CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Skilled therapies

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS:

To Be Rescinded: 5160-8-31

NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

To Be Rescinded: 5160-4-26, 5160-8-30, 5160-8-32, 5160-8-33, 5160-8-34

New: 5160-8-35

Date: April 16, 2018

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language. Please include the key provisions of the regulation as well as any proposed amendments.**

   The provision of skilled therapy (physical therapy, occupational therapy, speech-language pathology services, and audiology services) in non-institutional settings is currently addressed in five rules in Chapter 5160-8 of the Ohio Administrative Code (OAC):

   Rule 5160-8-30, "Skilled therapy: scope and definitions"
   Rule 5160-8-31, "Skilled therapy: providers"
   Rule 5160-8-32, "Skilled therapy: coverage"
   Rule 5160-8-33, "Skilled therapy: documentation of services"
   Rule 5160-8-34, "Skilled therapy: payment"

   These five rules have been rescinded and their content has been combined into a single new rule 5160-8-35, "Skilled therapy services." Outdated terminology and references as well as eligible providers have been updated to include the removal of the Medicare participation requirement. Duplicative, contradictory, or otherwise unnecessary provisions have been consolidated or removed. Except for services rendered in the Medicaid school program (MSP), language has been added in accordance with federal mandate to only cover services rendered in response to a prescription or a referral issued by a licensed practitioner of the healing arts.

   Rule 5160-4-26, "Physical medicine and rehabilitation services," allows Medicaid payment for covered physical medicine and rehabilitation services performed by a physician or by a licensed individual under the direct supervision of a physician. This rule has been rescinded because its provisions are addressed in other OAC rules.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   The Ohio Department of Medicaid (ODM) is promulgating these rules under section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes. In accordance with 42 C.F.R. 440.110 (October 1, 2017), skilled therapy services rendered must be in response to a prescription or a referral issued by a licensed practitioner of the healing arts. For Medicaid services provided under the Medicaid school program, R.C. 5162.366 makes physical therapists, occupational

therapists, speech-language pathologists, and audiologists licensed practitioners of the healing arts for the purpose of this federal regulation.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   This Medicaid rule does not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   This Medicaid rule currently in effect establishes which providers are eligible to render skilled therapy services.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of this rule will be measured by the extent to which operational updates to the Medicaid Information Technology System (MITS) result in the correct provider enrollment and payment of claims.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

ODM has worked with various skilled therapy stakeholders since 2014 when the skilled therapy rules were last amended and the resulting program changes were implemented.

These professional association stakeholders include the Ohio Occupational Therapy Association, Ohio Physical Therapy Association, Ohio Speech-Language-Hearing Association and Ohio Speech and Hearing Governmental Affairs Coalition which is a coalition consisting of OSLHA (Ohio Speech-Language-Hearing Association), AAO (Aphasiology Association of Ohio), OAA (Ohio Academy of Audiology), and OCSHA (Ohio Council of Speech and Hearing Administrators). ODM staff has presented "Medicaid program update" sessions at association annual conventions as well as attending various educational sessions at these statewide meetings.

Additionally ODM has interacted with ad hoc skilled therapy provider stakeholder groups and individual skilled therapy providers to discuss professional scope of practice, program coverage and billing.

These associations, certain member leaders and individual Medicaid therapy providers have been contacted several times since the fall of 2017 to seek their input and to notify them of the five-year rule review and timeline for amendment of these OAC rules. Meetings are being scheduled in follow-up with stakeholders.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   Stakeholder input resulted in the streamlining and consolidation of the rules and rule language. Stakeholder confusion regarding the Medicare conditions of participation for non-Medicare participants resulted in the removal of this requirement to encourage correct and timely completion of the provider enrollment application.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   The use of scientific data does not apply to the development of this rule.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    This rule involve the coverage of and payment for skilled therapy services. Whatever the policy may be, the form of the rule is the same; no alternative is readily apparent.

11. **Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.**

    The concept of performance-based regulation does not apply to these services.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    This rule involving Medicaid providers is housed exclusively in agency 5160 of the Ohio Administrative Code. This rule have been reviewed by legal services and policy staff members to prevent duplication.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

Medicaid will implement this regulation by updating Medicaid Information Technology System (MITS) in accordance.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

a. Identify the scope of the impacted business community;

Changes in this rule will affect all professional Medicaid providers of skilled therapy services rendered in non-institutional settings.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

In current rule 5160-8-31, independently practicing skilled therapists either must participate in the Medicare program or, if they limit their practice to pediatric treatment and do not serve Medicare beneficiaries, must meet all other requirements for Medicare participation. This requirement is being eliminated in proposed new rule 5160-8-35.

