



Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Physical Therapy and Occupational Therapy Services

Division of Integrated Healthcare

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1 General information

The purpose of the physical therapy and occupational therapy programs is to increase the ability of a Medicaid member, with a temporary or permanent disability, to function at a maximum level through the rehabilitative process.

Rehabilitation goals must include:

1. Evaluation of the potential of each member
2. Factual statement of the level of functions present
3. Identification of goal(s) that may reasonably be achieved
4. Predetermined space of time and concentration of services that would achieve the goal(s)

The Medicaid program is designed to provide services within financial limitations.

The objectives of the program are to:

1. Provide scope of service
2. Give supplementary information
3. Outline limitations
4. Give instructions concerning prior authorizations, billing, and utilization which direct the provider to accomplish the goals the provider has identified for the member

1-1 Objectives of physical and occupational therapy

Must include:

1. Evaluation and identification of the existing problem (not anticipated problem)
2. Evaluation of the potential level of function actually achievable
3. Restoration of functions which have been lost due to accident or illness
4. Establishment of functions lacking due to defects of birth
5. Termination or transfer of responsibility for identified procedures to family, guardians, or other caregivers
6. Increased level of adaptation, independence, or participation in everyday life activities for the member

1-2 General policy

Physical therapy (PT) and occupational therapy (OT) are optional services. Physical therapy and occupational therapy services are mandatory for individuals under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Physical therapy and occupational therapy as described in this manual are a benefit of the Utah Medicaid program. Physical therapy services must be provided by a licensed therapist. Services may be performed by a physical therapy assistant under the supervision of a physical therapist. Occupational therapy services must be performed by an occupational therapist or by an occupational therapy assistant.

This manual is designed to be used in conjunction with other sections of the Utah Medicaid provider manual, such as [Section I: General Information](#).

2 Health plans

Information specific to Managed Care Entities (MCEs) can be found in [Section I: General Information](#), Chapter 2, Health plans.

Refer to [Section I: General Information](#) Chapter 1-7, Fee for service and managed care, for information regarding MCEs and how to verify if a Medicaid member is enrolled in an MCE.

3 Provider participation requirements

To enroll as a Medicaid Provider refer to [Section I: General Information](#) Chapter 3, Provider participation and requirements.

3-1 Provider credentials

3-1.1 Physical therapist

A Medicaid provider who practices physical therapy must meet all of the following:

1. Graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the

- American Physical Therapy Association, or its equivalent
2. Licensed by the State in which the provider practices
 3. Enrolled as a provider for the Utah Medicaid program

3-1.2 Occupational therapist

A Medicaid provider who practices occupational therapy must meet all of the following:

1. Graduate of a program of occupational therapy approved by both the Council on Medical Education of the American Medical Association and the Accreditation Council for Occupational therapy (ACOTE), or its equivalents
2. Licensed by the State in which the provider practices
3. Enrolled as a provider for the Utah Medicaid program

4 Record keeping

Refer to [Section I: General Information](#), Chapter 4, Record keeping.

5 Provider sanctions

Refer to [Section I: General Information](#), Chapter 5, Provider sanctions.

6 Member eligibility

Refer to [Section I: General Information](#), Chapter 5, Provider sanctions.

7 Member responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements, refer to [Section I: General Information](#), Chapter 7, Member responsibilities.

8 Program coverage

Most procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Medicaid [Coverage and Reimbursement Lookup](#).

8-1 Definitions

Definitions of terms used in other Medicaid programs are available in [Section I: General Information](#), Chapter 1-9, Definitions.

Definitions specific to the content of this manual are provided below:

Supervision: to act under the requirements of Utah Code Section 58-42a-306 of the Occupational Therapy Practice Act, or Section 58-24b-304 of the Physical Therapy Practice Act.

Occupational therapist: an individual who is licensed as an occupational therapist and meets the practice requirements in the Utah licensing Occupational Therapy Practice Act Rule, R156-42a.

Occupational therapy: services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist.

Occupational therapy assistant: a person licensed to practice occupational therapy under the supervision of an occupational therapist.

Physical therapist: an individual who is licensed as a physical therapist and meets the practice requirements in the Utah licensing Physical Therapy Practice Act Rule, R156-24b.

