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 MAINECARE BENEFITS MANUAL
 CHAPTER II

SECTION 68	OCCUPATIONAL THERAPY SERVICES	ESTABLISHED 9/1/87 LAST UPDATED 1/1/14
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68.01 **PURPOSE**

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The purpose of this rule is to provide medically necessary occupational therapy services to MaineCare members who are adults (age twenty-one (21) and over) who are not residing in a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), and who have rehabilitation potential; and to provide medically necessary occupational therapy services to MaineCare members who are under age twenty-one (21).

68.02 **DEFINITIONS**

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68.02-1 **Functionally Significant Improvement:** demonstrable, measurable increase in the member's ability to perform specific tasks or motions that contributes to independence outside the therapeutic environment.

68.02-2 **Long-Term Chronic Pain:** is any pain that has lasted or is expected to last more than sixty (60) days and impacts or is expected to impact a member's level of function for more than sixty (60) days.

68.02-3 **Maintenance Care:** occupational services provided to a member whose condition is stabilized after a period of treatment or for whom no further functionally significant improvement is expected.

68.02-4 **Occupational Therapy Practitioner:** an individual who is licensed as an Occupational Therapist, Registered/Licensed (OTR/L), Occupational Therapist, Licensed (OT/L), Certified Occupational Therapy Assistant, Licensed (COTA/L) or Occupational Therapy Assistant, Licensed (OTA/L).

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68.02-5 **Occupational Therapy Services:** the assessment, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in the individual's daily pursuits. The practice of "Occupational Therapy" includes, assessment and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities or anticipated dysfunction

68.02-6 **Pain Management Care Plan:** is a plan of care ordered by a rendering or servicing provider, which must include the use of at least one (1) therapeutic treatment option.

68.02-7 **Practitioner of the Healing Arts:** Medical Doctors, Doctors of Osteopathy, and all others registered or licensed in the healing arts, including, but not limited to, nurse practitioners, podiatrists, optometrists, chiropractors, physical therapists, occupational therapists, speech therapists, dentists, psychologists and physicians' assistants.

68.02 **DEFINITIONS (cont.)**

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68.02-8 **Rehabilitation Potential:** documented expectation of measurable functionally significant improvement in the member's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan.

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68.02-9 **Terminal Illness:** is a medical condition resulting in a prognosis that a member has a life expectancy of six (6) months or less if the illness runs its normal course.

68.03 **ELIGIBILITY FOR CARE**

Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I.

68.04 **SPECIFIC ELIGIBILITY FOR CARE**

Services for members of all ages must be medically necessary. The Department or its authorized agent has the right to perform eligibility determination and/or utilization review to determine if services provided are medically necessary.

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Adult members (age twenty-one (21) and over) in an outpatient setting must have rehabilitation potential documented by a physician or primary care provider (PCP). Adult members are specifically eligible only for:

1. Treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities. If CMS approves, the treatment must start within six months of the hospital discharge and be specific to the diagnosed condition;
2. Treatment after a surgical procedure performed for the purpose of improving physical function. If CMS approves, the treatment must start within six months of discharge and be specific to the diagnosed condition;
3. Treatment for which a physician or PCP has documented that the patient has, at some time during the preceding thirty (30) days, required extensive assistance in the performance of one or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility;
4. Medically necessary treatment for other conditions including maintenance, subject to the limitations in Section 68.07;
5. Maintenance care to prevent deterioration in function that would result in an extended length of stay or placement in an institutional or hospital setting, as documented by physician or PCP;

68.04 **SPECIFIC ELIGIBILITY FOR CARE (cont.)**

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6. If CMS approves, rehabilitative services ordered by a physician or other licensed practitioner of the healing arts for the maximum reduction of physical disability and restoration of a member to his/her best possible functional level;
7. If CMS approves, medically necessary treatment when diagnosed with a terminal illness; or
8. Treatment used for pain management in conjunction with a prescribed pain management care plan subject to section 68.07.

68.05 DURATION OF CARE

Covered services must be medically necessary and must not exceed the limitations set in Section 68.07. The Department or its authorized agent reserves the right to request additional information to evaluate medical necessity.