***c.* Quantify the expected adverse impact from the regulation.**
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

It is likely that most independently practicing skilled therapists already participate in Medicare, so this Medicaid provider enrollment requirement in current rule 5160-8-31 is likely to have had minimal actual adverse impact. The adverse impact for a newly enrolling Medicare provider would be the time necessary to fill out the application form (approximately 15 pages in length, much of which asks for check marks and short answers), the effort required to compile supporting documentation, and payment of the $560 application fee to Medicare. This requirement is being eliminated in the new rule.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The Medicare participation requirement served as an additional program integrity tool for preventing fraud, waste, and abuse and for assuring access to therapy services. The Department removed the Medicare participation requirement because it is no longer necessary as a condition of Medicaid enrollment for skilled therapy providers.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

The requirements set forth in this rule is applied uniformly; no exception is made on the basis of an entity's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

This rule imposes no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-4-26 **Physical medicine and rehabilitation services.**

(A) Payment may be made for covered physical medicine and rehabilitation services performed by a physician or by a licensed individual under the direct supervision of a physician in accordance with rule 5160-4-02 of the Administrative Code.

(B) Physical therapy, occupational therapy, speech-language pathology, and audiology are addressed in Chapter 5160-8 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
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Rule Amplifies:	5164.02
Prior Effective Dates:	10/01/1983 (Emer.), 12/29/1983, 01/01/1986, 05/09/1986, 06/16/1988, 01/13/1989 (Emer.), 04/13/1989, 09/01/1989, 12/30/1994 (Emer.), 03/30/1995, 07/01/2002, 01/01/2008, 01/01/2014

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-8-30 **Skilled therapy: scope and definitions.**

(A) Rules 5160-8-31 to 5160-8-34 of the Administrative Code set forth provisions governing payment for skilled therapies as non-institutional professional services. Provisions governing payment for skilled therapies as the following service types are set forth in the indicated part of the Administrative Code:

(1) Hospital services, Chapter 5160-2;

(2) Nursing facility services, Chapter 5160-3;

(3) Home health services, Chapter 5160-12;

(4) Clinic services rendered by the following providers:

(a) Fee-for-service ambulatory health care clinics, Chapter 5160-13;

(b) Rural health clinics, Chapter 5160-16;

(c) Federally qualified health centers, Chapter 5160-28; or

(d) Outpatient health facilities, Chapter 5160-29;

(5) Medicaid school program services, Chapter 5160-35; and

(6) Intermediate care facility services, Chapter 5123:2-7.

(B) The following definitions apply to rules 5160-8-31 to 5160-8-34 of the Administrative Code:

(1) "Audiologist" is a person who holds a valid license as an audiologist under Chapter 4753. of the Revised Code.

(2) "Audiology aide" is a person who holds a valid license as an audiology aide under Chapter 4753. of the Revised Code.

(3) "Developmental services" are skilled therapy services rendered, in accordance with developmental milestones established by the American academy of pediatrics, to enable individuals younger than seven years of age to attain a level of age-appropriate functionality that they have not yet achieved but are expected to achieve.

(4) "Developmental disability" has the same meaning as in section 5123.01 of the Revised Code.

(5) "Eligible provider" has the same meaning as in rule 5160-1-17 of the Administrative Code.

(6) "Maintenance services" are skilled therapy services rendered to individuals for the purpose of maintaining but not improving functionality.

(7) "Mechanotherapist" is a person who holds a valid license as a mechanotherapist under Chapter 4731. of the Revised Code and works within the scope of practice defined by state law.

(8) "Non-institutional setting" is a location that is not a hospital or long-term care facility and that is appropriate to the delivery of skilled therapy services. Examples include but are not limited to practitioners' offices, clinics, licensed child day care centers, adult day care centers, and public facilities such as community centers.

(9) "Occupational therapist" is a person who holds a valid license as an occupational therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.