Physical therapy: services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a recipient by or under the direction of a qualified physical therapist.

Physical therapy assistant: a person licensed to engage in the practice of physical therapy, subject to the provisions of the Physical Therapy Practice Act, Subsection 58-24b-401(2)(a).

Physical medicine and rehabilitation: also referred to as Physiatry or Rehabilitation Medicine: a branch of medicine concerned with evaluation and treatment of, and coordination of care for, persons with musculoskeletal injuries, pain syndromes, and/or other physical or cognitive impairments or disabilities. The primary focus is on maximal restoration of physical and psychological function, and on alleviation of pain.

8-2 Covered services

Refer to the [Coverage and Reimbursement Lookup](#) for additional covered services.

8-2.1 Physical therapy and occupational therapy

To receive PT or OT services the member must be referred by a Doctor of Medicine, osteopathy, dentistry, or podiatry. Therapy services must require a level of proficiency and complexity, and/or the condition of the member must be such that therapy services can only be safely and effectively performed by a therapist.

Therapy services must be ordered, in writing, by a physician, physician assistant, or nurse practitioner as authorized by law.

Therapy sessions are limited to one PT session per day and one OT session per day. The evaluation and the first treatment may be billed on the same date of service.

Therapy services must be:

1. Professionally appropriate according to standards in the field

2. Utilize professionally appropriate methods and materials
3. In a professionally appropriate environment

Provision of service must be with the expectation:

1. Condition under treatment will improve in a reasonable and predictable time
2. Length of time and number of treatments will be predicted by Physical Therapy Association Guidelines
3. Service must be reasonable and necessary to the treatment of the member's condition

Treatment session: Physical therapy and occupational therapy treatment sessions should be based on the Medicaid member's specific medical condition and be supported in the treatment plan. A treatment session may include (post payment review):

1. Evaluation
2. Reassessment of the member's deficits, progress, rehabilitation potential, plan, and goals
3. Therapeutic exercise, including neuromuscular reeducation, coordination, and balance
4. Therapeutic oral motor, laryngeal, pharyngeal, or breathing exercises
5. Functional training in self-care and home management
6. Functional training in and modification of environments (home, work, school, or community), including biomechanics and ergonomics
7. Manual therapy techniques, including soft tissue mobilization, joint mobilization, and manual lymphatic drainage
8. Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, orthotics, and prosthetic devices
9. Airway clearance techniques
10. Compensatory or adaptive communication/swallowing

techniques and skills

11. Integumentary repair and protection techniques
12. Management of positioning, eating, and swallowing to enable/progress safe eating and swallowing
13. Electrotherapeutic modalities, physical agents and mechanical modalities when used in preparation for other skilled treatment procedures
14. Management of positioning, eating, and swallowing to enable/progress safe eating and swallowing
15. Training in assistive technology and adaptive devices, e.g., speech generating devices
16. Training in the use of prosthetic devices
17. Training of the member, caregivers, and family in home exercises, activity programs, and the development of a comprehensive maintenance program

Documentation of treatment sessions should include:

1. Date of treatment
2. Specific treatment(s) provided that match the procedure codes billed;
3. Total treatment time
4. The individual's response to treatment
5. Skilled ongoing reassessment of the individual's progress toward the goals
6. Any progress toward the goals in objective, measurable terms using consistent and comparable methods
7. Any problems or changes to the plan of care
8. Name and credentials of the treating clinician

Note: Documentation should be done in accordance with the clinician's professional organization (e.g., APTA or AOTA) standards.

Reevaluation: A reevaluation is indicated when there are new clinical findings, a rapid change in the individual's status, or failure to respond to physical

therapy interventions. There are several routine reassessments that are not considered reevaluations. These include ongoing reassessments that are part of each skilled treatment session, progress reports, and discharge summaries.

