers may render an occupational therapy service:
 - (a) An occupational therapist;
 - (b) An occupational therapy assistant who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider; or
 - (c) An occupational therapy student who is completing an internship, if the following conditions are met:
 - (i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy;
 - (ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;
 - (iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and
 - (iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met.
- (4) The following eligible providers may render a speech-language pathology service:
 - (a) A speech-language pathologist;

- (b) A speech-language pathology aide who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider;
- (c) A speech-language pathology student who is completing an internship, if the following conditions are met:
 - (i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy;
 - (ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;
 - (iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and
 - (iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met; or
- (d) A person holding a conditional license to practice speech-language pathology, if the eligible provider supervising the professional experience keeps on file a copy of the conditionally-licensed speech-language pathologist's plan of supervised professional experience, required by section 4753.071 of the Revised Code.

(5) The following eligible providers may render an audiology service:

- (a) An audiologist;
- (b) An audiology aide who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider;
- (c) An audiology student who is completing an internship, if the following conditions are met:
 - (i) The student provides the service under the supervision of the eligible provider responsible for the patient's therapy;
 - (ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;
 - (iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and
 - (iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met; or
- (d) An audiology student who is completing an externship, if the following conditions are met:
 - (i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy; and
 - (ii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the externship, including the beginning and ending dates.

(B) Billing ("pay-to") providers.

- (1) The following eligible providers may receive medicaid payment for submitting a claim for a skilled therapy service on behalf of a rendering provider:
 - (a) A hospital, rules for which are set forth in Chapter 5160-2 of the Administrative Code;
 - (b) A provider of physician services, rules for whom are set forth in Chapter 5160-4 of the Administrative Code;

- (c) A professional medical group;
 - (d) An ambulatory health care clinic, rules for which are set forth in Chapter 5160-13 of the Administrative Code;
 - (e) A rural health clinic, rules for which are set forth in Chapter 5160-16 of the Administrative Code;
 - (f) A federally qualified health center, rules for which are set forth in Chapter 5160-28 of the Administrative Code; or
 - (g) An outpatient health facility, rules for which are set forth in Chapter 5160-29 of the Administrative Code.
- (2) The following eligible providers may receive medicaid payment either for rendering a skilled therapy service themselves or for submitting a claim for a skilled therapy service on behalf of a rendering provider:
- (a) A skilled therapist; or
 - (b) A mechanotherapist.

Replaces: Part of 5160-8-01, part of 5160-8-02, part of 5160-8-03, part of 5160-34-01.2

Effective: 01/01/2014

R.C. 119.032 review dates: 01/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 12/20/2013

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5164.06, 5164.70

Prior Effective Dates: 04/07/1977, 09/19/1977, 12/21/1977, 12/30/1977, 07/01/2002, 01/01/2008

[MHTL 3334-13-11](#)

Effective Date: January 1, 2014

- (A) Payment may be made for a skilled therapy service if the following conditions are met:
- (1) The service is medically necessary, in accordance with rule 5160-1-01 of the Administrative Code.
 - (2) The service is rendered on the basis of a clinical evaluation and assessment and in accordance with a treatment plan. (Audiology must meet this condition in order to be considered skilled therapy for purposes of this chapter.) The performance of a clinical evaluation and assessment and the development of a treatment plan are discrete services; payment for them is made separately from payment for skilled therapy. The clinical evaluation and assessment and the treatment plan are described in rule 5160-8-33 of the Administrative Code; copies must be kept on file by the provider.
 - (3) The amount, frequency, and duration of treatment is reasonable. For rehabilitative services, the maximum treatment period without reevaluation is sixty days; for developmental services, the maximum treatment period without reevaluation is six months.
- (B) The following limitations and additional requirements are placed on the provision of skilled therapy services:
- (1) For dates of service January 1, 2014, and after, payment for skilled therapy services rendered without prior authorization in a non-institutional setting is subject to the following limits:
 - (a) For physical therapy services, a total of no more than thirty visits per benefit year;
 - (b) For occupational therapy services, a total of no more than thirty visits per benefit year; and
 - (c) For speech-language pathology and audiology services, a total of no more than thirty visits per benefit year.
 - (2) Payment for additional skilled therapy visits in a non-institutional setting can be requested through the prior authorization process, which is described in Chapter 5160-1 of the Administrative Code.
 - (3) For each type of skilled therapy, payment for evaluation services can be made not more than once per injury or condition.
 - (4) For each type of skilled therapy, payment for reevaluation of rehabilitative services cannot be made more often than once every sixty days.
 - (5) For each type of skilled therapy, payment for reevaluation of developmental services cannot be made more often than once every six months.
 - (6) No payment is made for the following services as skilled therapy:
 - (a) Services reported on a claim submitted by an entity that neither is nor acts on behalf of an eligible provider of skilled therapy services;
 - (b) Services not rendered by nor under the supervision of a physician or skilled therapist;
 - (c) Services that do not meet current accepted standards of practice;
 - (d) Services rendered in a non-approved location;
 - (e) Additional rehabilitative services for a patient who fails to demonstrate progress within a sixty-day treatment period;
 - (f) Additional developmental services for a patient who fails to demonstrate progress within a six-month treatment period;

(g) Consultations with family members or other non-medical personnel; and

(h) Services rendered in non-institutional settings and listed as non-covered in rule 5160-4-28 or in appendix DD to rule 5160-1-60 of the Administrative Code.

