Ohio Administrative Code

Rule 5160-8-35 Skilled therapy services.

Effective: January 1, 2024

(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) Services rendered by the following providers:

(a) Ambulatory health care clinics, Chapter 5160-13; or

(b) Federally qualified health centers (FQHCs) or rural health clinics (RHCs), 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) An ambulatory health care clinic; or

(v) An FQHC or RHC.

(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 are to 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 in rule 5160-1-61 of the Administrative Code as being excluded from coverage.

(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 an individual 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 to be 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) Payment will be made only for covered services that are listed in the treatment or maintenance plan.