



Rehabilitation Agency Provider Specific Policy Manual

Revision Table

Revision Date	Sections Revised	Description
8/6/04	N/A	A new provider manual for rehabilitation agencies
6/4/09	4.2	Updated the incorrect UB92 wording to the correct wording, UB04.

This page is left intentionally blank.



Rehabilitation Agency Provider Specific Policy Manual

Table of Contents

1.0 Overview

- 1.1 General Information

2.0 Qualified Providers

- 2.1 Requirements

3.0 Definition of Services

- 3.1 General Information
- 3.2 Physical Therapy Services
- 3.3 Speech Pathology Services
- 3.4 Occupational Therapy Services
- 3.5 Rehabilitation Program Services

4.0 Billing Information

- 4.1 General Information
- 4.2 Billing Form
- 4.3 Revenue Codes
- 4.4 ICD-9-CM Diagnosis Codes
- 4.5 HCPCS Procedure Codes

5.0 Reimbursement

- 5.1 Methodology

6.0 Obtaining Prior Authorization

- 6.1 Requirements
- 6.2 Prior Authorization Requests

This page intentionally left blank

Rehabilitation Agency Provider Specific Policy Manual

Health care services are provided to the majority of Medicaid clients through a Managed Care Organization (MCO). Rehabilitation agency services are included in the MCO benefits package. All Medicaid clients who are enrolled with an MCO must receive rehabilitation agency services through the MCO.

This manual reflects the policies as they relate to Medicaid clients who are exempt from the managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General policy).

1.0 Overview

1.1 General Information

- 1.1.1 A rehabilitation agency is an agency that provides an integrated, multidisciplinary program designed to upgrade the physical functions of handicapped disabled individuals by bringing specialized staff together to perform as a team (42 CFR 485.703). At a minimum, a rehabilitation agency must provide physical therapy or speech-language pathology services and social or vocational adjustment services.
- 1.1.2 Patients in need of rehabilitation therapy services may be accepted for treatment only on the order of a practitioner who indicates anticipated goals and is responsible for the general medical direction of such services as part of the total care of the patient.
- 1.1.3 The rehabilitation agency must maintain a clinical record in accordance with accepted professional principles for each of the agency's patients.
 - 1.1.3.1 The record must be complete and accurately documented and readily accessible, and systematically organized to facilitate retrieving and compiling information.
 - 1.1.3.2 Procedures must be in effect to assure confidentiality and maintenance of the clinical record and provide safeguards against loss, destruction, or unauthorized use.
 - 1.1.3.3 The clinical record shall contain sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to document the results accurately. All clinical records shall contain the following general categories of information:
 - 1.1.3.3.1 documented evidence of the assessment of the needs of the patient, of an appropriate plan of care, and of the care and services furnished;
 - 1.1.3.3.2 identification information and consent forms;

- 1.1.3.3.3 medical history;
- 1.1.3.3.4 report of physical examinations;
- 1.1.3.3.5 observations and progress notes;
- 1.1.3.3.6 reports of treatments and clinical findings; and
- 1.1.3.3.7 discharge summary including final diagnosis and prognosis.
- 1.1.3.4 Clinical records of discharged patients shall be completed promptly.
- 1.1.3.5 Each practitioner shall sign the entries that he or she makes in the clinical record.
- 1.1.4 The rehabilitation agency shall have an effective governing body that is legally responsible for the conduct of the agency. The governing body shall designate an administrator and shall establish administrative policies as set forth in 42 CFR §485.709.
- 1.1.5 Services provided by the rehabilitation agency must be medically necessary and be:
 - 1.1.5.1 the most appropriate level of service that can be safely provided;
 - 1.1.5.2 the least costly, appropriate available health service alternative; and
 - 1.1.5.3 appropriate with regard to standards of professional practice.
- 1.1.6 In some instances rehabilitation services must be prior authorized. Refer to the Prior Authorization section of this manual for details.

2.0 Qualified Providers

2.1 Requirements

- 2.1.1 Rehabilitation agencies, for the purpose of this manual are those which are licensed and certified by the Delaware Division of Public Health, Office of Health Facilities Licensing and Certification. Providers located in a state other than Delaware must be licensed or certified by the appropriate agency in the state in which the provider is located.
- 2.1.2 The training, experience, and membership requirements for personnel involved in the furnishing of services through a rehabilitation agency must meet the qualifications set forth in 42 CFR §485.705.
- 2.1.3 The rehabilitation agency will ensure that professional licenses of staff members are current.

