

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



July 30, 2014

James Golden, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Mr. Golden:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #13-028 - Provider Qualifications for Physical Therapy, Occupational
Therapy, Speech-Language Therapy, and Audiology
--Effective Date: October 1, 2013

If you have any additional questions, please have a member of your staff contact Courtenay Savage
at (312) 353-3721 or via e-mail at Courtenay.Savage@cms.hhs.gov.

Sincerely,

/s/

Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Ann Berg, MDHS
Sean Barrett, MDHS

Enclosure

STATE: MINNESOTA
Effective: October 1, 2013
TN: 13-28
Approved: 7/30/14

ATTACHMENT 3.1-A
Page 42

Supersedes: 12-06 (08-02, 05-21, 05-08, 01-23, 00-11)

11.a. Physical therapy services.

Coverage is limited to:

- 1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.
- 2) Services provided by a physical therapist or services delegated by a physical therapist to a physical therapist assistant ~~who is under the direction of a physical therapist.~~
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.
- 4) Services that are:
 - A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or
 - B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s) result in:
 - i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function.
 - ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

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Supersedes: 12-06 (08-02, 05-21, 05-08, 01-23, 00-11)

11.a. Physical therapy services. (continued)

- iii. health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

- i. prevents deterioration and sustains function;
- ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
- iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Physical therapist is defined as an individual who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent. Physical therapists must ~~meet~~ maintain applicable state licensure requirements, or be in compliance with state regulatory requirements in states that do not license when they are developed. Physical therapy services and providers must meet the requirements of 42 CFR § 440.110. Physical therapy services are provided by or under the ~~direction~~ supervision of a qualified physical therapist.

Physical therapist assistant is defined as ~~one qualified under the rules of the Board of Medical Examiners. These rules define a physical therapist assistant as a skilled technical worker who is a graduate of a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent a comparable national accrediting agency approved by the Board.~~ Physical therapist assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license. A physical therapist assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist to assist the physical therapist in patient, client or resident related activities.

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11. a. Physical therapy services. (continued)

~~Direction~~ Delegation of duties is defined as the actions of a physical therapist who ~~instructs~~ delegates to the physical therapist assistant ~~in~~ specific duties to be performed, monitors the provision of services on-site and documents the appropriateness of the services not less than every sixth treatment session, and meets the other supervisory requirements specified in law ~~the rules of the Board of Medical Examiners.~~

Coverage does not include:

- 1) Services provided in a nursing facility, ICF/MR, or day training and habilitation services center, if the cost of physical therapy has been included in the facility's per diem, such as:
 - A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;
 - B. Ambulation of a recipient who has an established gait pattern;
 - C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;
 - D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and
 - E. Bowel and bladder retraining programs.
- 2) Arts and crafts activities for the purposes of recreation.

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11.a. Physical therapy services. (continued)

- 3) Services that are not documented in the recipient's health care record.
- 4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.
- 5) Services by more than one provider of the same type for the same diagnosis.
- 6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
- 7) Evaluations or reevaluations performed by a physical therapist assistant.
- 8) Services provided by a physical therapist other than the therapist billing for the services, unless the physical therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case the agency, facility or physician must bill for the service.
- 9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.b. Occupational therapy services.

Coverage is limited to:

- 1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.
- 2) Services provided by an occupational therapist or services delegated by an occupational therapist to an occupational therapy assistant who is under the direction of an occupational therapist.
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.
- 4) Services that are:
 - A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or
 - B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical conditions(s) result in:
 - i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function;

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Supersedes: 12-06 (05-21, 03-03, 01-23)

11.b. Occupational therapy services. (continued)

- ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;
- iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

- i. prevents deterioration and sustains function;
- ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
- iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Occupational therapist is defined as an individual ~~certified by the National Board for Certification in Occupational Therapy~~ who maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license as an occupational therapist. Occupational therapy services and providers meet the requirements of ~~4342~~ CFR 440.110. Occupational therapy services are provided by or under the ~~direction~~ supervision of a qualified occupational therapist.

