INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

# Therapy Services

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# Revision History

| Version | Date | Reason for Revisions | Completed By |
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| 1.0 | Policies and procedures as of Oct. 1, 2015<br>Published: Feb. 25, 2016 | New document | FSSA and HPE |
| 1.1 | Policies and procedures as of April 1, 2016<br>Published: Aug. 25, 2016 | Scheduled update | FSSA and HPE |
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| 7.0 | Policies and procedures as of July 1, 2024<br>Published: Nov. 27, 2024 | Scheduled update:<br>• Edited text as needed for clarity<br>• Updated initial note to include PathWays<br>• Changed speech pathology references to speech-language pathology<br>• Clarified that initial evaluations that do not require PA are limited to one per 12-month period<br>• Added NPWT reference in the *Introduction* section<br>• Added note regarding *Medicaid Therapy Services Prior Authorization Checklist* to the *Prior Authorization for Therapy Services* section | FSSA and Gainwell |

| Version | Date | Reason for Revisions | Completed By |
|---|---|---|---|
| | | • Updated the *Billing and Reimbursement of Therapy Services* section and subsections:<br>– *Occupational Therapy Services*<br>– *Physical Therapy Services*<br>– *Speech-Language Pathology Services*<br>• Removed the procedure codes from the *Hippotherapy* and *Cognitive Rehabilitation Therapy for Traumatic Brain Injury* sections and included a reference to the online *Therapy Services Codes* | |

# Table of Contents

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system.*
>
> *For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging (PathWays) services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

# Introduction

The Indiana Health Coverage Programs (IHCP) covers therapy services for eligible members. This module outlines IHCP prior authorization (PA), billing and reimbursement policies for occupational therapy, physical therapy, respiratory therapy and speech-language pathology services. Information about cognitive rehabilitation therapy for the treatment of traumatic brain injury (TBI), hyperbaric oxygen therapy, pulmonary rehabilitation programs, cardiac rehabilitation programs, TBI programs and comprehensive outpatient rehabilitation facility (CORF) services is also included.

For information about audiology services, see the *Hearing Services* module. For information about behavioral therapy, including applied behavior analysis (ABA) therapy, see the *Behavioral Health Services* module. For information about negative pressure wound therapy (NPWT), see the *Durable and Home Medical Equipment and Supplies* module.

The IHCP reimburses for therapy services provided outside Indiana, subject to PA, as required by *Indiana Administrative Code 405 IAC 5-5-2*. However, the IHCP does **not** cover home health agency services outside Indiana. See the *Home Health Services* module for billing and PA guidelines related to provision of therapy by home health agencies.

# Occupational Therapy, Physical Therapy, Respiratory Therapy and Speech-Language Pathology Services

The following sections provide information about occupational therapy, physical therapy, respiratory therapy and speech-language pathology services.

> *Note: The IHCP covers robotic therapy as a tool used within other therapy services. Robotic therapy can be performed while providing therapy services, but a provider must bill the most appropriate procedure code for the therapy service rendered rather than specifically for robotic therapy. All PA requirements for covered therapy services apply.*

## *Prior Authorization for Therapy Services*

In accordance with *405 IAC 5-22-6(a)*, the IHCP requires PA for all occupational therapy, physical therapy, respiratory therapy and speech-language pathology services, with the following **exceptions**:

- Initial evaluations (one per 12 months)
- Emergency respiratory therapy
- Any combination of therapy services ordered in writing before a member's release or discharge from an inpatient hospital, continuing for a period not to exceed 30 units in 30 calendar days
- Deductible and copay or coinsurance for services covered by Medicare Part B
- Oxygen equipment and supplies necessary for the delivery of oxygen, with the exception of concentrators
- Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis or upper respiratory infection (not to exceed 14 hours or 14 calendar days without PA)
- Therapy services provided by a nursing facility or large private or small intermediate care facility for individuals with intellectual disabilities (ICF/IID), which are included in the facility's per diem rate

In accordance with *405 IAC 5-22-6(b)*, the following **PA criteria** apply to occupational therapy, physical therapy, respiratory therapy and speech-language pathology services:

- The IHCP requires written evidence of physician involvement and personal patient evaluation to document acute medical needs.
  - The therapy must be ordered by a qualifying provider, as indicated in the subsections of this module for each type of therapy.
  - Providers must attach a current plan of treatment and progress notes indicating the necessity and effectiveness of therapy to the PA request and make this documentation available for audit.

> *Note: When a member is enrolled in therapy, physician progress notes as to the necessity and effectiveness of therapy and ongoing evaluations to assess progress and redefine goals must be a part of the therapy documentation. The following information and documentation are to be included in the medical record:*
>
> - *Location (place of service code) at which services were rendered*
> - *Documentation of referrals and consultations*
> - *Documentation of test orders*
> - *Documentation of all services performed and billed*
> - *Documentation of medical necessity*
> - *Treatment plan*

- The therapy must be provided by a qualified therapist, or a qualified assistant under the direct supervision of the therapist, as appropriate.
- The level of complexity and sophistication of the therapy and the condition of the member must be such that the judgment, knowledge and skills of a qualified therapist are required.
- The therapy must be medically necessary.
- The IHCP does not cover therapy rendered for diversional, recreational, vocational or avocational purposes; for the remediation of learning disabilities; or for developmental activities that can be conducted by nonmedical personnel.

- The IHCP covers **rehabilitative** therapy services for members under 21 years of age when determined medically necessary. For members 21 years of age and older, the IHCP covers rehabilitative therapy services for no longer than two years from the initiation of the therapy, unless a significant change in medical condition requires longer therapy. Providers can prior authorize respiratory therapy services for a longer period on a case-by-case basis.
- The IHCP covers **habilitative** therapy services for members under 21 years of age on a case-by-case basis, subject to prior authorization. (Educational services, including, but not limited to, the remediation of learning disabilities, are not considered habilitative therapy and are not covered.) Habilitative therapy is not a covered service for members 21 years of age and older.