Reevaluation is a more comprehensive assessment that includes all the components of the initial evaluation, such as:

1. Data collection with objective measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods
2. Making a judgment as to whether skilled care is still warranted
3. Organizing the composite of current problem areas and deciding a priority/focus of treatment
4. Identifying the appropriate intervention(s) for new or ongoing goal achievement
5. Modification of intervention(s)
6. Revision in plan of care if needed
7. Correlation to meaningful change in function
8. Deciphering effectiveness of intervention(s)

Documentation of reevaluation should include all the components of the initial evaluation, in addition to:

1. Discussion regarding the appropriateness of continuing skilled therapy
2. List of current problems and deciding a priority/focus of treatment
3. Identifying the appropriate intervention(s) for new or ongoing goal achievement
4. Modification of interventions(s)
5. Revision of plan of care, as needed
6. Correlation to meaningful change in function
7. Deciphering effectiveness of intervention(s)

Note: Documentation should be done in accordance with the clinician's professional organization (e.g., APTA or AOTA) standards.

8-3 Physical therapy

Medicaid considers physical therapy services medically necessary when:

1. Therapy is aimed at preventing disability or improving, adapting or restoring functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality.
2. Therapy is for conditions that require the unique knowledge, skills, and judgment of a physical therapist for education and training that is part of an active skilled plan of treatment.
3. There is an expectation that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.

8-3.1 Evaluation

An initial physical therapy evaluation does not require a prior authorization unless the evaluation is performed by a Home Health Agency. See the [Home Health Services](#) provider manual. Evaluations are limited to one per calendar year; a written prior authorization is required beyond this limit.

The evaluation is essential to:

1. Determine if physical therapy services are medically necessary
2. Gather baseline data
3. Establish a treatment plan,
4. Develop goals based on the data

The initial evaluation is usually completed in a single session. An evaluation is required before implementing any PT treatment. Evaluation begins with the administration of appropriate and relevant assessments using standardized assessments and tools.

The evaluation should include (post payment review):

1. Prior functional level, if acquired condition
2. Specific standardized and non-standardized tests, assessments,

and tools

3. Summary of baseline findings
4. Objective, measurable, and functional descriptions of an individual's deficits
5. Summary of clinical reasoning and consideration with recommendations
6. Plan of care with specific treatment techniques or activities to be used in treatment sessions that should be updated as the individual's condition changes
7. Frequency and duration of treatment plan
8. Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data
9. Rehabilitation prognosis
10. Discharge plan that is initiated at the start of PT treatment

8-4 Occupational therapy

Medicaid considers occupational therapy medically necessary in selected cases when the following applies:

1. To learn or re-learn daily living skills (e.g., bathing, dressing, and eating) or compensatory techniques to improve the level of independence in the activities of daily living.
2. To provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury.
3. There is a reasonable expectation that occupational therapy will achieve measurable improvement in the member's condition in a reasonable and predictable period of time.

9 Non-covered services and limitations

9-1 Non-covered services

Refer to the [Coverage and Reimbursement Lookup](#) for additional non-covered services.

Physical therapy and occupational therapy services are not covered for:

1. Social or educational needs
2. Stable chronic conditions which cannot benefit from physical or occupational therapy services
3. No documented potential for improvement or no progress shown
4. Reached maximum potential for improvement and/or has achieved stated goals (see limitations regarding maintenance visits for EPSDT clients)
5. Non-diagnostic, non-therapeutic, routine, repetitive, or reinforced procedures; or maintenance therapy for non-pregnant adults
6. Residents of ICF/ID
 - a) An ICF/ID facility must provide and pay for PT or OT services when a member residing in the facility requires PT or OT services as part of the plan of care
 - b) Evaluation and therapy are components of the treatment plan and are the responsibility of the facility
7. Physical therapy or occupational therapy services in excess of one session per day
8. Physical therapy or occupational therapy services for maintenance. (Exception: EPSDT program eligible members.)
9. Physical therapy and occupational therapy services not included in the written plan of care
10. Physical therapy treatment for CVA which begins more than 60 days after onset of the CVA
11. Occupational therapy treatment for CVA which begins more than 90 days after onset of the CVA
12. Occupational therapy treatment of conditions other than one related to traumatic brain, spinal cord, or hand injury; neurodevelopment deficits, or CVA
13. Occupational therapy is not a benefit through Home Health except for EPSDT members and pregnant women
14. Occupational therapy if the child/family is able to follow prescribed program independently

