CHAPTER 17-000 PHYSICAL THERAPY SERVICES

17-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), the physical therapist must be licensed by the Nebraska Department of Health and Human Services. If services are provided outside Nebraska, the qualified physical therapist must be:

1. 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; or
2. Where applicable, licensed by the State.

17-001.01 Certified Physical Therapy Assistant: NMAP does not enroll certified physical therapy assistants (PTA) as providers. Services provided by a PTA are billable to NMAP when all requirements of 172 NAC 137 are met.

If services are provided outside Nebraska, the supervising physical therapy provider must submit a photocopy of the PTA's state certificate. The supervising physical therapist will be notified by the Department of Health and Human Services, Division of Medicaid and Long Term Care if services provided by the PTA are not billable to NMAP.

17-001.02 Provider Agreement: The physical therapist must complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit it to the Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care to be approved for provider enrollment.

17-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

17-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider must provide services only under arrangement with the HMO.

17-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. The client's primary care physician (PCP) in the PCCM must refer the client for physical therapy services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

17-003 Covered Services: NMAP covers physical therapy services when the following criteria are met:

1. The services are ordered by a licensed physician;
2. The services are medically necessary;
3. The services are of such a level of complexity and sophistication or the condition of the patient is such that only a licensed physical therapist can safely, and effectively perform the service; and
4. The physical therapy service meets at least one of the conditions listed in 471 NAC 17-003.01 or 17-003.02.

17-003.01 Services for Individuals Age 21 and Older: NMAP covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy and speech therapy). The services must be:

1. An evaluation; or
2. Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly within a reasonable period of time; or
3. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

17-003.02 Services for Individuals Age 20 and Younger: NMAP covers physical therapy services for individual birth to age 20 when the following criteria are met. The service must be:

1. An evaluation;
2. Reasonable and medically necessary for the treatment of the client's illness or injury; or
3. Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly with in a reasonable period of time; or
4. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
   a. DD Adult Comprehensive Services Waiver;
   b. DD Adult Residential Services Waiver;
   c. DD Adult Day Services Waiver;
   d. Community Supports Waiver; or
   e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

17-003.03 Maintenance Therapy: NMAP does not cover maintenance therapy provided by a physical therapist. The physical therapist must:

1. Evaluate the client's needs;
2. Design a maintenance program; and
3. Instruct the client, family members, or nursing facility staff in carrying out the program.

17-003.04 Orthotic Appliances and Devices: NMAP covers orthotic appliances and devices when medically necessary for the client's condition, and when the orthotic appliance or device is applied or used during the therapy session.

17-003.05 Supplies: NMAP will consider payment for certain supplies that are used during the course of treatment and require application by the physical therapist except those supplies that are considered incident to the procedure provided.

17-004 Non-Covered Physical Therapy Services: NMAP does not cover physical therapy in the following situations:

1. Clients Age 21 and Older – therapy sessions in excess of 60 sessions per fiscal year for any combination of physical therapy, occupational therapy and speech therapy;
2. Therapy for work hardening, or vocational and prevocational assessment and training;
3. Therapy for functional capacity evaluations, educational testing, drivers training, or training in non-essential self-help or recreational activities (e.g. homemaking, cooking, finance), training related to learning disability, attention disorder, visual perception training, or treatment of psychological conditions;
4. In-service training for nursing facility staff which is not client specific. (These services may be allowed under nursing facility reimbursement as a consulting service.);
5. Rental of equipment; or
6. Take home supplies.

17-005 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of “Treatment Services” in 471 NAC 33-001.04. These services must be prior authorized by the Division of Medicaid and Long-Term Care.

17-006 Payment for Physical Therapy Services

17-006.01 Individual Providers: The Nebraska Medical Assistance Program pays for covered physical therapy services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Division of Medicaid and Long-Term Care (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-517).

17-006.01A Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Division of Medicaid and Long-Term Care determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of the revisions and their effective dates.

17-006.02 Hospitals: For payment as a hospital service see 471 NAC 10-000, Hospital Services.

17-006.03 Home Health Agencies: For payment as a home health agency service, see 471 NAC 9-000, Home Health Agencies.

17-007 Billing Requirements

17-007.01 Medicare or Other Insurance Coverage: If the client is eligible for Medicare or has other insurance which may cover physical therapy, the provider must bill the Medicare carrier or the insurance company before submitting a claim to the Department.

17-007.02 Medical Necessity Documentation: The provider must provide the following information when submitting a claim for physical therapy services:

1. Date of illness/injury onset.
2. Date physical therapy plan established.
3. Date physical therapy started.
4. Number of physical therapy visits from onset.

17-007.03 Utilization Review: Claims for physical therapy services are subject to utilization review by the Department to determine medical necessity and appropriateness of the service.

17-007.04 Required Forms and Standard Electronic Transactions: Depending on the place of service, the provider must use the forms and transactions required by NMAP as follows:

1. If the service is provided at the patient's home or the therapist's office, the provider must claim payment on Form CMS-1500 (see 471-000-61) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The provider must use the appropriate place of service code and CPT or HCPCS codes on the claim;
2. If the service is provided in a hospital, inpatient or outpatient setting, the hospital submits claims to NMAP for physical therapy services on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837); and
3. If the service is provided by a home health agency, the agency must claim payment on Form CMS-1450 (see 471-000-57) or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

The provider or the provider's authorized agent must enter the provider's usual and customary charge for each procedure code listed on or in the claim.

17-007.05 Procedure Codes: Individual providers billing on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) must use the American Medical Association’s Current Procedural Terminology (CPT) or HCPCS procedure codes when billing NMAP.

Hospital providers billing on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) must use the appropriate revenue codes when billing NMAP.

Home health agencies billing on Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) must use the procedure codes listed in 471-000-57.