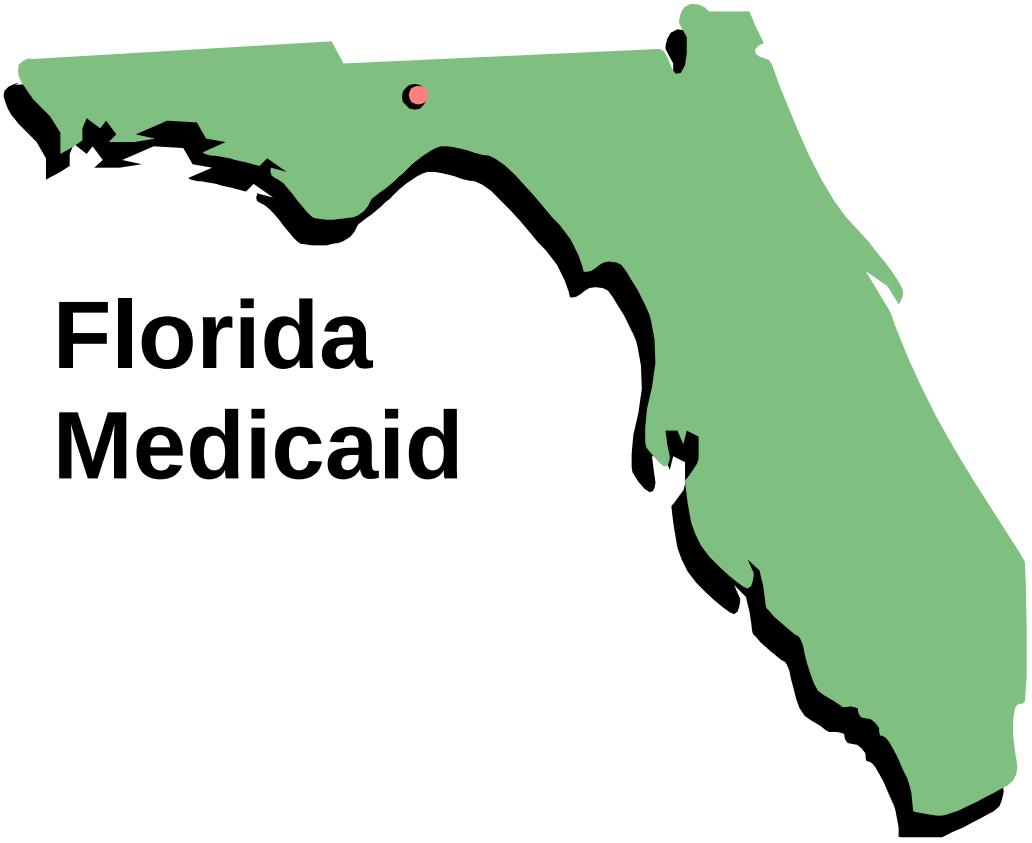

Florida Medicaid

THERAPY SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

August 2013

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG
THERAPY SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update will be issued as a completely revised handbook.

It is very important that the provider read the updated material in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
Replacement Pages	December 1999
Revised Handbook	October 2003
Replacement Pages	July 2008
Revised Handbook	August 2013

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COVERAGE AND LIMITATIONS HANDBOOK
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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

All Florida Medicaid Handbooks may be accessed via the internet at: www.mymedicaid-florida.com/. Select Public Information for Providers, then Provider Support and then Handbooks.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
- Title 42 of the Code of Federal Regulations;
- Chapter 409, Florida Statutes;
- Chapter 59G, Florida Administrative Code.

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Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: • Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. • Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
THERAPY SERVICES
PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Florida Medicaid Therapy Services Program, who is an eligible provider, and the requirements for enrollment.

Legal Authority

Therapy services are governed by Title XIX of the Social Security Act and the Code of Federal Regulations (CFR), Title 42, Part 440.110. The program was implemented through Chapter 409, Florida Statutes (F.S.), and Chapter 59G, Florida Administrative Code (F.A.C.).

Exceptions to Service Limits for Children

Early Periodic Screening Diagnosis, and Treatment (EPSDT) is a federal requirement that the state Medicaid agency cover diagnostic services, treatment, and other measures described in 42 USC 1396d(a). For Medicaid recipients under 21 years of age if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

Physical therapy, occupational therapy, and speech-language therapy services in excess of limitations described in Chapter 3, Appendix A may be prior authorized by the Medicaid Quality Improvement Organization (QIO) based on a plan of care submitted by the service provider. For all other therapy services, the process to request a service that is not covered or exceeds service limits for a child under 21, may be found in the Provider General Handbook.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

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Purpose and Definitions

Purpose

The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services to recipients under the age of 21. The therapy services program also provides limited services to recipients age 21 and older specifically SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings.

Purpose of This Handbook

This handbook is intended for use by providers who provide therapy services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C., and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Authorization Period

The date span for therapy services determined by the therapist; ordered by the primary care providers, Advanced Registered Nurse Practitioners (ARNP) or Physician Assistant (PA) designees, or designated physician specialist; and authorized by the Medicaid Quality Improvement Organization (QIO).

Purpose and Definitions, continued

Occupational Therapy	Occupational therapy is the provision of services that address the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development. Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits, minimize the disabling effect of these deficits, maintain a level of function, acquire a skill set or restore a skill set. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.
Supervision	Supervision must be in compliance with the appropriate discipline practice act. On-site refers to the immediate and physical availability of the licensed supervisor of the therapy discipline.
Physical Therapy	Physical therapy is a specifically prescribed program to develop, maintain, improve or restore neuro-muscular or sensory-motor function, relieve pain, acquire a skill set, restore a skill set, or control postural deviations to attain maximum performance. Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.

Purpose and Definitions, continued

Place of Residence	Place of residence is the location in which a recipient resides for an extended or a permanent period of time and is considered his home.
Respiratory Therapy	Respiratory therapy is treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Respiratory therapy services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilatory support; therapeutic and diagnostic use of medical gases; respiratory rehabilitation; management of life support systems and bronchopulmonary drainage; breathing exercises and chest physiotherapy.
Speech-Language Pathology	Speech-language pathology services involve the evaluation and treatment of speech-language disorders. Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies. Examples are techniques and instrumentation to evaluate the recipient's condition, remedial procedures to maximize the recipient's oral motor functions and communication via augmentative and alternative communication (AAC) systems.
Unit of Service	A unit of service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

Provider Qualifications

Introduction

Medicaid enrolls physical, occupational and respiratory therapists, speech-language pathologists, and home health agencies as therapy providers.

Provider Qualifications For Individual Therapists

To enroll as a Medicaid provider, the individual therapist must be currently licensed as a physical, occupational or respiratory therapist or speech-language pathologist under Chapter 468 or 486, F.S.

Provisionally Licensed Speech-Language Pathologists

A provisionally licensed speech-language pathologist may enroll as a Medicaid provider if he or she is:

- Provisionally licensed under the Florida Administrative Code (F.A.C.);
- In the process of meeting the qualifications for a certificate of clinical competence (CCC) from the American Speech and Hearing Association; and
- Supervised by a Medicaid enrolled licensed speech-language pathologist in accordance with Chapter 468 F.S. and Chapter 64B-20 F.A.C.

A provisionally licensed speech-language pathologist must be enrolled as a Florida Medicaid provider to be reimbursed by Medicaid.

Provider Qualifications, continued

Home Health Agencies

Medicaid reimburses home health agencies for occupational therapy, physical therapy, and speech-language pathology services through their home health agency provider numbers.

Medicaid does not reimburse home health agencies for respiratory therapy services through their home health agency provider number. Home health agencies may enroll as group therapy providers with a specialty in respiratory therapy. The home health agency must have at least two licensed registered respiratory therapists in the group that are enrolled as individual providers in Medicaid.

Provider Qualifications for Home Health Agencies

To enroll as a Medicaid provider, a home health agency must be licensed in accordance with Chapter 400, Part IV, F.S., and Chapter 59A-8, F.A.C. or the applicable laws of the state in which the services are furnished.

