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37 Therapy (Occupational, Physical, Speech, and Applied Behavior Analysis)

This chapter regarding therapy services is specifically designed for therapy providers who meet **either** of the following criteria:

- Provider receives a referral as a result of an EPSDT screening exam and possesses an EPSDT Referral form (Form 362) as a result of an abnormality discovered during the EPSDT exam
- Provider treats QMB recipients

Physical therapy is covered for acute conditions in a hospital outpatient setting for non-EPSDT recipients. For more information regarding this, refer to Chapter 19, Hospital.

The policy provisions for EPSDT referred therapy providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

37.1 Enrollment

Alabama Medicaid's Fiscal Agent enrolls therapy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative C*ode, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a therapy provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for therapy-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

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Therapy providers are assigned a provider type of 17 (Therapy). Valid specialties for therapy providers include the following:

- Occupational Therapy (171)
- Physical Therapy (170)
- Speech Therapy (173)
- Applied Behavior Analysis (ABA) Therapy (175)

Therapists may enroll independently and have their own NPI bill on a CMS-1500 claim form as an EPSDT/QMB-only provider. Refer to Chapter 19, Hospital, for billing information for therapists enrolled by a hospital.

Enrollment Policy for Therapy Providers

Services provided must be ordered by a physician or a non-physician practitioner for an identified condition(s) noted during the EPSDT screening and provided by or under:

- For physical therapy services, a qualified physical therapist
- For occupational therapy (OT) services, the direct supervision of a qualified occupational therapist
- For speech and language services, a qualified speech - language pathologist
- For applied behavior analysis services, a licensed behavior analyst, licensed psychologist or licensed psychiatrist with behavior analysis within their scope of practice

A qualified Speech Therapist must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology.

A qualified occupational therapist must be licensed by the Alabama State Board of Occupational Therapy.

A qualified physical therapist must be licensed by the Alabama Board of Physical Therapy.

A qualified behavior analyst must be licensed by the Alabama Behavior Analyst Licensing Board.

A licensed psychologist or psychiatrist may request to add the ABA therapy specialty – 175 to their enrollment.

37.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Services provided to Medicaid-eligible children by those working under the direction of licensed, enrolled speech therapists, occupational therapists, physical therapists or behavior analysts are subject to the following conditions:

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- The person providing the service must meet the minimum qualifications established by state laws and Medicaid regulations.
- A supervising provider must employ the person providing the service.
- The case record must identify the person providing the service.
- The supervising therapist must assume full professional responsibility for services provided and bill for such services.
- The supervising provider must assure that services are medically necessary and are rendered in a medically appropriate manner.
- Services must be ordered by a physician or a non-physician practitioner.

For more information about the Plan of Treatment (plan of care, treatment plan, etc.) required for therapy services, refer to Chapter 19.

Speech Therapists (ST-Speech Language Pathologists)

Speech therapy services must be provided by or under the direct supervision of a qualified speech therapist. Services are limited to those procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers.

Speech therapy assistants must be employed by a speech therapist, have a bachelor's degree in Speech Pathology, and be registered by the Alabama Board of Speech, Language Pathology, and Audiology. Assistants are only allowed to provide services commensurate with their education, training, and experience. They may not evaluate speech, language, or hearing; interpret measurements of speech language or hearing; make recommendations regarding programming and hearing aid selection; counsel patients; or sign test reports or other documentation regarding the practice of speech pathology. Assistants must work under the direct supervision of a licensed speech pathologist.

Direct supervision requires the physical presence of the licensed speech pathologist in the same facility at all times when the assistant is performing assigned clinical responsibilities. The licensed speech pathologist must document direct observation of at least 10% of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

NOTE:

Speech therapy services must be ordered by a physician and must be provided by or under the direct supervision of a qualified speech therapist.

A non-physician practitioner such as a nurse practitioner or a physician assistant can complete an EPSDT screening, order a speech therapy consult then sign an EPSDT referral to see a specialist.

Occupational Therapists (OT)

Occupational therapy services must be provided by or under the direct supervision of a qualified occupational therapist.

Services are limited to those procedures identified in Section 37.5.3, Procedure Codes and Modifiers. Some codes may require prior authorization before services are rendered. Medicaid does not cover recreational activities, such as movies, bowling, or skating.

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Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants a license by the Alabama State Board of Occupational Therapy (ASBOT). Supervision of OT assistants must comply with regulations of the ASBOT. The occupational therapist must render the hands – on treatment, write, and sign the treatment note at a minimum of every 6th visit or 90 days. When making a visit the supervising OT must document and sign notes regarding the visit. . The supervising OT assign the duties and responsibilities for which the assistant has been specifically educated and form.