This page intentionally left blank.

3.0 Definition of Services

3.1 General Information

- 3.1.1 For each patient in need of physical therapy, occupational therapy or speech pathology services there must be a written plan of care established and periodically reviewed by a physician, or by a physical therapist, occupational therapist or speech pathologist respectively.
- 3.1.2 The rehabilitation agency shall obtain the following prior to the initiation of treatment:
- 3.1.2.1 the patient's significant past history;
 - 3.1.2.2 current medical findings;
 - 3.1.2.3 diagnosis(es), if established;
 - 3.1.2.4 physician's orders;
 - 3.1.2.5 rehabilitation goals;
 - 3.1.2.6 contraindications, if any;
 - 3.1.2.7 the extent to which the patient is aware of the diagnosis(es) and prognosis; and
 - 3.1.2.8 if appropriate, the summary of treatment furnished and results achieved during previous periods of rehabilitation services.
- 3.1.3 For each patient there shall be a written plan of care established by the physician or by the physical therapist, occupational therapist or speech-language pathologist who furnishes the services. The plan of care for physical therapy, occupational therapy or speech pathology services shall indicate anticipated goals and specify the type, amount, frequency, and duration of those services.
- 3.1.3.1 The plan of care and results of treatment shall be reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action shall be taken. The plan must be reviewed by a physician at least every 30 days.
 - 3.1.3.2 Any changes in the plan of care shall be noted in the clinical record. If the patient has an attending physician, the therapist or speech-language pathologist who furnishes the services shall promptly notify him or her of any change in the patient's condition or in the plan of care.

3.2 Physical Therapy Services

- 3.2.1 An organization will be considered to have an adequate physical therapy program if it can:
- 3.2.1.1 provide services utilizing therapeutic exercise and the modalities of heat, cold, water, and electricity;
 - 3.2.1.2 conduct patient evaluations; and
 - 3.2.1.3 administer tests and measurements of strength, balance, endurance, range of motion, and activities of daily living.
- 3.2.2 A physical therapist must be present:
- 3.2.2.1 for the initiation of patient treatment for newly admitted patients or for those previously treated, discharged, and readmitted;
 - 3.2.2.2 prior to the provision of physical therapy services where a change in the physician's plan of care necessitates a change in treatment; and
 - 3.2.2.3 immediately prior to the discontinuing of treatment and discharge of patients.
- 3.2.3 A qualified physical therapist must be present or readily available to offer needed supervision to the physical therapist assistant regardless of whether patients are treated on the premises of the organization or in their home. If a qualified physical therapist is not on the premises during all hours of operations, patients must be scheduled in such a manner as to ensure the physical therapist is present when specific skills are needed.
- 3.2.4 When a physical therapist assistant furnishes services off the rehabilitation agency premises, those services are supervised by a qualified physical therapist who is required to make an onsite supervisory visit at least once every 30 days. Supervision of a physical therapist assistant does not qualify as a physical therapy visit
- 3.2.5 The number of properly qualified personnel must be adequate for the volume and diversity of physical therapy services offered.

3.3 Speech Pathology Services

- 3.3.1 A rehabilitation agency will be considered to have an adequate speech pathology program if it can provide the diagnostic and treatment services to effectively treat speech disorders.

- 3.3.2 The rehabilitation agency shall have the equipment and facilities required to provide the range of service necessary in the treatment of the types of speech disorders accepted for service.
- 3.3.3 Speech pathology services must be given or supervised by a qualified speech pathologist and the number of qualified speech pathologists must be adequate for the volume and diversity of speech pathology services offered.

3.4 Occupational Therapy Services

- 3.4.1 A rehabilitation agency may provide occupational therapy services if it provides treatment of the physically disabled by means of constructive activities designed to promote the restoration of an individual's ability to perform required daily living tasks and those required by the person's particular occupational role.
- 3.4.2 The occupational therapy service must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary the following conditions must be met:
- 3.4.2.1 The services must be considered under accepted standards of medical practice to be specific and effective treatment for the individual's condition;
- 3.4.2.2 The occupational therapy is performed to restore the individual's level of function that has been lost or reduced by illness or injury;
- 3.4.2.3 The occupational therapy must be a level of complexity and sophistication or the condition of the patient must be such that services required can be safely and effectively performed only by a qualified occupational therapist or under his or her supervision. Services which do not require the performance or supervision of a occupational therapist are not considered reasonable or necessary.
- 3.4.3 The services rendered under occupational therapy shall not be duplicated by physical therapy.

