**Nassau County**

**Department of Health**

# MEDICAID

**NON-CENTER BASED PROVIDERS**

**IMPORTANT**

**MEDICAID REQUIREMENTS**

**MEDICAL ASSISTANCE CLAIMS FOR RELATED SERVICES**

**Instructions for OT / PT Services**

**Occupational Therapy/Physical Therapy services are to be provided by:**

* NYS Licensed Occupational Therapist (OT) NYS Licensed Occupational Therapy Assistant (COTA) “Under the Direction of” such qualified licensed and registered OT.
* A NYS Licensed Physical Therapist **(PT),** graduated from a **CAPTE Accredited PT Education Program,** a NYS Licensed Physical Therapy Assistant **(PTA)** graduated from a **CAPTE Accredited PT Education Program,** “under the supervision of” such qualified licensed and registered PT. (Copy of educational degree confirming CAPTE accredited program required)

**Such treatment must be rendered** pursuant to a referral (prescription) **which includes**

**child’s diagnosis** signed by a licensed physician, physician’s assistant or nurse practitioner. Without this referral, service should not be provided. (Section 6731, c)

If a COTA or PTA provides OT/PT service, an OT/PT must provide appropriate supervision and complete all necessary documentation. (See OT/PT section for detailed instructions.)

**OT/PT Services Requiring “Under the Direction of**”

**SUPERVISON OF PHYSICAL THERAPY ASSISTANTS**

**A**. **Physical Therapy Assistants** must work under the direction of a NYS Licensed Physical Therapist. A PT must co-sign all physical therapy service reports, daily treatment logs and quarterly progress notes in accordance with42CFR 440.110(b) and applicable state and federal laws and regulations.

* This direction shall be on-site direction and not necessarily direct personal supervision, especially when the program is one of maintenance.

1. The PT ensuresthat individuals working under his or her direction have contact information to permit the assistant direct contact with the supervising therapist as necessary during the course of treatment and keep supporting documentation**.**

* The PT sets all goals, establishes the plan of care, and determines on an on-going basis whether a child is appropriate to receive services of a PTA, with joint visits of PT and PTA periodically.
* The PT monitors the need for continued services, spends as much time as necessary directly supervising services to ensure child is receiving services in a safe and efficient manner in accordance with accepted standards of practice.

**C.** The PT must completea Certification of Under the Direction for each PTA being supervised.

An “Under the Direction of” (UDO) Log must be used to record direct supervision of PTA. Note that it is child specific and must be prepared for each child. Keep all written documentation of such direction, including Certification and UDO Log. (See attached sample form and instructions.)

**D.** One PT cannot supervise more than 4 PTAs (section 3738 a)

1. Providers must request a new prescription each year. RX must cover the summer as well as the school year, as appropriate.

**Services are NOT to be provided without a prescription.**

**SUPERVISON OF OCCUPATIONAL THERAPISTS**

**A. Occupational Therapy Assistants** must work under the direction of a licensed Occupational

Therapist. An OT must co-sign all occupational therapy service reports, daily treatment logs and quarterly progress notes in accordance with42CFR 440.110(b) and applicable state and federal laws and regulations.

* + This direction shall be on-site direction and not necessarily direct personal supervision, especially when the program is one of maintenance.

**B.** The OT ensuresthat individuals working under his or her direction have contact information

to permit the assistant direct contact with the supervising therapist as necessary during the

course of treatment and keep supporting documentation.

* + The OT and OTA must provide an initial joint visit with the child and subsequent periodic face to face contact for each student being serviced by the OTA.

* The OT sets all goals, establishes the plan of care, and determines on an on-going basis whether a child is appropriate to receive services of OTA, with joint visits of OT and OTA periodically.
* The OT monitors the need for continued services, spends as much time as necessary directly supervising services to ensure child is receiving services in a safe and efficient manner in accordance with accepted standards of practice.

**C.** The OT must complete a Certification of Direction for each OTA being supervised. An “Under the Direction of” (UDO) log must be used to record direct supervision of OTA. Note that it is child specific and must be prepared for each child. Keep all written documentation of such supervision, including Certification and UDO Log. (See attached sample form and instructions.)

