Iowa Department of Human Services

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For Human Services use only:

General Letter No. 8-AP-483
Employees' Manual, Title 8
Medicaid Appendix

November 16, 2018

REHABILITATION AGENCY MANUAL TRANSMITTAL NO. 18-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***Rehabilitation Agency Manual***, Chapter III, *Provider-Specific Policies*, pages 6 through 9, revised.

Summary

The ***Rehabilitation Agency Manual*** is revised to align with current policies, procedures, and terminology.

Effective Date

Immediately.

Material Superseded

This material replaces the following pages from the ***Rehabilitation Agency Manual***:

Page	Date
Chapter III	
6	February 1, 2017
7-9	June 1, 2014

Additional Information

The updated provider manual containing the revised pages can be found at: http://dhs.iowa.gov/sites/default/files/Rehab.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

3. Location of Service

Services may be provided in the member's home by a speech pathologist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided in a nursing facility, intermediate care facility for persons with an intellectual disability, or a hospital are not considered to be provided in a member's home.

Services provided to a member residing in a residential care facility licensed under Iowa Code 249 by the Department of Inspections and Appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have the services available. The statement need only be submitted with the claim at the start of care, unless the situation changes.

Under no circumstances will payments be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility, or an intermediate care facility for persons with an intellectually disability. Therapy services provided to a resident of a nursing facility or intermediate care facility for persons with an intellectual disability are the responsibility of the facility. Payment will not be made for service provided in a hospital.

4. Maintenance Therapy

Generally, maintenance therapy means services to a member whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than post-hospital.

Maintenance therapy is also appropriate for persons whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels. Where a maintenance program is appropriate, the initial evaluation and the instruction of the member, family members, home health aides, facility personnel or other caregiver to carry out the program are considered a covered service.

Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of twelve months. The plan of treatment must specify the anticipated monitoring activities of any supervisor. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After twelve months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation is considered medically necessary only if there is a significant change in residential or employment situation or the member exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously counter-indicated restorative therapy. A statement by a developmentally disabled member's interdisciplinary team recommending a reevaluation and stating the basis for medical necessity is considered as supporting the necessity of a reevaluation and may expedite approval.

Examples of covered services:

- A member with Parkinson's Disease who has not been under a restorative physical therapy program may require a maintenance program established by a qualified physical therapist.
- A member who has received gait training has reached maximum restoration potential. The physical therapist is teaching the member and family how to safely perform the activities which are a part of the maintenance program being established. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) are covered since they are needed to establish the program.

- An adult with an intellectual disability has reached a plateau in progress in a restorative speech language therapy program; potential for further progress seems minimal though a discrepancy exists between the member's cognitive skills and communication abilities. A maintenance program may be established to ensure continued present level of functioning.
- A member who has suffered a stroke or a member with an intellectual disability (for example) exhibits deficits in communication function relative to the member's cognitive abilities, but requires a therapy plan that slowly progresses in complexity and involves repetitious exercises or activities. A program may be established to help the member advance through the levels. However, since it is of a less complex design, it does not require the constant contact with a skilled therapist and is payable as a maintenance program only.

5. Occupational Therapy

To be covered under rehabilitation agency services, occupational therapy services must:

- Be included in a plan of treatment.
- Improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the member's ability to perform tasks required for independent functioning.
- Be prescribed by a physician under a plan of treatment.
- Be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapy assistant under the general supervision of a qualified licensed occupational therapist, as allowed by Iowa licensure.
- Be reasonable and necessary for the treatment of the member's illness, injury, or disabling condition.

Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition. However, in cases where there is a valid expectation of improvement at the time the occupational therapy program is instituted, but the expectation is not realized, services are covered only up to the time one would reasonably conclude the member would not improve. Refer to Restorative Therapy. See Diagnostic or Trial Therapy.

For coverage of design and monitoring of a maintenance program, refer to Maintenance Therapy.

For coverage of diagnostic or trial therapy, refer to Diagnostic or Trial Therapy.

The selection and teaching of tasks designed to restore physical function are covered.

Planning and implementing therapeutic tasks are covered. Examples include activities to restore sensory-integrative functions, and providing motor and tactile activities to increase input and improve responses for a stroke patient.

The teaching of activities of daily living and energy conservation to improve the level of independence of a member which requires the skill of a licensed therapist and meets the definition of restorative therapy is covered. Refer to Restorative Therapy for further information.

The designing, fabricating, and fitting of orthotic self-help devices are considered covered services if they relate to the member's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

Vocation and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

6. Physical Therapy

The coverage decision for physical therapy shall be based on the need for the skills of a therapist and not only on the diagnosis.

To be covered under rehabilitation agency services, physical therapy services must:

- Relate directly and specifically to an active written treatment plan.
- Follow a treatment plan established by the licensed skilled therapist after consultation with the physician.
- Be reasonable and necessary to the treatment of the member's illness, injury, or disabling condition.
- Be specific and effective treatment for the member's medical or disabling condition.
- Be of such a level of complexity and sophistication, or the condition of the member must be such, that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.