Occupational therapy assistant is defined as an individual ~~who has successfully completed all academic and field work requirements of an occupational therapy assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and who is currently certified by the National Board for Certification in Occupational Therapy as an occupational therapy assistant.~~ Occupational therapy assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license.

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11.b. Occupational therapy services. (continued)

~~Direction~~ Delegation of duties is defined as the actions of an occupational therapist who ~~instructs~~ delegates to the occupational therapy assistant ~~in~~ specific duties to be performed, ~~and~~ monitors the provision of services, and collaborates with the occupational therapy assistant face-to-face at least every two weeks on site and documents the appropriateness of the services not less than every sixth treatment session of each recipient.

Coverage does not include:

- 1) Services provided in a nursing facility, ICF/MR, or day training and habilitation service center, if the cost of occupational therapy has been included in the facility's per diem, such as:
 - A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;
 - B. Ambulation of a recipient who has an established gait pattern;
 - C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;
 - D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and
 - E. Bowel and bladder retraining programs.
- 2) Arts and crafts activities for the purpose of recreation.
- 3) Services that are not documented in the recipient's health care record.

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11.b. Occupational therapy services. (continued)

- 4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.
- 5) Services by more than one provider of the same type for the same diagnosis.
- 6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
- 7) Evaluations or reevaluations performed by an occupational therapy assistant.
- 8) Services provided by an occupational therapist other than the therapist billing for the service, unless the occupational therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
- 9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

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Supersedes: 12-06 (04-14, 03-13)

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

- 1) Services provided upon written referral by a physician or licensed practitioner of the healing arts within the scope of the practitioner's practice under state law, or, in the case of a resident of a long-term care facility, on the written order of a physician as required by 42 CFR §483.45.
- 2) Services provided by a speech language pathologist ~~or a person completing the clinical fellowship year required for certification as a speech language pathologist under the supervision of a speech language pathologist.~~
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.
- 4) Services that are:
 - A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or
 - B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s) result in:

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

- i. Decreased functional ability compared to the recipient's previous level of function;
- ii. Decreased abilities relevant to the recipient's current environmental demands; or
- iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

- i. prevents deterioration and sustains function;
 - ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
 - iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.
- 5) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

Speech pathology services and providers meet the requirements of 42 CFR 440.110. Speech pathology services are provided by or under the supervision ~~direction~~ of a qualified speech pathologist.

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11.c. Speech, language; and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

Coverage of **speech-language therapy services** does not include:

- 1) Services that are not documented in the recipient's health care record.
- 2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
- 3) Services that are furnished by a provider ~~eligible to enroll with Medicare, but not~~ enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
- 4) Services that are provided without written referral.
- 5) Services not medically necessary.
- 6) Services that are not part of the recipient's plan of care.
- 7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
- 8) Services provided by a speech-language pathologist other than the pathologist billing for the service, ~~or a person completing the clinical fellowship year under the supervision of the pathologist,~~ unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
- 9) ~~Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.~~
- 10) ~~Services provided to dual eligibles by an independently enrolled speech language pathologist.~~

Coverage of **hearing (audiology) therapy services** is limited to:

- 1) Services provided upon written referral by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

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11. c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

- 2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary at least once every ~~60~~90 days by the attending physician or other licensed practitioner of the healing arts. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or physician's delegate as required by Medicare.
- 4) Restorative therapy provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period.
- 5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.
- 6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

Audiology services and providers meet the requirements in 42 CFR 440.110(c)(3). Audiology services are provided by or under the direction of a qualified audiologist.

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

'Under the direction of a qualified audiologist' means that a federally qualified audiologist who is directing audiology services must supervise each beneficiary's care. To meet this requirement the qualified audiologist must, at a minimum, have face-to-face contact with the beneficiary initially and periodically as needed, be familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law, have continued involvement in the care provided, and review the need for continued services throughout treatment. The supervising audiologist must also assume professional responsibility for the services provided under their direction and monitor the need for continued services. The supervising audiologist must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, the supervising audiologist must ensure that individuals working under their direction have contact information to permit them direct contact with the supervising audiologist as necessary during the course of treatment. In all cases, documentation must be kept supporting the supervision, provision of and claiming of services and ongoing involvement in the treatment. Absent appropriate service documentation, Medicaid payment for services may be denied providers.