1. Providers must request a new prescription each year.

**Services are NOT to be provided without a prescription.**

**CERTIFICATION OF**

**OCCUPATIONAL AND PHYSICAL THERAPY**

**UNDER THE DIRECTION AND ACCESSIBILITY**

**School District/Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, licensed ⁯ Occupational Therapist or

⁯ Physical Therapist with current license number \_\_\_\_\_\_\_\_\_\_ certify that

I am providing direction to the following Occupational Therapy Assistant

or Physical Therapy Assistant for the \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ school year:

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### Name of OTA/PTA License # and NPI #

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I am providing under the direction and accessibility in the following manner:

* Participate in the development of the child’s IEP, signing and dating the treatment plan
* Monitor the mandated delivery of OT or PT services;
* Be readily available to the OTA/PTA for assistance and consultation, via phone, email or fax;
* Perform an initial face to face contact with each student served by the OTA/PTA I am supervising and periodically observe the OTA/PTA with each student in the provision of services;
* Review periodic progress notes prepared by the OTA/PTA, consult with the OTA/PTA through regular monthly meetings and make recommendations, as appropriate; and
* Review service sheets used for Medicaid billing.

**I will keep the appropriate records documenting that “under the direction of” activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations etc.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

# Signature of Licensed Occupational/Physical Therapist (NPI #) Date

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| --- | --- | --- | --- | --- |
| **OCCUPATIONAL / PHYSICAL THERAPY “UNDER THE DIRECTION OF” LOG** | | | | |
|  |  |  |  |  |
| CHILD NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | SCHOOL YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  |  |  |  |
| AGENCY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | **OT/PT** SERVICES MANDATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  |  |  |  |
| ASSIGNED **OTA/PTA** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  |  |  |  |
| SUPERVISING **OT/PT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and OTA/PTA) | | | | |
| ACTIVITY | Meeting Date | Type of Meeting (Group, Individual, Telephone, Etc.) | Services / Evaluation Recommended | OT/PT SIGNATURE |
| IEP REVIEW |  |  |  |  |
| *INITIAL OBSERVATION - Face to Face with Child* |  |  |  |  |
| FIRST QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *2nd OBSERVATION - Face to Face with Child* |  |  |  |  |
| SECOND QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *3rd OBSERVATION - Face to Face with Child* |  |  |  |  |
| THIRD QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *4th OBSERVATION - Face to Face with Child* |  |  |  |  |
| FOURTH QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| **NOTE:** The supervising OT/PT **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an OTA/PTA. | | | | |
| The **PT** must have on file the manner in which he/she has provided direction to the PTA for each and every child being serviced. (One PT cannot supervise more than four (4) PTA, per Article 136, section 3738 a.) | | | | |
| The **OT** must have on file the manner in which he/she has provided “under the direction of” to the OTA for each and every child being serviced. The supervision must be direct supervision. | | | | |

**Instructions**

**for**

**Speech Language Services**

**and**

**Speech Language Services Requiring “Under the Direction of”**

**Speech Language Services may only be provided by:**

**NYS Licensed Registered Speech Language Pathologist** qualified in accordance with 42CFR Section 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under NYS law.

**Medicaid Billable Speech Language Services** may also be provided by the following when working **“Under the Direction of”** a qualified NYS licensed Speech Language Pathologist acting within his or her scope of practice under NYS law.

* Teacher of Speech & Hearing Handicapped **(TSHH)**
* Teacher of Students with Speech and LanguageDisabilities **(TSSLD)**
* An SLP working in his/her Clinical Fellowship year **(CFY)**
* **An SLP whose license has lapsed;** the services will not be billable unless the SLP is supervised by a NYS licensed Speech Language Pathologist.

**Speech Referral/Recommendation:** Speech services must be supported by a written Speech Language Referral/Recommendation for Evaluation/ Services form (See attached sample form) signed by Speech Language Pathologist or a Prescription from a Physician, Physician Assistant, or Nurse Practitioner. Attach a copy to your first month’s report. The Recommendation / Prescription must be signed and dated prior to the start of services for each and every Nassau County pre-school child receiving Speech Language Services.

