OCCUPATIONAL THERAPY

ND Medicaid covers occupational therapy provided to a member by an occupational therapist, or occupational therapy assistant under the supervision of a licensed, «qualified,» and enrolled occupational therapist.

COVERED SERVICES

Occupational therapy requires an order (prescription) for evaluation and treatment from a physician or practitioner of the healing arts allowed to prescribe under their scope of practice according to state law.

Occupational therapy includes services that address an individual's deficits in occupational performance, motor skills, cognitive skills, sensory integrative skills, preventive skills, therapeutic adaptations, and activities of daily living.

Occupational therapy services must be of a level of complexity and sophistication, or the condition of the member must be of a nature that requires the judgment, knowledge, and skills of an occupational therapist.

Occupational therapy provided on an ongoing basis to maximize the member's functional level is covered for members who have:

- experienced trauma;
- a chronic condition; or
- a condition due to congenital abnormality, deprivation, or disease

that interrupts or delays the sequence and rate of normal growth, development, and maturation.

Occupational therapy services provided to a resident in a nursing facility, «swing bed, hospital,» or ICF/IID are not separately billable. ND Medicaid pays for occupational therapy through the rate established for these facilities.

ND Medicaid covers the following CPT® codes:

96110	Developmental screening «with scoring and documentation, per standardized instrument.»
96112	Developmental test administration by «a physician or other» qualified health care professional with interpretation and report, first 60 minutes
96113	«Each» additional 30 minutes. «Use in conjunction with 96112.»
96127	Brief emotional or behavioral assessment
97039, 97139 & 97799	Unlisted modality, procedure, or service These codes always require service authorization and will not be considered for services identified as noncovered in this chapter.

97010	Application of hot or cold packs to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97032	Application of electrical stimulation to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97113	«Aquatic therapy with therapeutic exercises», each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97165	«Occupational therapy evaluation, low complexity», typically 30 minutes
97166	«Occupational therapy evaluation, moderate complexity», typically 45 minutes
97167	«Occupational therapy evaluation, high complexity», typically 60 minutes
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes

PLAN OF CARE

Occupational therapy services must be provided in accordance with the written plan of care. Plans of care must be dated and signed by the occupational therapist overseeing the plan.

The initial plan of care/treatment plan shall contain, at minimum:

- Diagnosis;
- A description of the member’s functional status;
- The objectives of the occupational therapy service;

- Short-term treatment goals;
- Long-term treatment goals; and
- Type, amount, duration, and frequency of therapy services;

The plan of care shall be consistent with the related evaluation, which is considered part of the plan. The plan should provide for treatment in the most efficient and effective manner and anticipate progress toward achieving the treatment goals within a relatively short amount of time, generally not to exceed 90 days. Long-term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long-term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. Therapists typically also establish short-term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care.

The occupational therapist must update the plan of care within 90 days of the initial evaluation or first therapeutic encounter; and each 90-day interval throughout the course of treatment. With each 90-day interval, the plan of care must be certified (signed and dated) by the «ordering or referring provider» who has knowledge of the need for and supports ongoing therapy services for the member.

Updates to the plan of care must include:

- Prior short-term goals;
- Prior long-term goals;
- Explanation of progress toward goal attainment since initial or previous plan of care update;
- New, modified or carried-over short-term goals; and
- New, modified or carried-over long-term goals.

LIMITATIONS

Occupational therapy evaluations are limited to one per calendar year. Occupational therapy is limited to 30 visits per calendar year for members age 21 and over.

SERVICE AUTHORIZATIONS

Members are limited to one evaluation per year which does not require a service authorization. Service authorizations are required for

- Additional evaluations,
- Reevaluations, and
- Therapy visits that exceed the limit of 30 visits per calendar year for members ages 21 and over.

ND Medicaid will not cover services exceeding the limit provided without a service authorization.

Service Authorization Requirements

The occupational therapist must submit a service authorization prior to the member's receipt of services requiring authorization. Therapists must:

- Complete and submit a Service Limits Service Authorization Request (SFN 481) to ND Medicaid along with a copy of the current plan of care and relevant progress notes.
    - SFN 481 is available at https://www.nd.gov/eforms/.

Upon receipt of the complete service authorization request, including the current plan of care and progress notes, ND Medicaid will evaluate the request for additional services for the following:

- Medical necessity;
- Progress toward goal attainment;
- Type, amount, duration, and frequency of continued therapy services; and
- Reasonableness of new, modified, or carried-over goals.

To be eligible for retroactive authorization consideration, all requirements for service authorization must be met, and ND Medicaid must receive the retroactive authorization request no later than 90 days from the date the service. The occupational therapy provider must demonstrate good cause for the failure to secure the required prior service authorization request. Retroactive authorization requests are reviewed and decided upon internally on a case-by-case basis.

NONCOVERED SERVICES

- Occupational therapy provided without an order from a physician or licensed practitioner of the healing arts;
- Services for contracture that do not interfere with the member's functional status;
- Ambulation of a member who has an established gait pattern;
- Services for conditions of chronic pain that do not interfere with the member's functional status and that can be maintained by routine nursing measures;
- Services for activities of daily living when performed without participation of the member;
- Arts and crafts activities for the purpose of recreation;
- Services that are not part of the member's plan of care or are specified in a plan of care but are not reviewed and revised as medically necessary;

- Services that are not designed to improve or prevent the digression of the functional status of a member;
- Duplicate therapy «is allowed when delivered 1) collaboratively pursuant to an existing Plan of Care or therapy series or 2) by a school district as specified in the member's Individualized Education Plan (IEP). Therapy received outside of an IEP cannot duplicate therapy received through the member's IEP.»
- A rehabilitative and therapeutic service that is denied by Medicare or private health insurance for payment because of the provider's failure to comply with Medicare or private health insurance requirements;
- Masseur or masseuse services;
- Unattended electrical stimulation;
- Unattended modalities;
- Graded motor imagery; guided visualization, or any other visualization therapy;
- Dry needling;
- Kinesio Taping;
- Acupuncture; and
- Maintenance therapy.

«DOCUMENTATION REQUIREMENTS

See the Documentation Guidelines for Medicaid Services found in the Provider Information policy.

DEFINITIONS

Duplicate therapy – means therapy and/or treatment provided by more than one provider of the same type for the same diagnosis.»

BILLING GUIDELINES

Practitioners: When billing for one code that is billed in units (i.e. 15 minutes) throughout a day, report the total amount of units on one claim line.