



Florida Medicaid

Physical Therapy Services Coverage Policy

Agency for Health Care Administration
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1.0 Introduction

1.1 Description

Physical therapy services develop, maintain, improve, or restore neuro-muscular or sensory-motor function to relieve pain, acquire a skill set, restore a skill set, or control postural deviations.

1.1.1 Florida Medicaid Policies

This policy is intended for use by physical therapy providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Physical therapy services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 440.110
- Sections 409.905 and 409.973, Florida Statutes (F.S.)
- Rule 59G-4.320, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.5 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.3.6 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.3.7 Therapy Treatment Visits

Active treatment sessions with a recipient for the purpose of providing therapy services.

1.3.8 Unit of Service

A minimum of 15 minutes of therapy treatment between the therapist or therapy assistant and the recipient.

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary physical therapy services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

2.3 Coinsurance and Copayments

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's General Policies on copayment and coinsurance.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid physical therapy services.

3.2 Who Can Provide

Services must be rendered by one of the following:

- Physical therapists licensed in accordance with Chapter 486, F.S.
- Physical therapy assistants licensed in accordance with Chapter 486, F.S.

Physical therapists may supervise physical therapy students while providing services to a recipient. The physical therapist must direct the care, make all clinical decisions, and be responsible for the recipient's assessment and treatment. The licensed therapist must be present for the entire treatment time and may not treat another patient or engage in other tasks while supervising a student.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following in accordance with the applicable fee schedule(s), or as specified in this policy:

- Wheelchair evaluations:
 - One initial wheelchair evaluation every five years, per recipient
 - One follow-up wheelchair evaluation including adjustments and fittings when the wheelchair is delivered
 - One follow-up wheelchair evaluation including adjustments and fittings six months after the wheelchair has been delivered
- Services for recipients under the age of 21 years:
 - One initial therapy evaluation per year, per recipient
 - One therapy re-evaluation every five months, per recipient
 - Up to 14 therapy treatment units per week (Sunday-Saturday), per recipient (maximum of 4 units per day)
 - Up to two casting and strapping applications per day, per recipient

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Developing and updating the plan of care (POC)
- Mileage and travel expenses
- Securing, installing, or maintaining therapy equipment
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy
- Time spent supervising assistants and students
- Treatment visits provided on the same day as an evaluation service

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

6.2 Specific Criteria

Providers must develop and update a recipient's POC based on the results of the physical therapy evaluation(s). The POC must include at least the following:

- Medical condition, including diagnostic codes
- Functional limitations
- Specific therapy to be provided
- Short and long-term therapeutic goals and objectives
- Medications, treatments, and equipment
- Treatment frequency, length, and duration
- Therapeutic methods and monitoring criteria
- Diet as indicated, if applicable
- Means of demonstrating and teaching the recipient, family and other relevant caregivers
- Coordination with other prescribed services

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization at least every 180 days, or upon a change in the recipient's condition requiring an alteration in services.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.