Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

600 Seventeenth Street
Suite 600 North
Denver, CO 80202

Medicaid Provider Services

303-534-0146
1-800-237-0757

Mailing Addresses

Claims & PARs
P.O. Box 30
Denver, CO 80201-0030

Correspondence, Inquiries & Adjustments
P.O Box 90
Denver, CO 80201-0090

Provider enrollment, Provider information, Changes, Signature authorization, and Claim requisitions
P.O. Box 1100
Denver, CO 80201-1100

Medicaid Fiscal Agent Information on the Internet

coloradomedicaid.acs-inc.com

Medicaid bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medicaid Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.

Please direct questions about bulletins and billing information to Medicaid Provider Services.

Distribution: Physical & Occupational therapy providers, Physical therapy clinics

January 2002

Reference: B0200119

Acute Care Outpatient Occupational Therapy and Physical Therapy

Effective February 15, 2002, Medicaid clients will be limited to six visits of acute care outpatient Occupational Therapy (OT) and six visits of acute care outpatient Physical Therapy (PT). To receive more than six visits of OT and PT, an approved Prior Authorization Request (PAR) from The Colorado Foundation for Medical Care (CFMC) must be on file with the fiscal agent. There are no retroactive authorizations. If a client receives more than six treatments without an approved PAR, the claim will deny and the provider will not be reimbursed for those treatments.

The PAR becomes active on the date it is approved. PARs are effective for a one-year time period and cover the approved number of authorized OT/PT treatments.

The rendering therapist or clinic shall submit the PAR along with documentation supporting medical necessity to CFMC.

A CFMC medical reviewer familiar with OT/PT will review, and approve or deny the request for services.

The PAR must include:

- A medical prescription from a licensed physician
- The client's name and Medicaid ID number
- The clinic name, business address, phone number, and Medicaid provider number, if the service is being billed through a clinic.
- The billing physician's name, address, phone number, and Medicaid provider number.
- The name, professional title, business address, and phone number of the referring physician.
- The name, professional title, business address, and phone number of the rendering therapist.
- A service plan for the client. The plan shall include:
  - ✓ Diagnosis
  - ✓ Statement of problem
  - ✓ Interventions and modality
  - ✓ The physical location or locations (i.e., home, clinic, school, etc.) where service will be provided
  - ✓ Goals of therapy (client, therapist, and family collaboration)
  - ✓ Statement identifying the expected number of treatments within a specific timeframe to meet goals

A Medicaid covered service that meets the "medical necessity" definition includes the following criteria.

The medically prescribed service:

1. Is found to be an equally effective treatment among other, less conservative or more costly treatment options; and,
2. Meets at least one of the following criteria:
   a. The service will, or is reasonably expected to, prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability.
   b. The service will, or is reasonably expected to, cure, correct, reduce or improve the physical, mental, cognitive or developmental effects of an illness, injury or disability.
   c. The service will, or is reasonably expected to, reduce or help the pain or suffering caused by an illness, injury, condition or disability.
   d. The service will, or is reasonably expected to, assist the individual to achieve or maintain individualized maximum functional capacity in performing activities of daily living.

If the client's medical condition requires more treatments than listed and authorized on the original PAR, a subsequent PAR is required. Each PAR must include all required information previously noted.

Retrospective reviews of OT and PT services may be performed for reasons such as, but not limited to:

- Goals not achieved *(as determined by physician, therapist, client)*
- New therapist
- Family requests a review of the case
- Provider requests a review of the case

Note: *These protocols apply only to Acute Care Outpatient Physical Therapy and Occupational Therapy, and* ***not*** *to Physical Therapy and/or Occupational Therapy services provided to clients by home health agencies or outpatient hospitals.*

Included with this bulletin:

1. A list of Physical Therapy/Occupational Therapy codes
2. A copy of the PAR form

Please direct questions about Medicaid acute care outpatient occupational therapy and outpatient physical therapy information in this bulletin to:

303-534-0146 or
1-800-237-0757 (toll free Colorado).

Physical Therapy/Occupational Therapy CPT* CODES

97001	Physical Therapy evaluation	97112	Neuromuscular reeducation of movement
97002	Physical Therapy re-evaluation	97113	Aquatic therapy
97010	PT – Application of a modality to one or more areas: hot or cold packs	97116	Gait training
97012	PT – Traction	97124	Massage, including effleurage
97014	PT – Electrical stimulation	97139	Unlisted therapeutic procedure
97016	Vasopneumatic devices	97140	Manual therapy techniques
97018	Paraffin bath	97150	Therapeutic procedure (group)
97020	Microwave	97504	Orthotics fitting and training
97022	Whirlpool	97520	Prosthetic training
97024	Diathermy	97530	Therapeutic activities
97026	Infrared	97542	Wheelchair management
97028	Ultraviolet	97545	Work hardening/ conditioning, initial 2 hours
97032	Application of electrical stimulation	97546	Each additional hour
97033	Iontophoresis, each 15 minutes	97601	Removal of devitalized tissue from wound
97034	Contrast baths, each 15 minutes	97602	Non-selective debridement, without anesthesia
97035	Ultrasound, each 15 minutes	97703	Checkout for othrotic/prosthetic use
97036	Hubbard tank, each 15 minutes	97750	Physical performance test or measurement
97039	Unlisted modality (specify type and time of constant attendance)	97799	Unlisted physical medicine/rehabilitation service or procedure
97110	Therapeutic procedure		
Occupational Therapy Codes			
97003	Occupational Therapy evaluation	97533	Sensory integrative techniques to enhance sensory processing
97004	Occupational Therapy re-evaluation	97535	Self care/home management
97532	Development of cognitive skills to improve attention	97537	Community work/ reintegration training
HCPCS			
Q0086	Physical therapy evaluation/treatment, per visit	G0152	Services of occupational therapist in home health setting (15 minutes)
G0151	Services of physical therapist in home health setting, (15 minutes)	S9129	Occupational therapy, in the home, per diem

*CPT codes, descriptions & 2 digit modifiers are copyright American Medical Association. All rights reserved.

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX ☐ M ☐ F	4. DATE OF BIRTH (MMDDYY)

5. CLIENT ADDRESS (Street, City, State, ZIP Code)	6. CLIENT TELEPHONE NUMBER ( )

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ YES ☐ NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME ***Leave blank - Not Applicable***

11. ICD-9-CM DIAGNOSIS CODE **and** DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)

12. REQUESTING AUTHORIZATION FOR REPAIRS
EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED
Leave blank - Not Applicable

13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?
Leave blank - Not Applicable

14. ESTIMATED COST OF EQUIPMENT
Leave blank - Not Applicable

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
TELEPHONE NUMBER ( )	23. PCP PROVIDER NUMBER	

24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION ***Enter the Billing Physician's name and address***	25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE

26. REQUESTING PHYSICIAN SIGNATURE ***Enter the Billing Physician's signature***	27. DATE SIGNED

TELEPHONE NUMBER ( )	28. REQUESTING PHYSICIAN PROVIDER NUMBER ***Enter the Billing Physician's provider number***	TELEPHONE NUMBER ( )	29. SERVICE PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **

* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SER-

** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013 **(REV. 12/98)**
COL — 106

White - AUTHORIZING AGENT Yellow - ORIGINATOR