68.06 COVERED SERVICES

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MaineCare will reimburse for covered medically necessary services in all outpatient settings. If CMS approves, covered services requiring a Prior Authorization are limited to one (1) evaluation and one (1) treatment per each condition or per each event unless specified under 68.07. Services must be of such a level, complexity, and sophistication that the judgment, knowledge, and skills of a qualified professional staff is required as defined in 68.09-1.

All services must be in accordance with acceptable standards of medical practice and be a specific and effective treatment for the member's condition. Services related to activities for the general good and welfare of members are not MaineCare covered occupational therapy services.

Pursuant to 42 CFR§440.110, MaineCare occupational therapy services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under Maine law and must be provided by or under the direction of a qualified professional staff as defined in 68.09-1.

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MaineCare reimburses providers for the following occupational therapy services:

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- 68.06-1 Evaluations or re-evaluations: For adults, one evaluation or re-evaluation per member per condition or event is a covered service. For children, additional evaluations or reevaluations are allowed as medically necessary.
- 68.06-2 Modalities: Modalities are any physical agents applied to produce therapeutic changes to biologic tissues; including but not limited to thermal, acoustic, light, mechanical, or electric energy. Except when performing supervised modalities, the therapist is required to have direct (one-on-one) continuous patient contact.
- 68.06-3 Therapeutic Procedures: Therapeutic procedures effect change through the application of clinical skills and/or services that attempt to improve function.

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68.06 **COVERED SERVICES (cont.)**

68.06-4 Tests and measurements: The therapist is required to have direct (one-on-one) continuous patient contact in performing testing and measurement.

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68.06-5 Splinting: Providers may bill for splinting supplies necessary for the provision of occupational therapy services. Covered supplies under this Section must be billed and reimbursed at the lesser of acquisition cost or the maximum allowed cost set by the Department. The acquisition cost must be documented by an invoice in the member's file. Please visit <http://www.maine.gov/dhhs/audit/rate-setting/documents/S68OccupationalTherapyServices.pdf> to access maximum allowed cost.

68.07 **LIMITED SERVICES**

68.07-1 **All ages:**

1. MaineCare will not reimburse for more than two (2) hours of occupational therapy services per day.
2. Supervised modalities (those without direct one-to-one continuous contact) that are provided on the same day as modalities requiring constant attendance or on the same day as any other therapeutic procedure are not billable. Billing for supervised modalities as stand-alone treatment is limited to one (1) unit per modality per day.

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68.07-2 **Children (under twenty-one (<21)):**

All services must be medically necessary.

68.07-3 **Adults (age twenty-one (21) and over):**

If CMS approves, Prior Authorization is required for all services.

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The Department or its Authorized Agent processes the Prior Authorization requests. Prior Authorization is approved upon medical necessity, as determined by the clinical judgment of the Department's medical staff. Prior Authorization forms can be found at: <https://mainecare.maine.gov/ProviderHomePage.aspx>. More information on the Prior Authorization process is in MaineCare Benefits Manual, Chapter I. Prior Authorizations will be issued in accordance with the following limits:

1. Services for adults who meet the specific eligibility requirements in 68.04 must be initiated within sixty (60) days from the date of physician or PCP referral..

LIMITED SERVICES (cont.)

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2. Within the scope of 68.04(1)-(3) services are limited to two (2) visits per condition or event.
3. Services for maintenance care are limited to two (2) visits per year to design a plan of care, to train the member or caretaker of the member to implement the plan, or to reassess the plan of care. This limitation does not apply to maintenance care for members who would otherwise experience deterioration in function as described in Section 68.04(6).
4. Services for adults with rehabilitation potential must be medically necessary as certified by a physician or PCP. The physician's documentation of rehabilitation potential must include the reasons used to support the physician's expectation. Such treatment is limited to no more than six (6) visits per condition by qualified staff.
5. Services that are medically necessary will be covered for terminally ill members.
6. Services for sensory integration are limited to a maximum of two (2) visits per year.
7. Members receiving occupational therapy in conjunction with a pain management care plan may not receive more than five (5) treatment visits and one (1) evaluation within twelve months (12), and reimbursement for such visits is conditional on Prior Authorization based on a demonstration that the service is medically necessary. The Prior Authorization criteria include:
- A. The member has long-term chronic pain that has lasted, or is expected to last, more than sixty (60) days and impacts or is expected to impact a member's level of function for more than sixty (60) days; and
 - B. The member requires occupational therapy services for the treatment of long-term chronic pain to end or avoid the use of narcotics.

