Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Rehabilitative Therapy Services

Updated 01.2025

PART II
REHABILITATIVE THERAPY SERVICES FEE-FOR-SERVICE PROVIDER MANUAL (PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH/LANGUAGE PATHOLOGY)

Introduction

FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare Managed Care Organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

Updated 01/18

PART II
REHABILITATIVE THERAPY SERVICES FEE-FOR-SERVICE PROVIDER MANUAL

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to physical therapy, occupational therapy, and speech/language pathology providers. It is divided into two subsections: Billing Instructions and Benefits and Limitations.

The **Billing Instructions** subsection gives information applicable to physical therapy, occupational therapy and speech/language services for completing and submitting the CMS 1500 Claim Form.

To bill KMAP for rehabilitative therapy services, the individual must be enrolled as a private practitioner or be employed in one of the following practice types: an unincorporated solo practice, unincorporated partnership, or unincorporated group practice. Physician and nonphysician practitioner (NPP) group practices may employ physical therapists in private practice (PTPP) and/or occupational therapists in private practice (OTPP) if state and local law permit this employee relationship.

Note: Coverage is available for rehabilitative physical therapy, occupational therapy, and speech/language therapy services. Rehabilitative therapy services may be billed by providers such as rehabilitation agencies, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), hospices, outpatient departments of hospitals, and suppliers (such as physicians; NPPs; physical, occupational, and speech/language therapists in private practice). Providers are limited to performing services within their scope of practice.

The **Benefits and Limitations** subsection defines specific aspects of the scope of physical therapy, occupational therapy, and speech/language services allowed within KMAP. Each practitioner or certified assistant must remain within his or her scope of practice. KMAP will not reimburse services provided by speech/language therapy assistants.

Access to Records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

7000. REHABILITATIVE THERAPY SERVICES BILLING INSTRUCTIONS
Updated 12/23

Introduction to the CMS 1500 Claim Form
Physical, occupational, and speech/language therapy providers must use the paper CMS 1500 Claim Form or equivalent ANSI X12 electronic transaction when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or on paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated. Any claim not submitted on the red claim from will be returned to the provider. The Kansas Modular Medicaid System (KMMS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

Any of the following billing errors may cause a CMS 1500 claim to deny or be sent back to the provider:

- Sending a CMS 1500 Claim Form carbon copy.
- Sending a KanCare paper claim to KMAP.
- Using a PO Box in the Service Facility Location Information field.

An example of the CMS 1500 Claim Form and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms and Instructions) heading.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers. Refer to **Section 1100** of the *General Introduction Fee-for-Service Provider Manual*.

Submission of Claim
Send completed claim and any necessary attachments to:

KMAP
Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 12/23

Copayments will no longer apply to Kansas Medicaid Fee-for-Service (FFS) members. The mandatory managed care authority for KanCare is transitioning from the 1115 Waiver to the Medicaid State Plan and a 1915b Waiver. Copayments are being removed from the Medicaid State Plan and will not apply to FFS members.

Managed Care members will continue to be exempt from copayments.

BENEFITS AND LIMITATIONS

8300. Benefit Plans Updated 01/18

KMAP members will be assigned to one or more benefit plans. These benefit plans entitle the member to certain services. If there are questions about service coverage for a given benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for information on eligibility verification.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 08/17

All therapy services must be prescribed by a physician.

Habilitative – Habilitative therapy is covered only for participants zero to under 21 years of age. Therapy **must** be medically necessary. Therapy is covered for any birth defects and/or developmental delays (habilitative diagnoses) only when approved and provided by an Early Childhood Intervention (ECI), Head Start or LEA program. Therapy treatments performed in the LEA settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. The purpose of this therapy is to maintain maximum possible functioning for children.

Developmental – Developmental physical, occupational, and speech/language therapy services are covered for children under 21 years of age. Individuals may receive developmental therapy services to treat Autism Spectrum Disorders (ASDs), birth defects, and other developmental delays in any appropriate community setting and from any qualified provider with prior authorization and medical necessity documentation.