> *Note: Habilitative therapy refers to therapy addressing chronic medical conditions where further progress is not expected. Habilitative therapy services include physical therapy, occupational therapy, respiratory therapy, speech-language pathology and audiology services provided to members for the purpose of maintaining their level of functionality, but not the improvement of functionality. Although the development of a habilitation therapy plan is considered part of rehabilitative services, the services furnished under a habilitation therapy plan are not skilled therapy. Educational services, including but not limited to the remediation of learning disabilities, are not considered habilitative therapy services and remain noncovered by the IHCP.*

- When a member is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. The IHCP does not separately reimburse for ongoing evaluations.
- One hour of billed therapy must include a minimum of 45 minutes of direct member care, with the balance of the hour spent in related patient services.
- The IHCP does not reimburse therapy services for more than one hour per day per type of therapy; additional therapy services require prior authorization and must be medically necessary.
- The IHCP does not authorize requests for therapy that would duplicate other services provided to a member.

Prior authorization requests for therapy services must include applicable procedure codes for the services to be rendered, along with appropriate modifiers, when required (see the *Occupational Therapy Services and Modifier GO* and *Physical Therapy Services and Modifier GP* sections for details). This guidance includes PA requests from outpatient facilities, which must submit the request for applicable procedure codes (and modifiers, when indicated) rather than for the relevant revenue code, even though outpatient therapy claims are reimbursed based on revenue code only.

> *Note: Providers of therapy services, including physical therapy, occupational therapy, respiratory therapy and speech-language pathology, can use the Medicaid Therapy Services Prior Authorization Checklist to prepare comprehensive PA requests, which should reduce suspensions for requests for additional information.*
>
> *The checklist is relevant to PA information needed for both fee-for-service (FFS) and managed care therapy services. Providers are not required to submit the checklist, but it is available to assist them in completing the IHCP Prior Authorization Request Form (or equivalent portal-based request), which must be completed in full and submitted as described in the Prior Authorization module.*
>
> *The checklist is available under Miscellaneous PA-Related Forms, in the Prior Authorization (Nonpharmacy) section of the Forms page at in.gov/medicaid/providers.*

# Billing and Reimbursement of Therapy Services

The following billing and reimbursement guidance applies for occupational therapy, physical therapy, respiratory therapy and speech-language pathology services provided in the indicated settings:

- **Outpatient facilities** – Therapy services rendered in an outpatient facility setting should be billed on an outpatient institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [IHCP Portal] institutional claim or 837I electronic transaction) using the appropriate revenue code and one or more procedure codes, along with any appropriate modifiers.

  The IHCP reimburses outpatient claims for therapy services at a flat, statewide fee based on the revenue code only. For rate information, see the Revenue Codes tab of the Outpatient Fee Schedule, available from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

  *Note: Procedure codes and applicable modifiers are required on the outpatient claim to confirm prior authorization. Separate reimbursement based on procedure code is not available for outpatient therapy claims; only the revenue code is reimbursable.*

- **Professional settings** – Therapy service rendered in an office or other professional setting should be billed on a professional claim (*CMS-1500* claim form, Portal professional claim or 837P electronic transaction) using applicable procedure codes, along with any appropriate modifiers.

  The IHCP reimburses professional claims for therapy services on a per-hour basis or per unit billed. Providers cannot bill for fractional units for less than one hour. Providers must accumulate and report time in one-hour increments. For rate information, see the Professional Fee Schedule, available from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. Reimbursement cutbacks are applied, when applicable, for services rendered by qualifying practitioners that are not eligible for IHCP enrollment, such as physical therapist assistants and speech-language pathologist aides.

  *Note: For billing purposes, the IHCP treats CORFs as a professional setting rather than an outpatient facility setting. CORFs must use the professional claim type when submitting claims to the IHCP. See the Comprehensive Outpatient Rehabilitation Facilities section for more information.*

For both outpatient and professional billing, all therapy procedure codes on the claim must have been prior authorized unless the service qualifies for an exception as indicated in the *Prior Authorization for Therapy Services* section. Additionally, for certain occupational and physical therapy procedure codes, the usage of modifier GO or GP on the claim must match the modifier usage on the approved PA. See the *Occupational Therapy Services and Modifier GO* and *Physical Therapy Services and Modifier GP* sections, for details.

All claims for services rendered by provider specialties 170–173 (Physical Therapist, Occupational Therapist, Speech/Hearing Therapist) must include the National Provider Identifier (NPI) of the provider that **ordered** the services. The ordering provider must be enrolled in the IHCP. For more information, see *Ordering, Prescribing and Referring Provider Requirements* in the *Claim Submission and Processing* module.

The following sections include additional information specific to each type of therapy service.

## Occupational Therapy Services

In accordance with *405 IAC 5-22-6(b)(1)(B)*, for IHCP reimbursement, occupational therapy services must be **ordered** by one of the following IHCP-enrolled providers:

- Physician (doctor of medicine or doctor of osteopathy)
- Podiatrist
- Advanced practice registered nurse

- Optometrist
- Physician assistant
- Chiropractor
- Psychologist

In accordance with *405 IAC 5-22-11*, occupational therapy services must be **performed** by a licensed occupational therapist or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist. For IHCP reimbursement to be made, a licensed occupational therapist must perform an evaluation.

The IHCP limits occupational therapy evaluations and reevaluations to three hours of service per evaluation. The initial evaluation does not require prior authorization. Any reevaluations within 12 months of an initial evaluation do require prior authorization, unless they are conducted during the initial 30 days after hospital discharge and the discharge orders include occupational therapy orders. Reevaluations within 12 months of an initial evaluation will not be authorized for a member unless documentation indicating significant change in the member's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.

