Limitations for Physical, Occupational, and Speech Therapy (House Bill 260)
Frequently Asked Questions

Question	Answer
Which provider types were affected by the House Bill 260 change to align Medicaid's therapy reimbursement methodology with Medicare's?	This change affected: • Independent physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) providers. • Outpatient hospitals providing PT, OT, and SLP services.
What are the current Medicaid limitations?	The current limitations are: • $1,960 for SLP services and PT (combined). • $1,960 for OT. All services provided under the limitation must meet all medical necessity criteria.
Why is the combined PT and SLP limitation the same as OT alone?	The Department was directed in HB260 to implement therapy caps that align with Medicare. These limitations are the same used by Medicare and will be adjusted with any Medicare changes to the limitation amount.
How will providers know if a participant is near or past the limitation?	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.

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What can a provider do if a participant has reached the limitation but still needs services?	If a participant has reached the limitation, the provider can continue to provide services if the provider: • The therapist assesses the participant to validate the medical necessity of the services and that the skills of a therapist are required. • The provider bills using a KX modifier. The KX modifier is the provider's attestation that the services are medically necessary.
What therapy claims is the department reviewing?	Beginning November 1, 2016, the utilization review process for therapy services will be primarily targeting claims which indicate high utilization, high dollars, adults transitioning to maintenance, feeding therapies, and other claims with unusual circumstances. The Department will select a number of claims billed with the KX modifier to review. All other claims will continue through the claims process. If, after the review, it is determined that a service does not meet criteria for coverage, the claim will be denied.

When should the provider send supporting documentation to the Department?	Beginning November 1, 2016, in order to ensure an effective and efficient review process, we are requesting for therapy providers to only submit supporting documents when requested by the Department. • Providers must submit the required documentation within two days of the receipt of the Department's request. Failure to provide the supporting documentation within this timeframe will result in denial of the claim. The required documentation includes: Therapy Service Documentation Coversheet (available at www.medunit.dhw.idaho.gov). Physician's order Evaluation Plan of care Current progress notes
Where does the provider send the requested supporting documentation?	Fax or mail supporting documentation to: Fax: 1 (877) 314-8779 Mail to: Medical Care Unit PO Box 83720 Boise, ID 83720-0009
Should providers bill any differently when submitting claims for the services that exceed the Medicaid limitation?	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.

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Can providers submit the requested 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.
Should providers request prior authorization for continued services?	While documentation of services that exceed the limitation (and all associated claims) is subject to post-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.