3.5 Rehabilitation Program Services

- 3.5.1 In addition to physical therapy, occupational therapy and speech pathology services a rehabilitation agency provides a rehabilitation program that includes social or vocational adjustment services to all of its patients who need them.
- 3.5.2 The agency shall provide for special qualified staff to:
- 3.5.2.1 evaluate the social and vocational factors;

- 3.5.2.2 counsel and advise on the social or vocational problems that arise from the patient's illness or injury; and
- 3.5.2.3 make appropriate referrals for needed services.
- 3.5.3 The rehabilitation agency's social or vocational adjustment services are furnished as appropriate by the following personnel:
 - 3.5.3.1 social or vocational adjustment services may be performed by a qualified psychologist or qualified social worker; and
 - 3.5.3.2 vocational adjustment services may be furnished by a qualified vocational specialist.
- 3.5.4 If a rehabilitation agency does not provide social or vocational adjustment services through salaried employees, it may provide those services through a written contract with others who meet the requirements and responsibilities set forth in 42 CFR §485 Subpart H.
 - 3.5.4.1 The contract must specify the term of the contract and the manner of termination or renewal and provide that the agency retains responsibility for the control and supervision of the services.

4.0 Billing Information

4.1 General Information

4.1.1.1 Rehabilitation agencies shall not bill the DMAP for services provided to patients of nursing facilities or hospitals.

4.2 Billing Form

4.2.1 Rehabilitation agencies must use the UB04 or the 837 Institutional claim when billing the DMAP.

4.3 Revenue Codes

4.3.1 Rehabilitation agencies must use revenue codes. A revenue code is a 4-digit code that identifies services provided to the recipient. The revenue code used must accurately describe the services provided. Refer to the *National Uniform Billing Manual* for a list of valid revenue codes.

4.4 ICD-9-CM Diagnosis Codes

4.4.1 Rehabilitation agencies must use ICD-9-CM diagnosis codes. ICD-9-CM diagnosis codes are common classifications of disease and related entities. The ICD-9-CM code describes the clinical picture of the patient. The ICD-9-CM diagnosis codes used must accurately describe the diagnosis of the patient.

4.5 HCPCS Procedure Codes

4.5.1 Rehabilitation agencies must use HCPCS procedure codes. HCPCS codes are a listing of descriptive terms for reporting medical services and procedures performed. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services. The HCPCS procedure codes used must accurately describe the services provided.

This page intentionally left blank

5.0 Reimbursement

5.1 Methodology

- 5.1.1 DMAP's reimbursement to rehabilitation agencies is based on the facility's usual and customary (U&C) charges.
- 5.1.2 Travel cost for rehabilitation services provided in the home is included in the reimbursement rate and shall not be billed separately.

This page intentionally left blank.

6.0 Obtaining Prior Authorization

6.1 Requirements

6.1.1 Prior authorization is required for the following rehabilitation agency services:

6.1.1.1 MR waiver clients needing rehabilitation agency services;

6.1.1.2 for individuals residing in adult foster/residential homes; and

6.1.1.3 for clients who may require more than one rehabilitation visit per day or more than one hour in duration.

6.2 Prior Authorization Requests

6.2.1 The attending practitioner or rehabilitation agency should fax requests for prior authorization to:

Medical Review Team
P.O. Box 906, Lewis Building
New Castle, DE 19720
Fax #: (302) 255-4481

6.2.2 The request should include the following information:

6.2.2.1 name of patient;

6.2.2.2 patient' Medicaid ID number;

6.2.2.3 patient's date of birth;

6.2.2.4 if developed, the plan of care (plan of care includes rehabilitation goals and objectives designed to restore, improve, or maintain the patient's optimal level of functioning);

6.2.2.5 name of rehabilitation agency;

6.2.2.6 rehabilitation agency provider number;

6.2.2.7 rehabilitation agency contact person and telephone number;

6.2.2.8 name/address/phone number of referring practitioner; and

6.2.2.9 detailed medical history that documents the need for the rehabilitation services requested.