The IHCP does **not** cover the following occupational therapy services:

- General strengthening exercise programs for recuperative purposes
- Passive range-of-motion services (as the only or primary mode of therapy)
- Occupational therapy psychiatric services

> *Note: The IHCP supports including occupational therapists on a substance use disorder (SUD) or behavioral health treatment team, when the occupational therapists provide services within their scope of licensure. The scope of occupational therapy practice allows the provision of psychosocial interventions, and the IHCP supports including occupational therapy in the treatment plan of members receiving behavioral health treatment services.*

The IHCP does not reimburse separately for occupational therapy services provided by a nursing facility or a large private or small ICF/IID. These services are included in the facility's established per diem rate and do not require PA.

## *Occupational Therapy Services and Modifier GO*

Certain procedure codes require that both the PA request and the claim include the appropriate modifier to indicate that the service was delivered under an occupational therapy plan of care, if applicable. If the PA request for one of these services includes modifier GO – *Services delivered under an occupational therapy plan of care*, then modifier GO must be billed on the claim.

The IHCP compares the way these codes are *billed* (with or without modifier GO) to the way they are *authorized*. If the modifier usage on the claim does not match the usage on the PA, the claim will deny with explanation of benefits (EOB) 3001 – *Dates of service not on the P.A. master file*. This guidance applies to both professional and outpatient claims. For outpatient claims, if the procedure code and modifier usage on the claim does not match what was prior authorized, both the procedure code and the associated revenue code will deny for lack of PA.

For applicable codes, see the *Physical and Occupational Therapy Codes That Require a Modifier Match (GO or GP) on the Authorization Request and Claim* table in *Therapy Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

## Physical Therapy Services

In accordance with *405 IAC 5-22-6(b)(1)(A)*, for IHCP reimbursement, physical therapy services must be **ordered** by one of the following IHCP-enrolled providers:

- Physician (doctor of medicine or doctor of osteopathy)
- Podiatrist
- Psychologist
- Chiropractor
- Dentist
- Advanced practice registered nurse
- Physician assistant

For IHCP reimbursement, physical therapy services must be **performed** by a licensed physical therapist or by a certified physical therapist assistant (PTA) under the direct supervision of a licensed physical therapist or physician as defined in *842 IAC 1-1-2(a)* and *Indiana Code IC 25-27-1-2*.

> *Note: The PTA is precluded from performing or interpreting tests, conducting initial or subsequent assessments, or developing treatment plans. See the Covered Procedures for Physical Therapist Assistants section for details. The PTA is required to meet with the supervising physical therapist each working day to review treatment, unless the physical therapist or physician is on the premises to provide constant supervision. The consultation can be either face-to-face or by telephone.*

Only the following activities related to the therapy can be performed by someone other than a licensed therapist or a certified PTA under the direct supervision of a licensed physical therapist. The IHCP allowance for the modality provided by the licensed therapist includes payment for the following services, and providers may not bill the IHCP separately for these services:

- Assisting members in preparation for treatment and, as necessary, during and at the conclusion of treatment
- Assembling and disassembling equipment
- Assisting a physical therapist in the performance of appropriate activities related to the treatment of the individual patient
- Following established procedures pertaining to the care of equipment and supplies
- Preparing, maintaining and cleaning treatment areas and maintaining supportive areas
- Transporting patients, records, equipment and supplies in accordance with established policies and procedures
- Performing established clerical procedures

The IHCP limits physical therapy evaluations and reevaluations to three hours of service per member evaluation. The initial evaluation does not require prior authorization. Any reevaluations within 12 months of an initial evaluation do require prior authorization, unless they are conducted during the initial 30 days after hospital discharge and the discharge orders include physical therapy orders. Reevaluations within 12 months of an initial evaluation will not be authorized for a member unless documentation indicating significant change in the member's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.

The IHCP does not reimburse separately for physical therapy services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility’s per diem rate and do not require PA.

### *Covered Procedures for Physical Therapist Assistants*

The IHCP has identified certain services that are eligible for reimbursement when performed by a PTA. For a table of applicable procedure codes, see *Therapy Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

When these services are performed by a PTA, providers must bill them with the modifier **HM** – *Less than a bachelor's degree.* These services, when billed with the HM modifier, are priced to reimburse at 75% of the rate for a physical therapist.

Note that evaluation and testing procedure codes are excluded from the table because PTAs may not administer tests or perform evaluations.

### *Physical Therapy Services and Modifier GP*

Certain procedure codes require that both the PA request and the claim include the appropriate modifier to indicate that the service was delivered under a physical therapy plan of care, if applicable. If the PA request for one of these services includes modifier **GP** – *Services delivered under a physical therapy plan of care*, then modifier GP must be billed on the claim.

The IHCP compares the way these codes are *billed* (with or without modifier GP) to the way the codes are *authorized*. If the modifier usage on the claim does not match the usage on the PA, the claim will deny with EOB 3001 – *Dates of service not on the P.A. master file*. This guidance applies to both professional and outpatient claims; if the procedure code and modifier usage on the outpatient claim does not match what was prior authorized, both the procedure code and the associated revenue code will deny for lack of PA.

For applicable codes, see the *Physical and Occupational Therapy Codes That Require a Modifier Match (GO or GP) on the Authorization Request and Claim* table in *Therapy Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

### *Hippotherapy*

The IHCP covers hippotherapy for physical therapy when the service is provided by a licensed physical therapist and billed using the appropriate Current Procedural Terminology (CPT®[1]) codes listed in the hippotherapy table in *Therapy Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Hippotherapy services must be included in the patient's treatment plan. Existing PA requirements for physical therapy apply to hippotherapy.

> *Note: The IHCP does **not** cover procedure code S8940 – Equestrian/hippotherapy, per session.*

## Respiratory Therapy Services

In accordance with *405 IAC 5-22-6(b)(1)(C)*, for IHCP reimbursement, respiratory therapy services must be **ordered** by an IHCP-enrolled physician (doctor of medicine or doctor of osteopathy).

