

# Physical Therapy Provider Manual





Iowa  
Department  
of Human  
Services

Provider  
**Physical Therapy**

Page  
1

Date  
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## TABLE OF CONTENTS

### [Chapter I. General Program Policies](#)

### [Chapter II. Member Eligibility](#)

### [Chapter III. Provider-Specific Policies](#)

### [Chapter IV. Billing Iowa Medicaid](#)

### [Appendix](#)

# III. Provider-Specific Policies





Iowa  
Department  
of Human  
Services

Provider and Chapter  
**Physical Therapy**  
Chapter III. Provider-Specific Policies

Page	1
Date	April 1, 2014

## TABLE OF CONTENTS

	<u>Page</u>
CHAPTER III. PROVIDER-SPECIFIC POLICIES .....	1
A. PHYSICAL THERAPISTS ELIGIBLE TO PARTICIPATE .....	1
B. COVERAGE OF PHYSICAL THERAPY SERVICES.....	2
C. BASIS OF PAYMENT.....	3
D. PROCEDURE CODES AND NOMENCLATURE .....	3
E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS .....	4



## CHAPTER III. PROVIDER-SPECIFIC POLICIES

### A. PHYSICAL THERAPISTS ELIGIBLE TO PARTICIPATE

For Medicaid payment purposes, a qualified physical therapist is a person who is licensed as a physical therapist by the state of Iowa and is certified as such by Medicare. Under Medicare, the therapist must meet one of the following requirements:

- ◆ The person has graduated from a physical therapy curriculum approved by the American Physical Therapy Association or by the Council on Medical Education and Hospitals of the American Medical Association and the American Physical Therapy Association.
- ◆ Before January 1, 1966, the person was admitted to membership by the American Physical Therapy Association or was admitted to registration by the American Registry of Physical Therapists or graduated from a physical therapy curriculum in a four-year college or university approved by a state department of education.
- ◆ The person has two years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary of Health and Human Services.

**EXCEPTION:** Such determinations of proficiency do not apply with respect to persons initially licensed by a state as a physical therapist after December 31, 1977, or seeking qualification as a physical therapist after that date.

- ◆ The person is licensed or registered before January 1, 1966, or before January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending physicians.
- ◆ If trained outside the United States, the person:
  - Graduated in 1928 or later from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy,
  - Meets the requirements for membership in a member organization of the World Confederation of Physical Therapy,
  - Has one year of experience under the supervision of an active member of the American Physical Therapy Association, and
  - Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.



## **B. COVERAGE OF PHYSICAL THERAPY SERVICES**

Total Medicaid payment for combined services provided by an independently practicing physical therapist and speech-language pathologist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid Services (CMS). Click <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/TherapyCap.html> to view the current cap information.

For Medicaid purposes, physical therapy services are those services furnished to a patient that meet all of the following conditions:

- ◆ The services are directly and specifically related to an active written treatment regimen that is:
  - Designed by the physician after any needed consultation with the qualified physical therapist, and
  - Included in the final treatment plan.
- ◆ The services are of such a level of complexity and sophistication or the condition of the patient is such that the judgment, knowledge, and skills of a qualified physical therapist are required.
- ◆ The services are in fact performed by or under the supervision of a qualified physical therapist, meaning that the qualified physical therapist:
  - Provides authoritative procedural guidance for the rendering of the services with initial direction and periodic inspection of the actual act, and
  - Is on the premises if the person performing the service does not meet the assistant-level qualifications.
- ◆ The services either:
  - Are provided with the expectation that the patient will improve significantly in a reasonable and generally predictable period of time, based on the physician's assessment of the patient's restorative potential after any needed consultation with a qualified physical therapist, or
  - Are necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.
- ◆ The services are considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition.
- ◆ The services are reasonable and necessary to the treatment of the patient's condition.



Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical therapy for Medicaid purposes.

Services that exceed the cap listed above may be provided if the therapist provides documentation that services were medically reasonable and necessary. The need for medically necessary and reasonable services must be documented in the medical record. Submit the documentation of the medical necessity of the services up to the limit of \$3,700 for physical therapy and speech-language pathology combined. If the services are not determined to be medically necessary and reasonable, the services are not covered.

### **C. BASIS OF PAYMENT**

The basis of payment for the services of an independently practicing physical therapist is based on a fee schedule.

Click [here](#) to view the fee schedule for Physical Therapy.

### **D. PROCEDURE CODES AND NOMENCLATURE**

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. Surgical procedures not covered by Medicare may be identified as payable by Medicaid. Reimbursement rates are established by the Medicaid program for those surgical procedures. The five-digit procedure code must be followed by an EP modifier if the service is the result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) physical.

It is the provider's responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the Iowa Medicaid Enterprise (IME).



Iowa  
Department  
of Human  
Services

Provider and Chapter

**Physical Therapy**

Chapter III. Provider-Specific Policies

Page

4

Date

April 1, 2015

## E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Physical Therapy are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click [here](#) to view a sample of the CMS-1500.

Click [here](#) to view billing instructions for the CMS-1500.

Refer to [Chapter IV. Billing Iowa Medicaid](#) for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:  
<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>.