Occupational therapy aides employed by the OT may perform only routine duties under the direct, on-site supervision of the OT with no charge for occupational.

Physical Therapists (PT)

Physical therapy assistants may provide service only under the supervision of a qualified physical therapist. PT assistants requires a license by the Alabama Board of Physical Therapy, and must be an employee of the supervising PT. The PT assistant must only be assigned duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Licensed certified physical therapist assistants (PTA) are covered providers when working under the direction of a Preferred Physical Therapist with the following provisions:

- The Physical Therapist must interpret the physician's referral.
- The Physical Therapist must perform the initial evaluation.
- The Physical Therapist must develop the treatment plan and program, including long and short-term goals.
- The Physical Therapist must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The Physical Therapist must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The Physical Therapist must implement (perform the first treatment) and supervise the treatment program
- The Physical Therapist must co-sign each treatment note written by the PTA.
- The Physical Therapist must indicate he/she has directed the care of the patient and agrees with the documentation as written by the PTA for each treatment note.

Long Term Therapy Services:

Therapeutic goals must meet at least one of the following characteristics:

- prevent deterioration and sustain function;
- provide interventions that enable the beneficiary to live at their highest level of independence in the case of a chronic or progressive disability;

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- and/or provide treatment interventions for a beneficiary who is progressing, but not at a rate comparable to the expectations of restorative care.

Maintenance Services:

- A repetitive service that does not require the knowledge or expertise of a qualified practitioner and that does not meet the therapy services. Maintenance services begin with the achievement of the therapeutic goals of a treatment plan or when no additional medical benefit is apparent or expected.

The Physical Therapist must render the hands-on treatment, write and sign the treatment note at a minimum of every sixth visit.

According to practice guidelines and state/federal law, written orders must include the date and signature of the provider, the service(s) ordered and the recipient's name. The EPSDT referral form is the physicians' order when meeting these guidelines.

NOTE:

To determine if a procedure code requires prior authorization, use the Automated Voice Response System (AVRS).

Applied Behavior Analysts (ABA Therapists)

Behavior Analyst services must be provided by or under the direct supervision of a qualified behavior analyst, psychologist, or psychiatrist. Services are limited to those procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers.

Applied Behavior Analysis services are covered when provided by a Licensed Behavior Analyst (BCBA), a Licensed Assistant Behavior Analyst (BCaBA) under the supervision of a BCBA, or by a Registered Behavior Technician (RBT) under the supervision of a BCBA or BCaBA within the scope of their practice as defined by state law. Providers must follow the current Behavior Analyst Certification Board® credentialing requirements. The BCBA and BCaBA must in good standing with the State of Alabama.

BCaBAs and RBTs must be employed by a BCBA and the BCBA assumes professional responsibility for the services provided by a RBT or a BCaBA. Claims must be submitted by the BCBA. The BCBA and BCaBA must document supervision and direct observation according to the current requirements of the Behavior Analyst Certification Board® for clinical services provided by a BCaBA or RBT.

Locum Tenens and Substitute Physical/Occupational Therapist Under Reciprocal Billing Arrangements

It is common practice for physical/occupational therapists to retain substitute physical/occupational therapists to take over their professional practices when the regular physical/occupational therapists are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physical therapist to bill and receive payment for the substitute physical/occupational therapists services as though he/she performed them.

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The substitute physical/occupational therapist generally has no practice of his/her own and moves from area to area as needed. The regular physical/occupational therapist generally pays the substitute physical/occupational therapist a fixed amount per diem, with the substitute physical/occupational therapist having the status of an independent contractor rather than of an employee. The substitute physical/occupational therapists are generally called “locum tenens” physical/occupational therapists.

Reimbursement may be made to a physical/occupational therapist submitting a claim for services furnished by another physical/occupational therapist in the event there is a reciprocal arrangement. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement. Effective for claims submitted on or after June 15, 2012, the reciprocal arrangement may not exceed 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement must be enrolled with the Alabama Medicaid Agency. The regular physical/occupational therapist should keep a record on file of each service provided by the substitute physical/occupational therapist and make this record available to Medicaid upon request. Claims will be subject to post-payment review.

37.3 Prior Authorization and Referral Requirements

Physical, Occupations, and Speech service procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Behavior Analysis service procedure codes require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the ACHN Program, refer to Chapter 40 - ACHN to determine whether your services require a referral from the Primary Care Physician (PCP). If the EPSDT screening provider wants to render treatment services himself, the provider completes a self-referral.

