Therapies

Physical, Occupational, Speech

Provider Manual
Volume II

March 2023

New Hampshire
Medicaid

Table of Contents

Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and complies with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to the NH Medicaid Program for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The General Billing Manual – Volume I Appendices section encompasses a range of supplemental materials such as Contact Information, Common Acronyms, and general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

These manuals are ***not*** designed for use by NH Medicaid members (hereinafter referred to as members).

1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

1.3 Document Disclaimer/Policy Interpretation

It is the Department's intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

1.4 Notifications & Updates

Providers are notified of NH Medicaid Program changes and any other changes applicable to participating providers through several types of media, including provider bulletins, provider notices, memos, letters, website updates, newsletters and/or updated pages to the General Billing Manual – Volume I, and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 Description of Change Log

All changes made to this manual are under change control management and are approved by Department and/or its associated organizations. The change log is located at the front of this document.

1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I, Appendices Section, for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

Each participating physical therapist, occupational therapist, and speech-language pathologist must be licensed by the state in which they practice and be an enrolled NH Medicaid provider.

Physical therapy assistants, occupational therapy assistants, and speech-language assistants shall not be eligible to enroll as NH Medicaid providers, but may provide services to members in accordance with the detailed requirements below under “covered services.”

A physical therapy assistant may work under a physical therapist’s general supervision. General supervision means that the physical therapist is not required to be on site for direction and supervision, but must be available at least by telecommunication.

3. Covered Services & Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit these requests can be found in this Provider Specific Billing Manual - Volume II.

Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders shall be covered when prescribed in writing by a physician or other licensed practitioner for each member treated.

Services are covered:

1. When performed by the physical therapist, occupational therapist, or speech-language pathologist; or
2. When performed by a physical therapy assistant, an occupational therapy assistant, or a speech-language assistant working under the direction of a PT, OT, or SLP, as applicable, and in accordance with applicable requirements in Phy 400, Occ 400, or Spe 600.

When services are provided by a physical therapy assistant, an occupational therapy assistant, or a speech-language assistant, working under the direction of a PT, OT, or SLP, as applicable, and in accordance with applicable requirements in Phy 400, Occ 400, or Spe 600, the individual responsible for the oversight of the assistant shall, in addition to any applicable requirements in Phy 400, Occ 400, or Spe 600:

1. See the member first to conduct the initial assessment and develop a plan of care;
2. See the member periodically thereafter;
3. Specify the type of care to be provided by the physical therapy assistant, occupational therapy assistant, or speech-language assistant;
4. Review the need for continued services;
5. Assume professional responsibility for services provided by the physical therapy assistant, occupational therapy assistant, or speech-language assistant; and
6. Ensure that services provided are within the scope of the prescribed services.

Hearing aid services and related auditory devices shall be covered subject to the requirements and limits set forth in He-W 567 HEARING AID SERVICES and in the applicable Provider Specific Billing Manual – Volume II.

3.1 Service Limits

The service limits for physical therapy, occupational therapy and services for speech, hearing and language disorders, shall apply to all such services, regardless of whether these services are provided by a hospital outpatient department or another provider, such as a home health agency, or by the individual therapists.

Physical therapy, occupational therapy, and services for speech, hearing and language disorders shall be limited to 80 fifteen-minute units per member per state fiscal year (July 1 – June 30).

The 80 units described above may be used for physical therapy, occupational therapy, services for speech, hearing and language disorders, or any combination of these services.

4. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered services is provided to a member, the provider must inform the member, **prior to** delivering the service, that it is non-covered by NH Medicaid, and that should the member still choose to receive the service, then the member is responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

Non-covered services include therapies provided for which service authorization is required, but was not obtained.

Also, note that children under the age of 3 may be eligible to receive client centered physical therapy, occupational therapy, and speech therapy as part of the early intervention services covered under "Family-Centered Early Supports and Services (ESS)." Children under the ages of 3 who are receiving Medicaid covered therapies under ESS (He-M 510) are not eligible to receive therapies under the State Plan FFS (He-W 568) as they are considered duplicative.

5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization for a specific item or service.