Coverage of **hearing (audiology) therapy services** does not include:

- 1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
- 2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
- 3) Services provided by an audiologist other than the audiologist billing for the services, ~~or a person completing the clinical fellowship year under the supervision of the audiologist,~~ unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

- 4) Services that are furnished by a provider not enrolled with Medicare, or in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

Hearing aid services: After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** for adults is limited to:

- 1) Medically necessary ~~One monaural and or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.~~
- 2) ~~Non-contract hearing aids require prior authorization.~~ No more than two replacement hearing aids due to loss, theft, or damage in the five years prior to the date of the request for a replacement.

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

(continued)

Coverage of **hearing aids** does not include:

- 1) Replacement batteries provided on a scheduled basis regardless of their actual need.
- 2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
- 3) Routine screening of individuals or groups for identification of hearing problems.
- 4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
- 5) Nonelectronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, and battery chargers.
- 6) Maintenance, cleaning; and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
- 7) Loaner hearing aid charges.
- 8) Canal type hearing aids.
- 9) A noncontract hearing aid that is obtained without prior authorization.
- 10) Services included in the dispensing fee when billed on a separate claim for payment.
- 11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or referral by the resident's family, guardian or attending physician.
- 12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
- 13) ~~Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.~~

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11.a. Physical therapy services.

Coverage is limited to:

- 1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.
- 2) Services provided by a physical therapist or services delegated by a physical therapist to a physical therapist assistant ~~who is under the direction of a physical therapist.~~
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.
- 4) Services that are:
 - A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or
 - B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s) result in:
 - i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function.
 - ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;

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11.a. Physical therapy services. (continued)

- iii. health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

- i. prevents deterioration and sustains function;
- ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
- iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Physical therapist is defined as an individual who is a graduate of a program of physical therapy ~~approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent~~ accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent. Physical therapists must ~~meet~~ maintain applicable state licensure requirements, or be in compliance with state regulatory requirements in states that do not license ~~when they are developed.~~ Physical therapy services and providers must meet the requirements of 42 CFR § 440.110. Physical therapy services are provided by or under the ~~direction~~ supervision of a qualified physical therapist.

Physical therapist assistant is defined as ~~one qualified under the rules of the Board of Medical Examiners. These rules define a physical therapist assistant as a skilled technical worker who is a graduate of a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent a comparable national accrediting agency approved by the Board.~~ Physical therapist assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license. A physical therapist assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist to assist the physical therapist in patient, client or resident related activities.

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11. a. Physical therapy services. (continued)

~~Direction~~ Delegation of duties is defined as the actions of a physical therapist who ~~instructs~~ delegates to the physical therapist assistant ~~in~~ specific duties to be performed, monitors the provision of services on-site and documents the appropriateness of the services not less than every sixth treatment session, and meets the other supervisory requirements specified in law ~~the rules of the Board of Medical Examiners.~~

Coverage does not include:

- 1) Services provided in a nursing facility, ICF/MR, or day training and habilitation services center, if the cost of physical therapy has been included in the facility's per diem, such as:
 - A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;
 - B. Ambulation of a recipient who has an established gait pattern;
 - C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;
 - D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and
 - E. Bowel and bladder retraining programs.
- 2) Arts and crafts activities for the purposes of recreation.

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11.a. Physical therapy services. (continued)

- 3) Services that are not documented in the recipient's health care record.
- 4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.
- 5) Services by more than one provider of the same type for the same diagnosis.
- 6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
- 7) Evaluations or reevaluations performed by a physical therapist assistant.
- 8) Services provided by a physical therapist other than the therapist billing for the services, unless the physical therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case the agency, facility or physician must bill for the service.
- 9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.b. Occupational therapy services.

