NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

October 1, 2019
10:00 a.m. Central Time
Gold's Building, Room 534
1033 O Street, Lincoln, Nebraska

The purpose of this hearing is to receive comments on adoption of amendments to and repeal of the following regulations:

The following regulation is proposed for AMENDMENT:

Title 471 NAC 14 – *Occupational Therapy Services*

The proposed changes will streamline the regulations by eliminating unnecessary and redundant language, definitions, and directions to agency staff from the regulations. The proposed changes will combine the current Chapter 14 and 17 into one chapter of regulations and update formatting.

The following regulation is proposed for REPEAL in its entirety. The relevant portions of the current Chapter 17 are being included in the proposed amendments to Chapter 14.

Title 471 NAC 17 – *Physical Therapy Services*

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 471	Prepared by: Malisa McCown
Chapter: 14	Date prepared: April 15, 2019
Subject: Occupational and Physical Therapy	Telephone: 402-471-1641

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: N/A

Political Subdivision: N/A

Regulated Public: N/A

If indeterminable, explain why: N/A

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 471	Prepared by: Malisa McCown
Chapter: 17	Date prepared: 4/15/19
Subject: Physical Therapy Services	Telephone: 402-770-1259

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

CHAPTER 14-000 OCCUPATIONAL THERAPY SERVICES

14-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), the occupational therapist must be licensed by the Nebraska Department of Health and Human Services. If services are provided outside Nebraska, the occupational therapist must be:

1. Registered by the American Occupational Therapy Association; or
2. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association; or
3. Where applicable, licensed by the State.

14-001.01 Licensed Occupational Therapy Assistants: NMAP does not enroll licensed occupational therapy assistants (LOTA) as providers. Services provided by a LOTA are billable to NMAP when all requirements of 172 NAC 114 are met.

If services are provided outside Nebraska, the supervising occupational therapist must submit a photocopy of the occupational therapy assistant license. The supervising occupational therapist will be notified by the Department of Health and Human Services, Division of Medicaid and Long Term Care, if services provided by the occupational therapy assistant are not billable to NMAP.

14-001.02 Provider Agreement: The occupational 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.

14-002 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.

14-002.01 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.

14-002.02 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 occupational therapy services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

14-003 Covered Services: NMAP covers occupational 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 occupational therapist can safely and effectively perform the service; and
4. The occupational therapy service meets at least one of the conditions listed in 471 NAC 14-003.01 or 14-003.02.

14-003.01 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;
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.

14-003.02 Services for Individuals Age 20 and Younger: NMAP covers occupational therapy services for individuals birth to age 20 when the following criteria are met. The service must be:

1. An evaluation; or
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.

14-003.03 Maintenance Therapy: NMAP does not cover maintenance therapy provided by a occupational therapist. The occupational therapist must:

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

14-003.04 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.

14-003.05 Supplies: NMAP will consider payment for certain supplies that are used during the course of treatment and require application by the occupational therapist except those supplies that are considered incident to the procedure provided.

Note: For coverage of orthotic appliances and devices or supplies by a hospital outpatient or emergency room see 471 NAC 10-000, Hospital Services.

14-004 Non-Covered Occupational Therapy Services: NMAP does not cover occupational therapy services in the following situations:

A. 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;
B. Therapy for work hardening, or vocational and prevocational assessment and training;
C. 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 a learning disability or attention disorder, visual perception training, or treatment of psychological conditions;
D. 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.);
E. Rental of equipment; or
F. Take home supplies.

14-005 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.

14-006 Payment for Occupational Therapy Services

14-006.01 Payment for Individual Providers: NMAP pays for covered occupational 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 in effect 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).

14-006.01A 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; or
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.

14-006.02 Hospitals: For payment as hospital service, see 471 NAC 10-000, Hospital Services.

14-006.03 Home Health Agencies: For payment as a home health agency service see 471 NAC 9-000, Home Health Agency Services.

14-007 Billing Requirements

14-007.01 Medicare or Other Insurance Coverage: If the client is eligible for Medicare or has other insurance which may cover occupational therapy, the provider must bill the Medicare carrier or the insurance company before submitting a claim to the Department.

14-007.02 Medical Necessity Documentation: The provider must provide the following information when submitting a claim for occupational therapy services:

1. Date of illness/injury onset.
2. Date occupational therapy plan established.
3. Date occupational therapy started.

4. Number of occupational therapy visits from onset.

14-007.03 Utilization Review: Claims for occupational therapy services are subject to utilization review by the Department to determine medical necessity and appropriateness of the service.

