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37 Therapy (Occupational, Physical, and Speech)

This chapter regarding therapy services is specifically designed for therapy providers who meet **either** of the following criteria:

- Provider receives a referral as a result of an EPSDT screening exam and possesses a Patient 1st/EPSDT Referral form (Form 362) as a result of an abnormality discovered during the EPSDT exam
- Provider treats QMB recipients

Physical therapy is also covered for acute conditions in a hospital outpatient setting for non-EPSDT recipients. For more information regarding this, refer to Chapter 19, Hospital.

The policy provisions for EPSDT referred therapy providers can be found in the *Alabama* Medicaid Agency Administrative Code, Chapter 11.

37.1 Enrollment

HP enrolls therapy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative C*ode, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a therapy provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for therapy-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Therapy providers are assigned a provider type of 17 (Therapy). Valid specialties for therapy providers include the following:

- Occupational Therapy (171)
- Physical Therapy (170)
- QMB/EPSDT (600)
- Speech Therapy (173)

Therapists may enroll independently and have their own NPI bill on a CMS-1500 claim form as an EPSDT/QMB-only provider. Refer to Chapter 19, Hospital, for billing information for therapists enrolled by a hospital.

Enrollment Policy for Therapy Providers

Services provided must be ordered by a physician or a non-physician practitioner for an identified condition(s) noted during the EPSDT screening and provided by or under:

- For physical therapy services, a qualified physical therapist
- For occupational therapy (OT) services, the direct supervision of a qualified occupational therapist
- The supervision of a qualified speech therapist

A qualified Speech Therapist must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology.

A qualified occupational therapist must be licensed by the Alabama State Board of Occupational Therapy.

A qualified physical therapist must be licensed by the Alabama Board of Physical Therapy.

37.2 Benefits and Limitations

Added: Refer to Chapter…Medically Necessary Care.

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Services provided to Medicaid-eligible children by those working under the direction of licensed, enrolled speech therapists, occupational therapists or physical therapists are subject to the following conditions:

- The person providing the service must meet the minimum qualifications established by state laws and Medicaid regulations.
- A supervising provider must employ the person providing the service.
- The case record must identify the person providing the service.
- The supervising therapist must assume full professional responsibility for services provided and bill for such services.
- The supervising provider must assure that services are medically necessary and are rendered in a medically appropriate manner.
- Services must be ordered by a physician or a non-physician practitioner.

For more information about the Plan of Treatment (plan of care, treatment plan, etc.) required for therapy services, refer to Chapter 19.

Speech Therapists (ST-Speech Language Pathologist)

Speech therapy services must be provided by or under the direct supervision of a qualified speech therapist. Services are limited to those procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers.

Speech therapy assistants must be employed by a speech therapist, have a bachelor's degree in Speech Pathology, and be registered by the Alabama Board of Speech, Language Pathology, and Audiology. Assistants are only allowed to provide services commensurate with their education, training, and experience. They may not evaluate speech, language, or hearing; interpret measurements of speech language or hearing; make recommendations regarding programming and hearing aid selection; counsel patients; or sign test reports or other documentation regarding the practice of speech pathology. Assistants must work under the direct supervision of a licensed speech pathologist.

Direct supervision requires the physical presence of the licensed speech pathologist in the same facility at all time when the assistant is performing assigned clinical responsibilities. The licensed speech pathologist must document direct observation of at least 10% of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

NOTE:

Speech therapy services must be ordered by a physician and must be provided by or under the direct supervision of a qualified speech therapist.

Occupational Therapists (OT)

Occupational therapy services must be provided by or under the direct supervision of a qualified occupational therapist.

Services are limited to those procedures identified in Section 37.5.3, Procedure Codes and Modifiers. Some codes may require prior authorization before services are rendered. Medicaid does not cover recreational activities, such as movies, bowling, or skating.

Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must include one-to-one on-site supervision at least every sixth visit. Each supervisory visit must be documented and signed by the OT making the visit. Supervision for non-certified limited permit holders shall consist of one-to-one, on-site supervision a minimum of 50% of direct patient time by an OT who holds a current license. The OT must document supervising visits. The supervising OT ensures that the assistant is assigned only duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Occupational therapy aides employed by the OT may perform only routine duties under the direct, on-site supervision of the OT. Care rendered by an OT aide may not be charged as occupational therapy.

Physical Therapists (PT)

Services provided must be provided by or under the supervision of a qualified physical therapist.

Physical therapy assistants may provide service only under the supervision of a qualified physical therapist. PT assistants must be licensed by the Alabama Board of Physical Therapy, and must be an employee of the supervising PT. The PT assistant must only be assigned duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Licensed certified physical therapist assistants (PTA) are covered providers when working under the direction of a Preferred Physical Therapist with the following provisions:

- The Physical Therapist must interpret the physician's referral.
- The Physical Therapist must perform the initial evaluation.
- The Physical Therapist must develop the treatment plan and program, including long and short-term goals.
- The Physical Therapist must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The Physical Therapist must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The Physical Therapist must implement (perform the first treatment) and supervise the treatment program
- The Physical Therapist must co-sign each treatment note written by the PTA.
- The Physical Therapist must indicate he/she has directed the care of the patient and agrees with the documentation as written by the PTA for each treatment note.