Additionally, in accordance with *405 IAC 5-22-10*, the IHCP reimburses for respiratory therapy services only when **performed** by a licensed respiratory therapist or by a certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency or clinic.

The IHCP considers the equipment necessary for rendering respiratory therapy part of the provider's capital equipment.

[1] *CPT copyright 2024 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

> *Note: The IHCP does not require PA for respiratory therapy given on an emergency basis. In addition, for a period not to exceed 14 hours or 14 calendar days, providers can perform respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis and upper respiratory infection without PA. If the member requires additional services after that date, the provider must obtain PA.*

The IHCP does not reimburse separately for respiratory therapy services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's established per diem rate.

## Speech-Language Pathology Services

Speech-language pathology services are provided for IHCP members with speech, hearing or language disorders. These services include diagnostic, screening, preventive and corrective services.

For IHCP reimbursement, speech-language pathology services must be **ordered** in writing by one of the following IHCP-enrolled providers:

- Physician (doctor of medicine or doctor of osteopathy)
- Nurse practitioner
- Clinical nurse specialist
- Certified nurse midwife
- Physician assistant

Additionally, in accordance with *405 IAC 5-22-9*, the speech-language pathology service must be **rendered** by a licensed speech-language pathologist or by a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. Registered speech-language pathology support personnel (aides, associates and assistants) may provide services subject to *880 IAC 1-2.1*. Procedures performed by speech-language pathologist aides must be billed with modifier HM using the supervising practitioner's NPI, and are reimbursed at 75% of the rate paid to a speech-language pathologist.

Evaluations and reevaluations for speech-language pathology are limited to three hours of service per evaluation. The initial evaluation does not require prior authorization. Any reevaluations within 12 months of an initial evaluation do require prior authorization unless they are conducted during the initial 30 days after hospital discharge, and the discharge orders include speech-language pathology orders. Reevaluations within 12 months of an initial evaluation will not be authorized for a member unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.

> *Note: On Oct. 15, 2024, the IHCP published a list of the services that are eligible for reimbursement when performed by a speech-language pathologist (specialty 173 – Speech/Hearing Therapist). For a table of applicable procedure codes, see Therapy Services Codes, accessible from the Code Sets page at in.gov/medicaid/providers.*

Group therapy is covered only in conjunction with, not in addition to, regular individual treatment. The IHCP will not reimburse for group therapy as the only or primary means of treatment.

The IHCP does not reimburse separately for speech-language pathology services provided by a nursing facility or large private or small ICF/IID. These services are included in the facility's established per diem rate.

# Cognitive Rehabilitation Therapy for Traumatic Brain Injury

*405 IAC 5-29-1(25)(I)* states that cognitive rehabilitation is a noncovered service, except for the treatment of traumatic brain injury (TBI).

The IHCP limits coverage of cognitive rehabilitation therapy procedure codes to the specific TBI diagnoses. For applicable codes, see the *Cognitive Rehabilitation Therapy Procedure Codes Covered for Traumatic Brain Injury* table in *Therapy Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

> *Note: For information about therapy services provided in a TBI facility, see the Traumatic Brain Injury Programs section. For information about TBI waiver services, see the Division of Disability and Rehabilitative Services Home- and Community-Based Services Waivers module.*

# Hyperbaric Oxygen Therapy

The IHCP covers hyperbaric oxygen therapy as an adjunctive treatment for the management of select nonhealing wounds, treatment of carbon monoxide poisoning and other conditions. Reimbursement is **not** available for hyperbaric oxygen therapy for the following conditions:

- Topical application of oxygen
- Cutaneous, decubitus and stasis ulcers
- Chronic peripheral-vascular insufficiency
- Anaerobic septicemia and infection other than clostridial
- Skin burns (thermal)
- Senility
- Myocardial infarction
- Cardiogenic shock
- Sickle-cell crisis
- Acute thermal and chemical pulmonary damage, including smoke inhalation with pulmonary insufficiency
- Acute or chronic cerebral-vascular insufficiency
- Hepatic necrosis
- Aerobic septicemia
- Nonvascular causes of chronic brain syndrome, including Pick's, Alzheimer's and Korsakoff's disease
- Tetanus
- Systemic aerobic infection
- Organ transplantation
- Organ storage
- Pulmonary emphysema
- Exceptional blood loss anemia
- Multiple sclerosis
- Arthritic diseases

Treatment may include multiple sessions, which may be administered over a duration ranging from less than one week to two months, the average being two to four weeks. Claims submitted for treatment sessions lasting more than a two-month period will be suspended for submission of documentation to support medical necessity of continued therapy.

Hyperbaric oxygen therapy must be clinically practical and should not be a replacement for other standard successful therapeutic measures.

# Pulmonary Rehabilitation Programs

The IHCP covers professional services for outpatient pulmonary rehabilitation programs, with prior authorization, billed using the following procedure codes:

- 94625 – *Professional services for outpatient pulmonary rehabilitation, per session*
- 94626 – *Professional services for outpatient pulmonary rehabilitation with continuous monitoring of blood oxygen, per session*

Programs must provide a comprehensive, evidence-based multidisciplinary intervention for patients with chronic respiratory impairment. The IHCP will pay for up to two one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) for pulmonary rehabilitation program services when documentation supports that ***all*** the following program requirements are met:

- Patient has a diagnosis of moderate to very severe chronic obstructive pulmonary disease (COPD) or other condition.
- Physician has prescribed exercise, and aerobic exercise is provided at each treatment session.
- An individualized plan of care is initially established by the physician as well as reviewed and signed by the physician every 30 days.
- Program services are physician-supervised with documentation supporting initial direct patient contact prior to treatment and at least one direct contact within each 30-day period.
- Services must be provided only in the following places of service (POS):
  - 11 – *Physician's office*
  - 22 – *Hospital outpatient*
- All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when program services are being furnished.
- Formal education must be thorough and ongoing with appropriate follow-up. The education requirement is **not** met by:
  - Handing out a booklet on how to stop smoking with no additional follow-up
  - Having the patient take an assessment at the beginning and end of the program
  - Documenting sporadic and/or vague instruction provided; for example, "discussed self-management techniques"
- Psychosocial assessment and reassessment must be thorough and occur at periodic intervals.
- Significant outcomes assessment with clinical measures (initial/ending) must be evident in the medical record.