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68.08 NON-COVERED SERVICES

Refer to Chapter I of the MaineCare Benefits Manual for additional non-covered services, including academic, vocational, socialization or recreational services.

68.09 POLICIES AND PROCEDURES

68.09-1 **Qualified Professional Staff are:**

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Occupational Therapist, Registered, Licensed (OTR/L);
Occupational Therapy, Licensed (OT/L);
Certified Occupational Therapy Assistant, Licensed (COTA/L); and
Occupational Therapy Assistant, Licensed (OTA/L).

All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure. An OTR/L or an OT/L may be self-employed or employed by an agency or business. Agencies or businesses may enroll as a provider of service and bill directly for services provided by qualified staff. A COTA/L or an OTA/L may not enroll as an independent billing provider.

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68.09-2 **Member's Records**

Providers must maintain a specific record for each member, which shall include, but not necessarily be limited to:

1. Member's name, address, birthdate, and MaineCare ID number;
2. The member's social and medical history, and medical diagnoses indicating the medical necessity of the service or services;
3. A personalized plan of service including (at a minimum):
 - A. Type of occupational therapy needed;
 - B. How the service can best be delivered, and by whom the service shall be delivered;
 - C. Frequency of services and expected duration of services;
 - D. Long and short range goals;
 - E. Plans for coordination with other health service agencies for the delivery of services;
 - F. Any medical supplies for which a Practitioner of the Healing Arts' order is necessary; and

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- G. Practitioner of the Healing Arts' orders including, for adults, their documentation of the member's rehabilitation potential.

The physician or primary care provider must review, sign and date the member's plan of care at least once every three (3) months for adult members (age twenty-one (21) and over). The plan of care must be kept in the member's record and is subject to Departmental review along with the contents of the member's record.

4. Written progress notes shall contain:
- A. Identification of the nature, date and provider of any service given;
 - B. The start time and stop time of the service, indicating the total time spent in delivering the service;
 - C. Any progress toward the achievement of established long and short range goals;
 - D. The signature of the service provider for each service provided; and
 - E. A full account of any unusual condition or unexpected event, including the date and time when it was observed and the name of the observer.

Entries are required for each service billed. When the services delivered vary from the plan of care, entries in the member's record must justify why more, less, or different care than is specified in the plan of care was provided.

68.09-3 Utilization Review

The Department or its authorized agent has the right to perform utilization review. If at any point of an illness or disabling condition, it is determined that the expectation for measurable functionally significant improvement will not be realized, or if they are already realized and no more services are needed, the services are no longer considered reasonable and necessary, and will not be covered

68.09-4 Program Integrity

Requirements for Program Integrity are detailed in Chapter I of the MaineCare Benefits Manual.

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68.10 REIMBURSEMENT

The amount of payment for services rendered shall be the lowest of the following:

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1. The amount for services is listed in Chapter III, Section 68, "Allowances for Occupational Therapy Services" of the MaineCare Benefits Manual.
2. The lowest amount allowed by the Medicare carrier.
3. The provider's usual and customary charge.

See section 68.06-5 for reimbursement for splinting supplies.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of a rendered service prior to billing MaineCare.

68.11 COPAYMENT

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Note: Requirements regarding co-payment disputes and exemptions are contained in Chapter I of the MaineCare Benefits Manual.

1. A copayment will be charged to each MaineCare member receiving services, with the exception of those exempt, as specified in the MaineCare Eligibility Manual, such as children. The amount of the copayment shall not exceed \$2.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 or more	\$2.00

2. The member is responsible for copayments up to \$20.00 per month whether the copayment has been paid or not. After the \$20.00 cap has been reached, the member will not be required to make additional copayments and the provider will receive full MaineCare reimbursement for covered services.

68.12 BILLING INSTRUCTIONS

1. Providers must bill in accordance with the Department's billing instructions for the CMS 1500 claim form.
2. All services provided on the same day must be submitted on the same claim form.