KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

Rehabilitative Therapy Services

- Physical Therapy
- Occupational Therapy
- Speech/Language Pathology
**PART II**  
**REHABILITATIVE THERAPY PROVIDER MANUAL**

**Introduction**

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**BENEFITS AND LIMITATIONS**

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**FORMS**

All forms pertaining to this provider manual can be found at the following link, [https://www.kmap-state-ks.us/Public/forms.asp](https://www.kmap-state-ks.us/Public/forms.asp).

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PART II

REHABILITATIVE THERAPY PROVIDER MANUAL

Issued 09/09

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

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

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

Note: Although coverage is available for physical or occupational therapy services rendered by independent practitioners, no similar coverage exists for speech/language services furnished by a speech pathologist as an independent practitioner. The services of speech/language pathologists may be billed by providers such as rehabilitation agencies, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), hospices, outpatient departments of hospitals, and suppliers such as physicians, NPPs, physical and occupational therapists in private practice.

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

HIPAA Compliance

As a participant in the KHPA Medical Plans, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general’s office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider must not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.
7000. REHABILITATIVE THERAPY BILLING INSTRUCTIONS  Issued 09/09

Introduction to the CMS-1500 Claim Form

Physical and occupational therapy providers must use the CMS-1500 red claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under the KHPA Medical Plans. Any claim not submitted on the red claim from will be returned to the provider. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.


The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to the Form Reordering section in the introduction of the General Billing Provider Manual.

SUBMISSION OF CLAIM

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

KHPA Medical Plans  
Office of the Fiscal Agent  
P.O. Box 3571  
Topeka, Kansas  66601-3571
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Issued 09/09

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

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

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

8300. Benefit Plans  Issued 09/09

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

8400. MEDICAID Issued 09/09

All therapy services must be prescribed by a physician.

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

Rehabilitative – All therapies must be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or illness.

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

Therapy treatments are not covered for psychiatric diagnoses.

Providers of rehabilitative therapy can submit claims with a combination of the following rehabilitation therapy procedure codes and a diagnosis code in the range of V57.0-V57.9 as the primary diagnosis. Providers are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when one of these V-codes is billed as a primary diagnosis.

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Provider Requirements

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

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

Occupational therapy services are those services provided within the scope of practice of
occupational therapists (OTs) and necessary for the diagnosis and treatment of impairments,
functional disabilities or changes in physical function and health status.

Occupational therapy is medically prescribed treatment concerned with improving or restoring
functions which have been impaired by illness or injury or where function has been
permanently lost or reduced by illness or injury to improve the individual’s ability to perform
those tasks required for independent functioning. A qualified OT is an individual who is
licensed by the Kansas Board of Healing Arts or jurisdiction in which the service is provided.
Occupational therapy services may also be provided by an occupational therapy assistant
(OTA) working under the supervision of an OT.

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

Procedure Codes

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

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

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

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

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

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

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

Autoauthentication (computerized authentication) of documentation for the medical record is acceptable as long as it meets federal guidelines. Federal regulation 42CFR 482.24 (c) (1) (i) requires there be a method for determining whether the individual authenticated the document after transcription. All entries must be legible and complete. Entries must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for providing the service. The author of each entry must be identified and authenticate his or her entry. Authentication may include the author's signature, written initials or computer entry.

If services were performed by a certified therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the registered PT or OT initialing each treatment note written by a certified therapy assistant or the registered PT or OT writing “Treatment was supervised” followed by his or her signature.

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

Limitations

Therapy services are limited to six months for non-KAN Be Healthy (KBH) participants per injury or illness, to begin at the discretion of the provider. There are no limitations for medically necessary services for KBH participants. Traumatic brain injury (TBI) beneficiaries may receive six months of therapy services as a state plan benefit. When state benefit plan services are exhausted, TBI beneficiaries may receive additional rehabilitative therapy services content of the TBI waiver.
Vacuum Assisted Wound Closure Therapy

Vacuum assisted wound closure therapy is covered for specific benefit plans. Prior authorization is required and criteria must be met. Refer to the DME Provider Manual for criteria. For questions about service coverage for a given benefit plan, contact the KMAP Customer Service Center at 1-800-933-6593 or 785-274-5990. All prior authorization must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.