



Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 70—Therapy Program

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Title 13—DEPARTMENT OF SOCIAL SERVICES

Division 70—Division of Medical Services Chapter 70—Therapy Program

13 CSR 70-70.010 Therapy Program

PURPOSE: This rule establishes the regulatory basis for the administration of the therapy program. This rule provides for such methods and procedures relating to the utilization of, and the payment for, care and services available through the Medicaid program as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Specific details of provider participation, criteria and methodology for provider reimbursement, recipient eligibility, and amount, duration and scope of services covered are included in the therapy provider program manual, which is available at the website www.dss.mo.gov/dms.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Missouri Medicaid therapy program shall be administered by the Department of Social Services, Division of Medical Services. The therapy services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services and shall be included in the therapy provider manual and bulletins, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/dms, July 1, 2006. This rule does not incorporate any subsequent amendments or additions. Therapy services

shall include only those which are clearly shown to be medically necessary as determined by the treating physician. The division reserves the right to affect changes in services, limitations and fees with notification to therapy providers by amending this rule.

(2) Persons Eligible. Medically necessary therapy services as determined by the treating physician are covered for individuals under the age of twenty-one (21). The Healthy Children and Youth (HCY) Program (also known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT)) ensures a comprehensive, preventive health care program for Medicaid eligible children under the age of twenty-one (21) years. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid covered services be provided, based on medical necessity as identified in a HCY (EPSDT) screening. These services include physical, occupational, and speech/language therapy services. The recipient must be eligible on the date the service is furnished. Recipients may have specific limitations to therapy program services according to the type of assistance for which they have been determined eligible. It is the provider's responsibility to determine the coverage benefits for a recipient based on their type of assistance as outlined in the therapy provider manual. The provider shall ascertain the patient's Medicaid/MC+ status before any service is performed. The recipient's eligibility shall be verified in accordance with methodology outlined in the therapy provider program manual.

(3) Provider Participation.

(A) To be eligible for participation in the Missouri Medicaid therapy program, a provider must meet the criteria specified for his or her profession as outlined in the therapy provider program manual and be an enrolled Medicaid provider.

(B) The enrolled Medicaid provider shall agree to:

1. Keep any records necessary to disclose the extent of services the provider furnishes to recipients; and

2. On request furnish to the Medicaid agency or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services under the plan.

(4) Covered Services. The recipient shall have a referral for speech therapy services from a Medicaid enrolled primary care provider. The recipient shall have a prescription for occupational and physical therapy

services from a Medicaid enrolled primary care provider.

(5) Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services. Providers must bill their usual and customary charge for therapy services. Reimbursement will not exceed the lesser of the maximum allowed amount determined by the Division of Medical Services or the provider's billed charges. Physical, occupational and speech therapy services are only payable to the enrolled, eligible, participating provider. The Medicaid program cannot reimburse for services performed by non-enrolled persons.

(6) Documentation. For physical, occupational and speech therapy services, the Division of Medical Services requires that the following documentation be included in the recipient's record:

(A) Recipient's complete name;

(B) Date the service was provided;

(C) Actual treatment provided for the recipient (more than "treatment given") on the specific date of service;

(D) Individual or group therapy (the provider must document the type of therapy given);

(E) The time the service was delivered must be clearly documented in the client record (e.g., 4:00-4:15 p.m.); providers cannot bill for charting time, only the time they spend doing the therapy;

(F) The signature of the therapist who provided the service; and

(G) The official Individual Education Plan (IEP) or Individual Family Services Plan (IFSP) which must be in the record when billing therapy with a WQ modifier.

(7) Records Retention. These records must be retained for five (5) years from the date of service. Fiscal and medical records coincide with and fully document services billed to the Medicaid agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal or retain adequate documentation for services billed to the Medicaid program, as specified above, is a violation of this regulation.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. Original rule filed Nov. 1, 2002, effective May 30, 2003. Amended: Filed June 1, 2006, effective Dec. 30, 2006.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.*