empower HEALTHCARE SOLUTIONS

Outpatient Medical PT/OT/Speech: Yearly Benefit Limits (Jan. - Dec.)

Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Description	Units of Service	Weekly/Daily Max	EOB required if units are exhausted
Occupational Therapy								
97165					Evaluation for Occupational Therapy, low complexity	Unit=30 Minutes	4 units per day	4 units per year
97166					Evaluation for Occupational Therapy, moderate complexity	Unit=45 Minutes	3 units per day	3 units per year
97167					Evaluation for Occupational Therapy, high complexity	Unit=60 Minutes	2 units per day	2 units per year
97168					Re-Evaluation for Occupational Therapy, established plan of care (Cannot be billed on new patients)	Unit=30 Minutes	4 units per day	4 units per year
97530					Individual Occupational Therapy	Unit=15 Minutes	6 units per week	144 units
97150	U2				Group Occupational Therapy (max 4 clients per group)	Unit=15 Minutes	6 units per week	144 units
97530	UB				Individual Occupational Therapy by Occupational Therapy Assistant	Unit=15 Minutes	6 units per week	144 units
97150	UB	U1			Group Occupational Therapy by Occupational Therapy Assistant (max 4 clients per group)	Unit=15 Minutes	6 units per week	144 units
Physical Therapy								
97161					Evaluation for Physical Therapy, low complexity	Unit=20 Minutes	4 units per day	4 units per year
97162					Evaluation for Physical Therapy, moderate complexity	Unit=30 Minutes	3 units per day	3 units per year
97163					Evaluation for Physical Therapy, high complexity	Unit=45 Minutes	2 units per day	2 units per year
97164					Re-Evaluation for Physical Therapy, established plan of care (Cannot be billed on new patients	Unit=20 Minutes	4 units per day	4 units per year
97110					Individual Physical Therapy	Unit=15 Minutes	6 units per week	144 units
97150					Group Physical Therapy (max 4 clients per group)	Unit=15 Minutes	6 units per week	144 units
97110	UB				Individual Physical Therapy by Physical Therapy Assistant	Unit=15 Minutes	6 units per week	144 units
97150	UB				Group Physical Therapy by Physical Therapy Assistant (max 4 clients per group)	Unit=15 Minutes	6 units per week	144 units
Speech Therapy								
92507					Individual Speech Session	Unit=15 Minutes	6 units per week	144 units
92508					Group Speech Session (max 4 clients per group)	Unit=15 Minutes	6 units per week	144 units
92507	UB				Individual Speech Therapy by Speech-Language Pathology Assistant	Unit=15 Minutes	6 units per week	144 units
92508	UB				Group Speech Therapy by Speech-Language Pathology Assistant (max 4 clients per group)	Unit=15 Minutes	6 units per week	144 units
92521	UA				Evaluation of speech fluency (e.g. stuttering, cluttering)	Unit=30 Minutes	N/A	4 units per year
92522	UA				Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Unit=30 Minutes	N/A	4 units per year
92523	UA				Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language)	Unit=30 Minutes	N/A	4 units per year

Revision Date: 8-20-20

92524	UA				Behavioral and qualitative analysis of voice and resonance	Unit=30 Minutes	N/A	4 units per year

***(For the therapy services only, if more units of services than the weekly benefit max allows are needed up front, then a PA is required)**