Developmental therapy services can be billed using the following range of diagnosis codes:

- F840 - F849 Autism Spectrum Disorder
- F801 - F809 Developmental Speech and Language Disorder
- H9325 Central Auditory Processing Disorder
- F70 - F79 Intellectual Disabilities
- G800 - G809 Infantile Cerebral Palsy
- Q000 - Q899 Congenital Anomalies

ASD coverage is available for the diagnosis and treatment of ASD. Diagnosis must be established using an appropriate assessment instrument and performed by an appropriately licensed medical provider. Services must be preapproved and may include developmental speech therapy, developmental occupational therapy, or developmental physical therapy as appropriate. An initial comprehensive assessment to establish a baseline must be completed. Periodic re-evaluations and assessments are required at least every six months and continuous improvement must be shown to qualify for continued treatment.

The provision of services for all children with birth defects and developmental delays, which include ASD, will be allowed by any qualified provider in any appropriate place of service. The services will include developmental physical therapy, developmental occupational therapy, and developmental speech/language pathology services as documented in a comprehensive treatment plan.

Treatment plan means a submission by a provider or group of providers and signed by both the provider(s) and parent(s)/caregiver(s) that includes:

- The type of therapy to be administered and methods of intervention
- The goals including specific problems or behaviors requiring treatment
- Frequency of services to be provided
- Frequency of parent or caregiver participation at therapy sessions

- Description of supervision
- Periodic measures for the therapy, including the frequency at which goals will be reviewed and updated
- Who will administer the therapy and the patient's current ability to perform the desired results of therapy

Note: An acceptable ICD-10 diagnosis will be required on the treatment plan. Diagnosis codes R68.89 (Other general symptoms and signs), R62.50 (Unspecified lack of expected normal physiologic development in childhood), and R62.59 (Other lack of expected normal physiologic development in childhood) will not be accepted as a primary diagnosis.

For additional information regarding developmental therapy services, reference General Therapy Guidelines and Requirements in **Section 2710** of the *General Benefits Fee-for-Service Provider Manual*.

Rehabilitative – All therapies **must** be physically rehabilitative. Therapies are covered for adults 21 years of age and over only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or illness.

Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit.

Therapy treatments are not covered for psychiatric diagnoses.

Providers of rehabilitative therapy can submit claims with the following diagnosis code: Z5189 – Encounter for other specified aftercare. This replaces ICD-9 diagnosis codes V570 -V579 as the primary diagnosis. Providers are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when Z5189 is used as the primary diagnosis.

Note: Refer to **Section 2720** of the *General Benefits Fee-for-Service Provider Manual* for complete details regarding Telemedicine.

~~**Wheelchair seating assessments**~~

~~Physical Medicine and Rehabilitation procedure codes 97542, 97755, and 97760 will be covered as medically necessary for management of wheelchair seating assessments for all Medicaid members. Regardless of provider, reimbursement will not exceed $500 per member per year for seating assessment services.~~

~~Reimbursement for wheelchair seating assessments is limited to the following approved Kansas Medicaid Seating Clinic providers:~~

- ~~Cerebral Palsy Research Foundation (Carney Center Seating Clinic), Wichita, Kansas~~
- ~~Children's Mercy Hospital Seating Clinic, Kansas City, Missouri~~
- ~~KU Medical Center Seating Clinic, Kansas City, Kansas~~
- ~~Therapy in Motion PA, Olathe, Kansas~~

