



MEMORANDUM

TO: Physical Therapy, Occupational Therapy, and Speech-Language Pathology Providers
FROM: Melissa Weatherton
DATE: July 10, 2023
SUBJECT: Updated OT, PT, and Speech Evaluation and Re-evaluation Guidance

Thank you to all the clinicians who reached out to provide comments through your therapy associations on the guidance memorandum dated June 12, 2023. DHS has decided to issue this updated guidance memorandum based upon clinician feedback and discussion with our therapy advisory group. This guidance memorandum will completely supersede and replace in its entirety the prior guidance memorandum dated June 12, 2023.

There have been numerous recent inquiries from clinicians concerning the interpretation of Section 214.100(D) of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Medicaid Manual (“Medicaid Manual”) pertaining to habilitative evaluation and treatment planning services. This memorandum is intended to clarify how this section of the Medicaid Manual applies to each discipline.

Occupational and Physical Therapy Evaluations, Re-Evaluations, and Treatment Planning

Section 214.100(D) of the Medicaid Manual states that habilitative occupational therapy and physical therapy evaluation and treatment planning services are reimbursed based on complexity, and that a single billable unit includes all time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental test and tools, writing an evaluation report and comprehensive assessment along with time spent developing the treatment plan.

The purpose of the recent transition to complexity-based evaluation codes was to compensate a clinician with a flat fee for a beneficiary’s evaluation and treatment plan development and remove the necessity of clinicians tracking time. This flat fee is tiered at three different levels (each tier with its own procedure code) based on beneficiary’s diagnosis and situational complexity. A clinician must determine a beneficiary’s appropriate complexity level and bill a single unit using the appropriate complexity procedure code for the entire evaluation and treatment planning process from start to finish, regardless of how much time or how many days the evaluation and treatment planning process requires. Barring the unusual circumstance of a separate event or injury, a beneficiary should only have one (1) evaluation and treatment planning complexity code unit billed during a fiscal year.

The method for billing required annual re-evaluations relating to a beneficiary’s original diagnosis will depend on the age of the beneficiary. Annual re-evaluations of a beneficiary under the age of

twenty-two (22) should be billed using the same complexity codes as the initial evaluation (based on beneficiary's diagnosis and situational complexity), due to the significant developmental and physical changes that beneficiaries under the age of twenty-two (22) experience each year. Annual re-evaluations relating to the original diagnosis of a beneficiary aged twenty-two (22) and older should be billed using the re-evaluation procedure code (97164 for PT and 97168 for OT), which is a single, separate procedure code from the initial evaluation and treatment planning complexity codes.

A second evaluation and treatment planning unit during the same state fiscal year (regardless of whether the second unit billed is a complexity or re-evaluation procedure code) should be billed only when a beneficiary is seen for a new diagnosis not previously treated by this clinician or when a patient is beginning a new plan of care after a discharge from care. As a result, any claim involving a beneficiary's second evaluation and treatment planning unit during the same state fiscal year will be a red flag for audit purposes for service dates after the date of this memorandum. It is recommended a clinician include within their evaluation report a detailed explanation of why billing a second evaluation and treatment planning unit during a single state fiscal year is appropriate.

Speech-Language Pathology Evaluations and Treatment Planning

Currently, Section 214.100(D) *incorrectly* states that speech-language evaluation and treatment planning services are reimbursed based on complexity, and that the billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental test and tools, writing an evaluation report and comprehensive assessment along with time spent developing the treatment plan.

The Medicaid Manual fee schedule currently lists four (4) separate, timed speech-language evaluation and treatment planning procedure codes, each permitting one (1) unit to be billed for every thirty (30) minutes of time spent by the clinician performing face-to-face beneficiary evaluation and treatment planning up to the applicable maximum limits. The procedure code billed depends on the type of evaluation performed.

When determining the amount of time to bill for speech-language evaluation and treatment planning services, speech-language pathology clinicians must follow the American Medical Association standard of only allowing face-to-face time with the beneficiary during evaluation and treatment planning to be billed. Time spent scoring an evaluation, writing an evaluation report/comprehensive assessment, and time spent developing the treatment plan, should typically not be billed unless performed during the face-to-face evaluation of the beneficiary. Please remember, Section 251.000(A)(1) of the Medicaid Manual permits only full units of any service to be billed. Partial units of service may not be rounded up to the nearest unit and are not reimbursable for billing purposes.

I apologize for any confusion that these issues and the prior memorandum have caused, and the Department of Human Services will be amending Section 214.100(D) of the Medicaid Manual to explicitly clarify these issues when it is next promulgated. In the meantime, please do not hesitate to reach out to me or your therapy associations with any questions.