NEW YORK STATE

MEDICAID PROGRAM

REHABILITATION SERVICES

PROCEDURE CODES &

FEE SCHEDULE

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General Rules and Information

Occupational therapy and speech therapy visits in private practitioners' offices, certified hospital out-patient departments, and diagnostic and treatment centers (free-standing clinics) are limited to 20 each per twelve-month benefit year and physical therapy visits are limited to 40 per twelve-month benefit year. Medicaid will pay for up to 40 physical therapy visits, 20 occupational therapy visits, and 20 speech therapy visits per enrollee in a twelve-month benefit year.

For Medicaid fee-for-service (FFS) enrollees, the twelve-month benefit year is a state fiscal year beginning April 1 of each year and running through March 31 of the following year.

Utilization of a prior authorization (PA) process allows both the Department of Health and rehabilitation providers to track the number of therapy visits authorized for each beneficiary.

Prior Authorization/Dispensing Validation System (DVS)

When the procedure code description is preceded by "#", Medicaid Eligibility Verification System (MEVS) dispensing validation is required. The request for prior authorization should be submitted before the provision of service. A unique prior authorization number must be obtained through the Dispensing Validation System (DVS) for each visit. The DVS operates on "real time" and will give an immediate response to a request for prior authorization. A DVS authorization does not guarantee payment. However, without a prior authorization the claim will be denied. A request for prior authorization should be submitted before the provision of service. The request may be made after the date of service and can be approved if the enrollee has not already been authorized for the maximum number of visits. A maximum of 20 prior authorization numbers will be issued for occupational therapy, 20 for speech therapy, and 40 for physical therapy. Further instructions on obtaining a DVS authorization number can be accessed online at:

https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx

Exemptions

Certain Medicaid enrollees, settings, and circumstances are exempt from the visit limitations. These include:

- Children from birth to age 21 (until their 21st birthday)
- Individuals with a developmental disability (members with R/E code 95)
- Individuals with a traumatic brain injury (TBI) (members with R/E code 81, or having a traumatic brain injury as defined in Public Health Law Article 27-cc: https://codes.findlaw.com/ny/public-health-law/pbh-sect-2741.html)
- Individuals with both Medicare Part B and Medicaid coverage (dually eligible enrollees) when Medicare Part B payment is approved for the therapy service
- Rehabilitation services received as a hospital inpatient
- Individuals receiving rehabilitation services in a nursing home in which they reside
- Rehabilitation services provided by a certified home health agency (CHHA)

Payment in Full

Fees paid in accordance with the allowances in the Rehabilitation Services Manual shall be considered full payment for services rendered. No additional charge shall be made.

Modifiers

Modifier	Description
GP	Services delivered under an outpatient physical therapy plan of care.
GO	Services delivered under an outpatient occupational therapy plan of care.
GN	Services delivered under an outpatient speech-language pathology plan of care.

The appropriate modifier must be used for prior authorization requests and reported with therapy procedure codes on Medicaid claims.

Note: The National Correct Coding Initiative (NCCI) associated modifiers are recognized for NCCI code pairs/related edits. For additional information please refer to the CMS website:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/

Occupational Therapist, Physical Therapist and Speech Language Pathologist Services

This section contains the appropriate procedure codes necessary for completion of forms required in submitting claims for Rehabilitation Services.

SPEECH LANGUAGE PATHOLOGY SERVICES

		Non Facility Fee*
#92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation): individual. **(30 minute minimum session length)**	39.91
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	71.33
92522	Evaluation of speech sound production (eg, articulation phonological process, apraxia, dysarthria);	57.80
92523	with evaluation of language comprehension and expression(eg, receptive and expressive language)	120.25
92524	Behavioral and qualitative analysis of voice and resonance	60.56

PHYSICAL THERAPY SERVICES AND OCCUPATIONAL THERAPY SERVICES

		Non Facility Fee*
#97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), **each 15 minutes**	17.87
#97542	Wheelchair management (e.g., assessment, fitting, training), **each 15 minutes**	16.39

*The above fees apply to services rendered in a private office setting. If physical therapy, occupational therapy, or speech therapy services are rendered in any other setting (e.g., D&TC, HOPD, nursing home) the therapist cannot bill Medicaid directly and would be paid by the medical institution.