



**CHAPTER 515 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR
OCCUPATIONAL/PHYSICAL THERAPY SERVICES**

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 515.1	Definitions	02/08/05	05/01/05
Section 515.6	Non-Covered Services and Documentation Requirements	02/08/05	05/01/05
Section 515.8	School Services vs. Private Practitioners	02/08/05	05/01/05
Section 515.9	Billing and Reimbursement	02/08/05	05/01/05
Attachment 1	Occupational / Physical Therapy Services Covered by WV Medicaid	01/01/05	05/01/05
Attachment 2	Occupational/Physical Therapy Services Prior Authorization Form with Header page	10/01/04	11/01/04

**CHAPTER 515 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR
OCCUPATIONAL/PHYSICAL THERAPY SERVICES**

FEBRUARY 8, 2005

SECTION 515.1

Introduction: Clarification of definition.

Change: Removed the word “or” and replaced with “and” in the definition of Physical Therapist.

Directions: Replace old pages with new pages.



SECTION 515.6

Introduction: Rewritten to provide more clarity.

Change: Deleted text – “when rendered by a therapist in independent practice” from second sentence in first paragraph.

Deleted sixth bullet regarding *Occupational/Physical Therapy services rendered in the school system.*

Added wording to seventh bullet – Occupational / physical therapy services will not be authorized for members who have reached maximum rehab potential

Deleted text, “such as the evaluation or another modality,” from the ninth bullet.

Directions: Replace old pages with new pages.

SECTION 515.8

Introduction: Added section to coincide with WV Department of Education regulations regarding services available in schools.

Change: Re-number section and create new heading “School Services vs. Services Provided by Private Practitioners.”

Directions: Replace old pages with new pages.

SECTION 515.9

Introduction: Changes made for formatting and clarification

Change: Section re-numbered and change heading to Billing and Reimbursement

Directions: Replace old pages with new pages.

JANUARY 1, 2005

ATTACHMENT 1

Introduction: 1) Reformatted the entire section for better clarity.

2) Procedure code 97601 has been replaced with 97597 and 97598 and included in with the codes that have a 20 unit limit.

Directions: Attachment 1 in this section supercedes previous policy.

Change: Replace old pages with new pages.



OCTOBER 1, 2004

ATTACHMENT 2

Introduction: This section has been updated and reformatted.

Directions: Attachment 2 in this section supercedes previous policy.

Change: Replace old pages with new pages.



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EXCLUSIONS FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES
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CHAPTER 515—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR OCCUPATIONAL/PHYSICAL THERAPY SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program covers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible beneficiaries. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

WV Medicaid covers certain occupational therapy and physical therapy services when provided in an outpatient setting, ordered by a licensed attending physician, and furnished by or under the direct supervision of a qualified occupational or physical therapist.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the WV Code. The BMS (BMS) in the WV Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the WV Medicaid Program.

515.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200. In addition, the following definitions also apply to the requirements for payment of the services described in this chapter.

Modality – any physical agent supplied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical or electric charge.

Occupational Therapist - a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association (AMA) and the American Occupational Therapy Association and is licensed or registered in the State in which he or she practices.

Occupational Therapy Assistant - an Associate of Arts graduate employed by and under the direct supervision of an Occupational Therapist and is licensed by the Board of Occupational Therapy in the State in which he/she practices.

Physical Therapist - a graduate of a program of physical therapy approved by the American Physical Therapy Association and the Committee on Allied Health Education and Accreditation of the AMA, and is licensed or registered in the State in which he or she practices.

Physical Therapy Assistant – an Associates of Arts graduate under the direct supervision of a Physical Therapist and licensed by the Board of Physical Therapy in the State he/she practices.



515.2 PROVIDER ENROLLMENT REQUIREMENTS

Occupational and Physical Therapists in private practice that wish to participate in the WV Medicaid Program must meet the general enrollment requirements in Chapter 300.

515.3 COVERED THERAPY SERVICES

Attachment 1 is a list the occupational / physical therapy services that are covered by WV Medicaid. To be covered, occupational and physical therapy services must be ordered by a participating physician or nurse practitioner and provided by or under the direction of a registered licensed occupational /physical therapist on an outpatient basis.

“Under the direction of” means that the therapist is on the premises when the services are rendered and is available for any emergency or question that may arise. As circumstances permit, the therapist must be involved in patient education, including but not limited to, teaching the patient exercise, manipulation, and how to use devices for their own rehabilitation.

Continuous progress/improvement must be documented for coverage of therapy. The member must show compliance with therapy and the home regimen plan. Continuation of services may be considered, when an exacerbated episode of a chronic condition is clearly documented; otherwise chronic conditions are non-covered.

It is the responsibility of the service provider to verify Medicaid eligibility before individual receives services. Gaps in Medicaid eligibility may occur, with an individual ineligible for Medicaid coverage at the time of a specific treatment. Therefore, it is recommended that the therapist review the individual’s medical care before provision of each service. PRIOR AUTHORIZATION does NOT guarantee payment. The individual receiving services must be eligible when the service is provided regardless of prior authorization.