(10) "Occupational therapy" has the same meaning as in section 4755.04 of the Revised Code.

(11) "Occupational therapy assistant" is a person who holds a valid license as an occupational therapy assistant under Chapter 4755. of the Revised Code.

(12) "Physical therapist" is a person who holds a valid license as a physical therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.

(13) "Physical therapist assistant" is a person who holds a valid license as a physical therapist assistant under Chapter 4755. of the Revised Code.

(14) "Physical therapy" has the same meaning as in section 4755.40 of the Revised Code.

(15) "Rehabilitative services" are skilled therapy services rendered to individuals for the purpose of improving functionality.

(16) "Skilled therapist" is a collective term encompassing physical therapist, occupational therapist, speech-language pathologist, and audiologist.

(17) "Skilled therapy" is a collective term encompassing physical therapy, occupational therapy, speech-language pathology, and audiology.

(18) "Speech-language pathologist" is a person who holds a valid license as a speech-language pathologist under Chapter 4753. of the Revised Code.

(19) "Speech-language pathology aide" is a person who holds a valid license as a speech-language pathology aide under Chapter 4753. of the Revised Code.

(20) "Standardized test" is a diagnostic tool or procedure that has a standardized administration and scoring process, the results of which can be compared to an appropriate normative sample. Standardized tests must be norm-referenced, age-appropriate, and specific to areas of deficit.

(21) "Supplemental test" is a non-diagnostic screening or criterion-referenced tool that is used to provide further documentation of deficits and to corroborate the results of a standardized test. A supplemental test may not be used in place of a standardized test.

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Prior Effective Dates:	01/01/2008, 01/01/2014

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-8-31 **Skilled therapy: providers.**

(A) Rendering providers.

(1) Independently practicing skilled therapists either must participate in the medicare program or, if they limit their practice to pediatric treatment and do not serve medicare beneficiaries, must meet all other requirements for medicare participation.

(2) The following eligible providers may render a physical therapy service:

(a) A physical therapist;

(b) A physical therapist assistant who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider;

(c) A physical therapy student who is completing an internship, if the following conditions are met:

(i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy;

(ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;

(iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and

(iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met; or

(d) A mechanotherapist.

(3) The following eligible providers may render an occupational therapy service:

(a) An occupational therapist;

(b) An occupational therapy assistant who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider; or

(c) An occupational therapy student who is completing an internship, if the following conditions are met:

(i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy;

(ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;

(iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and

(iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met.

(4) The following eligible providers may render a speech-language pathology service:

(a) A speech-language pathologist;

(b) A speech-language pathology aide who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider;

(c) A speech-language pathology student who is completing an internship, if the following conditions are met:

(i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy;

(ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;

(iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and

(iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met; or

(d) A person holding a conditional license to practice speech-language pathology, if the eligible provider supervising the professional experience keeps on file a copy of the conditionally-licensed speech-language pathologist's plan of supervised professional experience, required by section 4753.071 of the Revised Code.

(5) The following eligible providers may render an audiology service:

(a) An audiologist;

(b) An audiology aide who is licensed to provide the particular service and who provides the service to only one person at a time under the supervision of an eligible provider;

(c) An audiology student who is completing an internship, if the following conditions are met:

(i) The student provides the service under the supervision of the eligible provider responsible for the patient's therapy;

(ii) The eligible provider responsible for the patient's therapy has face-to-face contact with the patient during provision of the service;

(iii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the internship, including the beginning and ending dates; and

(iv) The eligible provider responsible for the patient's therapy includes in the patient's medical record documentation that appropriate service was provided under supervision, that the eligible provider checked and updated the medical record at least once a week, and that all requirements for payment were met; or

(d) An audiology student who is completing an externship, if the following conditions are met:

(i) The service is provided under the supervision of the eligible provider responsible for the patient's therapy; and

(ii) The eligible provider responsible for the patient's therapy keeps on file official documentation of the externship, including the beginning and ending dates.

(B) Billing ("pay-to") providers.