The home health agency must:

- Meet the Medicare Conditions of Participation as determined through a survey conducted by the Agency for Health Care Administration, Division of Health Quality Assurance (HQA); or
- Be accredited and deemed by the Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP) as meeting the Medicare Conditions of Participation; and
- Employ or contract with occupational therapists, physical therapists, registered respiratory therapists or speech-language pathologists who are currently licensed under Chapter 468 or 486, F.S.; and
- Be certified as a rehabilitation agency or comprehensive rehabilitation facility under Title XVIII of the Social Security Act to be exempt from home health licensure or licensed under Chapter 400, F.S. as a home health agency providing two or more types of therapy.

Home Health agencies receiving accreditation and deemed status by JCAHO or CHAP are responsible for providing accreditation documentation to HQA.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Provider Qualifications, continued

Expired License	A therapy services provider whose license has expired is, after written notice, automatically excluded from participation in the Medicaid program. If the provider's license is reinstated, he may reapply to be a Medicaid provider.
Therapists with Temporary Licenses	Medicaid recognizes occupational therapists with temporary licenses who have applied for licensure according to Chapter 468, F.S. Occupational therapists (OT) who hold temporary licenses cannot enroll as Medicaid providers. However, a licensed, Medicaid enrolled OT may supervise services rendered by professionals who have temporary licenses. The supervision must be in accordance with Chapter 468, F.S. and the Chapter 64B-11, F.A.C. The Medicaid enrolled OT will be reimbursed for supervising services provided by a temporary licensed OT according to the codes and rates in the Therapy Services Procedure Codes and Maximum Fee Schedule. All documentation must be signed by both the temporary licensed OT and the supervising Medicaid enrolled OT. Note: See Chapter 3, Appendix A, of this handbook for the Therapy Services Procedure Codes and Maximum Fee Schedule
Therapy Assistants	Physical therapy assistants, occupational therapy assistants, and speech-language pathology assistants cannot enroll as providers. The physical therapist, occupational therapist, speech-language pathologist who supervises, or home health agency that employs the therapy assistant may be reimbursed for the therapy assistant's visits. Note: See Chapter 1 to reference on-site supervision.
Therapy Assistant Requirements	In order for a therapy assistant's services to be reimbursed by Medicaid, the therapy assistant must meet the following requirements: Physical therapy assistants must be licensed under Chapter 486, F.S., and meet all the requirements that pertain to physical therapy assistants in the (F.A.C.) Occupational therapy assistants must be licensed under Chapter 468, F.S., and meet all the requirements that pertain to occupational therapy assistants in the F.A.C. Speech-language pathology assistants must be certified under Chapter 468, F.S., and meet all the requirements that pertain to speech-language pathology assistants in the F.A.C.

Provider Qualifications, continued

General Enrollment Requirements	Therapy providers must meet the general Medicaid provider enrollment requirements contained in the Florida Medicaid Provider General Handbook. In addition, they must follow the specific enrollment requirements listed in this section.
Qualified at the Time of Enrollment	Therapy providers must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.
Group Providers	Two or more providers practicing together must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

Provider Responsibilities

General Requirements	In addition to the general provider requirements and responsibilities contained in the Florida Medicaid Provider General Handbook, therapy providers (trading partners) are also responsible for complying with the provisions contained in this section.
Provider Responsibility and HIPAA	Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This coverage and limitations handbook contains information regarding procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbook contains the claims processing requirements for Florida Medicaid necessary to comply with HIPAA. Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 1 the Florida Medicaid Provider General Handbook. Note: For more information regarding claims processing and billing see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 or contact the help desk at 800-289-7799, select Option 3.

Provider Responsibilities, continued

Record Keeping Requirements

Therapy providers must follow the record keeping requirements listed in the Florida Medicaid Provider General Handbook.

Note: See the Florida Medicaid Provider General Handbook for additional information. The handbook is available on the Medicaid fiscal agent's Web Site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Non-Compliance

Therapy providers found non-compliant with the rules contained in this handbook are subject to the following actions:

- Recoupment of funds; and
- Termination as a provider of Medicaid Therapies; and
- Sanctions or other penalties afforded by law.

Note: See the Florida Medicaid Provider General Handbook for information on Medicaid fraud and abuse. The handbook is available on the Medicaid fiscal agent's Web Site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Multiple Therapy Providers

When services from more than one therapy provider are required to provide medically necessary care to a recipient, Medicaid applies the following criteria for reimbursement:

- Medicaid will not reimburse the same service provided by different therapy providers from the same discipline on the same day if the total service units exceed four units of service per day;
- Each therapy provider is responsible for coordinating the plan of care with other involved therapy providers;
- Each therapy provider is responsible for noting on the plan of care the services being provided by another therapy provider;
- Each therapy provider is accountable for the provided services and billing pursuant to the authorized plan of care;
- When requesting prior authorization, each therapy provider is responsible for informing the Medicaid contracted Quality Improvement Organization (QIO) of other therapy providers also providing services to the recipient.

CHAPTER 2
THERAPY SERVICES
COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Therapy Services Program, the requirements for service provision, and the service limitations and exclusions.

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Requirements to Receive Services

Introduction

Medicaid reimburses for the physical therapy (PT), occupational therapy (OT), respiratory therapy (RT), and speech-language pathology (SLP) services described in this handbook. The Florida Medicaid Therapy Services Program reimburses only for the therapy services listed on the Procedure Codes and Maximum Fee Schedule in Chapter 3, Appendix A of this handbook.

Who Can Receive Therapy Services

Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21. Medicaid also reimburses limited services to recipients age 21 and older, specifically: SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings. These are the only services in the therapy program that Medicaid reimburses for adults.

Requirements to Receive Services, continued

Service Requirements	Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.
Medically Necessary Definition Chapter 59G-1.010 (166), Florida Administrative Code	Chapter 59G-1.010 (166), F.A.C. defines medically necessary as follows: (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must: (a) Meet the following conditions: 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain; 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Prior Authorization

Prior Authorization

Prior authorization is the approval process required prior to providing certain services to recipients. Medicaid will not reimburse for these services without prior authorization when it is required. Therapy service providers are required to adhere to requirements outlined in this section in order to receive reimbursement for services. Failure to comply with the prior authorization requirements may result in suspending a provider's access to obtain new prior authorizations for Medicaid services until deficiencies are addressed.

Services Requiring Prior Authorization

The following therapy services require prior authorization for reimbursement:

- Physical therapy;
- Occupational therapy;
- Speech-language pathology.

General Requirements

The following general requirements apply to prior authorizations for therapy services:

- The request must be submitted to the Medicaid QIO via its Web-based Internet system;
- All required documentation to support the request must be submitted directly to the QIO at the time of the request;
- For initial service requests, it is recommended that the therapy services provider submit the request to the QIO at least ten business days prior to the start of care;
- For subsequent authorization requests (continued stay requests), the therapy services provider must submit the request to the QIO at least ten business days prior to the new certification period;
- The earliest effective date of the authorization is the date the request is received by the Medicaid QIO; and
- When requesting prior authorization, each therapy provider is responsible for informing the QIO of other therapy providers also providing services to the recipient.

Prior Authorization, continued

Requesting Prior Authorization

All requests for prior authorization must be submitted to the Medicaid QIO via its web-based internet system.

At a minimum, each prior authorization request must include all of the following:

- Recipient's name, address, date of birth, and Medicaid ID number;
- Therapy provider's Medicaid provider number, name and address;
- Procedure code(s), with modifier(s) if applicable, matching the services reflected in the plan of care;
- Units of service requested;
- Summary of the recipient's current health status, including diagnosis(es);
- Planned dates and times of service;
- Ordering provider's Medicaid provider number, National Provider Identifier, or Florida Medical License number, name, and address;
- The complete evaluation and plan of care, reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist;
- Patient condition summaries that substantiate medical necessity and the need for requested services, such as a hospital discharge summary (if services are being requested as a hospital discharge summary (if services are being requested as a result of a hospitalization), physician or nurse progress notes, or history and physical;
- A copy of the documentation demonstrating the recipient has been examined or received medical consultation by the ordering or attending physician before initiating services and every 180 days thereafter.

