MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Adriena Krul-Hall

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This policy modifies the billing requirements for skilled maintenance therapy outlined in MSA 18-29 and updates benefit maximums for services performed in outpatient and nursing facility settings. Maintenance therapy may be provided up to four times per 90 days without prior authorization (PA) when performed in an outpatient setting and up to four times per 60 days without PA in a nursing facility setting. The four sessions should not exceed a total of 16 units. Providers are required to report maintenance therapy under a specified set of therapeutic procedure codes and a designated modifier.

Reason for policy (problem being addressed):

Allowing maintenance therapy to be reported under therapeutic procedure codes instead of re-evaluation visits will align Medicaid with CMS billing guidance.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No

Does policy have operational implications on other parts of MDHHS?

No

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☒ Yes ☐ No If Yes, please provide status: ☐ Approved ☒ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☒ Yes ☐ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2337-Therapy	**Date:** September 19, 2023

Comments Due: October 24, 2023
Proposed Effective Date: January 1, 2024
Direct Comments To: Adriena Krul-Hall
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Policy Subject: Skilled Maintenance Therapy

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild, Children's Special Health Care Services (CSHCS)

Distribution: Practitioners, Federally Qualified Health Centers, Rural Health Clinics, Medicaid Health Plans, Integrated Care Organizations, Tribal Health Centers, Outpatient Hospitals, Nursing Facilities

Summary: This policy modifies the billing requirements for skilled maintenance therapy outlined in MSA 18-29 and updates benefit maximums for services performed in outpatient and nursing facility settings. MDHHS is removing the requirement that providers report maintenance therapy under a re-evaluation procedure code. Providers may now report maintenance therapy under a specified set of therapeutic procedure codes along with a designated modifier. Maintenance therapy is covered up to four times per 90 days without prior authorization (PA) when performed in an outpatient setting and up to four times per 60 days without PA in a nursing facility setting. The four sessions should not exceed a total of 16 units.

Purpose: To update Medicaid billing requirements for skilled maintenance therapy to align with CMS guidance.

Cost Implications: Budget Neutral

Potential Hearings & Appeal Issues: Aware of None

State Plan Amendment Required: Yes ☒ **No** ☐ **If yes, date submitted:**	**Public Notice Required: Yes** ☒ **No** ☐ **Submitted date:** 8/04/2023

Tribal Notification: Yes ☒ **No** ☐ **- Date:** 08/24/2023

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Practitioners, Federally Qualified Health Centers, Rural Health Clinics, Medicaid Health Plans, Integrated Care Organizations, Tribal Health Centers, Outpatient Hospitals, Nursing Facilities

Issued: December 1, 2023 (Proposed)

Subject: Skilled Maintenance Therapy

Effective: January 1, 2024 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild, Children's Special Health Care Services (CSHCS)

Note: Portions of this bulletin are contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS)

This policy modifies the billing requirements for skilled maintenance therapy outlined in bulletin MSA 18-29 and updates benefit maximums for services performed in outpatient and nursing facility settings. The information in this bulletin is effective for dates of services on or after January 1, 2024.

Standards of Coverage

Medicaid covers skilled maintenance therapy when the skills of a physical, occupational, or speech therapist are required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Skilled maintenance therapy may be provided up to four times per 90-consecutive day treatment period without prior authorization (PA) when performed in an outpatient setting and up to four times per 60-consecutive day treatment period without PA when performed in nursing facility or home health setting. Beneficiaries may receive up to four sessions under each discipline.

Outpatient and Nursing Facility Billing

Effective for dates of services on and after January 1, 2024, Medicaid will no longer require outpatient and nursing facility skilled maintenance therapy to be reported under a therapy re-evaluation procedure code. Therapists should report maintenance services under select therapeutic procedure codes. When reporting services under a time-based procedure code, the four sessions should not exceed a total of 16 units per 60- or 90-day applicable period. If more than 16 units or four sessions are required with the applicable period, the therapist must

request PA. (Refer to the Therapy Services chapter in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual for PA instructions.)

Therapists may report skilled maintenance therapy under any of the following procedure codes:

Physical Therapy			
Code	**Short Description**	**Code**	**Short Description**
97110	Therapeutic Exercises	97530	Therapeutic Activities
97112	Neuromuscular Reeducation	97533	Sensory Integration
97116	Gait Training Therapy	97535	Self Care Mngment Training
97129	Ther Ivntj 1st 15 Min	97542	Wheelchair Mngment Training
97130	Ther Ivntj Ea Addl 15 Min	97763	Orthc/Prostc Mgmt Sbsq Enc
97140	Manual Therapy 1/> Regions		

Occupational Therapy			
Code	**Short Description**	**Code**	**Short Description**
92526	Oral Function Therapy	97140	Manual Therapy 1/> Regions
97110	Therapeutic Exercises	97530	Therapeutic Activities
97112	Neuromuscular Reeducation	97533	Sensory Integration
97116	Gait Training Therapy	97535	Self Care Mngment Training
97129	Ther Ivntj 1st 15 Min	97542	Wheelchair Mngment Training
97130	Ther Ivntj Ea Addl 15 Min		

Speech Therapy			
Code	**Short Description**	**Code**	**Short Description**
92507	Speech/Hearing Therapy	97533	Sensory Integration
92526	Oral Function Therapy	97129	Ther Ivntj 1st 15 Min
92609*	Use Of Speech Device Service	97130	Ther Ivntj Ea Addl 15 Min
* Covered in the outpatient setting only.			

When billing for skilled maintenance therapy, providers must report the appropriate modifier to distinguish the discipline under which the service is delivered (i.e., GP, GO, or GN) and the TS modifier to identify the service as maintenance therapy related. If the TS modifier is not reported, services will be considered restorative in nature and applicable rehabilitative benefit maximums and/or PA requirements will be applied. (Refer to the Therapy Services chapter in the MDHHS Medicaid Provider manual for details.)

When the maintenance therapy is habilitative in nature, along with the discipline and TS modifiers, services must be also be reported with modifier 96.

Home Health Billing

Maintenance visits provided in a home care setting should continue to be reported under the appropriate home therapy visit code. If more than four sessions are required with the 60-day period, the therapist must request PA. Maintenance therapy claims should include the TS modifier to identify the service as maintenance related.

Medicaid Health Plans/Integrated Care Organizations

Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. MHPs and ICOs are allowed to develop PA requirements and utilization management review criteria that differ from FFS Medicaid requirements. For beneficiaries enrolled in an MHP or ICO, the provider must check with the MHP/ICO for PA requirements.