8400. MEDICAID Updated 01/25

Special Seating/Positioning Center Application

Criteria for Approval

- **Goal:** To identify facilities with the capability to evaluate, prescribe and provide custom positioning/seating systems for individuals of all ages with special needs.
- **Purpose:** To provide custom positioning/seating with an optimal wheelchair which meets an individual's requirements for positioning, improving function, reducing secondary medical complications and maximizing comfort, which enhance the individual's ability to perform activities of daily living, ability to go to school, work and maximize individual independence for Medicaid members with special seating needs.
- **Premise**: Providing the optimal seating system and wheelchair is often a tedious, labor intensive and complex undertaking. The systems themselves consist of the wheelchair frame combined with seat cushions, back cushions and other accessories and components. Some systems are simple, while other systems are extremely customized due to an individual's orthopedic deformities and functional deficits and support the individual's ability to experience a high quality of life and community engagement, including effective mobility for school, work and recreation. The systems must be portable and accommodate functional and physical changes, such as rapid growth in children and life changes in adults, such as weight gain, weight loss or further decline in functional ability. The systems must accommodate this growth for an extended time (usually 5 years). KanCare is a source of reimbursement and most generally the payor of last resort after third party insurance reimbursement. Most third-party payers require extensive documentation from a qualified medical professional that justifies the wheelchair frame, seating, components, and accessories before they will approve payment. It is important that the device be thoroughly evaluated and that the individual and their family are intensively educated on the equipment to ensure the system is functional and appropriate to meet the individual's seating needs. This process should be documented as well.
- functional and appropriate to meet the individual's seating needs. This process should be documented as well.
- ctional and appropriate to meet the individual's seating needs. This process should be documented as well.
    - Currently KanCare requires an approved "Seating /Positioning Center" to produce documentation justifying all equipment. The Division of Health Care Finance (DHCF), in collaboration with Kansas Special Health Care Needs, is the sanctioning body for all approved KanCare seating clinics. This document will identify best practice requirements to become an approved seating clinic provider.

Team Members

The composition of a functioning seating clinic can be varied. It commonly involves a team consisting of the adult member or child and his or her family (support), experienced medical professionals such as Occupational Therapists (OT), Physical Therapists (PT), Physicians (MD), Doctor of Osteopathy (DO), Physicians Assistants (PA), Nurse Practitioners (NP), or Advanced Practice Registered Nurse (APRN) and an experienced Durable Medical Equipment (DME) provider/supplier. It may also include, but is not limited to, intake specialists, billers, schedulers, and technicians. The most important member of the team is the adult member or child and family that are receiving the system. They are the core of the team, and their needs are paramount. The adult member or child and family views are of great value to the functionality of the system within the family's

Special Seating/Positioning Center Application- Team Members continued

daily tasks being considered extremely important. Others may be involved in the process including social workers, case managers, school professionals etc.

Note: In this document the Assistive Technology Professional (ATP) certification is consistently a preferred qualification. An individual who holds an ATP certificate has documented experience in the field of providing complex assistive technologies (including wheelchairs and seating systems) along with passing a rigorous test proving their competence. The person with an ATP certification has signed a code of ethics and must prove continued competency every two years by attending continuing education coures.

Minimum Requirements of Sponsoring Organization

A sponsoring organization is defined as the company, corporation, or legal entity that provides the evaluation, fitting spaces and the medical professionals (employed or contracted). The sponsoring organization must hold certifications from an outside accrediting body that proves the organization has passed a regular inspection that assures that the facility is safe, efficient, and has a proven track record of providing quality medical services. The facility will have policies and procedures in place that prove the facility has records retention, HIPAA compliance, privacy practices etc. All medical professional employees/contractors are subject to the policies and procedures of the sponsoring organization.

Minimum Requirements for Team Members

The following outlines the minimum requirements for team members working in a Special Seating/Positioning Center.

- **Medical Professionals (OT, PT, MD, DO, PA, or APRN):** This is the responsible party for the evaluation and Letter of Medical Necessity (LMN). Two years of experience working with the population served (pediatrics, adults, or both). Must maintain current licensure in the State of Kansas to practice in their individual fields. It is preferred that at least one medical professional in the clinic hold a current certification as an Assistive Technology Professional (ATP) though the Rehabilitation Engineering Society of North America (RESNA).
- iety of North America (RESNA).
- **Durable Medical Equipment (DME) Provider:** An individual who has 2 years of experience in providing wheelchairs and seating systems to the population served (pediatrics, adults, or both).
- **Technician:** An individual who has at least one year of experience at adjusting and repairing wheelchairs and seating systems to the population served (pediatrics, adults, or both) or active mentoring with a technician who has five years of experience doing such. This technician may be employed by the DME provider.