Note: The QIO will authorize service up to a 180 day period. This is called the certification period; and

- A prescription for the therapy services in accordance with the prescription requirements described in this chapter.

Review Criteria

The QIO may use a national standardized set of criteria, approved by the Agency for Health Care Administration (AHCA), as a guide to establish medical necessity for prior authorization of therapy services at the first review level. If services cannot be approved by the first level reviewer, the QIO's physician peer reviewer will determine medical necessity using his clinical judgment, acceptable standards of care, and AHCA's medical necessity definition.

Prior Authorization, continued

Approval Process

The QIO will review each prior authorization request and approve, deny or request additional information to support the request.

Prior authorization requests for therapy services that appear to deviate from treatment norms, established standards of care, or utilization norms may be subject to a more intensified review by the QIO prior to rendering a determination. This may include a telephonic or face-to-face contact with the Medicaid recipient in his place of residence, interviews with the ordering physician, and a review of the recipient's medical record.

The Medicaid QIO will post the status of the request on its Internet system. Providers must check the Internet system for the status of submitted prior authorization requests.

Approved Request

When the request is approved, the approval will contain a prior authorization number for billing and reference.

An approved request is not a guarantee that Medicaid will reimburse the services. The provider and recipient must be eligible on the date of service, and the service must not have exceeded any applicable service limits.

Content and Limitation on Approved Requests

The approval of services is accessed via the Internet system and specifies:

- Procedure code;
- Units of service authorized;
- Dates of service;
- The discipline authorized to provide the service; and
- The number of days for which the prior authorization is valid.

Changes to Approved Requests (Modifications)

For any requested change, the provider must submit via the Internet, additional new information, not previously submitted, documenting the need for additional visits or hours.

When requesting additional visits or hours within a certification period, the provider should indicate that the request:

- Is for additional visits or hours or a change to an already requested certification period; and
- Includes the attending physician's approved plan of care, new orders, and a reason for adjustment.

Prior Authorization, continued

Medicaid Quality Improvement Organization Decision Process

If a physician denial or modified approval is proposed, the Medicaid peer review organization informs the provider via the internet. (In a modified approval, a portion of the requested visits or hours may be denied due to lack of medical necessity.)

The Medicaid QIO will post the notice of denial or modified approval on its internet system.

If the physician determines that services are not medically necessary, the recipient and provider will be notified in writing that the services will be denied or reduced. The notification letter will include information regarding the recipient's appeal rights.

Reconsideration Review

If a denial determination is rendered, the provider, recipient, or physician may request reconsideration. If reconsideration is requested, additional information must be submitted to the QIO to facilitate the approval process.

A reconsideration review of the denial decision must be requested via the Medicaid QIO internet system within five business days of the date of the final denial or modified approval determination.

Prior Authorization Number

When the request is approved, the approval will contain a prior authorization number for billing and reference. Only one prior authorization number will be issued per certification period. For Medicaid to reimburse the services:

- The prior authorization number must be entered in field 23 on the claim form;
- The certification period, corresponding to the prior authorization number entered in field 23, must match the dates of services shown on the claim; and
- The Medicaid provider number and Medicaid recipient identification number on the claim form and the plan or care must match.

The Medicaid provider must not submit a claim prior to providing the services.

Termination of Services

A modification request must be submitted to the Medicaid QIO when a therapy services provider terminates services. The modification request must include, at a minimum, the last date that services were provided to the recipient and the number of units used on the prior authorization number up until the point of discharge. Failure to comply with this discharge procedure requirement may result in suspending a provider's access to obtaining new prior authorizations for Medicaid services until deficiencies are addressed.

Prior Authorization, continued

Recipients Exempt from Prior Authorization

Therapy services for the following recipients are exempt from prior authorization by the QIO:

- Recipients who are members of a Medicaid Health Maintenance Organization (HMOs); and,
- Recipients who are members of a Medicaid Provider Service Network (PSNs).

Medically-Needy Eligibility

A Medically-Needy recipient is an individual who would qualify for Medicaid except that the individual's income or resources exceed Medicaid's income or resource limits.

On a month-by-month basis, the individual's medical expenses are subtracted from his income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the month or for part of the month, depending on the date the medical expenses were incurred.

Providers must ensure that Medically-Needy recipients who are approved for services are eligible for services at the time services are rendered.

Note: See the Florida Medicaid Provider General Handbook for additional information on Medically-Needy eligibility. See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for billing information on Medically-Needy recipients.

Medically-Needy Authorization

The Medicaid QIO cannot provide a prior authorization number for a Medically-Needy individual who is in a period of ineligibility. If the individual becomes eligible for the dates that the services were rendered, the provider must notify the QIO via its Internet system that the recipient is a Medically-Needy individual and state the recipient's dates of eligibility for each month authorization is being requested. This will be a retrospective review.

Prior Authorization, continued

Prescription for Services

To be reimbursed by Medicaid, all therapy services, including evaluations, must be prescribed by the recipient's primary care provider, an advanced registered nurse practitioner (ARNP), a designated physician assistant (PA), or a designated physician specialist.

The prescription should be as specific as possible, and must include:

- The recipient's diagnosis or diagnoses contributing to the need for therapy;
- Signature of the prescribing provider;
- Name, address and telephone number of the prescribing provider;
- Date of prescription;
- The specific type of evaluation or service requested
- For therapy services, the duration and frequency of the therapy treatment period; and
- The physician's MediPass authorization number, if applicable.

If the prescription has not been received before the service is rendered, Medicaid will not reimburse for the service.

Prescriptions to evaluate recipients are valid for up to 60 days.

The plan of care may suffice as a prescription for treatment visits if the signed plan of care indicates that the plan of care is to serve as a prescription and satisfies the above requirements.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies' provision of therapy services. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Prior Authorization, continued

Prescription for the Continuation of Services	Before expiration of the authorization period for which the services were approved the primary care provider shall review the recipient's plan of care and may prescribe the continuation of services. The plan of care, with the primary care provider's, ARNP's or PA designee's, or designated physician specialist's signature requesting the continuation of services, must be submitted to the QIO with all other required documentation, and the approval must be received prior to beginning services for the next authorization period. Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Evaluations

Description	Evaluations determine the recipient's level of function and competencies through therapeutic observation and standardized testing measures appropriate to the language, speech, or physical limitations and specific to the therapeutic services required. Evaluation results should be used to develop baseline data to identify the need for early intervention for therapeutic services and to address the recipient's functional abilities, capabilities, and activity level deficits and limitations.

Evaluations, continued

Provider Requirements

Medicaid reimburses the following Medicaid enrolled providers for evaluations:

- Licensed physical and occupational therapists;
- Certified and registered respiratory therapists;
- Licensed and provisionally licensed speech-language pathologists; and
- Home health agencies that employ or contract with licensed physical and occupational therapists and speech-language pathologists.

Medicaid does not reimburse for evaluations performed by therapy assistants.

Temporary Licensed Therapists

A Medicaid enrolled supervising occupational therapist or home health agency may be reimbursed for evaluations performed by an occupational therapist with a temporary license. To receive reimbursement, both the supervising therapist and the therapist with the temporary license must sign and date the evaluation.

Evaluations Tests to be Used

Tests should be:

- Standardized for a specific disorder identified; or
- Consist of a standardized caregiver report format; or
- Composed of professionally acceptable therapeutic observational techniques.

Age equivalent score reporting does not report a standard score and is not an acceptable evaluation test.

Plan of Care

The therapist or speech-language pathologist must write the recipient's therapy plan of care based on the results of the evaluation. Reimbursement for writing the initial plan of care is included in the reimbursement for the evaluation.

Reimbursement Limitations

Medicaid reimburses one initial evaluation per recipient, per discipline, per year. A recipient who has received therapy services within the previous 180 days and whose diagnosis has not changed is not eligible for an initial evaluation and must receive a re-evaluation.