(1) The following eligible providers may receive medicaid payment for submitting a claim for a skilled therapy service on behalf of a rendering provider:

(a) A hospital, rules for which are set forth in Chapter 5160-2 of the Administrative Code;

(b) A provider of physician services, rules for whom are set forth in Chapter 5160-4 of the Administrative Code;

(c) A professional medical group;

(d) An ambulatory health care clinic, rules for which are set forth in Chapter 5160-13 of the Administrative Code;

(e) A rural health clinic, rules for which are set forth in Chapter 5160-16 of the Administrative Code;

(f) A federally qualified health center, rules for which are set forth in Chapter 5160-28 of the Administrative Code; or

(g) An outpatient health facility, rules for which are set forth in Chapter 5160-29 of the Administrative Code.

(2) The following eligible providers may receive medicaid payment either for rendering a skilled therapy service themselves or for submitting a claim for a skilled therapy service on behalf of a rendering provider:

(a) A skilled therapist; or

(b) A mechanotherapist.

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*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-8-32 **Skilled therapy: coverage.**

(A) Payment may be made for a skilled therapy service if the following conditions are met:

(1) The service is medically necessary, in accordance with rule 5160-1-01 of the Administrative Code.

(2) The service is rendered on the basis of a clinical evaluation and assessment and in accordance with a treatment plan. (Audiology must meet this condition in order to be considered skilled therapy for purposes of this chapter.) The performance of a clinical evaluation and assessment and the development of a treatment plan are discrete services; payment for them is made separately from payment for skilled therapy. The clinical evaluation and assessment and the treatment plan are described in rule 5160-8-33 of the Administrative Code; copies must be kept on file by the provider.

(3) The amount, frequency, and duration of treatment is reasonable. For rehabilitative services, the maximum treatment period without reevaluation is sixty days; for developmental services, the maximum treatment period without reevaluation is six months.

(B) The following limitations and additional requirements are placed on the provision of skilled therapy services:

(1) For dates of service January 1, 2014, and after, payment for skilled therapy services rendered without prior authorization in a non-institutional setting is subject to the following limits:

(a) For physical therapy services, a total of no more than thirty visits per benefit year;

(b) For occupational therapy services, a total of no more than thirty visits per benefit year; and

(c) For speech-language pathology and audiology services, a total of no more than thirty visits per benefit year.

(2) Payment for additional skilled therapy visits in a non-institutional setting can be requested through the prior authorization process, which is described in Chapter 5160-1 of the Administrative Code.

(3) For each type of skilled therapy, payment for evaluation services can be made not more than once per injury or condition.

(4) For each type of skilled therapy, payment for reevaluation of rehabilitative services cannot be made more often than once every sixty days.

(5) For each type of skilled therapy, payment for reevaluation of developmental services cannot be made more often than once every six months.

(6) No payment is made for the following services as skilled therapy:

(a) Services reported on a claim submitted by an entity that neither is nor acts on behalf of an eligible provider of skilled therapy services;

(b) Services not rendered by nor under the supervision of a physician or skilled therapist;

(c) Services that do not meet current accepted standards of practice;

(d) Services rendered in a non-approved location;

(e) Additional rehabilitative services for a patient who fails to demonstrate progress within a sixty-day treatment period;

(f) Additional developmental services for a patient who fails to demonstrate progress within a six-month treatment period;

(g) Consultations with family members or other non-medical personnel; and

(h) Services rendered in non-institutional settings and listed as non-covered in rule 5160-4-28 or in appendix DD to rule 5160-1-60 of the Administrative Code.

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Prior Effective Dates:	01/01/2008, 01/01/2014

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TO BE RESCINDED

5160-8-33 **Skilled therapy: documentation of services.**

(A) A clinical evaluation and assessment of the need for skilled therapy services includes the following elements:

(1) A diagnosis of the type and severity of the disorder or a description of the deficit in physical or sensory functionality;

(2) A review of the individual's current physical, auditory, visual, motor, and cognitive status;

(3) A case history, including, when appropriate, family perspectives on the individual's development and capacity to participate in therapy;

(4) The outcomes of standardized tests and any non-standardized tests that use age-appropriate developmental criteria;

(5) Other test results and interpretation;

(6) An evaluation justifying the provision of skilled therapy services, which may be expressed as one of two prognoses of the patient's rehabilitative or developmental potential:

(a) The patient's functionality is expected to improve within sixty days after the evaluation because of the delivery of rehabilitative skilled therapy services or within six months after the evaluation because of the delivery of developmental skilled therapy services, and the patient is expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months; or

(b) The patient is not expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months, but a safe and effective maintenance program may be established; and

(7) Any recommendations for further appraisal, follow-up, or referral.