Replaces: Part of 5160-34-01.2

Effective: 01/01/2014

R.C. 119.032 review dates: 01/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 12/20/2013

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5164.06, 5164.70

Prior Effective Dates: 01/01/2008

MHTL 3334-13-11**Effective Date: January 1, 2014**

- (A) A clinical evaluation and assessment of the need for skilled therapy services includes the following elements:
- (1) A diagnosis of the type and severity of the disorder or a description of the deficit in physical or sensory functionality;
 - (2) A review of the individual's current physical, auditory, visual, motor, and cognitive status;
 - (3) A case history, including, when appropriate, family perspectives on the individual's development and capacity to participate in therapy;
 - (4) The outcomes of standardized tests and any non-standardized tests that use age-appropriate developmental criteria;
 - (5) Other test results and interpretation;
 - (6) An evaluation justifying the provision of skilled therapy services, which may be expressed as one of two prognoses of the patient's rehabilitative or developmental potential:
 - (a) The patient's functionality is expected to improve within sixty days after the evaluation because of the delivery of rehabilitative skilled therapy services or within six months after the evaluation because of the delivery of developmental skilled therapy services, and the patient is expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months; or
 - (b) The patient is not expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months, but a safe and effective maintenance program may be established; and
 - (7) Any recommendations for further appraisal, follow-up, or referral.
- (B) A treatment or maintenance plan for skilled therapy services is based on the clinical evaluation and assessment. It should be coordinated, when appropriate, with services provided by non-medicaid providers or programs (e.g., child welfare, child care, or prevocational or vocational services), and it should provide a process for involving the patient or the patient's representative in the provision of services. A complete treatment or maintenance plan includes the following elements:
- (1) The patient's relevant medical history;
 - (2) Specification of the amount, duration, and frequency of each skilled therapy service to be rendered; the methods to be used; and the areas of the body to be treated;
 - (3) A statement of specific functional goals to be achieved, including the level or degree of improvement expected within the appropriate time period;
 - (4) The date of each treatment;
 - (5) The signature of the practitioner responsible for the treatment plan;
 - (6) Documentation of participation by the patient or the patient's representative in the development of the plan;
 - (7) Specific timelines for reevaluating and updating the plan;
 - (8) A statement of the degree to which the patient has made progress; and
 - (9) A recommendation for one of several courses of action:
 - (a) The development of a new or revised treatment plan;
 - (b) The development of a maintenance plan; or

(c) The discontinuation of treatment.

Replaces: Part of 5160-34-01.2

Effective: 01/01/2014

R.C. 119.032 review dates: 01/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 12/20/2013

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5164.06, 5164.70

Prior Effective Dates: 01/01/2008

[MHTL 3340-14-01](#)

Effective Date: July 31, 2014

Most Current Prior Effective Date: [January 1, 2014](#)

- (A) If more than one skilled therapy service ~~of the same type~~ of the same discipline (e.g., physical therapy) is rendered by the same a non-institutional provider or provider group to ~~an individual patient~~ a recipient on the same date, then the service with the highest payment amount specified in appendix DD to rule 5160-1-60 of the Administrative Code is considered ~~to be~~ the primary procedure. The maximum ~~fee~~ payment amount for a skilled therapy service is the lesser of the provider's submitted charge or a percentage of the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code, determined in the following manner:
- (1) For ~~a single skilled therapy service or~~ the first unit of a primary procedure, ~~it is~~ one hundred per cent.
 - (2) For each additional unit or procedure within the same therapy discipline, ~~it is fifty~~ eighty per cent.
- (B) Services reported on claims must correspond to the services listed in the treatment plan.
- (C) Providers must report appropriate procedure codes and modifiers on claims.
- (D) Unattended electrical stimulation and iontophoresis therapy are considered to be part of the associated therapy procedure or medical encounter; no separate payment is made.
- (E) Skilled therapy performed during ~~a~~ an inpatient hospital stay is treated as a hospital service.
- (F) Payment for skilled therapy services rendered to a resident of a nursing facility (NF) is made to the NF through the facility per diem payment mechanism. A non-institutional provider that renders a skilled therapy service to a NF resident must seek payment from the NF.

Effective: 07/31/2014

R.C. 119.032 review dates: 01/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 07/21/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5164.06, 5164.70, 5165.47

Prior Effective Dates: 01/01/2008, 07/31/2009 (Emer), 10/29/2009, 01/01/2014

Billing Instructions

Click [here](#) to view the Billing instructions eManual.

Notice

A Physical Therapy provider handbook is currently not available.

Below please find Ohio Administrative Code (OAC) rules regarding Physical Therapy and links to the OAC (found in the Legal Services collection) regarding all limited practitioners.