# Cardiac Rehabilitation Programs

Progressive exercise programs have demonstrated benefit in the management and rehabilitation of individuals with cardiac disease, especially following certain cardiac events. The IHCP provides reimbursement for comprehensive cardiac rehabilitation programs as described in this section. Prior authorization is not required for cardiac rehabilitation services.

Cardiac rehabilitation requires that specific components be included in the rehabilitation program. Required components include:

- Medical evaluation
- A program to modify cardiac risk factors (for example, nutritional counseling, assessing smoking status, history and control of diabetes or hypertension, lipid management, weight management, and any psychosocial interventions such as depression screening)
- Prescribed exercise
- Education
- Counseling
- Direct supervision of a physician

Cardiac rehabilitation programs are typically divided into three phases. The following sections describe IHCP coverage and reimbursement policies for each of these three phases.

## *Phase I*

Phase I reimbursement is included in the inpatient diagnosis-related group (DRG); therefore, the IHCP does not provide separate reimbursement for Phase I.

## *Phase II*

IHCP reimbursement is available for cardiac rehabilitation services for Phase II when considered medically reasonable and necessary. The member must be referred by the physician and must have at least a moderate level of risk stratification. Services provided in connection with a cardiac rehabilitation program may be considered reasonable and necessary up to a maximum of 36 sessions, usually three sessions a week in a single 12-week period.

Coverage for continued participation in a cardiac rehabilitation program beyond 12 weeks requires documentation (in the member's medical record) that fully supports the medical necessity for cardiac rehabilitation along with exit criteria, as it is covered by the IHCP. Reimbursement is not available for Phase II cardiac rehabilitation services exceeding a maximum of 24 weeks.

### Diagnosis Requirements

Prior to the initiation of the Phase II program, the member must have had one of the following:

- Stable angina pectoris with reduced activity tolerance substantially altering lifestyle. Members who qualify for a Phase II cardiac rehabilitation program are expected to have a functional classification of Class II or Class III on the Canadian Cardiovascular Society Functional Classification
- Documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months
- Coronary artery-bypass surgery
- Heart-valve repair/replacement

- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- Heart or heart-lung transplant

## Service Requirements

A routine cardiac rehabilitation visit must include at least one of the following services:

- Continuous electrocardiogram (ECG) telemetric monitoring during exercise
- ECG rhythm strip with interpretation and physician's revision of exercise prescription
- Physician's evaluation to assess the member's performance, adjust medication or other treatment changes

Other cardiac rehabilitation services may include but are not limited to the following:

- New patient comprehensive evaluation, including history, physical and preparation of initial exercise prescription – One comprehensive evaluation is allowed and separately payable at the beginning of the program, if not already performed by the member's attending physician, or if the evaluation performed by the member's attending physician is not acceptable to the program's director. An assessment performed by a nurse or other personnel does not meet this requirement.
- ECG stress test (treadmill or bicycle ergometer) with physician monitoring and report – One ECG stress test is allowed at the beginning of the program and one after three months (usually at the completion of the program). Pharmacologic stress testing may be indicated in certain circumstances and would be allowed with appropriate documentation of medical necessity in the member's medical records.

## Billing and Coding

Phase II cardiac rehabilitation services are billed on the institutional claim (*UB-04* claim form or electronic equivalent).

For a routine cardiac rehabilitation visit, revenue code is 943 is billed with one of the following CPT procedure codes:

- 93797 – *Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)*
- 93798 – *Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)*

All charges associated with the elements of a cardiac rehabilitation service, including telemetry and supplies for telemetry, are to be included in this charge. Separate reimbursement for telemetry, electrodes and so on, is not provided.

One unit equals one cardiac rehabilitation visit. The number of units must be shown on the claim (field 46 on the *UB-04* claim form). The date of onset or surgery must be indicated with occurrence code 11 on the claim (fields 31–36 on the *UB-04* claim form). The date of the first cardiac rehabilitation session must be indicated with occurrence code 46 (fields 32–35 on the *UB-04* claim form). The total number of cardiac rehabilitation visits from the start of care, including the current claim, must be entered with value code 53 (fields 39–41 on the *UB-04* claim form).

> *Note: As indicated in the Service Requirements section, certain cardiac rehabilitation services beyond those provided during a routine visit may be covered during Phase II. The new patient comprehensive evaluation, delivered as described in the previous section, may be billed using the appropriate evaluation and management (E/M) code along with the applicable revenue code. The ECG stress test, delivered as described in the previous section, may be billed using revenue code 482 and the appropriate procedure code.*

Claims for Phase II cardiac rehabilitation services must include an appropriate ICD diagnosis code. See the *Diagnosis Requirements* section for allowable diagnoses. The use of an applicable ICD diagnosis code does not ensure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this policy.