14-007.04 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, the hospital makes payment to the occupational therapist. The hospital submits claims to NMAP for occupational therapy services provided in the hospital to inpatients and outpatients 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 of the provider's authorized agent must enter the provider's usual and customary charge for each procedure code listed on or in the claim.

14-007.05 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 (ASC X12N 837) must use the appropriate procedure codes

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.~~

TITLE 471 - NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 17 - (Repealed)

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 14 OCCUPATIONAL AND PHYSICAL THERAPY SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute §§ 68-901 et seq.

002. DEFINITIONS.

002.01 INTERVENTION. A therapeutic procedure defined by the Current Procedural Terminology (CPT) manual of the American Medical Association.

002.02 MOBILIZATION OR MANUAL THERAPY. A group of techniques comprising a continuum of skilled passive movements to the joints or related soft tissues, or both, throughout the normal physiological range of motion that are applied at varying speeds and amplitudes, without limitation.

002.03 OCCUPATIONAL THERAPIST. A person holding a current license to practice occupational therapy.

002.04 OCCUPATIONAL THERAPY. The use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the process of aging in order to maximize independent function, prevent further disability, and achieve and maintain health and productivity. Occupational therapy encompasses evaluation, treatment, and consultation and may include:

(A) Remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes;
(B) Adaptation of task, process, or the environment, or the teaching of compensatory techniques, in order to enhance performance;
(C) Disability prevention methods and techniques which facilitate the development or safe application of performance skills; and
(D) Health promotion strategies and practices which enhance performance abilities.

002.05 OCCUPATIONAL THERAPY ASSISTANT. A person holding a current license to assist in the practice of occupational therapy.

002.06 PHYSICAL AGENT MODALITIES. Modalities that produce a bio physiological response through the use of water, temperature, sound, electricity, or mechanical devices.

002.07 PHYSICAL THERAPY OR PHYSIOTHERAPY. Physical Therapy or Physiotherapy means:

(A) Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations, and disabilities or other conditions related to health and movement and, through analysis of the evaluative process, developing a plan of therapeutic intervention and prognosis while assessing the ongoing effects of the intervention;

(B) Alleviating impairment, functional limitation, or disabilities by designing, implementing, or modifying therapeutic interventions, which does not include the making of a medical diagnosis, but which may include any of the following:

(i) Therapeutic exercise;

(ii) Functional training in home, community, or work integration or reintegration related to physical movement and mobility;

(iii) Therapeutic massage;

(iv) Mobilization or manual therapy;

(v) Recommendation, application, and fabrication of assistive, adaptive, protective, and supportive devices and equipment;

(vi) Airway clearance techniques;

(vii) Integumentary protection techniques;

(viii) Non-surgical debridement and wound care;

(ix) Physical agents or modalities;

(x) Mechanical and electrotherapeutic modalities; and

(xi) Patient-related instruction.

(C) Purchasing, storing, and administering topical and aerosol medication in compliance with applicable rules and regulations of the Board of Pharmacy regarding the storage of such medication;

(D) Reducing the risk of injury, impairment, functional limitation, or disability, including the promotion and maintenance of fitness, health, and wellness; and

(E) Engaging in administration, consultation, education, and research.

002.08 PHYSICAL THERAPIST. A person licensed to practice physical therapy.

002.09 PHYSICAL THERAPIST ASSISTANT. A person certified as a physical therapist assistant.

002.10 TAKE HOME SUPPLIES. Expendable or specified reusable supplies required for care of a medical condition and used in the client's home.

002.11 WORK HARDENING. An occupational rehabilitation program that is focused on assisting the injured worker to return to the job while minimizing the risk of re-injury.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, providers of physical therapy and occupational therapy services must comply with all applicable provider participation requirements codified in 471 Nebraska Administrative Code (NAC) 2 and 3. In the event that provider participation requirements in 471 NAC 2 or 3 conflict

with requirements outlined in this 471 NAC 14, the individual provider participation requirements in 471 NAC 14 will govern.

003.02 SPECIFIC PROVIDER REQUIREMENTS.

003.02(A) LICENSED OCCUPATIONAL THERAPIST (OT) ASSISTANTS AND CERTIFIED PHYSICAL THERAPIST (PT) ASSISTANTS. The Department does not enroll occupational therapy assistants (OTA) or physical therapy assistants (PTA) as providers. Services provided by an occupational therapy assistant (OTA) are covered by the Department when all requirements of 172 NAC 114 are met. Services provided by a physical therapy assistant (PTA) are covered by the Department when all requirements of 172 NAC 137 are met.