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The Contact information in the Appendices of the General Billing Manual – Volume I or on the SA form itself should be consulted for the name and method of contact.

PT/OT/ST services do not require service authorizations unless services are requested in excess of the service limits (see the General Billing Manual – Volume I).

Providers of hearing aid services and devices shall request prior authorization in accordance with He-W 567 HEARING AID SERVICES.

6. Documentation

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer. See the "Record Keeping" section of the General Billing Manual – Volume I, for more detailed documentation requirements.

The documentation of each therapy service described in "Covered Services" above shall include:

1. The date of each therapy service provided;
2. The length of time spent rendering the therapy service provided;
3. A description of the therapeutic modality used during the therapy service;
4. Measurable short-term and long-term goals to be achieved;
5. Objectives of the therapy service provided;
6. Modalities;
7. Frequency of therapy services prescribed;
8. An estimation of the duration of treatment needed to meet goals and objectives;
9. Ongoing progress notes evaluating the member's progress in relation to the established goals and estimated duration of treatment; and
10. An indication as to whether the services provided were for individual or group therapy.

The following organizations also have published guidelines for documentation of therapy which can be used as a reference guide:

- The American Occupational Therapy Association;
- The American Physical Therapy Association; and
- The American Speech-Language-Hearing Association.

7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These utilization review activities are required and carried out in accordance with state and federal rules, statutes, regulations CMS transmittals, provider fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume I.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for exclusions as outlined in in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume I.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

Reimbursement to providers of physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders shall be made in accordance with fee schedules established by the Department.

Providers shall bill with a therapy procedure code as defined by the American Medicaid Association's "Current Procedural Terminology (CPT) 2022 Professional Edition".

Providers shall submit claims for payment for services in accordance with the following:

- Only direct treatment by a therapist or a physical therapy assistant, occupational therapy assistant, or speech-language assistant shall be billed, meaning the time the therapist or physical therapy assistant, occupational therapy assistant, or speech-language assistant spends providing direct treatment to one recipient;
- Therapists working as a team to treat one or more recipients shall not each bill separately for the same or different service provided at the same time to the same recipient; and
- If a recipient requires co-treatment simultaneously by 2 therapists, visits shall be billed separately by each provider for the total time the recipient was receiving actual therapy services.
- The time a recipient spends not being treated, for any reason, shall not be billed.

Services provided by a physical therapy assistant, occupational therapy assistant, or speech-language assistant, in accordance with He-W 568.05(b) and (c) and outlined above, shall be billed by the enrolled therapist providing oversight of the physical therapy assistant, occupational therapy assistant, or speech-language assistant.

11. Claims

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes. One procedure or revenue code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

11.2 Service Authorizations (SAs)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, the NH Medicaid Program does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

Service authorizations are not required for PT/OT/ST services unless the service limit is to be exceeded.

11.3 Claim Completions Requirements for Therapies – PT/OT/ST

Therapy (PT/OT/ST) providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P.

Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted area show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

12. Terminology

Department means the New Hampshire department of health and human services.

Medicaid means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

Modalities means methods of prescribed therapy.

Occupational therapy (OT) means "occupational therapy" as defined in RSA 326-C:1, III.

Occupational therapy assistant means "occupational therapy assistant" as defined in RSA 326-C:1, IV.

Physical therapy (PT) means the "practice of physical therapy" as defined in RSA 328-A:2, XI.

Physical therapy assistant means "physical therapy assistant" as defined in RSA 328-A:2, VIII.

Recipient means any individual who is eligible for and receiving medical assistance under the Medicaid program.

Services for speech, hearing and language disorders means diagnostic, screening, preventive, or corrective speech-language pathology.

Speech-language pathology (SLP) means "speech-language pathology" as defined in RSA 326-F:1, IV.

Speech-language assistant means "speech-language assistant" as defined in RSA 326-F:1, II-a.

Title XIX means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the Medicaid program.

Title XXI means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the Medicaid program.

Visits are defined as a meeting scheduled by an individual to see an occupational therapist, physical therapist, or a speech-language pathologist for evaluation, treatment, or advice.