Preferred Requirements for Team Members

It is preferred that the operation of a special seating/positioning center would meet the following criteria:

- **Medical Professionals:** All medical professionals who are responsible for the evaluation or Letter of Medical Necessity (LMN), should hold a current certification as an Assistive Technology Professional (ATP) through the Rehabilitation Engineering Society of North America (RESNA).

Special Seating/Positioning Center Application Preferred Requirements for Team Members continued

- **Durable Medical Equipment (DME) Provider:** DME provider would hold a current certification as an Assistive Technology Professional (ATP) though the Rehabilitation Engineering Society of North America (RESNA).

- **Technician:** Five years of experience adjusting and repairing wheelchairs and seating systems for the population served (pediatrics, adults, or both).
- The DME provider shall be present if the medical professional conducting the evaluation does not hold a current ATP certification.
- A written prescription by a licensed physician is required. This prescription authorizes the designated medical professional who will perform and document the wheelchair and seating evaluation and LMN. The evaluation shall be completed by a medical professional meeting minimum requirements at the seating clinic facility, or designated outreach location, with the adult member or child/family present. A physician shall sign off on the evaluation.
- child/family present. A physician shall sign off on the evaluation.
- The evaluation must include the following:
    1) Diagnosis
    2) Reason for referral
    3) Medical history
    4) Current wheelchair and seating system
    5) Concerns/problems list
    6) Description of orthopedic, neurologic, positioning needs
    7) Functional capabilities of the child
    8) Data including range of motion, muscle testing, strength, weight, body measurements, etc.
    9) Goals and objectives related to the wheelchair and seating system
    10) List of specific wheelchair frames, parts, cushions, backs, accessories, and components and medical/functional reasoning for each.
- The DME provider shall submit the evaluation to the third-party payers for approval.
    - For all items that are not approved, the DME provider will consult with the medical professional to decide on the course of action to be taken (appeal, replacement, peer to peer meeting with third party payer, dropping or replacement of denied item, or re-evaluation of the child).
- Once all recommended parts are received, the DME provider or technician shall prepare the system for delivery to the adult member or child/family.
- The medical professional will be present while the wheelchair and seating system is delivered. The technician shall instruct the individual/family on the functions of the wheelchair. The medical professional shall instruct on positioning, contraindications, problems, possible future issues, and skin management. Extensive photographs, video, or other digital media shall be taken at the time of delivery.
    - Any wheelchair, seating, accessories, or components that are deemed inappropriate for the member by the technician, medical professional or family will be returned to the DME provider. The DME provider shall consult with the medical professional on the needed course of action (replacement, re-evaluation, return to program, etc.).

~~**Special Seating/Positioning Center Application Preferred Requirements for Team Members continued**~~

- ~~The DME provider shall provide the medical professional with all data related to the delivery of the services.~~
- ~~The medical professional shall provide a written sign off that they approve of the system that was delivered. This document should include the status of goals and objectives that were written in the evaluation.~~
- ~~The adult member or family shall be contacted from 1-3 months post-delivery to check on the status of equipment and quality of the service provided. Documentation of any problems or negative contacts will be provided to the director of the program. The director of the program will follow up with the family to rectify any issues or discrepancies.~~
- ~~Positioning/seating clinics desiring to be designated as a Title V provider by the Secretary of the Kansas Department of Health and Environment should request application forms here:~~

~~Kansas Special Health Care Needs Program~~
~~Bureau of Family Health~~
~~1000 SW Jackson Suite 220~~
~~Topeka, KS 66612~~
~~Phone (785) 296-1313~~

~~Positioning/Seating Centers desiring to become an approved KanCare provider must complete the KDHE Application for consideration to serve KanCare children and adults with specialized seating assessment needs. This form* must be completed and submitted with other required documentation.~~

SPECIALIZED WHEELCHAIR SEATING ASSESSMENTS

Effective with dates of service on and after January 1, 2025, the following guidance is applicable to specialized Wheelchair Seating Assessments (WSAs).