(B) A treatment or maintenance plan for skilled therapy services is based on the clinical evaluation and assessment. It should be coordinated, when appropriate, with services provided by non-medicaid providers or programs (e.g., child welfare, child care, or

prevocational or vocational services), and it should provide a process for involving the patient or the patient's representative in the provision of services. A complete treatment or maintenance plan includes the following elements:

(1) The patient's relevant medical history;

(2) Specification of the amount, duration, and frequency of each skilled therapy service to be rendered; the methods to be used; and the areas of the body to be treated;

(3) A statement of specific functional goals to be achieved, including the level or degree of improvement expected within the appropriate time period;

(4) The date of each treatment;

(5) The signature of the practitioner responsible for the treatment plan;

(6) Documentation of participation by the patient or the patient's representative in the development of the plan;

(7) Specific timelines for reevaluating and updating the plan;

(8) A statement of the degree to which the patient has made progress; and

(9) A recommendation for one of several courses of action:

(a) The development of a new or revised treatment plan;

(b) The development of a maintenance plan; or

(c) The discontinuation of treatment.

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Prior Effective Dates:	01/01/2008, 01/01/2014

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-8-34 **Skilled therapy: payment.**

(A) If more than one skilled therapy service of the same discipline (e.g., physical therapy) is rendered by the same non-institutional provider or provider group to a recipient on the same date, then the service with the highest payment amount specified in appendix DD to rule 5160-1-60 of the Administrative Code is considered the primary procedure. The maximum payment amount for a skilled therapy service is the lesser of the provider's submitted charge or a percentage of the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code, determined in the following manner:

(1) For the first unit of a primary procedure, one hundred per cent.

(2) For each additional unit or procedure within the same therapy discipline, eighty per cent.

(B) Services reported on claims must correspond to the services listed in the treatment plan.

(C) Providers must report appropriate procedure codes and modifiers on claims.

(D) Unattended electrical stimulation and iontophoresis therapy are considered to be part of the associated therapy procedure or medical encounter; no separate payment is made.

(E) Skilled therapy performed during an inpatient hospital stay is treated as a hospital service.

(F) Payment for skilled therapy services rendered to a resident of a nursing facility (NF) is made to the NF through the facility per diem payment mechanism. A non-institutional provider that renders a skilled therapy service to a NF resident must seek payment from the NF.

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Prior Effective Dates:	01/01/2008, 07/31/2009 (Emer.), 10/29/2009, 01/01/2014, 07/31/2014

*** DRAFT - NOT YET FILED ***

5160-8-35 **Skilled therapy services.**

(A) Scope. This rule sets forth provisions governing payment for skilled therapies as non-institutional professional services furnished by skilled therapists and skilled therapist assistants or aides. Provisions governing payment for skilled therapies as the following service types are set forth in the indicated part of the Administrative Code:

(1) Hospital services, Chapter 5160-2;

(2) Nursing facility services, Chapter 5160-3;

(3) Physical medicine services furnished by or under the supervision of a physician, advanced practice registered nurse, or physician assistant, Chapter 5160-4;

(4) Physical medicine services furnished by or under the supervision of a podiatrist, Chapter 5160-7;

(5) Home health services, Chapter 5160-12;

(6) Clinic services rendered by the following providers:

(a) Service-based ambulatory health care clinics, Chapter 5160-13; or

(b) Cost-based clinics, Chapter 5160-28;

(7) Medicaid school program services, Chapter 5160-35; and

(8) Intermediate care facility services, Chapter 5123:2-7.

(B) Definitions.

(1) "Audiologist" is a person who holds a valid license as an audiologist under Chapter 4753. of the Revised Code.

(2) "Audiology aide" is a person who holds a valid license as an audiology aide under Chapter 4753. of the Revised Code.

(3) "Eligible provider" has the same meaning as in rule 5160-1-17 of the Administrative Code.

(4) "Maintenance services" are skilled therapy services rendered to individuals for the purpose of maintaining but not improving functionality.

(5) "Mechanotherapist" is a person who holds a valid license as a mechanotherapist under Chapter 4731. of the Revised Code and works within the scope of practice defined by state law.