### Documentation Requirements

The member's medical record must contain documentation that fully supports the medical necessity for cardiac rehabilitation, as it is covered by the IHCP. This documentation includes but is not limited to the following:

- Medical records confirming the diagnosis
  - The diagnosis of stable angina should be substantiated with a physician history and physical (H&P), a hospital-discharge summary, or a physician statement to confirm the diagnosis.
- Evidence of the elements of a cardiac rehabilitation session (for example, telemetry-monitoring strips)
- Medical records indicating the medical necessity for unusual frequency or duration of Phase II cardiac rehabilitation
  - For Phase II cardiac rehabilitation provided beyond 12 weeks, providers must maintain medical documentation indicating that the member has not reached an exit level within 12 weeks.
- Documentation that is specific in terms of exit criteria and/or setbacks that changed the exercise prescription

### Reasons for Denial

Although members may meet a provider's protocol for cardiac rehabilitation services, they must also meet the IHCP coverage criteria for medical necessity. The IHCP will deny reimbursement for reasons including but not limited to the following:

- Lack of documentation of a covered diagnosis
- Lack of documentation of the elements of a cardiac rehabilitation visit
- Duration beyond 12 weeks without documentation showing medical necessity, as indicated in the previous section
- Duration beyond 24 weeks
- Services determined to be not reasonable and necessary, as stated previously in this section

## *Phase III*

The IHCP does not provide reimbursement for Phase III cardiac rehabilitation programs.

A member may progress to the maintenance (Phase III) program when the following criteria are met:

- The member has achieved a stable level of exercise tolerance without ischemia or dysrhythmia, as evidenced by an ECG.

- Symptoms of angina or dyspnea are stable at the member's maximum exercise level.
- The member's resting blood pressure and heart rate are within normal limits, or are stable on optimal medical therapy.
- The stress test is not positive during exercise. (A positive test in this context means an ECG with a junctional depression of greater than or equal to 2 millimeters, associated with slowly rising, horizontal or down-sloping ST segment).

# Traumatic Brain Injury Programs

TBI is an injury sustained after birth from physical trauma, an anoxia or hypoxic episode, allergic conditions, toxic substances, or other acute medical clinical incidents resulting in psychological, neurological or anatomical changes in brain functions. Traumatic brain injury does not include:

- Strokes that can be treated in nursing facilities providing routine rehabilitation services
- Spinal cord injuries for which there are no known or obvious injuries to the intracranial central nervous system
- Progressive dementias and other mentally impairing conditions
- Depression and psychiatric disorders in which there is no known or obvious central nervous system damage
- Intellectual disability and birth defect-related disorders of long-standing nature
- Neurological, degenerative, metabolic and other medical conditions of a chronic, degenerative nature

The IHCP covers services in a TBI program when the services are provided in compliance with all IHCP guidelines, including obtaining prior authorization, for members who have been determined to meet eligibility.

Services are provided based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function.

Per diem reimbursement is determined based on the member's level of need in each of the 10 domains listed in the following section. Based on the total score from all 10 domains, the member falls within one of four level-of-service reimbursement categories, as described in the *Level-of-Service Categories* section.

## *Level of Need by Service Domain*

Each case is assessed based on the intensity of services needed within each of 10 domains, as shown in Table 1. The level of need in each domain is rated on a scale of 1 to 3 (for low, medium or high).

Table 1 – Service Domains and Levels of Need

| Domain | Level of Need |
|---|---|
| Residential | 1 – Low: Basic residential services<br>2 – Medium: Moderate assistance with residential living<br>3 – High: Significant assistance with residential needs |
| Case Management | 1 – Low: Minimal logistical assistance<br>2 – Medium: Moderate coordination of care and family engagement<br>3 – High: Significant management of complex medical and social issues |

| Domain | Level of Need |
|---|---|
| Medical Management | 1 – Low: Routine medical care<br>2 – Medium: Moderate basic medical services and care delivery<br>3 – High: Significant and complex medical services |
| Speech/Language Therapy | 1 – Low: Maintenance services for speech and language skills<br>2 – Medium: Moderate frequency of speech therapy with progress to goals<br>3 – High: Intensive speech therapy for language, speech and receptive skills |
| Productive Activity/ Physical Therapy | 1 – Low: Basic activity that does not require skilled staff<br>2 – Medium: Moderate individualized therapy with progress to goals<br>3 – High: Intensive and frequent services requiring skilled professional staff |
| Occupational Therapy | 1 – Low: Basic activity that does not require skilled staff<br>2 – Medium: Moderate individualized therapy with progress to goals<br>3 – High: Intensive and frequent services requiring skilled professional staff |
| Rehabilitation Therapy | 1 – Low: Basic activity that does not require skilled staff<br>2 – Medium: Moderate individualized therapy with progress to goals<br>3 – High: Intensive and frequent services requiring skilled professional staff |
| Vocational Therapy | 1 – Low: Basic activity that does not require skilled staff<br>2 – Medium: Moderate individualized therapy with progress to goals<br>3 – High: Intensive and frequent services requiring skilled professional staff |
| Neurocognitive Therapy | 1 – Low: Basic activity that does not require skilled staff<br>2 – Medium: Moderate individualized therapy with progress to goals<br>3 – High: Intensive and frequent services requiring skilled professional staff |
| Behavioral Health/Psychiatric Therapy | 1 – Low: Basic activity that does not require skilled staff<br>2 – Medium: Moderate individualized therapy with progress to goals<br>3 – High: Intensive and frequent services requiring skilled professional staff |

## *Level-of-Service Categories*

The goal of TBI rehabilitation is reintegration into the community. The member's ability to live at home or in the community is related to the severity of the illness (SI) and intensity of services (IS). The member's needs must be balanced with the resources available in the recovery environment. These resources include:

- Physical healthcare needs
- Behavioral healthcare needs
- Cognitive impairments
- Safety needs
- Other support needs

The IHCP developed four level-of-service categories using the 10 domains of service, identifying the severity of the illness and the intensity of services required by each member. The four levels of service are described in the following sections.

### Level I – Intense NeuroRehabilitation/NeuroBehavioral Programming

Level I is assigned to members who require immediate admission into a TBI program to receive intensive therapy, and may be appropriate for up to the first four months of intervention. Members requiring additional days after the first four months for Level I services will be reviewed on a case-by-case basis.