- Specialized WSAs will not be limited to the previously identified specialized wheelchair seating clinics.
- Providers will no longer be required to be a designated specialized wheelchair seating center or have a formal interdisciplinary team.
- Specialized WSAs may also take place in the home or other natural member environment.
- Members must be offered a choice of DME provider.

Complex Rehabilitation Technology (CRT) includes medically necessary and individually configured manual and power wheelchairs, seating and positioning systems, and other adaptive equipment. This specialized equipment requires evaluation, configuration, fitting, adjustment, or programming to meet the individual's medical needs and maximize function and independence. These products are designed to meet the specific and unique medical and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from injury or trauma.

Specialized WSAs are considered medically necessary for members who meet the following criteria:

1. Are unable to sit safely on a conventional seating surface or standard wheelchair.

8400. Updated 01/25

SPECIALIZED WHEELCHAIR ASSESSMENTS continued

2. Require specialized positioning to safely perform essential activities of daily living without an assistive device.
3. Exhibit one or more of the following functional limitations:
    a. Significant head and trunk instability and /or weakness.
    b. Significant hypotonicity, hypertonicity, athetosis (writhing movements), ataxia (loss of muscle control/coordination), spasticity or muscle spasming which results in uncontrollable movements and position change.
    c. Absence or latency of protective reactions.
    d. Inability to maintain an unsupported sitting position independently.

The evaluation may be completed in a natural environment such as, home or treating outpatient clinic.

WSAs must be done in collaboration with the following providers:

Category A:

Physician, Doctor of Osteopathy, Physician Assistant, Nurse Practitioner, Advance Practice Registered Nurse (Initiates the order and supplies documentation; not required to be at the clinic appointment).

- 09/094 Nurse Practitioner
- 10/100 Physician Assistant
- 31/000 Physician

Category B:

A specialty WSA must be performed by a licensed or certified medical professional (such as a Physical Therapy (PT), Occupational Therapy (OT) or physician) within their scope of practice, who has no financial relationship with the DME provider and has specific training or experience in CRT wheelchairs or CRT wheelchair seating evaluations.

- 01/010 Hospital, Acute Care
- 01/012 Hospital, Rehabilitation
- 17/170 Physical Therapist
- 17/171 Occupational Therapist

Category C:

Assistive Technology Professional (ATP), employed by a DME and must have certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). The ATP must meet the supplier and quality standards established for DME suppliers and must be present during member evaluation to:

- Assist in selecting the appropriate CRT items for such needs and capacities.
- Provide the member technology- related training in the proper use and maintenance of the selected CRT items.
- Be directly involved with the assessment, and determination of the appropriate individually configured complex rehabilitation technology for the member, with such involvement to Include seeing the member in person within a reasonable time frame during the determination process. This service will not be allowed via telemedicine.

8400. Updated 01/25

SPECIALIZED WHEELCHAIR ASSESSMENTS continued

***Note*:** The DME supplier must maintain a reasonable supply of parts, adequate physical facilities, and qualified services or repair technicians to provide members with prompt service and repair of all CRT it sells or supplies. Must provide the member written information at the time of sale as to how to access services and repairs.

Specialized WSAs/evaluations and DME must have a physician order and a letter of medical necessity. The physician must have a face-to-face encounter with the member in accordance with 42 CFR 440.70 (f) (2). The physician must sign off on the completed evaluation.

Members that have previously received a specialized WSA will not require a re-evaluation to receive wheelchair repairs or updates unless deemed medically necessary.

Note: Members who do not have functional limitations as noted above and are not dependent on CRT devices will not require specialized WSAs to obtain a standard wheelchair for ambulation.