(6) "Non-institutional setting" is a location that is not a hospital or long-term care facility and that is appropriate to the delivery of skilled therapy services. Examples include but are not limited to practitioners' offices, clinics, licensed child day care centers, adult day care centers, and public facilities such as community centers.

(7) "Occupational therapist" is a person who holds a valid license as an occupational therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.

(8) "Occupational therapy" has the same meaning as in section 4755.04 of the Revised Code.

(9) "Occupational therapy assistant" is a person who holds a valid license as an occupational therapy assistant under Chapter 4755. of the Revised Code.

(10) "Physical therapist" is a person who holds a valid license as a physical therapist under Chapter 4755. of the Revised Code and works within the scope of practice defined by state law.

(11) "Physical therapist assistant" is a person who holds a valid license as a physical therapist assistant under Chapter 4755. of the Revised Code.

(12) "Physical therapy" has the same meaning as in section 4755.40 of the Revised Code.

(13) "Skilled therapist" is a collective term encompassing physical therapist, occupational therapist, speech-language pathologist, and audiologist.

(14) "Skilled therapy" is a collective term encompassing physical therapy, occupational therapy, speech-language pathology, and audiology.

(15) "Speech-language pathologist" is a person who holds a valid license as a speech-language pathologist under Chapter 4753. of the Revised Code.

(16) "Speech-language pathology" and "audiology" have the same meaning as in section 4753.01 of the Revised Code.

(17) "Speech-language pathology aide" is a person who holds a valid license as a speech-language pathology aide under Chapter 4753. of the Revised Code.

(18) "Treatment" is a collective term encompassing two types of skilled therapy service:

(a) "Developmental service" is a skilled therapy service rendered, in accordance with developmental milestones established by the American academy of pediatrics, to enable individuals younger than seven years of age to attain a level of age-appropriate functionality that they have not yet achieved but are expected to achieve.

(b) "Rehabilitative service" is a skilled therapy service rendered to individuals for the purpose of improving functionality.

(C) Providers.

(1) Rendering providers. The following practitioners may render a skilled therapy service in the applicable discipline, within their scope of practice, and in accordance with any requirements established by their credentialing board:

(a) A skilled therapist or mechanotherapist;

(b) A licensed physical therapist assistant, occupational therapy assistant, speech-language pathology aide, or audiology aide who provides a particular service to one individual at a time under supervision;

(c) A physical therapy student, occupational therapy student, speech-language pathology student, or audiology student who is completing an internship or externship in accordance with the clinical requirements of the specific discipline as established by the credentialing board; or

(d) A person holding a conditional license to practice speech-language pathology, if the eligible provider supervising the professional experience fulfills all applicable requirements for documentation.

(2) Billing ("pay-to") providers.

(a) The following eligible providers may receive medicaid payment for submitting a claim for a skilled therapy service on behalf of a rendering provider:

(i) A hospital;

(ii) A physician, advanced practice registered nurse, physician assistant, or podiatrist;

(iii) A professional medical group;

(iv) A service-based ambulatory health care clinic; or

(v) A cost-based clinic.

(b) The following eligible providers may receive medicaid payment either for rendering a skilled therapy service themselves or for submitting a claim for a skilled therapy service on behalf of a rendering provider:

(i) A skilled therapist; or

(ii) A mechanotherapist.

(D) Coverage.

(1) Payment may be made for a skilled therapy service if the following conditions are met:

(a) The service is medically necessary, in accordance with rule 5160-1-01 of the Administrative Code.

(b) The amount, frequency, and duration of service is reasonable. For rehabilitative services, reevaluation may be performed not more frequently than every thirty days nor less frequently than every sixty days; for developmental services, reevaluation may be performed not more frequently than every thirty days nor less frequently than every six months.

(c) The service is rendered on the basis of a clinical evaluation and assessment and in accordance with a treatment or maintenance plan. The performance of a clinical evaluation and assessment and the development of a treatment or maintenance plan are discrete services; payment for them is made separately from payment for skilled therapy. Copies of the clinical evaluation and assessment and the treatment or maintenance plan must be kept on file by the provider.

(d) The service is rendered in response either to a prescription (in the case of physical therapy or occupational therapy) or to a referral (in the case of speech-language pathology and audiology) issued by a licensed practitioner of the healing arts, in accordance with 42 C.F.R. 440.110 (October 1, 2017) and rule 5160-1-17.9 of the Administrative Code. This condition does not apply to services rendered through the medicaid school

program, which is described in Chapter 5160-35 of the Administrative Code.