After receiving a screening referral form, Medicaid providers may seek reimbursement for medically necessary services to treat or improve the defects, illnesses, or conditions identified on the referral form. The consulting provider completes the corresponding portion of this form and returns a copy to the screening provider. If services or treatment from additional providers is indicated, a copy of the referral form must be sent to those providers for their medical records. A completed Referral for Services Form must be present in the patient’s medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee (physician or non-physician practitioner) is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

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All orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. The EPSDT referral form may be considered as the physicians' order if these guidelines are met.

37.4 Cost Sharing (Copayment)

Copayment does not apply to therapy services.

37.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Therapy providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Therapy services are billed using the CMS-1500 claim form. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

37.5.1 Time Limit for Filing Claims

Medicaid requires all claims for therapy services to be filed within one year of the date of service. Refer to Chapter 5, Filing Limits, for more information regarding timely filing limits and exceptions.

37.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P. O. Box 930876 Atlanta, GA 31193-0873 or 1-800-621-8335. American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

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NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

37.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Speech Therapy

Speech Therapy focuses on receptive language, or the ability to understand words spoken to you, and expressive language, or the ability to use words to express yourself. It also deals with the mechanics of producing words, such as articulation, pitch, fluency, and volume. Identifying those with communicative or oropharyngeal disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills.

Speech Therapy is covered only when service is rendered to a recipient as a result of an identified condition(s) noted during the EPSDT Screening exam or to QMB recipient. In order for the service to be covered the diagnosis must be speech related, such as stroke (CVA) or partial laryngectomy. In order to be a covered benefit, speech therapy must be ordered by a physician and perform in an office location. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician. Speech therapy is not covered by Medicaid unless actually performed by a practitioner in person.

Use revenue codes 44x when billing speech therapy. Speech therapy providers are limited to the procedure codes listed below:

Procedure Code	***Description***	***Requires a Prior Authorization***
92521	Evaluation of speech therapy	No
92522	Evaluation of speech sound production	No
92523**	Evaluation of speech sound production with evaluation of language comprehension and expression	No
92524	Behavioral and qualitative analysis of voice and resonance	No

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Procedure Code	*Description*	*Requires a Prior Authorization*
92526	Treatment of swallowing and/ or oral feeding function	No
92507**	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	No
92508**	Group, two or more individuals	No
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	No
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes	No
92609	Therapy Service for use of speech-generating device with programming.	No
92610	Evaluation of swallowing function	No
96112	Administration of development test, first hour	No
96113	Administration of development test, additional 30 minutes	No
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.	No
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community, initial 30 minutes.	No
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community, each additional 15 minutes .	No
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community.	No

Added: 92609 Therapy Service…with programming No

Added: 97550 Caregiver training…or community. No
Added: 97551 Caregiver training…or community. No
Added: 97552 Group Caregiver…or community. No

****Effective June 1, 2023, procedure codes 92507, 92508, and 92523 can be reimbursed for Audio-Only Telecommunication and only be used in lieu of the audio and video telecommunication where telemedicine is approved by Medicaid.**

Providers must place the "FQ" modifier on the claim to designate that the service was rendered via audio only telecommunication method.

Physical Therapy

Physical therapy services address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation. This is covered based on medical necessity.

Key service functions include the following:

- Screening, evaluation and assessment to identify movement dysfunction

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- Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing developmental and functionally appropriate services

Records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet *established* medical *criteria's*. Physical therapy is subject to the following criteria:

- Physical therapy is covered in an outpatient setting for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.
- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition.

If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician. Physical therapy providers are limited to the procedure codes and max units listed below. These procedure codes cannot be span billed and must be submitted for each date of service provided. Documentation by therapist in medical record must support number of units billed on claim.

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	No
95852	ROM measurements and report (separate procedure);hand, with or without comparison with normal side		1	No
96112	Administration of development tests, first hour		1	No
96113	Administration development test, additional 30 minutes		1	No
97161	Evaluation of physical therapy, low complexity, typically 20 minutes		1	No
97162	Evaluation of physical therapy,		1	No