004. SERVICE REQUIREMENTS.

004.01 GENERAL SERVICE REQUIREMENTS.

004.01(A) MEDICAL NECESSITY. The Department incorporates the medical necessity requirements outlined in 471 NAC 1 as if fully rewritten herein. Services and supplies that do not meet the requirements in 471 NAC 1 are not covered.

004.01(B) SERVICE CRITERIA. The Department covers occupational therapy (OT) or physical therapy (PT) services when the following criteria are met. The service must be:

(i) An evaluation;
(ii) Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly within a reasonable period of time; or
(iii) For physical therapy (PT) services only, recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver programs:
  (1) Developmental Disabilities (DD) Adult Comprehensive Services Waiver;
  (2) Developmental Disabilities (DD) Adult Residential Services Waiver;
  (3) Developmental Disabilities (DD) Adult Day Services Waiver;
  (4) Community Supports Waiver; or
  (5) Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

004.01(C) SERVICES FOR INDIVIDUALS AGE 21 AND OLDER. For clients age 21 and older, the Department covers a combined total of 60 therapy sessions per fiscal year (July 1 through June 30). The combined total of 60 therapy sessions per fiscal year includes all occupational therapy (OT), physical therapy (PT), and speech therapy sessions provided to the client.

004.02 COVERED SERVICES. The Department covers occupational therapy (OT) or physical therapy (PT) services when the following criteria are met:

(1) The services are ordered by a licensed physician or nurse practitioner;
(2) The services are medically necessary; and
(3) The services are such that only a licensed occupational therapist (OT) or physical therapist (PT) can safely and effectively perform the service.

004.02(A) MAINTENANCE PROGRAM. The occupational therapist (OT) or physical therapist (PT) must:

(i) Evaluate the client's needs;
(ii) Design a maintenance program; and
(iii) Instruct the client, family members, or nursing facility staff in carrying out the program.

004.02(B) ORTHOTIC APPLIANCES AND DEVICES. The Department covers orthotic appliances and devices when medically necessary for the client's condition, and when the orthotic appliance or device is used during the therapy session.

004.02(C) SUPPLIES. The Department covers supplies used during the course of treatment that require application by the occupational therapist (OT) or physical therapist (PT) when they are not incidental to the procedure.

004.03 NON-COVERED OCCUPATIONAL THERAPY OR PHYSICAL THERAPY SERVICES. The Department does not cover occupational therapy (OT) or physical therapy (PT) services in the following situations:

(A) Maintenance therapy provided by an occupational therapist (OT) or physical therapist (PT);
(B) Therapy for work hardening, or vocational and prevocational assessment and training;
(C) Therapy for functional capacity evaluations, educational testing, drivers training, training in non-essential self-help or recreational activities, training related to a learning disability or attention disorder, visual perception training, or treatment of psychological conditions;
(D) In-service training for nursing facility staff which is not client specific;
(E) Rental of equipment; or
(F) Take home supplies.

005. BILLING AND PAYMENT FOR OCCUPATIONAL THERAPY OR PHYSICAL THERAPY SERVICES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that individual billing requirements in 471 NAC 3 conflict with billing requirements outlined in this 471 NAC 14, the individual billing requirements in 471 NAC 14 will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS.

005.01(B)(i) BILLING INSTRUCTIONS. The provider must bill the Department using the appropriate claim form or electronic format.

005.01(B)(ii) USUAL AND CUSTOMARY CHARGE. The provider or the provider's authorized agent must submit the provider's usual and customary charge for each procedure code listed on the claim. Healthcare Common Procedure Coding System

(HCPCS) procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule.

005.01(B)(iii) MEDICAL NECESSITY DOCUMENTATION. The provider must provide the following information when submitting a claim for occupational therapy (OT) or physical therapy (PT) services:

(1) Date of illness or injury onset;
(2) Date occupational therapy or physical therapy plan established;
(3) Date occupational therapy or physical therapy started; and
(4) Number of occupational therapy or physical therapy visits from onset.

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. The Department will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this 471 NAC 14, the individual payment regulations in 471 NAC 14 will govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS.

005.02(B)(i) PAYMENT FOR INDIVIDUAL PROVIDERS. The Department pays for covered occupational therapy (OT) or physical therapy (PT) services at the lower of:

(1) The provider's submitted charge; or
(2) The allowable amount for that Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect on the date that the service was rendered.