15. Occupational therapy that does not require the skilled services of a licensed occupational therapist or licensed occupational therapy assistant
16. Conditions which can reasonably be expected to spontaneously improve with:
 - a) Age and development
 - b) As the member resumes normal activity
17. Physical therapy or occupational therapy service is not considered reasonable and necessary when the potential for rehabilitation is insignificant in relation to the extent and duration of occupational therapy
18. If at any point in treatment, there is no longer the expectation of significant improvement in a reasonable time. (This is based on Medicaid's best professional judgment)

9-2 Limitations

Physical therapy and occupational therapy services for maintenance are limited to EPSDT program eligible members and to one PT and one OT maintenance visit per month for care-giver training, to provide routine, repetitive or reinforced procedures of routine care in the residence.

9-2.1 Physical therapy limitations

1. Physical therapy services for Traditional Medicaid members are limited to twenty (20) therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 20 sessions.) Prior authorization is required for more than 20 sessions per calendar year.
2. Physical therapy and occupational therapy services for Non-Traditional Medicaid members are limited to sixteen (16) total aggregate physical or occupational therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 16 sessions). Prior authorization is required for more than 16 sessions per calendar year. (Note: On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan ended, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024.

Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.)

3. Physical therapy services must be performed by a physical therapist or by a physical therapy assistant under the supervision of a physical therapist.
4. Treatments that do not require the skills of a physical therapist may be administered by a physical therapy assistant. These same treatments may require the skills, knowledge, and judgment of a Physical Therapist where the member's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. If such treatments are given prior to, but as an integral part of, a skilled physical therapy procedure, these treatments would be considered part of the physical therapy service.
5. Ultrasound, Shortwave, Microwave Treatments, and similar modalities must always be performed by a physical therapist.
6. The skills of a physical therapist are required for gait evaluation and training when provided to a member whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality.
7. Gait evaluation and training that cannot reasonably be expected to improve significantly the member's ability to walk; such services by a physical therapist would not be considered reasonable or medically necessary. Repetitious exercises to improve gait, maintain strength and endurance, and assist in walking, such as provided in support for feeble or unstable members, are appropriately provided by supportive personnel (e.g., PT/OT Assistant or nursing personnel).
8. Range of motion (ROM) tests and therapeutic exercises constitute physical therapy if required to be performed by or under the supervision of a physical therapist, due either to the type of exercise employed or condition of the member.
9. Generally, ROM exercises related to the maintenance of function do not require the skills of a physical therapist and are not reimbursable
 - a) ROM exercises that require the skills of a physical therapist when they are part of active treatment of a specific disease which has resulted in the loss or restriction of mobility (as evidenced by physical therapy

- notes showing the degree of motion lost and the degree to be restored)
- b) Such exercises, either because of their nature or condition of the member, may be performed safely and effectively by a physical therapist
10. Wound debridement is covered if hydrotherapy is used to facilitate the debridement
- a) A simple bandage change is not reimbursable as a physical therapy treatment
11. For limitations to PT/OT in Home Health refer to the [Home Health Services Utah Medicaid Provider Manual](#).

9-2.2 Occupational therapy limitations

1. Occupational therapy services must be performed by an occupational therapist or by an occupational therapy assistant under the supervision of an occupational therapist.
2. Occupational therapy services for Traditional Medicaid members are limited to twenty (20) therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 20 sessions.) Prior authorization is required for more than 20 sessions per calendar year.
3. Occupational therapy and physical therapy for Non-Traditional Medicaid members are limited to sixteen (16) total aggregate physical or occupational therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 16 sessions). Prior authorization is required for more than 16 sessions per calendar year. (Note: On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan ended, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.)
4. Occupational therapy is limited to conditions resulting from traumatic brain injury, spinal cord injury, hand injury, congenital anomalies or developmental disabilities causing neurodevelopmental deficits, or CVA

(treatment must begin within 90 days of the incident).

- a) Other conditions are not covered
5. Occupational therapy in the home is a benefit for EPSDT members and pregnant women when the home is the most appropriate and cost-effective place for the service to be provided.

10 Prior authorization

Prior authorization (PA) is required for occupational and physical therapy services, if limitations are exceeded. Failure to obtain prior authorization will result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization before providing services. Exceptions may be made if any of the conditions listed in section 10-3 of the Medicaid Section 1 Provider Manual are met.