(2) Payment for skilled therapy services rendered without prior authorization in a non-institutional setting is subject to the following limits:

(a) For physical therapy services, a total of not more than thirty visits per benefit year;

(b) For occupational therapy services, a total of not more than thirty visits per benefit year; and

(c) For speech-language pathology and audiology services, a total of not more than thirty visits per benefit year.

(3) Payment for additional skilled therapy visits in a non-institutional setting can be requested through the prior authorization process, which is described in rule 5160-1-31 of the Administrative Code.

(4) For each type of skilled therapy, payment for evaluation services can be made not more than once per injury or condition.

(5) Unattended electrical stimulation and iontophoresis therapy are considered to be part of the associated therapy procedure or medical encounter; no separate payment is made.

(6) No payment is made for the following services as skilled therapy:

(a) Services that do not meet current accepted standards of practice;

(b) Consultations with family members or other non-medical personnel; and

(c) Services that are rendered in non-institutional settings but are listed as non-covered in rule 5160-1-61 or in Appendix DD to rule 5160-1-60 of the Administrative Code.

(E) Clinical documentation.

(1) A clinical evaluation and assessment of the need for skilled therapy services includes the following elements:

(a) A diagnosis of the type and severity of the disorder or a description of the deficit in physical or sensory functionality;

(b) A review of the individual's current physical, auditory, visual, motor, and cognitive status;

(c) A case history, including, when appropriate, family perspectives on the individual's development and capacity to participate in therapy;

(d) The outcomes of standardized tests and any non-standardized tests that use age-appropriate developmental criteria;

(e) Other test results and interpretation;

(f) An evaluation justifying the provision of skilled therapy services, which may be expressed as one of two prognoses of the patient's rehabilitative or developmental potential:

(i) The patient's functionality is expected to improve within sixty days after the evaluation because of the delivery of rehabilitative skilled therapy services or within six months after the evaluation because of the delivery of developmental skilled therapy services, and the patient is expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months; or

(ii) The patient is not expected to attain full functionality or make significant progress toward expected developmental milestones within twelve months, but a safe and effective maintenance program may be established; and

(g) Any recommendations for further appraisal, follow-up, or referral.

(2) A treatment or maintenance plan for skilled therapy services is based on the clinical evaluation and assessment. It should be coordinated, when appropriate, with services provided by non-medicaid providers or programs (e.g., child welfare, child care, or prevocational or vocational services), and it should provide a process for involving the patient or the patient's representative in the provision of services. A complete treatment or maintenance plan includes the following elements:

(a) The patient's relevant medical history;

(b) Specification of the amount, duration, and frequency of each skilled therapy service to be rendered; the methods to be used; and the areas of the body to be treated;

(c) A statement of specific functional goals to be achieved, including the level or degree of improvement expected within the appropriate time period;

(d) The date of each skilled therapy service;

(e) The signature of the practitioner responsible for the treatment or maintenance plan;

(f) Documentation of participation by the patient or the patient's representative in the development of the plan;

(g) Specific timelines for reevaluating and updating the plan;

(h) A statement of the degree to which the patient has made progress; and

(i) A recommendation for one of several courses of action:

(i) The development of a new or revised treatment plan;

(ii) The development of a new or revised maintenance plan; or

(iii) The discontinuation of therapy.

(F) Claim payment.

(1) If more than one skilled therapy service of the same discipline (e.g., physical therapy) is rendered by the same non-institutional provider or provider group to a recipient on the same date, then the service with the highest payment amount specified in appendix DD to rule 5160-1-60 of the Administrative Code is considered the primary procedure. Payment for a covered skilled therapy service is the lesser of the provider's submitted charge or a percentage of the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code, determined in the following manner:

(a) For the first unit of a primary procedure, one hundred per cent; or

(b) For each additional unit or procedure within the same therapy discipline, eighty per cent.

(2) Services reported on claims must correspond to the services listed in the treatment or maintenance plan.

Replaces: 5160-8-30, 5160-8-31, 5160-8-32, 5160-8-33, 5160-8-34

Effective:

Five Year Review (FYR) Dates:

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