Wheelchair seating assessment services will be billed with codes **97542** and **97755** and are payable only to the therapist (Provider Type/Provider Specialty (PT/PS) 17/170 or 17/171) or the hospital billing on behalf of the therapist (PT/PS 01/010 or 01/012). Reimbursement will not exceed $500 per member per year for seating assessments.

PT and OT evaluations and re-evaluations are a covered service, this policy will allow members to receive periodic PT and OT evaluations as reasonable and necessary for purchase of a new wheelchair and/or adjustments to their current wheelchair.

97161	97162	97163	97164	97165	97166	97167	97168

Documentation Requirements:

- Letter of medical necessity completed by the ordering physician or other qualified practitioner.
- Evaluation documentation completed by a qualified therapist.
- DME recommendation completed by a RESNA certified ATP.

A specialty WSA is an assessment performed by a licensed/certified medical professional (such as a PT, OT, or physician) who has no financial relationship with the DME supplier and who has specific training and experience in complex rehab technology wheelchair evaluations. The WSA includes the physical and functional evaluation, treatment plan, goal setting, preliminary device feature determination, trials/simulations, fittings, function related training, determination of outcomes, and related follow-up. This evaluation is performed in conjunction with an equipment supplier who is a RESNA certified ATP, and who assists with the home environment accessibility, system configuration, fitting, adjustments, programming, and product related follow-up.
The specialized WSA must include the following:

1. Diagnosis
2. Reason for referral
3. Medical history
4. Current wheelchair and seating system

8400. Updated 01/25

SPECIALIZED WHEELCHAIR ASSESSMENTS continued

5. Concerns/problem list
6. Description of orthopedic, neurologic, positioning needs
7. Functional capabilities of the member
8. Data including range of motion, muscle testing, strength, weight, body measurements, etc.
9. Goals and objectives related to the wheelchair and seating system.
10. List of specific wheelchair frames, parts, cushions, backs, accessories and components and medical/functional reasoning for each.

Specialty evaluation is required for:

Children and adults with functional limitations as noted above will require specialized WSA.

- A new CRT wheelchair or a replacement CRT wheelchair is limited to 1 per 5 years. Wheelchair replacement may occur sooner with medical necessity documentation. Kan Be Healthy – Early Periodic Screening, Diagnostic, and Treatment (KBH-EPSDT) participants are exempt from this limitation.
- A new custom contoured seating system or modification.
- Modification to a seating system
- An addition of power seating or alternative drive control to a wheelchair.

Prior authorization will not be required for specialized WSAs. Upon post pay review, claims submitted that do not meet criteria will be subject to recoupment.

Additional Specialized Seating for Wheelchairs Guidelines:

1. Procedure codes for special seating include all assembly of the special seating and attachment to the wheelchair.
2. Special seating codes are not covered for rental.
3. If a manufacturer allows one free growth kit free of charge on pediatric wheelchairs, only second, third, or subsequent growth kits will be covered, if needed.
4. Manufacturer wheelchair options should be included under the wheelchair code and not itemized out under special seating codes. The allowable for the wheelchair is calculated accordingly.
5. Backdating is allowed for wheelchairs and special seating to the date the member was seen by the seating assessment provider.

Coverage Criteria

1. Covered for Medicaid members aged 0-999.
2. Not covered for MediKan.
3. Not covered for member in state institutions, adult care homes, or skilled nursing facilities.
4. Not covered for aspen seating.

Additional Coverage Criteria

1. Wheelchair (manual or power) criteria must also be met if wheelchair is being requested with special seating.
2. Headrests are covered for all tilt chairs.
3. Headrests are covered for non-tilt chairs if the member has a complete lack of head control.