Members at this level must demonstrate needs in the following areas:

- Cognitive/behavioral needs
  - Cognition – Memory, impulsivity, poor judgment, lack of initiation, poor problem solving, poor social skills that significantly impact safety and well being
  - Unwanted behaviors, including demonstration, frequency and intensity of high-risk behaviors secondary to the brain injury
  - Noncompliance with traditional therapies due to cognitive/behavioral barriers
  - Crisis intervention and ultra-high-risk support
- Safety needs
  - Supervision – May require additional one-on-one supervision for behaviors
  - Environment – May require durable, secure, highly supervised living environment to decrease risk to self or others
- Physical healthcare needs
  - Medical needs requiring daily nursing availability to ensure safety/well-being
  - Medication management
  - Coordination of physician specialists and/or any orthotic/prosthetic devices
  - Pharmacological intervention through psychiatrist consults
  - Medically necessary therapeutic interventions in all the following areas:
    - Residential
    - Case management
    - Medical management
    - Speech-language therapy
    - Productive activity/physical therapy
    - Occupational therapy
    - Rehabilitation therapy
    - Vocational therapy
    - Neurocognitive therapy
    - Behavioral health/psychiatric therapy
- Other needs
  - Transportation/escort
  - Interagency communication/coordination
  - Family/caregiver training
  - Available continuum of treatment/environmental options to practice skill acquisition and simulate discharge environment
  - Discharge planning as part of the program to match IHCP Home- and Community-Based Services (HCBS)

Members at Level I have a total domain score between 26 and 30. For applicable procedure codes and per diem rates, see the *Billing and Reimbursement for TBI Services* section.

## Level II – Active NeuroRehabilitation/NeuroBehavioral Step-Down Program

Level II offers individualized support needed at any time, specifically during times of crisis, and a member may require or be provided additional residential and programmatic support. The team may change the intensity of assistance from time to time, while taking advantage of certain "therapeutic windows." Regardless of the setting or type of program, rehabilitation interventions are intended to help members practice strategies to remain free from harm and attain personal goals that are durable over time. Discharge planning efforts continue to be geared toward exploring and securing living environments, therapeutic services and productive activities that match the needs and desires of the member with a focus on returning to the home community.

Level II members have made progress in active rehabilitation and exhibit the following needs:

- In need of training in self-management of behavioral, cognitive and/or medical/physical challenges
- Continuing to require specialized therapeutic intervention in the following areas, although at a reduced frequency and duration:
  - Residential
  - Case management
  - Medical management
  - Speech-language therapy
  - Productive activity/physical therapy
  - Occupational therapy
  - Rehabilitation therapy
  - Vocational therapy
  - Neurocognitive therapy
  - Behavioral health/psychiatric therapy
- Still unable to access their home environment, independent living options or transitional supported living due to the continual unwanted behaviors or the significant cognitive/physical challenges.
- Ready to engage in therapeutic interventions geared toward maintaining the durability of goals achieved as well as continued work on upgraded objectives

Members at Level II have a total domain score between 21 and 25. For applicable procedure codes and per diem rates, see the *Billing and Reimbursement for TBI Services* section.

## Level III: NeuroRehabilitation/NeuroBehavioral Step-Down Program

Level III members have made progress in more intensive, active rehabilitation and require reduced formal clinical service delivery. Members who are appropriate for this level of program will transition into a residential and programmatic continuum designed to replicate the type of support the person will experience when they return to their home community. Members will continue to practice strategies to increase independence, safety and behavioral self-management while pursuing discharge placement in the discharge community. During times of crisis, a member may require or be provided additional residential and programmatic support. If the crisis maintains, the member may need to move to Level I or II with the corresponding rate until stabilized.

Level III places strong emphasis on discharge planning as the member continues to practice skills attained and prepares for transfer to an alternative environment or to reside in the most independent environment possible.

Level III members exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral or medical strategies to minimize health and safety risk
- Continued need for specialized therapeutic intervention in the following areas, although at a reduced frequency and duration:
  - Residential
  - Case management

  - Medical management
  - Speech-language therapy
  - Productive activity/physical therapy
  - Occupational therapy
  - Rehabilitation therapy
  - Vocational therapy
  - Neurocognitive therapy
  - Behavioral health/psychiatric therapy

Members at Level III have a total domain score between 16 and 20. For applicable procedure codes and per diem rates, see the *Billing and Reimbursement for TBI Services* section.

## Level IV: NeuroRehabilitation/Neurobehavioral Step-Down Support Services

Level IV members have made progress in more intensive, active rehabilitation and are appropriate for step-down services to maintain goals achieved through supportive services. Members who are appropriate for this level of step-down support services will attempt to replicate the type of interventions the individual will experience once they return to their home community. Members will continue to practice learned strategies to increase independence, safety and behavioral self-management while pursuing discharge placement in the appropriate community. During times of crisis, members may require or be provided additional residential and programmatic support. If the crisis maintains, the member will be recommended to a move to Level I, II or III with the corresponding rate until stabilized.

Level IV places a strong emphasis on discharge planning as the member continues to practice skills attained and maintain those skills designed to meet future placement needs in the home community.

Level IV members exhibit the following needs:

- Additional experience and feedback with a variety of daily living situations to ensure self-management skills are effective and risk is minimized
- Supported living skill training and supervision with feedback
- Productive activity and community involvement with therapeutic intervention and feedback provided
- Supported practice with individualized cognitive, behavioral or medical strategies to maintain current health and overall functioning level
- Continued need for specialized therapeutic intervention at a moderate level in the following areas, although at a reduced frequency and duration:
  - Residential
  - Case management
  - Medical management
  - Speech-language therapy
  - Productive activity/physical therapy
  - Occupational therapy
  - Rehabilitation therapy
  - Vocational therapy
  - Neurocognitive therapy
  - Behavioral health/psychiatric therapy

Members at this level have a total domain score between 10 and 15. For applicable procedure codes and per diem rates, see the *Billing and Reimbursement for TBI Services* section.