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Procedure Code	*Physical Therapy*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
	moderate complexity, typically 30 minutes			
97163	Evaluation of physical therapy, high complexity, typically 45 minutes		1	No
97164	Re-evaluation of physical therapy, typically 20 minutes		1	No
97010	Application of a modality to one or more areas; hot or cold packs	3, 5	1	No
97012	Traction, mechanical	5	1	No
97014	Electrical stimulation, unattended	2	4	No
97016	Vasopneumatic device	5	1	No
97018	Paraffin bath	3, 5	1	No
97022	Whirlpool	3	1	No
97024	Diathermy	5	1	No
97026	Infrared	5	1	No
97028	Ultraviolet		1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3, 5	1	No
97113	Aquatic therapy with therapeutic exercises	5	1	No
97116	Gait training (includes stair climbing)	5	1	No
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).	3, 5	1	No
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	5	1	No
97150	Therapeutic procedure(s), group (2 or more individuals)	5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15	3, 5	4	No

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Procedure Code	*Physical Therapy*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
	minutes			
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes		4	No
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider each 15 minutes.	3, 5	4	Yes
97542	Wheelchair management/propulsion training, each 15 minutes	3, 5	4	No
97550	Caregiver training in strategies and techniques to facilitate the patient's functional, performance in the home or community, initial 30 minutes		1	No
97551	Caregiver training in strategies and techniques to facilitate the patient's functional, performance in the home or community, each additional 15 minutes		1	No
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional, performance in the home or community		1	No
97597	Removal of devitalized tissue From wounds		1	No
97598	Removal of devitalized tissue From wounds		8	No
97750	Physical performance test or measurement, (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3, 4, 5	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

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NOTE:

1. Reserved

2. 97014 cannot be billed on same date of service as procedure code 20974, 20975 or 20982.

3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient for the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for procedure, not the maximum units allowed for both providers.

4. 97760 should not be reported with 97116 for the same extremity.

5. Procedures 97010, 97012, 97016, 97018, 97024, 97026 (therapy procedures) must be billed with one of the following codes: 97014, 97020, 97110, 97112, 97113, 97116, 97124, 97140, 97150, 97530, 97535, or 97542 (therapeutic treatment).

Occupational Therapy

Occupational Therapy is a service that addresses the functional needs related to adaptive development, adaptive behavior and sensory, motor and postural development. These services are designed to improve the functional ability to perform tasks in the home and community settings.

Occupational therapy procedure codes cannot be span billed and must be submitted for each date of service provided. Some codes may require attainment of prior authorization before services are rendered. Documentation by therapist in medical record must support number of units billed on claim. Use revenue code 43x when billing claims for occupational therapy.

Medicaid does not cover group occupational therapy. Covered occupational therapy services do not include recreational and leisure activities such as movies, bowling, or skating. Individual occupational therapy providers are limited to the following procedure codes:

Code	*Description*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
96112	Administration of development tests, first hour		1	No
96113	Administration of development tests, additional 30 minutes		1	No
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.		1	No
97165	Evaluation of occupational therapy, low complexity, typically 30 minutes		1	No
97166	Evaluation of occupational therapy, moderate complexity, typically 45		1	No

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Code	*Description*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
	minutes			
97167	Evaluation of occupational therapy established plan of care, high complexity, typically 60 minutes		1	No
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes		1	No
97010	Application of a modality to one or more areas; hot or cold packs	1, 3, 5	1	No
97018	Paraffin bath	1, 3, 5	1	No
97022	Whirlpool	3	1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense posture, and proprioception	3, 5	1	No
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	3, 5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3, 5	4	No
97533	Sensory technique to enhance processing and adaptation to environmental demands, each 15 minutes		4	No
97535	Self-care / home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.	3, 5	4	Yes
97542	Wheelchair management /propulsion training, each 15 minutes	3, 5	4	No
97550	Caregiver training in strategies and techniques to facilitate the patient's functional, performance in the home or		1	No

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Code	*Description*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
	community, initial 30 minutes			
97551	Caregiver training in strategies and techniques to facilitate the patient's functional, performance in the home or community, each additional 15 minutes		1	No
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional, performance in the home or community		1	No
97597	Removal of devitalized tissue from wounds		1	No
97598	Removal of devitalized tissue from wounds		8	No
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

NOTE:
Procedure code 96125 used for standardized cognitive performance testing should not be billed with autism diagnostic testing codes 96112 and 96113.

Applied Behavior Analysis (ABA) Therapy

ABA therapy is the behavioral treatment approach most commonly used with children with Autism Spectrum Disorder (AS).

Techniques based on ABA include:

- Discrete Trial Training, Incidental Teaching, Pivotal Response Training, and Verbal Behavioral Intervention
- Structured environment, predictable routines, individualized treatment, transition and aftercare planning, and significant family involvement
- Attempts to increase skills related to behavioral deficits and reduce behavioral excesses including eliminating barriers to learning
- Behavior deficits may occur in the areas of communication, social and adaptive skills, but are possible in other areas as well.
    - Examples of deficits may include: a lack of expressive language, inability to request items or actions, limited eye contact with others, and inability to engage in age-appropriate self-help skills such as tooth brushing or dressing.