8400. Updated 01/25

SPECIALIZED WHEELCHAIR ASSESSMENTS continued

Required Information

1. Itemized list and requested amounts for each item for every code requested
2. Estimated repair costs for member's current seating
    a. Explanation of why current seating cannot be repaired
    b. Age of current seating
3. Seating evaluation for members (within prior six months) must include:
    a. Medical necessity for each requested item including what deformities are going to be helped by the special seating and the projected outcomes
    b. Diagnosis, prognosis, and mobility
    c. Number of hours per day the member will be in the wheelchair
    d. Member's environment including accessibility of home, school, and transportation
4. Current MSRP
5. All other information as requested by Kansas Medicaid

A follow-up evaluation is required from the seating provider (post-pay) to verify the member received the recommended wheelchair and special seating. The provider must maintain this evaluation on file and submit to Kansas Medicaid upon request. If this statement is not on file or sent to Kansas Medicaid upon request, paid claims are subject to recoupment. A signed statement from the seating assessment provider that the member has failed to follow-up will be accepted.
Note: Pricing guidelines will be according to current policy and procedures.

The completed application packet and other supporting documentation must be submitted to the Medicaid State Program Manager for approval in consultation with the Kansas Special Health Care Needs Program. Immediate attention will be given to review complete application packets and providers will be contacted within 14 business days.

Provider Requirements

Physical therapy services are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. A qualified PT is a person who is licensed as a PT by the Kansas Board of Healing Arts or has licensure or certification in the jurisdiction in which the service is provided.

All physical therapy services must be prescribed by a physician and performed by either a registered PT or by a certified physical therapy assistant (PTA) working under the supervision of a registered PT. Supervision must be clearly documented. This may include, but is not limited to, the registered PT initialing each treatment note written by the certified PTA or the registered PT writing "Treatment was supervised" followed by his or her signature.

Provider Requirements continued

Occupational therapy services are those services provided within the scope of practice of OTs and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status.

Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or where function has been permanently lost or reduced by illness or injury to improve the individual's ability to perform those tasks required for independent functioning. A qualified OT is an individual who is licensed by the Kansas Board of Healing Arts or jurisdiction in which the service is provided. Occupational

therapy services may also be provided by an occupational therapy assistant (OTA) working under the supervision of an OT. Supervision must be clearly documented as noted above.

Speech-language pathology (SLP) services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. According to the Kansas Medicaid State Plan, speech therapy must be provided by a speech pathologist with a certificate of clinical competence from the American Speech and Hearing Association.

An SLP with a temporary license may provide services to Medicaid members during the completion of their supervised clinical fellowship year (CFY). The fully credentialed, supervising SLP or approved biller may submit claims to KMAP for services performed by the temporarily licensed SLP. Speech and Hearing services must be provided in accordance with 42 CFR 440.110 (c)(2).

Services for individuals with speech, hearing, and language disorders
Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

An SLP is an individual who has one of the following:

- A certificate of clinical competence from the American Speech and Hearing Association (ASHA)
- Completed the equivalent educational requirements and work experience necessary for the certificate
- Completed the academic program and is acquiring supervised work experience to qualify for the certificate

ASHA considers the CFY an important transitional phase between supervised graduate-level practicum and the independent delivery of services. Inherent in this transition:

- Development of a total commitment to quality service delivery
- Integration and application of theoretical knowledge
- Development of clinical skills consistent with the current scope of practice

The CFY is a transition between being a student and being an independent provider of clinical services that involve a mentor's professional experience after the completion of academic course work and clinical practicum.

It is the student's responsibility to seek employment in a setting where the CFY supervisory requirements can be met.

8400. **MEDICAID Updated 05/17**

Provider Requirements continued

The mentor must have an active, unencumbered license to enroll in KMAP with Provider Type/Provider Specialty (PT/PS):

- 17 - Therapist
- 173 - Speech Therapist/SLP

Supervision requirements in accordance with K.A.R 28-61-2:

- The supervisor must evaluate the applicant on no less than 36 occasions, monitoring activities with at least four hours per month.
- The supervisor must make at least 18 on-site observations with at least two hours per month.
- Monitoring occasions may include on-site observations, conferences in person or on the telephone, evaluation of written reports, evaluations by professional colleagues, or correspondence.
- The supervisor must maintain detailed written records of all contacts and conferences during the CFY.