Medicaid reimburses one re-evaluation per recipient, per discipline, every 150 days, beginning 150 days after the initial evaluation. Re-evaluations rendered within 150 days of a previous evaluation are not reimbursable by Medicaid.

Therapy visits performed on the same day as evaluations are not reimbursable.

Evaluations, continued

Codes and Fees	See Chapter 3, Appendix A, in this handbook for a list and description of procedure codes and fees.

Plan of Care

Description	A therapy plan of care is an individualized and specific written program developed by health care professionals for a recipient. The plan of care is designed to meet the medical, health and rehabilitative needs of the recipient.
Plan of Care Requirements	After the therapist or speech-language pathologist performs the initial evaluation of a recipient, and before providing services, the therapist or speech language pathologist must write an initial plan of care for the recipient based on the results of the initial evaluation. All therapy services must be included in the therapy plan of care, except for evaluations, wheelchair evaluations and fittings, and augmentative and alternative communication (AAC) systems. AAC systems require a specific plan of care. If any amendments to the plan of care are necessary, those amendments must be made by the therapist and must be reviewed, approved and signed by the primary care provider before service is provided. The therapist must review the plan of care every 180 days or prior to the end of the authorization period and make necessary revisions. The therapist and the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy must retain a copy of the plan of care in his or her records for the recipient. The plan of care may suffice as a prescription if the signed plan of care indicates that the plan of care is to serve as a prescription and all prescription requirements are met.

Plan of Care, continued

Provider Requirements

Only the following providers may initiate, develop, submit or change the plan of care:

- Licensed physical, occupational and respiratory therapists; and
- Licensed and provisionally licensed speech-language pathologists.

Initial Plan of Care Components

The plan of care must include the following information:

- Recipient's name, date of birth, and Medicaid ID number;
- The specific therapy to be provided;
- Specific, achievable, measurable, time-related long and short term therapeutic goals and objectives that are related to the functioning of the recipient and are based on the primary care provider's, ARNP's or PA designee's, or designated physician specialist's prescription;
- Medications, treatments, and equipment relevant to the plan of care;
- Description of medical condition, including the most specific diagnosis codes within the therapist's scope of practice contributing to the recipient's need of therapy shown in the current edition of the International Classification of Diseases, Clinical Modification;
- Functional limitations;
- Frequency, length of each treatment and the duration of the treatment;
- Therapy methods and monitoring criteria;
- Methods for monitoring equipment needs and recommendations for equipment needs;
- Diet as indicated, if applicable and relevant to the plan of care;
- Methods of demonstrating and teaching the recipient;
- Methods of demonstrating and teaching the family and other relevant caregivers who are involved with the recipient; and,
- How the treatment will be coordinated with the other service needs prescribed for the recipient.

Plan of Care, continued

Initial Plan of Care Components, continued

In addition to the initial plan of care requirements, the renewed plan of care must include:

- A progress report that evaluates the recipient's accomplishments toward a stated goal;
- A description of the recipient's attitudes and behaviors toward the therapy;
- An assessment of the effectiveness of services provided;
- An assessment of the recipient's rehabilitation potential;
- Modifications to the plan of care; and,
- Justification of medical necessity for services provided to maintain functionality.

Plan of Care Approval

The plan of care must be reviewed, signed and dated by the therapist and by the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy. The prescriber's signature indicates approval of the plan of care.

The prescriber must review, certify, and sign the renewed plan of care, based on the recipient's re-evaluation, before the end of the authorization period.

Electronic signatures are permissible as defined by Chapter 668, Part 1, F.S., and CFR Title 45, Part 164.312. All signatures on the plan of care must be legible and dated.

If the plan of care has not been signed and approved before the service is rendered, Medicaid will not reimburse for the service.

Note: See the Florida Medicaid Provider General Handbook for requirements of electronic signatures and electronic record keeping. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Therapy and Speech-Language Treatment Visits

Description

Therapy and speech-language treatment visits are face-to-face encounters with a recipient for the purpose of providing physical, occupational or respiratory therapy or speech-language pathology services. The treatment visit includes all of the therapist's activities with the recipient, except for evaluations; splints and casts; wheelchair evaluations and fittings; and AAC system fittings, adjustments and training.

Reimbursement for demonstrating and teaching, which include the family and other relevant caregivers who are involved with the recipient, is included in the reimbursement for treatment visits if the recipient is present. Otherwise, these services are not reimbursable by Medicaid.

Note: See Splints and Casts, Wheelchair Evaluations and Fittings, and Augmentative and Alternative Communication in this chapter for additional information on these procedures.

Provider Requirements

Medicaid reimburses the following providers for treatment visits:

- Licensed physical and occupational therapists;
- Certified and registered respiratory therapists;
- Licensed speech-language pathologists and provisionally licensed speech-language pathologists; and
- Home health agencies that employ or contract with licensed physical and occupational therapists, licensed speech-language pathologists, and provisionally licensed speech-language pathologists.

Temporary Licensed Therapists

A Medicaid enrolled occupational therapist or home health agency may be reimbursed for treatment visits performed by an occupational therapist with a temporary license being supervised under general supervision requirements. To receive reimbursement, both the supervising therapist and the therapist with the temporary license must sign and date the treatment records.

Therapy and Speech-Language Treatment Visits, continued

Therapy Assistants

A supervising therapist or home health agency may be reimbursed for treatment visits performed by a physical or occupational therapy assistant or speech-language pathology assistant, if the following requirements are met:

- Speech-language pathology assistants must provide the services under the direct supervision of a speech-language pathologist;
- Occupational therapy assistants may provide services under general supervision in a different location than the supervising therapist, but the supervising therapist must be in the same geographical area and accessible by phone for the therapy assistant providing services. The supervising occupational therapist must conduct an on-site supervisory visit to the recipient who has been receiving services from a therapy assistant once every 60 days;
- Physical therapy assistants may provide services under the general supervision of a physical therapist which does not require on-site supervision if the recipient related activities were ordered by a board-certified orthopedic physician or physiatrist licensed pursuant to Chapter 458, F.S., or Chapter 459, F.S., or a practitioner licensed under Chapter 460, F.S. The supervising physical therapist must conduct an on-site supervisory visit every 60 days to a recipient who has been receiving services from a therapy assistant;
- General supervision of a physical therapy assistant shall not require on-site supervision by the physical therapist. The physical therapist shall be accessible by two-way communication, which enables the physical therapist to respond to an inquiry when made and to be readily available for consultation during the delivery of care and shall be within the same geographic location as the assistant;
- Patient-related activities that were not ordered by a board-certified orthopedic physician or physiatrist licensed pursuant to Chapter 458, F.S., or Chapter 459, F.S. and patient-related activities performed for practitioners licensed under Chapter 461, F.S. or Chapter 466, F.S., shall be performed under the onsite supervision of a physical therapist;
- The activity of supervision is not a Medicaid reimbursable service; and
- A therapy assistant treatment visit and therapist treatment visit cannot be reimbursed on the same day.

Therapy and Speech-Language Treatment Visits, continued

Service Requirements

To be reimbursed by Medicaid, physical, occupational and speech-language pathology treatment visits must be:

- Authorized via a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist; in accordance with the Florida Statutes and Licensing requirements;
- Authorized in the recipient's valid and approved plan of care; and
- Prior authorized by the Medicaid contracted Quality Improvement Organization.

To be reimbursed by Medicaid, respiratory therapy treatment visits must be:

- Authorized via a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist; and
- Included in the recipient's plan of care.

To be reimbursed by Medicaid, respiratory therapy services provided in a PPEC center must be:

- Authorized via a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist in accordance with the Florida Statutes and licensing requirements;
- Authorized in the recipient's valid and approved plan of care; and
- Submitted for medical review by the Medicaid contracted Quality Improvement Organization.

For respiratory therapy services provided in a PPEC center, authorization will be valid for up to six months and the medical review authorization must be maintained in the recipient's case files.