Long Term Therapy Services:

- Therapeutic goals must meet at least one of the following characteristics: prevent deterioration and sustain function; provide interventions that enable the beneficiary to live at their highest level of independence in the case of a chronic or progressive disability; and/or provide treatment interventions for a beneficiary who is progressing, but not at a rate comparable to the expectations of restorative care.

Maintenance Services:

- A repetitive service that does not require the knowledge or expertise of a qualified practitioner and that does not meet the requirements for covered restorative therapy and/or long term therapy services. Maintenance services begin when the therapeutic goals of a treatment plan have been achieved or when no additional medical benefit is apparent or expected.

The Physical Therapist must render the hands-on treatment, write and sign the treatment note at a minimum of every sixth visit.

All orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. The Pt. 1st/EPSDT referral form may be considered as the physicians' order if these guidelines are met.

NOTE:

To determine if a procedure code requires prior authorization, use the Automated Voice Response System (AVRS).

Locum Tenens and Substitute Physical/Occupational Therapist Under Reciprocal Billing Arrangements

It is common practice for physical/occupational therapists to retain substitute physical/occupational therapists to take over their professional practices when the regular physical/occupational therapists are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physical therapist to bill and receive payment for the substitute physical/occupational therapists services as though he/she performed them. The substitute physical/occupational therapist generally has no practice of his/her own and moves from area to area as needed. The regular physical/occupational therapist generally pays the substitute physical/occupational therapist a fixed amount per diem, with the substitute physical/occupational therapist having the status of an independent contractor rather than of an employee. The substitute physical/occupational therapists are generally called "locum tenens" physical/occupational therapists.

Reimbursement may be made to a physical/occupational therapist submitting a claim for services furnished by another physical/occupational therapist in the event there is a reciprocal arrangement. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement. Effective for claims submitted on or after June 15, 2012, the reciprocal arrangement may not exceed 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement must be enrolled with the Alabama Medicaid Agency. The regular physical/occupational therapist should keep a record on file of each service provided by the substitute physical/occupational therapist and make this record available to Medicaid upon request. Claims will be subject to post-payment review.

37.3 Prior Authorization and Referral Requirements

Therapy procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

If the EPSDT screening provider wants to render treatment services himself, the provider completes a self-referral.

After receiving a screening referral form, Medicaid providers may seek reimbursement for medically necessary services to treat or improve the defects, illnesses, or conditions identified on the referral form. The consulting provider completes the corresponding portion of this form and returns a copy to the screening provider. If services or treatment from additional providers is

indicated, a copy of the referral form must be sent to those providers for their medical records. A completed Referral for Services Form must be present in the patient's medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee (physician or non-physician practitioner) is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

All orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. The Pt. 1st/EPSDT referral form may be considered as the physicians' order if these guidelines are met.

37.4 Cost Sharing (Copayment)

Copayment does not apply to therapy services.

37.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Therapy providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Therapy services are billed using the CMS-1500 claim form. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

37.5.1 Time Limit for Filing Claims

Medicaid requires all claims for therapy services to be filed within one year of the date of service. Refer to Chapter 5, Filing Limits, for more information regarding timely filing limits and exceptions.

37.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P. O. Box 930876 Atlanta, GA 31193-0873 or 1-800-621-8335.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

37.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Speech Therapy

Speech Therapy focuses on receptive language, or the ability to understand words spoken to you, and expressive language, or the ability to use words to express yourself. It also deals with the mechanics of producing words, such as articulation, pitch, fluency, and volume. Identifying those with communicative or oropharyngeal disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills.

Speech Therapy is covered only when service is rendered to a recipient as a result of an identified condition(s) noted during the EPSDT Screening exam or to QMB recipient. In order for the service to be covered the diagnosis must be speech related, such as stroke (CVA) or partial laryngectomy. In order to be a covered benefit, speech therapy must be ordered a physician must order and perform in an office location. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician. Speech therapy is not covered by Medicaid unless actually performed by a physician in person.

Use revenue codes 44x when billing speech therapy. Speech therapy providers are limited to the procedure codes listed below:

Procedure Code	***Description***	***Requires a Prior Authorization***
92521	Evaluation of speech therapy	No
92522	Evaluation of speech sound production	No

Procedure Code	***Description***	***Requires a Prior Authorization***
92523	Evaluation of speech sound production with evaluation of language comprehension and expression	No
92524	Behavioral and qualitative analysis of voice and resonance	No
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	No
92508	Group, two or more individuals	No
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Yes
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes	Yes
92609	Therapeutic services for the use of speech-generating device, including programming and modification See Note Box Below.	Yes
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.	No

NOTE:

For procedure code 92609, documentation must support that Augmentative Communication Device (ACD) has been purchased by Medicaid. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Physical Therapy

Physical therapy services address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation. This is covered based on medical necessity.