In accordance with K.S.A. 68-6506(e) and K.A.R. 28-61-4(a), a temporary SLP license is valid for a period of 12 months and may be renewed for one subsequent 12-month period with approval from the Kansas Department for Aging and Disability Services (KDADS) Secretary.

Note: After the completion of the supervised CFY period, the temporarily licensed SLP must independently enroll in KMAP for reimbursement to continue. The provision of SLP services provided by a temporarily licensed SLP are subject to post-payment review and recoupment as warranted.

Procedure Codes

Physical therapists and occupational therapists must bill their services using appropriate *Current Procedural Terminology (CPT®)* codes. Refer to **Section 1300** in the *General Introduction Fee-for-Service Provider Manual* for information on how to obtain a *CPT* codebook.

Therapists will not be reimbursed for services provided outside their scope of practice. Questions regarding specific procedure code coverage can be directed to Customer Service. Refer to **Section 1000** of the *General Introduction Fee-for-Service Provider Manual*.

When a *CPT* code is not available, the service is not covered by KMAP. Not otherwise classified codes are not covered. Unlisted procedure codes are not covered.

Claims only describing a service without the proper *CPT* procedure code will be denied.

Documentation
A copy of the physician's order for physical therapy, occupational therapy, and speech/language pathology services must be retained with the medical record.

To verify services provided during a post payment review, documentation in the member's medical record must support the service billed. Documentation must be legible and complete.

8400. MEDICAID Updated 05/17

Provider Requirements continued

Proper documentation does not need to be in any specific format. However, it must include the following:

- Pertinent past and present medical history with approximate date of diagnosis
- Identification of expected goals or outcomes
- Description of therapy and length of time spent on treatment
- Member's response to therapy
- Progress toward goal(s)
- Date and signature of therapist by each entry

Auto authentication (computerized authentication) of documentation for the medical record is acceptable only if it meets federal guidelines. Federal regulation 42CFR 482.24 (c) (1) (i) requires there be a method for determining whether the individual authenticated the document after transcription. All entries must be legible and complete. Entries must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for providing the service. The author of each entry must be identified and authenticate his or her entry. Authentication may include the author's signature, written initials or computer entry.

If services were performed by a certified therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the registered PT or OT initialing each treatment note written by a certified therapy assistant or the registered PT or OT writing "Treatment was supervised" followed by his or her signature.

Note: When therapy services are provided due to an acute exacerbation of pain and decline in mobility or function related to an existing condition, documentation must support the provision of the visits. Therapies provided in such a situation are expected to address comfort and mobility and should be of a short duration. Provision of therapies for an extended duration to treat symptoms related to an existing or chronic condition is not acceptable due to lack of rehabilitation potential. These visits are subject to recoupment in a postpay review.

Limitations
Therapy services are limited to up to six consecutive months per injury or illness for participants 21 years of age and older. Therapy services will begin at the discretion of the provider. There are no limitations for medically necessary services for EPSDT participants. Traumatic brain injury (TBI) members may receive six months of therapy services as a state plan benefit. When state

plan therapy benefits are exhausted, TBI members may receive additional rehabilitative therapy services content of the TBI waiver as outlined in the waiver approved plan of care.

Vacuum Assisted Wound Closure Therapy

Vacuum assisted wound closure therapy is covered for specific benefit plans. Prior authorization is required, and criteria must be met. Refer to the *DME Fee-for-Service Provider Manual* for criteria. For questions about service coverage for a given benefit plan, contact KMAP Customer Service at 1-800-933-6593. All prior authorization must be requested in writing by a KMAP DME provider. All medical documentation must be submitted to the KMAP DME provider.

APPENDIX

Updated 01/20

Procedure codes billable for developmental physical, occupational, and speech/language therapy services require prior authorization and include, but are not limited to, the following CPT codes:

92521	92522	92523	92524	92507	92508	97110	97112	97113	97116
97150	97530	97533	97535	97537	97129	97130			