General prior authorization information can be found in the provider manual, [Section I: General Information](#). Code specific coverage and prior authorization requirements are provided on the Medicaid [Coverage and Reimbursement Lookup](#).

For the purposes of determining when limitations have been met for occupational and physical therapy, Utah Medicaid considers each date of service to be one (1) visit, regardless of how many modalities are provided on that date of service.

Specify whether the services being requested are for physical therapy or occupational therapy, and the desired number of visits you are requesting, on each prior authorization request. Prior authorizations will be issued for the number of visits allowed, based on medical necessity and providers will bill for the individual modalities that were provided on each visit. Visits are authorized based on the documented diagnosis, history, and goals of the plan of treatment (not to exceed one PT visit per day and one OT visit per day).

The evaluation and the first treatment visit may be billed on the same date of service.

Note: All claims are subject to national correct coding requirements and MUE limitations, regardless of the number of units authorized.

10-1 Prior authorization criteria

Prior authorization requests for treatment are reviewed and approved or denied based on the information submitted to the Prior authorization unit.

The provider must include in the request for treatment (post payment review):

1. Prior Authorization Request Form (found at: <https://medicaid.utah.gov>, Forms)
2. Written plan of treatment for the member or a document which includes:
 - a) The diagnosis and the severity of the medical disorder or disability
 - b) The prognosis for progress within a reasonable and predictable time to an identified level
 - c) The expected goals and objectives for the member
 - d) A plan that explicitly states the method(s) of treatment to be used and the discharge goals
 - e) The start and anticipated end date of therapy, number of visits requested and frequency of visits
 - f) Relevant documentation showing recent patient progress (i.e., sufficient recent clinic notes or a summary of recent patient progress)

11 Billing

Refer to [Section I: General Information](#), Chapter 11, Billing Medicaid, for more information about billing instructions.

11-1 Billing procedure

For coverage and reimbursement information for specific procedure codes, see the Medicaid [Coverage and Reimbursement Code Lookup](#).

Billing codes

Report physical and occupational therapy services with the appropriate modifier:

1. “GP” modifier for physical therapy
2. “GO” modifier for occupational therapy

12 Coding

Refer to [Section I: General Information](#), Chapter 12, Coding, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure codes, see the Medicaid [Coverage and Reimbursement Code Lookup](#). Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee for service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

13 Reimbursement

A rehabilitation facility providing therapy services must be enrolled as a Medicaid provider. The rehabilitation facility must bill for services using the assigned Medicaid procedure codes. Service claims must be submitted from the Medicaid rehabilitation facility provider. Therapists providing services for the agency may not bill directly for services.

14 Resource table

For information regarding:	
Administrative Rules	Utah Administrative Code Table of Contents R156-24b, Physical Therapy Practice Act Rule R156-42a, Occupational Therapy Practice Act Rule R414-1, Utah Medicaid Program R414-14, Home Health Services
General information including: Billing Fee for service and managed care	Section I: General Information Claims Managed Care: Accountable Care Organizations

Member eligibility Prior authorization Provider participation	Utah Medicaid Prior Authorization Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301. Program Benefits and Date of Eligibility. R414-306.
Information including policy and rule updates: Medicaid Information Bulletins (Issued bimonthly), Medicaid Provider Manuals, Utah State Bulletin (Issued on the 1 st and 15 th of each month)	Utah Medicaid Official Publications Utah State Bulletin
Medicaid forms including: PA Request	Utah Medicaid Forms
Medical supplies and DME	Medical Supplies And Durable Medical Equipment Provider Manual Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	Section I: General Information
Patient (Member) Eligibility Lookup Tool	Eligibility Lookup Tool
Prior authorization	Prior Authorization Form Utah Medicaid Prior Authorization
Provider portal access	Provider Portal Access
Provider training	Utah Medicaid Provider Training
References including: Social Security Act Code of Federal Regulations Utah Code Utah State Plan Amendment (SPA)	42 CFR 440.70 Social Security Act 1905(a) Social Security Act 1861 (r) Utah Annotated Code Title 58 Utah State Plan Amendment (SPA)