## *Billing and Reimbursement for TBI Facility Services*

The per diem rates include the following services:

- Room and board
- Staffed residence
- Therapeutic interventions

The total score of the 10 domains determines the billing level and reimbursement rate. Rates are adjusted according to the level of intensity, on a scale of 1–3, as evidenced by medical necessity based on the member's individual needs. All reimbursement rates are directly communicated to the provider via the Notice of Action (Admission or Extension) letter.

After a member's admission or extension is approved, the provider is authorized to bill for that member using HCPCS procedure code H2013 – *Psychiatric health facility service, per diem* in combination with the applicable modifier based on the member's billing level and reimbursement rate. Providers are required to bill on the professional claim (*CMS-1500* claim form or electronic equivalent) using the exact procedure code and modifier combination listed on the prior authorization letter received for each member. Any claims submitted with incorrect code-modifier combinations will deny for payment. Billing, payment and enrollment is contingent upon member's Medicaid eligibility.

Table 2 lists the billing level, procedure code-modifier combination and per diem reimbursement rate based on total domain score. Level assignment and rate determinations are based on the information supplied by the TBI facility from documentation submitted for review and dialogue from collaborative case rounds with the prior authorization contractor. Each member's reimbursement rate is reviewed at the time of the clinical reassessment and the extension request.

Table 2 – TBI Facility Billing Codes and Per Diem Rates

| Total Score of Domains | Billing Level (Level of Service) | Procedure Code and Modifier | Per Diem |
|---|---|---|---|
| 30 | Level I | H2013 UB | $624 |
| 28–29 | Level I | H2013 UA | $595 |
| 26–27 | Level I | H2013 U9 | $560 |
| 25 | Level II | H2013 U8 | $525 |
| 23–24 | Level II | H2013 U6 | $490 |
| 21–22 | Level II | H2013 U5 | $454 |
| 20 | Level III | H2013 U4 | $419 |
| 16–19 | Level III | H2013 U3 | $384 |
| 15 | Level IV | H2013 U2 | $349 |
| 10–14 | Level IV | H2013 U1 | $314 |

# Prior Authorization for TBI Facility Services

Currently, TBI programs are available only through TBI facilities located outside Indiana. Prior authorization is required for TBI facility services per *405 IAC 5-5*. The IHCP does not reimburse providers for any services requiring prior authorization unless prior authorization is obtained first.

## Admission Requests

Placement within a TBI facility is available to members who have been determined to meet eligibility. Qualifications for enrollment in the TBI program include but are not limited to the following:

- A diagnosis of TBI must be made:
  - The injury resulted from an acute anoxic event or brain injury caused by external trauma.
- The member has a medical need for long-term neurocognitive rehabilitation.
- The therapeutic benefit from rehabilitation services proposed is reasonable.
- Acute services for brain injury and other services within Indiana must have been considered and used, when available.
- A formal clinical assessment for need of long-term rehabilitation has been conducted by brain injury specialists within Indiana.
- The member must be 18 years of age or older.
  - Requests for admission for members under age 18 will be reviewed on a case-by-case basis.

Consideration of admission includes submission of documentation to support the following criteria:

- Diagnosis of TBI
- One or both of the following:
  - Rancho Los Amigos Levels of Cognitive Functioning level of V or greater
  - Mayo-Portland Adaptability Inventory (MPAI-4)
- Current residence/living situation
- Summary of complete medical history, including:
  - Past hospitalizations
  - Rehabilitation services
  - Initial date of any head injury
  - History of previous head injury or cerebral harm
  - History of preinjury behavior and social condition (including history of drug abuse, abuse or police arrests)
- Evidence of behavioral problems including:
  - Aggressiveness
  - Sexual inappropriateness
  - Danger to self or others
- Neuropsychiatric evaluation (if completed)
- Psychiatric history (including depression, suicide attempts and so on)
- Ability to participate in a minimum of three hours of therapy per day
- Free of mental illness or illicit drug use
- Medically stable
- A reasonable expectation for improvement with therapy

- A reasonable expectation that the member would be eligible to return to the member's community for ongoing services upon completion of program
- Head injury that is no more than 4 years old, except when the member has had no previous treatment for TBI
- Cannot be placed and adequately cared for in any in-state facility
- Meets one of the four levels of service

All TBI admission requests are reviewed by the PA contractor on a case-by-case basis. The PA contractor determines the medical necessity for placement and if appropriate services are available to address the member's needs within Indiana. When members qualify for placement, the level of services provided is reviewed as submitted by the requesting facility.

### Extension Requests

Providers must submit a reassessment of the member's functional status along with the extension request. The reassessment is used to review each case based on the 10 domains of service, the intensity of service within each discipline, as well as services provided to the member during the review process, and initial or ongoing discharge planning efforts.

Each domain will be evaluated by the PA contractor as documented in the extension request and a determination will be made based on the member's level of need in each of the 10 domains.

### Prior Authorization Administrative Review and Appeal Procedures

Procedures for requesting administrative review and appeals of prior authorization determinations are outlined in the *Prior Authorization* module.

## Comprehensive Outpatient Rehabilitation Facilities

A comprehensive outpatient rehabilitation facility (CORF) is a facility that is primarily engaged in providing outpatient rehabilitation to people who are injured or disabled, or to patients recovering from illness with a plan of treatment under the supervision of a physician. The purpose of a CORF is to permit the member to receive multidisciplinary rehabilitation services per *515 IAC 2-1-3*, at a single location, in a coordinated fashion.

CORF services include the following:

- Outpatient mental health services in accordance with *405 IAC 5-20-8* (required service)
- Physical therapy (required service)
- Physician services (required service)
- Speech-language pathology
- Occupational therapy

CORF services are to be billed to the IHCP on a professional claim (*CMS-1500* claim form or electronic equivalent) with place-of-service code 62 – *Comprehensive outpatient rehabilitation facility*. Facility charges are not separately reimbursed.

However, if a crossover claim for CORF services is transmitted from Medicare on an institutional claim, it will be processed.