IMPORTANT: *The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider’s responsibility to verify Medicaid eligibility before services are provided.*

515.3.1 INITIAL SESSIONS

For Medicaid payment purposes, prior authorization is not required for members who need no more than 20 occupational / physical therapy visits during a calendar year, in addition to the evaluation and re-evaluation. This benefit is for each member, per calendar year.

Attachment 1 - list the valid procedure codes for occupational /physical therapy services. Certain service limitations and regulations do apply.

515.4 PRIOR AUTHORIZATION

Prior authorization (PA) is required when service limits exceed the Medicaid limit defined in 515.3.1. Service limits for occupational/physical therapy services are 20 visits in a calendar year. One visit may include any combination of occupational/physical therapy procedures performed on the same day, excluding the evaluation and re-evaluation codes.



For payment purposes, prior approval must be obtained before therapy is continued. However, prior authorization does not necessarily mean that WV Medicaid will pay for the services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) in order for a qualified therapist to provide a member with more than 20 occupational / physical therapy sessions during the calendar year. The WVMI can be called at (304) 346-9167, option 5 or faxed at 304-346-8185. Their mailing address is:

WV Medical Institute
Occupational / Physical Therapy Review
3001 Chesterfield Avenue, S.E.
Charleston, WV 25304

Attachment 2 is a copy of the prior authorization request form. At a minimum, the therapist must submit the following information to the WVMI for its determination of whether to approval occupational or physical therapy services beyond the service limits:

- Signed written physician's prescription, including diagnosis
- A patient summary that includes:
 1. A description of the treatment already provided including the number of session and the modalities utilized.
 2. A description of the progress the patient has made toward short and long term treatment goals.
 3. A summary of the continuing treatment plan, including the number and frequency and duration of session, proposed modalities, and special equipment needed.
 4. A statement indicating whether the patient is able to reach the functional goals by consistent application of the home program, using equipment available at home or with assistance of a trained or non-professional friend or relative.

515.5 MANAGED CARE

If a Medicaid member is a member of an HMO, occupational and physical services must be prior authorized in accordance with the particular HMO's prior authorization requirements. If the member is a member of the PAAS Program, the service must be authorized by the member's PCP. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met.

515.6 NON-COVERED SERVICES

WV Medicaid does not cover the following occupational / physical therapy services.

- Occupational / physical therapy services that are rendered to an inpatient in a hospital, skilled nursing facility, or other facility.



- Occupational / physical therapy services in excess of 20 visits provided for chronic conditions, such as arthritis, cerebral palsy, and developmental delay.
- More than 20 outpatient occupational / physical therapy visits during a calendar year, unless approved in advance by the BMS or Utilization Management Agency (UMA)
- Occupational / physical therapy services furnished to persons who are not eligible for such services on the date the services are rendered
- Occupational / physical therapy services furnished by persons who are not licensed or certified and enrolled in the WV Medicaid Program.
- Occupational / physical therapy services paid to therapists in private practice when rendered in the school system.
- Occupational / physical therapy services will not be authorized for members who have reached maximum rehabilitation potential
- Unsupervised care rendered by an occupational / physical therapist aide or assistant
- Separate payment for hot or cold packs (CPT 97010). Payment for this code has been bundled into the payment for other services.
- Experimental services or drugs.

515.7 DOCUMENTATION REQUIREMENTS

Documentation in the therapist's records must contain at least the following information about the occupational / physical therapy that a member received:

- Diagnosis—the diagnosis must substantiate the patient's need for occupational or physical therapy. A brief description of the patient's medical condition may be necessary
- Date of injury or onset of illness, if applicable
- Name and Medicaid provider number of the physician prescribing the occupational or physical therapy
- Dates of each therapy session—beginning date and ending date
- Name of the registered therapist and facility providing the therapy
- Copy of the Individualized Education Plan if a school-age member needs occupational therapy or physical therapy, if applicable.

Documentation of the services provided on the date billed must substantiate fully the amounts charged to the Medicaid Program. The records must be clear and concise and include the physician's prescription. Documentation must be made available upon request to the BMS or its representative.

515.8 SCHOOL SERVICES VS. SERVICES PROVIDED BY PRIVATE PRACTITIONERS

Parents have the freedom to choose services from Medicaid providers outside the school system. However, West Virginia cannot cover this duplication of services, that is, pay claims for the same services provided in the school system and also outside the school system by private



practitioners for the same Medicaid member. Therefore, the parent/guardian must notify the school district to not seek Medicaid reimbursement for the relevant services.

If parents do not want the county boards of education to seek reimbursement through Medicaid, they must notify the Regional Educational Services Agency or the local education Agency in writing. A copy of the letter must be attached to the request for prior approval submitted to the West Virginia Medical Institute by the private practitioner chosen to provide the services.