Services are NOT to be provided without a recommendation / prescription.

**SPEECH REQUIRING “UNDER THE DIRECTION OF”**

**Guidelines for submitting documentation for speech services** provided by a Teacher of Speech & Hearing Handicapped **(TSHH)** or a Teacher of Students with Speech and Language Disabilities **(TSSLD)** ora Clinical Fellow **(CFY)** being supervised by a **NYS Licensed** Speech Language Pathologist **(SLP):**

**To meet the requirements for speech “under the direction of”**

* **The SLP** must have initial and subsequent periodic face-to-face contact with each student that is being serviced by a **TSHH**, **TSSLD or CFY**. This face to face contact **MUST** take place at the start of service. Any services done prior to the initial face to face cannot be claimed for Medicaid reimbursement.
* **The SLP is familiar with the treatment plan** as recommended by the referring physician or other licensed practitioner of the healing arts practicing under state law;
* **The SLP has input** into the type of care provided;
* **The SLP has continued involvement** in the care provided, and reviews the need for continued services throughout treatment;
* **The SLP** assumes professional responsibility for the services provided under his or her direction and spends as much time as necessary directly supervising services to ensure child is receiving services in a safe and efficient manner in accordance with accepted standards of practice. SLP keeps documentation supporting the supervision of services and ongoing involvement in treatment.
* **The SLP assures the delivery of speech** services in accordance with the IEP: This can be done by having the SLP initial a copy of the IEP *or* sign a statement indicating that the IEP was reviewed; **and sign** the monthly service records.
* **The SLP must be available to the TSHH/TSSLD/CFY for assistance** and consultation but need not be on the premise 100% of the time.
* **The SLP** must complete a **Certification of “Under the Direction of**” (UDO) for each **TSHH**

**/ TSSLD / CFY** being supervised. An **“Under the Direction of” (UDO) Log** mustbe used to

record direct supervision of **TSHH/TSSLD/CFY/SLP whose license has lapsed**. Note that these forms are child specific and must be prepared for each child. Keep all written documentation of such supervision, including Certification and “UDO” Log. (See attached sample form and instructions.)

**CERTIFICATION**

**OF**

## UNDER THE DIRECTION AND ACCESSIBILITY

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, CCC-SLP, Licensed Speech-Language Pathologist, with current license number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that I am providing "Under the Direction of" services to the following TSHH, TSSLD,

CFY or SLP (with lapsed license) for the \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ school year:

**Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| Name of Therapist being Supervised | License # and NPI # |
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**I am providing accessibility to the above referenced therapist in the following manner:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will keep the appropriate records documenting that the **"Under the Direction of”** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student,** etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Signature of Licensed Speech/Language Pathologist Date

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| --- | --- | --- | --- | --- |
| **SPEECH "Under the Direction of" LOG** | | | | |
|  |  |  |  |  |
| CHILD NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | SCHOOL YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  |  |  |  |
| SPEECH SERVICES MANDATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |
|  |  |  |  |  |
| **ASSIGNED THERAPIST** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| TSHH, TSSLD, CFY, SLP |  |  |  |  |
| SUPERVISING SLP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  |  |  |  |
| ACTIVITY | Meeting Date | Type of Meeting (Group, Individual, Telephone, Etc.) | Services / Evaluation Recommended | SLP SIGNATURE |
| IEP REVIEW |  |  |  |  |
| *INITIAL OBSERVATION - Face to Face with Child* |  |  |  |  |
| FIRST QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *2nd OBSERVATION - Face to Face with Child* |  |  |  |  |
| SECOND QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *3rd OBSERVATION - Face to Face with Child* |  |  |  |  |
| THIRD QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *4th OBSERVATION - Face to Face with Child* |  |  |  |  |
| FOURTH QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| **NOTE:** The supervising SLP **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a **Therapist** "under the direction of". The SLP must have on file the manner in which he/she has provided supervision to the **Therapist** for each and every child being serviced. | | | | |