Key service functions include the following:

- Screening, evaluation and assessment to identify movement dysfunction
- Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems
- *Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems*
- Providing developmental and functionally appropriate services

Records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet *established* medical *criteria's*. Physical therapy is subject to the following criteria:

- Physical therapy is covered in an outpatient setting for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.

- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition.

If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician in his office. Physical therapy providers are limited to the procedure codes and limits listed below. These procedure codes cannot be span billed and must be submitted for each date of service provided. Documentation by therapist in medical record must support number of units billed on claim.

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report		1	No
95832	Muscle Testing Manual of hand		1	No
95833	Total evaluation of body, excluding hands		1	No
95834	Total evaluation of body, including hands		1	No
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	No
95852	ROM measurements and report (separate procedure);hand, with or without comparison with normal side		1	No
97001	Physical therapy evaluation		1	No
97002	Physical therapy reevaluation		1	No
97010	Application of a modality to one or more areas; hot or cold packs	1, 3, 5	1	No
97012	Traction, mechanical	1, 5	1	No
97014	Electrical stimulation, unattended	1, 2	4	No
97016	Vasopneumatic device	1 , 5	1	No
97018	Paraffin bath	1, 3, 5	1	No
97022	Whirlpool	3	1	No
97024	Diathermy	1, 5	1	No

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
97026	Infrared	1, 5	1	No
97028	Ultraviolet		1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3, 5	1	No
97113	Aquatic therapy with therapeutic exercises	5	1	No
97116	Gait training (includes stair climbing)	5	1	No
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).	3, 5	1	No
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	5	1	No
97150	Therapeutic procedure(s), group (2 or more individuals)	5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3, 5	4	No
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training) direct (one on one) patient contact by the provider, each 15 minutes		4	No
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes		4	No
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider each 15 minutes.	3, 5	4	Yes

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
97542	Wheelchair management/propulsion training, each 15 minutes	3, 5	4	No
97597	Removal of devitalized tissue From wounds		1	No
97598	Removal of devitalized tissue From wounds		8	No
97750	Physical performance test or measurement, (e.g., muscoloskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3, 4, 5	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service.)

2. 97014 cannot be billed on same date of service as procedure code 20974, 20975 or 20982.

3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient for the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for procedure, not the maximum units allowed for both providers.

4. 97760 should not be reported with 97116 for the same extremity.

5. Procedures 97010, 97012, 97016, 97018, 97024, 97026 (therapy procedures) must be billed with one of the following codes: 97014, 97020, 97110, 97112, 97113, 97116, 97124, 97140, 97150, 97530, 97535, or 97542 (therapeutic treatment).

Occupational Therapy

Occupational Therapy is a service that addresses the functional needs related to adaptive development, adaptive behavior and sensory, motor and postural development. These services are designed to improve the functional ability to perform tasks in the home and community settings.

Occupational therapy procedure codes cannot be span billed and must be submitted for each date of service provided. Some codes may require attainment of prior authorization before services are rendered. Documentation by therapist in medical record must support number of units billed on claim. Use revenue code 43x when billing claims for occupational therapy.

Medicaid does not cover group occupational therapy. Covered occupational therapy services do not include recreational and leisure activities such as movies, bowling, or skating. Individual occupational therapy providers are limited to the following procedure codes:

Code	***Description***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.		1	No
97003	Occupational therapy evaluation		1	No
97004	Occupational therapy re-evaluation		1	No
97010	Application of a modality to one or more areas; hot or cold packs	1, 3, 5	1	No
97018	Paraffin bath	1, 3, 5	1	No
97022	Whirlpool	3	1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense posture, and proprioception	3, 5	1	No
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	3, 5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3, 5	4	No
97532	Development of cognitive skills to improve attention, memory, or problem solving, each 15 minutes			No
97533	Sensory technique to enhance processing and adaptation to environmental demands, each 15 minutes		4	No
97535	Self-care / home management training (e.g., activities of daily living (ADL) and	3, 5	4	Yes

Code	Description	See Note	Max Units Per Day	Requires Prior Authorization
	compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.			
97542	Wheelchair management /propulsion training, each 15 minutes	3, 5	4	No
97597	Removal of devitalized tissue from wounds		1	No
97598	Removal of devitalized tissue from wounds		8	No
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

NOTE:

Refer to Chapter 108, Early Intervention Services for therapy delivered to infants/children enrolled in Alabama's Early Intervention System (AEIS).

37.5.4 Place of Service Codes

The following place of service codes apply when filing claims for therapy services:

POS Code	Description
11	Office

37.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Chapter 5, Required Attachments, for more information on attachments.

37.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Added: Medical Necessity/Medically Necessary Care, Chapter 7

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N