Coverage is limited to:

- 1) Services prescribed by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.
- 2) Services provided by an occupational therapist or services delegated by an occupational therapist to an occupational therapy assistant ~~who is under the direction of an occupational therapist.~~
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.
- 4) Services that are:
 - A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or
 - B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical conditions(s) result in:
 - i. Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient's previous level of function;

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11.b. Occupational therapy services. (continued)

- ii. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, cardiovascular function, integumentary status, positioning necessary for completion of the recipient's activities of daily living, or decreased abilities relevant to the recipient's current environmental demands, or;
- iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

- i. prevents deterioration and sustains function;
- ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
- iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.

Occupational therapist is defined as an individual ~~certified by the National Board for Certification in Occupational Therapy~~ who maintains applicable state licensure or is in compliance with state regulatory requirements in states that do not license as an occupational therapist. Occupational therapy services and providers meet the requirements of ~~4342~~ CFR 440.110. Occupational therapy services are provided by or under the ~~direction~~ supervision of a qualified occupational therapist.

Occupational therapy assistant is defined as an individual ~~who has successfully completed all academic and field work requirements of an occupational therapy assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and who is currently certified by the National Board for Certification in Occupational Therapy as an occupational therapy assistant.~~ Occupational therapy assistants must maintain applicable state licensure or be in compliance with state regulatory requirements in states that do not license.

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11.b. Occupational therapy services. (continued)

~~Direction~~ Delegation of duties is defined as the actions of an occupational therapist who ~~instructs~~ delegates to the occupational therapy assistant ~~in~~ specific duties to be performed, ~~and~~ monitors the provision of services, and collaborates with the occupational therapy assistant face-to-face at least every two weeks on-site and documents the appropriateness of the services not less than every sixth treatment session of each recipient.

Coverage does not include:

- 1) Services provided in a nursing facility, ICF/MR, or day training and habilitation service center, if the cost of occupational therapy has been included in the facility's per diem, such as:
 - A. Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;
 - B. Ambulation of a recipient who has an established gait pattern;
 - C. Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures;
 - D. Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide; and
 - E. Bowel and bladder retraining programs.
- 2) Arts and crafts activities for the purpose of recreation.
- 3) Services that are not documented in the recipient's health care record.

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11.b. Occupational therapy services. (continued)

- 4) Services that are not designed to improve, maintain, or prevent deterioration of the functional status of a recipient with a medical condition.
- 5) Services by more than one provider of the same type for the same diagnosis.
- 6) A rehabilitative and therapeutic service that is furnished by a provider not enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
- 7) Evaluations or reevaluations performed by an occupational therapy assistant.
- 8) Services provided by an occupational therapist other than the therapist billing for the service, unless the occupational therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
- 9) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

- 1) Services provided upon written referral by a physician or licensed practitioner of the healing arts within the scope of the practitioner's practice under state law, or, in the case of a resident of a long-term care facility, on the written order of a physician as required by 42 CFR §483.45.
- 2) Services provided by a speech language pathologist ~~or a person completing the clinical fellowship year required for certification as a speech language pathologist under the supervision of a speech language pathologist.~~
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician or other licensed practitioner of the healing arts at least once every ~~60~~90 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.
- 4) Services that are:
 - A. Restorative therapy and are provided to a recipient whose functional status is expected by the physician or licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period; or
 - B. Specialized maintenance therapy is provided only to a recipient under 21 years of age. It is provided to a recipient whose condition cannot be maintained or treated only through rehabilitative nursing services or services of other care providers, or by the recipient because the recipient's medical condition(s) result in:

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

- i. Decreased functional ability compared to the recipient's previous level of function;
- ii. Decreased abilities relevant to the recipient's current environmental demands; or
- iii. Health and safety risks for the recipient.