Therapy and Speech-Language Treatment Visits, continued

Place of Service

Physical, occupational, and respiratory therapy and speech language pathology treatment services can be provided in the recipient's place of residence or other community setting, such as schools, Prescribed Pediatric Extended Care (PPEC) centers, or day care centers. Reimbursement for services provided in the recipient's place of residence or other community setting is paid directly to the provider on a fee-for-service basis in accordance with the Therapy Services Procedure Codes and Maximum Fee Schedule in Appendix A.

Respiratory therapy services provided in a PPEC center is limited to children who have a complex respiratory diagnosis or condition, requiring extensive airway management, for example, ventilator support, while attending a PPEC center. Respiratory therapy services will be reviewed by the Medicaid contracted Quality Improvement Organization based on the medical needs of the child.

Place of residence is the location in which a recipient resides for an extended or a permanent period of time and is considered the recipient's home. Place of residence may include:

- Recipient's private home;
- Assisted Living Facility (ALF);
- Developmental disabilities group home;
- Foster or medical foster care home; or
- Any home where unrelated individuals reside together in a group.

Services can also be provided in an inpatient and outpatient hospital. Payment for these services is included in the facility's per diem. The therapist cannot be reimbursed directly by fee-for-service for services provided in these locations. Evaluations provided by hospitals are not counted against the recipient's evaluation reimbursement limitations. Inpatient and outpatient hospital therapy services are reimbursed according to the Florida Medicaid Hospital Services Coverage and Limitations Handbook.

Providers cannot bill the same procedure provided in the school setting and community setting in the same day.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. See the Florida Medicaid Hospital Services Coverage and Limitations Handbook for information about hospital services. All Medicaid handbooks are available on the Medicaid fiscal agent's Web Site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Therapy and Speech-Language Treatment Visits, continued

Reimbursement Limitations

Medicaid reimbursement for therapy services is based on units-of-service. Each unit-of-service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

The units-of-service may be combined into one treatment visit or provided as individual treatment visits. Up to four units-of-service, per type of therapy, may be provided on a single date of service. Daily treatments may not exceed four units-of-service. No more than 14 units-of-service, per therapy, will be reimbursed per calendar week from Sunday to Saturday.

Only one type of therapy will be reimbursed for a given 15-minute session. Multiple providers, be it the school district or a community provider, cannot be reimbursed for the same procedure provided to a recipient on the same day.

Physical, occupational, and respiratory therapy must be with an individual recipient, not a group of children. Speech therapy may be rendered to a group of children as described in the Group Therapy Treatment Visits for Speech Therapy.

Physical therapy, occupational therapy, and speech-language therapy services in excess of limitations described in Chapter 3, Appendix A shall be prior authorized by the Medicaid QIO based on a plan of care submitted by the provider.

Therapy and Speech-Language Treatment Visits, continued

Group Therapy Treatment Visits for Speech Therapy	To be reimbursed by Medicaid, a group speech therapy session is limited to six children. All the children do not have to be Medicaid recipients. The group must receive a minimum of 30 minutes of therapy. Medicaid will not reimburse for both group and individual speech therapy sessions for a recipient on the same day.
Documentation	The therapist must record, for each treatment, the time services began and the time the services concluded; the type of services rendered; the progress achieved; and the change in the recipient's status due to treatment. Each entry must be signed and dated by the Medicaid enrolled treating provider on the date the service is provided. Note: See the Florida Medicaid Provider General Handbook for information on record keeping and documentation requirements.
Service Exclusions	Medicaid reimbursement for the therapy treatment visit does not include telephone responses to questions, conferences with the child's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time. Medicaid reimbursement for a respiratory therapy visit does not include securing, installing, or maintaining respiratory therapy equipment. Medicaid does not reimburse a respiratory therapy visit that is solely for the purpose of oximetry services. Medicaid will not reimburse for treatment visits provided the same day as an evaluation for the same type of therapy.
Codes and Fees	Note: See Chapter 3, Appendix A, of this handbook for the therapy treatment visit procedure codes and fee schedule.

Augmentative and Alternative Communication (AAC)

Description	AACs are designed to allow individuals the capability to communicate. As defined by the American Speech-Language Hearing Association (ASHA), an AAC attempts to compensate for the impairment and disability patterns of individuals with severe, expressive communication disorders, i.e., individuals with severe speech-language and writing impairments. Dedicated systems are designed specifically for a disabled population. Non-dedicated systems are commercially available devices such as laptop computers with special software. Medicaid does not reimburse for non-dedicated systems. Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for information specific to AACs. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.
Covered Services for Recipients Under the Age of 21	AAC evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for recipients under the age of 21. Fittings, adjustments, and training are only reimbursed for recipient owned AAC devices.
Covered Services for Recipients Age 21 and Older	AAC initial evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for recipients age 21 and older. Fittings, adjustments, and training are only reimbursed for recipient owned AAC devices. AAC evaluation services provided to recipients age 21 and older are reimbursed only when provided by speech language pathologists.
AAC System Reimbursement	AACs are reimbursed through the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program. Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Augmentative and Alternative Communication (AAC), continued

Who is Eligible to Receive an AAC

For Medicaid to reimburse for an AAC system, the recipient must meet the following criteria:

- Demonstrate a severe, expressive communication disorder; and
- Have the physical, cognitive and language abilities necessary to use the AAC system as documented in an evaluation performed and dated by a licensed speech-language pathologist within the past six months.

Interdisciplinary Team and Evaluation of Recipients Under the Age of 21 Enrolled In Public School

For recipients under the age of 21 enrolled in public school, an interdisciplinary team (ID team) must be formed to evaluate the recipient, recommend an AAC, and write an individualized action plan or plan of care.

The ID team must consist of at least two members and must include a speech-language pathologist who will lead the team. The speech-language pathologist may request the assistance of an occupational therapist and physical therapist. It is expected that most cases will require the need for an occupational therapist to be a part of the ID team. If appropriate, the recipient who will use the AAC should be encouraged to participate on the ID team as well as the recipient's caregivers, teachers, social workers, case managers, and any other members deemed necessary.

It is the responsibility of the team leader to provide the team members and other appropriate individuals with the necessary documentation to review and make a determination of concurrence. Documentation must include an evaluation and individual action plan or plan of care.

Interdisciplinary Team and Evaluation of Recipients Under the Age of 21 Attending Home School

For recipients attending home school, a speech-language pathologist is responsible for performing an evaluation, recommending an AAC device and accessories, and for writing an individualized action plan or plan of care.

An interdisciplinary team for recipients attending home school must consist of the evaluating speech-language pathologist, the home school teacher, and the recipient's parent or responsible caregiver. If the recipient is currently receiving occupational or physical therapy services, the occupational or physical therapist should be included on the team.

Augmentative and Alternative Communication (AAC), continued

Evaluation for Recipients Age 21 and Older or Recipients Not Enrolled in Public or Home School	For recipients age 21 or older or recipients not enrolled in public school or not home schooled, a speech-language pathologist is responsible for performing an evaluation, recommending an AAC device and accessories, and for writing an individualized action plan or plan of care.
Initial Evaluation	The ID team, led by the speech-language pathologist, must perform an initial evaluation on the recipient for an AAC system that meets, at a minimum, the evaluation documentation requirements listed in the Provider Qualifications for Initial Evaluations.
Provider Qualifications for Initial Evaluations	Medicaid reimburses the following provider types for AAC initial evaluations through the therapy services program: • For recipients under the age of 21: _ Licensed and provisionally licensed speech-language pathologists; _ Licensed physical therapists; _ Licensed occupational therapists; and _ Home health agencies that employ or contract with licensed and provisionally licensed speech-language pathologists, licensed physical therapists, and licensed occupational therapists. • For recipients age 21 and older: _ Licensed and provisionally licensed speech-language pathologists; and _ Home health agencies that employ or contract with licensed and provisionally licensed speech-language pathologists.
Initial Evaluation Reimbursement Limitations	For recipients under age 21, Medicaid reimburses one speech-language pathologist, one occupational therapist and one physical therapist who are designated members of the ID team for an initial evaluation. Medicaid reimburses for one initial evaluation per recipient, per provider. AAC evaluations are valid for six months from the date of the initial evaluation. For recipients age 21 and older, Medicaid reimburses one speech-language pathologist for an initial evaluation, per recipient.