When school is not in session, continuation of therapy services, if necessary, should be coordinated with a qualified therapist in private practice. The treatment plan established by the school system should be written in a way that the private practitioner can pick up where the school therapist ended.

515.9 BILLING AND REIMBURSEMENT

General billing requirements and procedures are discussed in Chapter 600. Direct billing by therapists is required using the professional claim format, ASC X12N 837 (004010X098A1) for electronic or CMS -1500 paper claims.

Occupational and physical therapy services provided in an outpatient hospital setting are billed using the Institutional format, ASCX12N 837 (004010X096A1) or the UB92 paper claim. The following revenue codes are required for billing occupational and physical therapy services:

Occupational therapy:	Evaluation	0434
	Reevaluation	0439
	Therapy Procedures	0430,0431
Physical therapy:	Evaluation	0424
	Reevaluation	0429
	Therapy procedures	0420, 0421

The Medicaid payment amount equals the lower of the provider’s usual and customary charges or the RBRVS fee. The claim can not be submitted until the service has been rendered.

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OCCUPATIONAL/PHYSICAL THERAPY SERVICES
JULY 1, 2004

ATTACHMENT 1
OCCUPATIONAL/PHYSICAL THERAPY SERVICES
COVERED BY WEST VIRGINIA MEDICAID

REVISED MAY 1, 2005

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Procedure Code Listing

Billable services for Occupational and Physical Therapists.

Neurology and Neuromuscular Procedures

CPT Code	Description	Service limits
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	1 daily
95832	Muscle testing, manual separate procedure with report, hand, with or without comparison with normal side.	1 daily
95833	Muscle testing, manual separate procedure with report, total evaluation of body, excluding hand.	1 daily
95834	Muscle testing, manual separate procedure with report, total evaluation of body, including hands.	1 daily
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).	1 daily
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side.	1 daily

Evaluation Services

CPT Code	Description	Services limits
97001	Physical therapy evaluation.	1 per calendar year
97002	Physical therapy re-evaluation.	2 per calendar year
97003	OT evaluation	1 per calendar year
97004	OT re-evaluation	2 per calendar year

Other Services

For the occupational/physical therapy services listed below the service limits are 20 visits/dates of services in a calendar year. One visit may include any combination of the following occupational/physical therapy services listed below. Services exceeding the limit will require PA from the UMA, who will issue the prior authorization based on the code and service units.

CPT Code	Description
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices

97018	Application of a modality to one or more areas; paraffin bath
97020	Application of a modality to one or more areas; microwave
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039*	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139*	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (eg. Mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive response to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with / without suction, sharp selective debridement with scissors, scalpel and forceps), with or with out topical applications(s), wound assessment, and instructions(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 sq. centimeters.

97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with / without suction, sharp selective debridement with scissors, scalpel and forceps), with or with out topical applications(s), wound assessment, and instructions(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 sq centimeters.
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97799*	Unlisted physical medicine/rehabilitation service or procedure.

* Prior authorization required

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JULY 1, 2004

ATTACHMENT 2
PRIOR AUTHORIZATION REQUEST FORM FOR
OCCUPATIONAL / PHYSICAL THERAPY SERVICES
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**OCCUPATIONAL/ PHYSICAL THERAPY SERVICES
PRIOR AUTHORIZATION REQUEST FORM**

WEST VIRGINIA MEDICAL INSTITUTE (WVMI), 3001 Chesterfield Place, Charleston, WV 25304
PHONE: 1-800-982-6334: Opt. 5 FAX: 1-877-762-4338 or 1-304-346-8185

Date: ___/___/___ Patient's name: _____ DOB: ___/___/___

Patient Address: _____

Street City State Zip

Medicaid Identification Number: _____

A. Date & history of onset of illness, injury or surgical procedure: _____

B. Diagnosis with ICD-9 codes:

1. Primary _____

2. Secondary _____

C. Subjective Complaints:

1. _____ 2. _____

3. _____ 4. _____

D. Objective Findings: _____

E. Treatment Plan: _____

Page 2 of 2 (Continue) Patient's name: _____

F. Short-Term Goals: (With expected dates that goals are to be met) _____

G. Long-Term Goals: (With expected dates that goals are to be met) _____

H. Prognosis: _____

I. Progress notes of past treatments and dates of service for the past calendar year _____

J. Frequency of requested visits:

1. Original start of care date: _____

2. This request is for _____ Treatments: For period _____ to _____

3. Treatments are to be rendered _____ Time per week for _____ weeks

4. Requested CPT procedure code: _____

5. How many units of OT/PT has the patient had this calendar year? _____

K. Ordering Physician's Name: _____ Phone #: _____

L. Treating Therapist's Name: _____ Fax #: _____

Phone #: _____

M. Therapist's Medicaid provider number _____

NOTE: The therapist must obtain prior authorization before rendering treatment beyond Medicaid's service limits.

Physician's order and copy of *initial* evaluation must be attached to this form

PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT

It is the provider's responsibility to verify eligibility by the Medicaid card or calling

Unisys 1-888-483-0793 or 304-348-3360.