Kansas
Medical Assistance
Program

November 2006 **Provider Bulletin Number 690b**

Physical Therapy Providers

Rehabilitation Therapy

Effective with dates of service on and after December 1, 2006, providers of rehabilitative therapy will be able to submit claims with a combination of the following rehabilitation therapy procedure codes and a diagnosis code in the range of V57.0-V57.9 as the primary diagnosis. Providers are required to submit a secondary diagnosis code to describe the origin of the impairment for which rehabilitative therapy is needed when one of these V-codes is billed as a primary diagnosis.

97001	97003	97010	97012	97014
97016	97018	97022	97024	97026
97028	97032	97033	97034	97035
97036	97110	97112	97113	97116
97124	97140	97150	97530	97535
97750				

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, please view the *Physical Therapy Provider Manual*, pages 8-3 through 8-4.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or (785) 274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

BENEFITS AND LIMITATIONS
8400. MEDICAID Updated 11/06

Physical Therapy Services:

All therapy **must** be prescribed by a physician.

Habilitative - Habilitative therapy is covered only for participants age 0 to under the age of 21. Therapy **must** be medically necessary. Therapy is covered for any birth defects/developmental delays only when approved and provided by an Early Childhood Intervention (ECI), Head Start, or Local Education Agency (LEA) program. Therapy treatments performed in the Local Education Agency (LEA) settings may be habilitative or rehabilitative for disabilities due to birth defects or physical trauma/illness. The purpose of this therapy is to maintain maximum possible functioning for children.

Rehabilitative - All therapies **must** be physically rehabilitative. Therapies are covered only when rehabilitative in nature and provided following physical debilitation due to an acute physical trauma or illness.

Therapy codes must be billed as one unit equals one visit unless the description of the code specifies the unit.

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Provider Requirements:

Physical therapy services can be provided by a registered physical therapist, licensed in the State of Kansas, or by a certified physical therapy assistant working under the supervision of a registered physical therapist.

Procedure Codes:

Physical therapists shall bill their services using appropriate Current Procedural Terminology (CPT) codes. Refer to Section 1300 in the provider manual for information on how to obtain a CPT manual.

8400. MEDICAID Updated 11/06

Procedure Codes continued:

Therapists will not be reimbursed for services provided outside their scope of practice. Questions regarding specific procedure code coverage can be directed to the Provider Assistance Unit (refer to Section 1000).

When a CPT code is not available, the service is not covered by Kansas Medical Assistance Program. NOC (not otherwise classified) codes are non-covered.

Claims which only describe a service and do not provide the CPT procedure code will be denied.

Documentation:

A copy of the physician's order for physical therapy must be retained with the medical record.

To verify services provided in the course of a postpayment review, documentation in the consumer's medical record must support the service billed. Documentation shall be legible and complete. Proper documentation need not appear in any specific format; however, it must include the following:

- Pertinent past and present medical history with approximate date of diagnosis
- Identification of expected goals or outcomes
- Description of therapy and length of time spent on treatment
- Consumer's response to therapy
- Progress toward goal(s)
- Therapist shall date and sign by discipline each entry

Autoauthentication (computerized authentication) of documentation for the medical record is acceptable as long as it meets federal guidelines. Federal regulation 42CFR 482.24 (c) (1) (i) requires that there be a method of determining that the individual authenticated the document after transcription. All entries shall be legible and complete. Entries must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for providing the service. The author of each entry must be identified and authenticate his/her entry. Authentication may include the author's signature, written initials, or computer entry.

If services were performed by a certified physical therapy assistant, supervision must be clearly documented. This may include, but is not limited to, the registered physical therapist initializing each treatment note written by the certified physical therapy assistant, or the registered physical therapist writing “Treatment was supervised” followed by their signature.

Limitations:

Therapy services are limited to six months for non-KAN Be Healthy participants (except the provision of therapy under HCBS), per injury, to begin at the discretion of the provider. There is no limitation for KAN Be Healthy participants.