Augmentative and Alternative Communication (AAC), continued

Speech-Language Pathologist's Evaluation Documentation Requirements

Once the ID team (or speech-language pathologist for recipients age 21 and older) has evaluated the recipient and recommended an AAC, the speech-language pathologist must document the following information in writing (the first three items are obtained from the recipient's medical record):

- Significant medical diagnosis(es);
- Significant treatment information and medications;
- Medical prognosis;
- Motor skills, i.e., posture or positioning, selection abilities, range and accuracy of movement, wheelchair use (if applicable include make, model, and serial number of wheelchair), etc.;
- Cognitive skills, i.e., alertness, attention span, vigilance, etc.;
- Sensory or perceptual abilities, i.e., hearing, vision, etc.;
- Language comprehension;
- Expressive language capabilities;
- Oral motor speech status;
- Use of communication or present communication abilities;
- Communication needs including the need to enhance conversation, writing and signaling emergency, basic care and related needs;
- Writing impairments, if any;
- Environment, i.e., home, work, etc., with a description of communication barriers;
- AAC recommendation, which may include symbol selection, encoding method, selection set (physical characteristics of display), type of display, selection technique, message output, literacy assessment, vocabulary selection, and participation patterns;
- The evaluator's printed name, title, copy of current professional license or Department of Education certification, and legible and dated signature; and
- The evaluator's telephone number for contact purposes.

Team Approval of the Evaluation

The evaluation, which includes the individualized action plan, must be signed, titled (credentials), and dated by all contributing ID team members (or the speech-language pathologist for recipients age 21 and older).

Augmentative and Alternative Communication (AAC), continued

Individualized Action Plan or Plan of Care	The ID team members headed by the speech-language pathologist (or the speech-language pathologist for recipients age 21 and older) are responsible for developing the recipient's individualized action plan or plan of care. Reimbursement for the development of the individualized action plan or plan of care is included in the reimbursement for the evaluation.
Individualized Action Plan or Plan of Care Components	The ID team members led by the speech-language pathologist (or the speech-language pathologist for recipients age 21 and older) must write the recipient's individualized action plan or plan of care. The plan must include the following information: • An explanation of any AAC currently being used or owned by the recipient at home, work or school; • The current use of the system(s) and its limitations; • The appropriate long and short-term therapy objectives; • The recommended AAC (based on cost-effectiveness and the recipient's needs); • The recommended length of a trial period, if applicable; • A description of any AACs that the recipient has previously tried; • The specific benefits of the recommended AAC over other possibilities; • An established plan for mounting, if necessary, repairing, and maintaining the AAC; • Who is responsible to deliver and program the AAC to operate at the level recommended by the ID team; • Who will train the support staff, recipient and primary caregiver in the proper use and programming of the AAC; and • Documentation of medical necessity.

Augmentative and Alternative Communication (AAC), continued

AAC Systems Reimbursed Through the DME Program	Medicaid reimburses for only AACs that are dedicated systems. AAC systems must be prior authorized by Medicaid. Medicaid will reimburse for one AAC system every five years per recipient, and a software upgrade every two years, if needed. Modifications, which may be in the form of replacing the AAC system or upgrading the AAC's software, may be reimbursed only if the new technology will improve communication significantly. Medicaid will reimburse for replacement of devices, components or accessories when there is irreparable failure or damage not caused by willful abuse or neglect**.**
Trial Period for AACs	The ID team (or the speech-language pathologist for recipients age 21 and older) may recommend that the recipient have a trial period with the AAC system. The trial period must be prior authorized by Medicaid. All the steps for completion of a prior authorization package and the components of the prior authorization package must be completed for a trial period to be authorized.
Concurrence by School Personnel	If the recipient is in the public school system, school personnel must be given the opportunity to comment and concur with the ID team's recommended device. School personnel must agree that the recipient's teacher and school therapist are knowledgeable in the use of the AAC or will be trained in its use.
Concurrence of Home School Teacher	The home school teacher must concur with the recommendation of the AAC device, by providing his printed name, title, and dated signature on the individualized action plan or plan of care. As appropriate, the speech-language pathologist must train the home school teacher regarding the AAC device and its use.

Augmentative and Alternative Communication (AAC), continued

Physician Approval

The speech-language pathologist must send the evaluation, which includes the recommended AAC, the individualized action plan or plan of care, and the speech-language pathologist's plans for management of the recipient's communicative disorder to the recipient's primary care provider, ARNP or PA designee, or designated physician specialist.

The recipient's primary care provider, ARNP or PA designee, or designated physician specialist must review the evaluation and individualized action plan or plan of care, and if he or she concurs, sign and date the evaluation and prescribe the AAC. The prescription must include the primary care provider's, ARNP's or PA designee's, or designated physician specialist's name, address, telephone number, medical license number, and MediPass authorization number, if applicable. (If the recipient is in MediPass, the AAC must be authorized by the recipient's MediPass primary care provider.)

If the recipient is enrolled in MediPass, the recipient's MediPass primary care provider must authorize the AAC device prior to the DME provider's submission of a prior authorization request to the Medicaid fiscal agent.

The primary care provider, ARNP or PA designee, or designated physician specialist returns the signed and dated evaluation, individualized action plan or plan of care, and prescription to the speech-language pathologist.

Note: See the Florida Medicaid Provider General Handbook for information on MediPass and Medicaid Health Maintenance Organizations (HMOs).

Conflict of Interest for AAC Device

The medical professionals who evaluate the recipient, serve on the ID team, or prescribe the AAC device must not have a financial relationship with or receive any financial gain from the AAC device manufacturer or the DME provider.

A signed and dated statement of non-conflict from each member of the ID team must be included in the therapist's documentation and included with the prior authorization request packet.

Note: See Self-Referral and Conflict of Interest in the Provider Requirements section in the Durable Medical Equipment and Medical Supply Services Coverage and Limitation Handbook. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Augmentative and Alternative Communication (AAC), continued

Referral to the DME Provider

The speech-language pathologist is responsible for submitting the following information to the DME provider:

- The recipient's evaluation, which is completed, signed, titled (credentials) and dated by the interdisciplinary team members (or speech-language pathologist for recipients age 21 and older) and the recipient's primary care provider, ARNP or PA designee, or designated physician specialist;
- Individualized action plan; and
- The recipient's primary care provider's, ARNP's or PA designee's, or designated physician specialist's prescription for the AAC system.

Prior Authorization by Medicaid

AACs must be prior authorized by the Medicaid consultant. The DME provider is responsible for requesting prior authorization.

Prior authorization (PA) requests for AAC devices, AAC device accessories, and repairs must be reviewed for medical necessity by Medicaid's professional consultant or designated staff member and authorized by the Medicaid DME and Medical Supply Services Program.

Current procedure codes used for AAC devices and listed on the DME and Medicaid Supply Services Provider Fee Schedule.

Note: For information regarding the authorization process and where to submit prior authorization requests for AAC devices, accessories and repairs, see the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Prior and Post Authorization and Exceptions to the Service Limits section in the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Augmentative and Alternative Communication (AAC), continued

Steps for Completion of a PA Package for Recipients Under 21 Years of Age Enrolled in Public or Home School

The steps below must be followed to obtain Medicaid authorization for an AAC device for recipients who are under 21 years of age and enrolled in public school or attending home school.