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- Examples of behavioral excesses may include, but are not limited to: physical aggression, property destruction, elopement, self-stimulatory behavior, self-injurious behavior, and vocal stereotypy.

Applied behavior analysis therapy is a service that may be used for children diagnosed with F84.0 Autistic Disorder, F84.3 Other Childhood Disintegrative Disorders, F84.5 Asperger's, F84.8 Other Pervasive Developmental Disorders, F84.9 Pervasive Developmental Disorder Unspecified.

Applied behavior therapy procedure codes cannot be span billed and must be submitted for each date of service provided. Most codes require attainment of prior authorization before services are rendered. Documentation by the therapist in the medical record must support the number of units billed on claim. An ABA Therapy Behavior Assessment Form is required as part of the support documentation for the prior authorization request. This form can be accessed by visiting the following link on the Medicaid website: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.3_EPSDT.aspx .

Individual behavior therapy providers are limited to the following procedure codes:

Code	Description	Requires Prior Authorization
97151	Behavior Identification Assessment	No
97152	Observational F/U assessment	Yes
0362T	Exposure Behavioral F/U assessment	Yes
97153	Adaptive Behavior Tx	Yes
97154	Group Adaptive Behavior Tx	Yes
97158	Social Skills Group	Yes
0373T	Exposure Adaptive Behavior Tx	Yes
97155	Adaptive Behav Modification	Yes
97156	Family Adaptive Behavior Tx Guidance	Yes
97157	Multiple Family, Group Tx Guidance	Yes

Positive Behavior Support (PBS) Services are a set of researched-based strategies that combine behavioral and biomedical science with person-centered, valued outcomes and systems change to increase quality of life and decrease problem behaviors by teaching new skills and making changes in a waiver recipient's environment.

PBS services may be used for children diagnosed with F-70 to F-79 Intellectual Disabilities and should billed with 0373T - Exposure Adaptive Behavior Tx with prior authorization as described above.

For ABA therapy or PBS services listed above provided via telemedicine, enrolled providers are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to participate in the telemedicine program:

- Providers must be enrolled with Alabama Medicaid with a specialty type of 931 (Telemedicine Service).
- To be enrolled with the 931 specialty, providers must submit the Telemedicine Service Agreement/Certification form which is located on

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the Medicaid website at: www.medicaid.alabama.gov. Electronic signatures will be acceptable for the telemedicine agreement. The agreement may be uploaded through the provider web portal along with a request to add the 931 specialty. See Chapter 2 – Becoming a Medicaid Provider for further information.

- Providers must obtain prior consent from the recipient before services are rendered. A sample recipient consent form is attached to the Telemedicine Service Agreement.

Services must be administered via an interactive audio and video telecommunications system which permits two-way communication between the distant site provider and the origination site where the recipient is located (this does not include a telephone conversation, electronic mail message, or facsimile transmission between the provider, recipient, or a consultation between two providers).

Telemedicine health care providers shall ensure that the telecommunication technology and equipment used at the recipient site and at the provider site, is sufficient to allow the provider to appropriately evaluate, diagnose, and/or treat the recipient for services billed to Medicaid. Transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

The provider shall maintain appropriately trained staff, or employees, familiar with the recipient's treatment plan, immediately available in-person to the recipient receiving a telemedicine service to attend to any urgencies or emergencies that may occur during the session. The provider shall implement confidentiality protocols that include, but are not limited to:

- specifying the individuals who have access to electronic records; and
- usage of unique passwords or identifiers for each employee or other person with access to the client records; and
- ensuring a system to prevent unauthorized access, particularly via the Internet; and
- ensuring a system to routinely track and permanently record access to such electronic medical information

These protocols and guidelines must be available to inspection at the telemedicine site and to the Medicaid Agency upon request.

Claims submitted for ABA therapy or PBS services delivered via telemedicine should include a valid place of service listed in 37.5.4 with the modifier GT.

NOTE:

Refer to Chapter 108, Early Intervention Services for therapy delivered to infants/children enrolled in Alabama's Early Intervention System (AEIS).

37.5.4 Place of Service Codes

The following place of service codes apply when filing claims for therapy services:

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POS Code	*Description*
11	Office
12	Home (for ABA therapy only)

37.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Chapter 5, Required Attachments, for more information on attachments.

37.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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