

CAPS FOR PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (HOUSE BILL 260)

FREQUENTLY ASKED QUESTIONS

Question	Answer
Which provider types will be affected by the House Bill 260 change to align Medicaid's therapy reimbursement methodology with Medicare's?	<p>This change will affect:</p> <ul style="list-style-type: none"> • Independent physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) providers. • Outpatient hospitals providing PT, OT, and SLP services.
What are the new Medicaid caps?	<p>The new caps are:</p> <ul style="list-style-type: none"> • \$1,870 for SLP services and PT (combined). • \$1,870 for OT. <p>All services provided under the cap must meet all medical necessity criteria.</p>
Why is the combined PT and SLP cap the same as OT alone?	<p>The Department was directed in HB260 to implement therapy caps that align with Medicare. These caps are the same caps used by Medicare and will be adjusted with any Medicare changes to the cap amount.</p>
How will providers know if a participant is near or past the cap?	<p>Providers should check participants' eligibility before each visit by using the www.idmedicaid.com website, by dialing 1 (866) 686-4272, or through a 270/271 transaction. The response will contain information that will allow providers to monitor the dollar amount of claims that have already been paid on behalf of the participant for that calendar year. It won't include claims that haven't been billed or are pending.</p>

Question	Answer
<p>What can a provider do if a participant has reached the cap but still needs services?</p>	<p>If a participant has reached the cap, the provider can continue to provide services if the provider:</p> <ul style="list-style-type: none"> • The therapist assesses the participant to validate the medical necessity of the services and that the skills of a therapist are required. • Prior to billing, the provider sends supporting documentation to: <ul style="list-style-type: none"> Fax: 1 (877) 314-8779 (preferred) Mail: Idaho Medicaid Medical Care Unit PO Box 83720 Boise, ID 83720-0009 • The provider bills using a KX modifier
<p>What documentation must a provider send in?</p>	<p>The provider must send the:</p> <ul style="list-style-type: none"> • Therapy Service Documentation Coversheet (available at www.medunit.dhw.idaho.gov). • Physician's order • Evaluation • Plan of care • Current progress notes
<p>Should providers bill any differently when submitting claims for the services that exceed the Medicaid cap?</p>	<p>Yes. Providers should bill all procedure codes for therapy services that are past the limit with a KX modifier to indicate that they meet Medicaid criteria for those services. Claims submitted for services past the limit without this modifier will be denied.</p>
<p>What happens if a provider submits a claim for services that exceeds the Medicaid cap but the provider doesn't send</p>	<p>The claim will be denied.</p>

Question	Answer
or fax the Department any supporting documentation?	
Must providers send all supporting documentation for every claim that exceeds the Medicaid cap?	No. In most cases providers will only need to submit the information one time. If there is a significant change in condition or if a new evaluation is done, then the provider should submit that documentation. The Department may also contact you to request additional information upon claim review.
Can providers submit this documentation as a claim attachment instead?	No. If the documents are attached to a single claim, they will not be available to the Department's review staff and the claim will be denied.
Should providers request prior authorization for continued services?	While documentation of services that exceed the caps (and all associated claims) is subject to pre-payment review, prior authorization isn't necessary.
What if the Department reviews the documentation and determines that the service does not meet criteria?	That claim and all subsequent claims will be denied for that calendar year unless the participant has a change in condition.
Can a participant ever receive therapy services after a claim denial?	Yes. If a participant has had services denied, but later has a change in condition requiring therapy services, the provider can submit updated documentation of the change in condition to establish the necessity for continued services.