Written documentation from each step must be included in the Medicaid prior authorization package:

- Interdisciplinary team (ID team), led by the speech-language pathologist, evaluates the recipient, recommends an AAC device, and writes an individualized action plan or plan of care.
- Speech-language pathologist sends the evaluation, which includes the recommended AAC device, the individualized action plan or plan of care, the speech-language pathologist's plans for management of the recipient's communication disorder, and the non-conflict of interest statement to the recipient's physician, treating physician's ARNP or physician assistant, or designated physician specialist.
- Treating physician, treating physician's prescribing ARNP or physician assistant, or designated physician specialist must review the evaluation and individualized action plan or plan of care and, if he concurs, sign and date the evaluation and prescribe the AAC device.
- Recipient's MediPass primary care provider authorizes the AAC device if the recipient is enrolled in MediPass. (The DME provider must obtain MediPass authorization in order to be reimbursed for the claim.)
- The speech-language pathologist forwards the prior authorization package to the DME provider.
- The DME provider completes the prior authorization package by attaching an invoice, proof of manufacture's cost, warranty information, and a Florida Medicaid Authorization Request form, PA-01, and submits the package to the Medicaid fiscal agent.
- The Medicaid professional consultant reviews the prior authorization package and recommends approval or denial of the authorization request.

Augmentative and Alternative Communication (AAC), continued

Steps for Completion of a PA Package for Recipients 21 or Older or for Recipients not Enrolled in Public or Home School

The following steps must be followed to obtain Medicaid authorization for an AAC device for recipients who are age 21 or older or recipients who are not enrolled in public or home school.

The written documentation for each step must be included in the Medicaid prior authorization package:

- Speech-language pathologist sends the evaluation, which includes the recommended AAC device, the individualized action plan or plan of care, the speech-language pathologist's plans for management of the recipient's communication disorder, and the non-conflict of interest statement to the recipient's physician, treating physician's ARNP or physician assistant, or designated physician specialist.
- Treating physician, treating physician's prescribing ARNP or physician assistant, or designated physician specialist must review the evaluation and individualized action plan or plan of care and, if he concurs, sign and date the evaluation and prescribe the AAC device.
- Recipient's MediPass primary care provider authorizes the AAC device if the recipient is enrolled in MediPass. (The DME provider must obtain MediPass authorization in order to be reimbursed for the claim.)
- Speech-language pathologist forwards the prior authorization package to the DME provider.
- DME provider completes the prior authorization package by attaching an invoice, proof of manufacturer's cost, and a Florida Medicaid Authorization request form, PA-01, and submits the package to the Medicaid fiscal agent.
- The Medicaid professional consultant reviews the prior authorization package and recommends approval or denial of the authorization request.

Augmentative and Alternative Communication (AAC), continued

Medicaid Approval of the AAC	Medicaid's decision for coverage will be based on a medical rationale for the request of a particular system, a comparative analysis of equipment tested, and the individual recipient's ability to use the equipment as it relates to a medical need. Medicaid will not deny an AAC based solely on the fact that the recipient can communicate in writing.
Additional Evaluation Requested by Medicaid	The Medicaid reviewer may request a video of the recipient in different functional communication settings for the evaluation of the prior authorization request. Florida Medicaid reserves the right to request an evaluation of a recipient from another physician or an individual who is board-certified as a neurologist, physiatrist, otolaryngologist, audiologist, optometrist, or ophthalmologist for the purpose of establishing the appropriateness of the device being recommended.
DME Provider Responsibilities	Prior to billing for an AAC system, the DME provider is responsible to ensure the properly selected system and all components have been delivered to the recipient and are operational in the recipient's home.

Augmentative and Alternative Communication (AAC), continued

Follow-up Evaluations	Medicaid reimburses the speech-language pathologist for one follow-up evaluation per rented or purchased device when the AAC system is delivered in order to ensure that the system is appropriate for meeting the needs of the recipient. Medicaid reimburses follow-up evaluations only for recipients under age 21.
Follow-up Evaluation Documentation	Documentation for a follow-up evaluation must be a progress note, signed and dated on the date of service that describes the session with the recipient and AAC, and any alterations made to the initial evaluation and/or the individualized action plan or plan of care.
Re-Evaluations	Medicaid requires that the recipient be re-evaluated for the appropriateness of the AAC system every six months. The first re-evaluation must take place within six months of the follow-up evaluation. Medicaid reimburses re-evaluations only for recipients under age 21.
Re-Evaluation Documentation	Documentation for a re-evaluation must consist of the elements of the initial evaluation.
Provider Requirements for Follow-Up and Re-Evaluations and AAC Fitting, Adjusting and Training Sessions	Medicaid reimburses the following provider types for follow-up evaluation, re-evaluations, and AAC fitting, adjusting and training sessions. • Licensed and provisionally licensed speech-language pathologists; and • Home health agencies that employ or contract with licensed or provisionally licensed speech-language pathologists. Medicaid does not reimburse speech-language pathology assistants for AAC evaluations, fittings, adjustments and training.
Follow-up and Re-Evaluation Reimbursement Limitations	Medicaid reimburses for one follow-up evaluation per recipient under age 21, per device, per provider. Medicaid reimburses up to two re-evaluations per recipient under age 21, per device, per provider, per calendar year. Medicaid will reimburse for only one follow-up evaluation plus one re-evaluation or two re-evaluations per recipient under age 21, per device, per provider, per calendar year.

Augmentative and Alternative Communication (AAC), continued

AAC Fitting, Adjustment and Training Sessions	Treatment sessions for AAC fitting, adjustment and training are face-to-face encounters with a recipient for the purpose of providing instructions on the use of the AAC device and making minor adjustments on the device as needed. Medicaid reimburses for these sessions for all recipients. The sessions must be a face-to-face contact with an individual recipient. Medicaid does not reimburse for group AAC fitting, adjustment and training.
AAC Fitting, Adjustment and Training Sessions Reimbursement Limitations	Medicaid reimburses the provider for medically necessary AAC fitting, adjustments, and training sessions. Medicaid reimburses up to a maximum of eight 30-minute sessions per recipient, per device, per year. The provider may be reimbursed for only one session, per recipient, per day. Providers may also be reimbursed for one treatment session on the same day as a fitting, adjustment and training session for recipients under age 21.
Service Exclusions	Medicaid reimbursement for the AAC fitting, adjustment and training sessions does not include telephone responses to questions, conferences with the child's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time.
Documentation for AAC Fitting, Adjustment and Training	The therapist must record on a per treatment basis the time period and the type of service rendered, the progress of the recipient in the use of the AAC device, and change in the recipient's status due to the services rendered. Each entry must be signed and dated by the Medicaid enrolled treating provider on the date the service was provided. Note: See the Florida Medicaid Provider General Handbook, for information on record keeping and documentation requirements.
Codes and Fees	See Chapter 3, Appendix A, of this handbook for the AAC procedure codes and fee schedule.

Strappings and Castings

Description	Medicaid reimburses physical and occupational therapists for applying strappings and casts that are needed for a recipient's therapy.
Provider Requirements	Only licensed physical and occupational therapists can be reimbursed for applying strappings and castings.
Service Requirements	To be reimbursed by Medicaid, the strapping or casting service must be: • Authorized by a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist; and • Included in the recipient's plan of care.
Reimbursement Limitations	Medicaid reimburses for a maximum of two casting and strapping applications per day, per recipient. This is a combined total. A therapy visit and a casting or strapping application may be reimbursed on the same day for the same recipient. Application of strappings or castings must require a professional level of expertise and should not be construed to be the application of orthotics or a similar activity that is taught to family or caregiver.
Codes and Fees	See Chapter 3, Appendix A, of this handbook for the strapping and casting procedure code and fee schedule.

Wheelchair Evaluations and Fittings

Description

Medicaid reimburses physical and occupational therapists for an initial evaluation of a recipient's need for a wheelchair~~,~~ and follow-up evaluations after it is delivered to make adjustments and to properly fit the wheelchair to the recipient.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for information specific to wheelchairs. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Provider Requirements

Only licensed physical and occupational therapists may be reimbursed for wheelchair evaluations.

The therapist who performed the initial wheelchair evaluation must:

- Be available to the durable medical equipment provider that is supplying the wheelchair; and
- Be present upon delivery of the wheelchair to perform the follow-up evaluation to make adjustments and properly fit the chair to the recipient.

Service Requirements

To be reimbursed by Medicaid, the following criteria must be met:

- The initial wheelchair evaluation must be prescribed by the primary care provider, ARNP or PA designee, or a designated physician specialist;
- The therapist must complete, sign and date a wheelchair evaluation report documenting the recipient's need for a wheelchair and the specific type of wheelchair needed; and
- The primary care provider, ARNP or PA designee, or a designated physician specialist must provide the durable medical equipment provider with a written prescription for the wheelchair repair or replacement.