Specialized maintenance therapy must meet at least one of the following:

- i. prevents deterioration and sustains function;
 - ii. for a chronic or progressive medical condition, provides interventions that enable a recipient to live at his or her highest level of independence; or
 - iii. provides treatment interventions for a recipient who is progressing but not at a rate comparable to the expectations of rehabilitative and therapeutic care.
- 5) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

Speech pathology services and providers meet the requirements of 42 CFR 440.110. Speech pathology services are provided by or under the supervision ~~direction~~ of a qualified speech pathologist.

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11.c. Speech, language; and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

Coverage of **speech-language therapy services** does not include:

- 1) Services that are not documented in the recipient's health care record.
- 2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
- 3) Services that are furnished by a provider ~~eligible to enroll with Medicare, but not~~ enrolled with Medicare, or, in the case of dual eligibles, furnished by a provider who does not first bill Medicare.
- 4) Services that are provided without written referral.
- 5) Services not medically necessary.
- 6) Services that are not part of the recipient's plan of care.
- 7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
- 8) Services provided by a speech-language pathologist other than the pathologist billing for the service, ~~or a person completing the clinical fellowship year under the supervision of the pathologist,~~ unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
- 9) ~~Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.~~
- 10) ~~Services provided to dual eligibles by an independently enrolled speech language pathologist.~~

Coverage of **hearing (audiology) therapy services** is limited to:

- 1) Services provided upon written referral by a physician or other licensed practitioner of the healing arts within the scope of the practitioner's practice under state law.

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11. c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

- 2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.
- 3) Services specified in a plan of care that is reviewed and revised as medically necessary at least once every ~~60~~90 days by the attending physician or other licensed practitioner of the healing arts. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or physician's delegate as required by Medicare.
- 4) Restorative therapy provided to a recipient whose functional status is expected by the physician or other licensed practitioner of the healing arts to progress toward or achieve the objectives in the recipient's plan of care within a ~~60~~90-day period.
- 5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.
- 6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

Audiology services and providers meet the requirements in 42 CFR 440.110(c)(3). Audiology services are provided by or under the direction of a qualified audiologist.

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

'Under the direction of a qualified audiologist' means that a federally qualified audiologist who is directing audiology services must supervise each beneficiary's care. To meet this requirement the qualified audiologist must, at a minimum, have face-to-face contact with the beneficiary initially and periodically as needed, be familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law, have continued involvement in the care provided, and review the need for continued services throughout treatment. The supervising audiologist must also assume professional responsibility for the services provided under their direction and monitor the need for continued services. The supervising audiologist must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, the supervising audiologist must ensure that individuals working under their direction have contact information to permit them direct contact with the supervising audiologist as necessary during the course of treatment. In all cases, documentation must be kept supporting the supervision, provision of and claiming of services and ongoing involvement in the treatment. Absent appropriate service documentation, Medicaid payment for services may be denied providers.

Coverage of **hearing (audiology) therapy services** does not include:

- 1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
- 2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
- 3) Services provided by an audiologist other than the audiologist billing for the services, ~~or a person completing the clinical fellowship year under the supervision of the audiologist,~~ unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

- 4) Services that are furnished by a provider not enrolled with Medicare, or in the case of dual eligibles, furnished by a provider who does not first bill Medicare.

Hearing aid services: After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** for adults is limited to:

- 1) Medically necessary ~~One monaural and or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.~~
- 2) ~~Non-contract hearing aids require prior authorization.~~ No more than two replacement hearing aids due to loss, theft, or damage in the five years prior to the date of the request for a replacement.

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11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).
(continued)

Coverage of **hearing aids** does not include:

- 1) Replacement batteries provided on a scheduled basis regardless of their actual need.
- 2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
- 3) Routine screening of individuals or groups for identification of hearing problems.
- 4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
- 5) Nonelectronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, and battery chargers.
- 6) Maintenance, cleaning; and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
- 7) Loaner hearing aid charges.
- 8) Canal type hearing aids.
- 9) A noncontract hearing aid that is obtained without prior authorization.
- 10) Services included in the dispensing fee when billed on a separate claim for payment.
- 11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or referral by the resident's family, guardian or attending physician.
- 12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
- 13) ~~Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.~~