Wheelchair Evaluations and Fittings, continued

Wheelchair Evaluation Report

The wheelchair evaluation report must contain the following information:

- Identification of the recipient's physical conditions that make a wheelchair reasonable and medically necessary;
- If an electric wheelchair is recommended, justification of its appropriateness based on the recipient's capacity and medical condition;
- Justification of all accessories and add-on components based on the recipient's medical needs; and
- Explanation of the medical or health related purpose for each accessory or add-on component, the medical consequences of omitting the item, and why the physical disability of the recipient justifies the inclusion of the item.

Send the request directly to the following address for review:
Bureau of Medicaid Services
DME Prior Authorization
2727 Mahan Drive, Mail Stop 20
Tallahassee, FL 32308

PA requests for custom manual and custom power-operated wheelchairs (K0009 and K0014) must be submitted on either the Custom Wheelchair Evaluation, AHCA-Med Serv Form 015, July 2007, or another document that contains the same information as the form.

Note: See the Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook for the AHCA-Med Serv Form 015, July 2007. The handbook may be accessed at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Reimbursement Limitations

Medicaid reimbursement for wheelchair evaluations and fittings is limited to:

- One initial wheelchair evaluation per recipient, per provider, every five years;
- One follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the chair to the recipient; and
- One follow-up evaluation six months after the wheelchair is delivered to recommend any additional adjustments.

The Florida Medicaid Durable Medical Equipment Program reimburses one mobility device every five years.

Codes and Fees

See Chapter 3, Appendix A, of this handbook for the wheelchair evaluations and fitting procedure codes and fee schedule.

CHAPTER 3
THERAPY SERVICES PROCEDURE CODES

Overview

Introduction

This chapter describes the procedure codes for Medicaid reimbursable services that must be used by therapists providing services to eligible recipients.

Procedure and Diagnosis Code Origination

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. The CPT includes HCPCS descriptive terms and parameters and numeric identifying codes for reporting service and procedures.

A diagnosis code is required on the CMS-1500 claim form for all medical procedures. Use the most specific code available. Fourth and fifth digits are required when available.

In This Chapter

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Reimbursement Information

Submission of a Prior Authorization Claim for Payment

Providers submit a claim for payment for a prior authorized procedure after the service has been approved and provided.

In order to receive reimbursement for the service, the provider must enter the 10 digit prior authorization number on the claim form.

Note: For additional information on completing the claim form, see the Florida Medicaid Provider Reimbursement Handbook, CMS 1500. The handbook may be accessed at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and the Provider Handbooks.

Prior Authorization Number

When a prior authorization request is approved, the approval will contain a prior authorization number for billing and reference. Only one prior authorization number will be issued per certification period.

For Medicaid to reimburse the service:

- The 10-digit prior authorization number must be entered in field 23 on the claim form;
- The authorization period, corresponding to the prior authorization number entered in field 23, must match the dates of service shown on the claim;
- The Medicaid provider number and Medicaid recipient identification number on the claim form and the plan of care must match; and
- The Medicaid provider must provide the service before submitting the claim.

Therapists with Temporary Licenses

Medicaid enrolled, supervising therapists and home health agencies may be reimbursed for services rendered by occupational therapists with temporary licenses. The provider bills the procedure code for the service that the temporary licensed therapist rendered.

Note: See Appendix A in this chapter for the therapy procedure codes and fees.

Therapy Assistants

Medicaid enrolled, supervising therapists and home health agencies may be reimbursed for services rendered by physical therapy assistants, occupational therapy assistants and speech-language pathology assistants. Providers must use the therapy assistant procedure codes to bill for services rendered by therapy assistants. These codes have lower maximum fees than the therapy procedure codes. Reimbursement for supervision is included in the therapy assistant fee. Providers may not bill an additional charge for the supervision of a therapy assistant.

Note: See Appendix A in this chapter for the therapy assistant procedure codes and fees.

Reimbursement Information, continue

Services Provided in Institutions	Therapy services provided in a nursing home facility, an intermediate care facility for developmental disabilities (ICF/DD), or an inpatient and outpatient hospital are not reimbursed according to the fee schedule in Appendix A. Medicaid reimbursement for therapy services is included in the facility's cost-based reimbursement.

How to Read the Therapy Fee Schedule

Description	The therapy fee schedule lists the procedure codes, modifiers, their descriptors and maximum fees. The following information explains the procedure codes and maximum fee schedule columns, reading from left to right.
Code	The five-digit, alpha-numeric code in this column identifies the procedure being billed.
Description of Service	The information in this column describes the service or procedure associated with the procedure code.
Maximum Fee	The fee in this column is the maximum amount Medicaid will pay for the procedure. The maximum fee encompasses the professional and technical components of the service.
Maximum Allowable Units	The maximum amount of units reimbursable by Medicaid to a provider for the specified period of time.

APPENDIX A
PROCEDURE CODES AND MAXIMUM FEE SCHEDULE

APPENDIX A
PROCEDURE CODES AND MAXIMUM FEE SCHEDULE

AUGUMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC)

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
92597		AAC Initial Evaluation Provided by a Speech-Language Pathologist	$97.50	1 per 5 years
92597	GP	AAC Initial Evaluation Provided by a Physical Therapist	$97.50	1 per 5 years
92597	GO	AAC Initial Evaluation Provided by an Occupational Therapist	$97.50	1 per 5 years
92597	GN	AAC Re-Evaluation Provided by a Speech-Language Pathologist	$50.00	1 per 6 months
92609		AAC Fitting, Adjustment, and Training Visit	$40.00	8 per year

OCCUPATIONAL THERAPY

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
97003		Occupational Therapy Evaluation, Initial	$48.50	1 per year
97004		Occupational Therapy Re-Evaluation, Periodic	$48.50	1 per 5 months
97530		Occupational Therapy Treatment Visit	$16.97	4 per day, 14 per week*
29799	HA	Application of Casting or Strapping	$18.58	2 per day

PHYSICAL THERAPY

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
97001		Physical Therapy Evaluation, Initial	$48.50	1 per year
97002		Physical Therapy Re-Evaluation, Periodic	$48.50	1 per 5 months
97110		Physical Therapy Treatment Visit	$16.97	4 per day, 14 per week*
29799	HA	Application of Casting or Strapping	$18.58	2 per day

APPENDIX A
PROCEDURE CODES AND MAXIMUM FEE SCHEDULE

RESPIRATORY THERAPY

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
S5180	HA	Initial Evaluation/Re-evaluation - Rendered by a Registered Respiratory Care Practitioner	$48.50	1 per 6 months
G0238		Respiratory Therapy Visit - Rendered by a Registered Respiratory Care Practitioner	$16.97	4 per day, 14 per week

SPEECH THERAPY

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
92506		Speech Therapy Evaluation/Re-evaluation	$48.50	1 per 5 months
92507		Speech Therapy Visit	$16.97	4 per day, 14 per week*
92508	HA	Group Speech Therapy per child in the group per 15 minutes	$ 3.30	4 per day, 14 per week*

THERAPY ASSISTANTS: PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
92507	HM	Speech Therapy Visit Provided by a Speech Therapy Assistant	$13.58	4 per day, 14 per week
97530	HM	Occupational Therapy Visit Provided by an Occupational Therapy Assistant	$13.58	4 per day, 14 per week
97110	HM	Physical Therapy Visit Provided by a Physical Therapy Assistant	$13.58	4 per day, 14 per week

WHEELCHAIR EVALUATION AND FITTING

Code	Modifier	Description of Service	Maximum Fee	Maximum Allowable Units
97001	TG	Wheelchair Evaluation and Fitting by a Physical Therapist	$48.50	3 per five years*
97003	TG	Wheelchair Evaluation and Fitting by an Occupational Therapist	$48.50	3 per five years*

***See Chapter 2 for more details**