Additional Services (Dermatology-Hearing-Podiatry-Vision): Yearly Benefit Limits

Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Description	Units of Service	Daily Max	EOB required if units are exhausted
92521	UA				Evaluation of speech fluency (e.g., stuttering, cluttering)	Unit=30 Minutes	n/a	4 units per year
92522	UA				Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Unit=30 Minutes	n/a	4 units per year
92523	UA				Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language)	Unit=30 Minutes	n/a	4 units per year
92524	UA				Behavioral and qualitative analysis of voice and resonance.	Unit=30 Minutes	n/a	4 units per year
V5008	EP				Use the following procedure code for hearing screenings for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.			
See Medicaid fee schedule for billable codes					Hearing Aid Procedures (Audiologists or physicians services) 2 Hearing aids per beneficiary each six months. Cochlear implantation is covered for beneficiaries under 21 in the EPSDT program	n/a	n/a	n/a
See Medicaid fee schedule for billable codes					Podiatrist (Office and outpatient services, home visits, office and inpatient consultations, laboratory and x-ray services, physical therapy and surgical services) ***Eligible beneficiaries are 21 and over; Medical visits for individuals under the age of 21 in the EPSDT program do not have a benefit limit	n/a	n/a	2 new patient visit procedure code per beneficiary per year. *surgical services provided by a podiatrist are not included in the 2 visits per calendar year.

Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Description	Units of Service	Daily Max	EOB required if units are exhausted
See Medicaid fee schedule for billable codes					Vision Care (Screening, examination, diagnosis and treatment of conditions of the eye for the prescribing and fitting of eyeglasses, contact lenses and low vision aids billed by an optometrist) **Over 21** -one visual examination and one pair of glasses every 12 months. **will only reimburse for replacement glasses for post-cataract patients -One prescription services fee every 12 months from the last date of service -Lens replacement as medically necessary -One visual prosthetic device every 24 months from the last date of service.	n/a	n/a	**n/a**
See Medicaid fee schedule for billable codes					Vision Care (Screening, examination, diagnosis and treatment of conditions of the eye for the prescribing and fitting of eyeglasses, contact lenses and low vision aids billed by an optometrist) **Under 21** -One exam and one pair of glasses every 12 months -One additional pair may be covered if glasses are broken beyond repair or lost within the 12 month benefit limit -One developmental test within a 12 month period *Lasik is not covered	n/a	n/a	**n/a**

Home Health Services Yearly Benefit Limits

Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Description	Units of Service	Daily Max	EOB required if units are exhausted
T1021					Home Health Aide Visit	Per Encounter	1	50 per year
T1021	TE				Home Health LPN Visit	Per Encounter	1	
T1021	TD				Home Health RN Visit	Per Encounter	1	
S9131					Home Health Physical Therapy by a Qualified Licensed Physical Therapist	Per Encounter	1	No annual limits
S9131	UB				Home Health Physical Therapy by a Qualified Physical Therapy Assistant	Per Encounter	1	No annual limits

Pain Management Procedures/Meds Yearly Benefit Limits

Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Description	Units of Service	Daily Max	EOB required if units are exhausted
PROCEDURES								
20552					Trigger Point Injections 1/2 muscle	Per Encounter	n/a	6 per year
20553					Trigger Point Injections 1-2 muscles	Per Encounter	n/a	6 per year
20610					Drain/injection of a major joint to relieve pain or swelling	Per Encounter	n/a	6 per year
60210					Excision procedures on the Thyroid	Per Encounter	n/a	6 per year
20611					Drain/injection of the Joint/Bursa	Per Encounter	n/a	6 per year
MEDICATIONS								
J1000					Injection, depo-estradiol cypionate, up to 5 mg	Per Encounter	n/a	6 per year
J1020					Injection, methylprednisolone acetate, 20 mg	Per Encounter	n/a	6 per year
J1030					Injection, methylprednisolone acetate, 40 mg	Per Encounter	n/a	6 per year
J1040					Injection, methylprednisolone acetate, 80 mg	Per Encounter	n/a	6 per year
J1094					Injection, dexamethasone acetate, 1 mg	Per Encounter	n/a	6 per year
J1700					Injection, hydrocortisone acetate, up to 25 mg	Per Encounter	n/a	6 per year
J1710					Injection, hydrocortisone sodium phosphate, up to 50 mg	Per Encounter	n/a	6 per year
J1720					Injection, hydrocortisone sodium succinate, up to 100 mg	Per Encounter	n/a	6 per year
J3300					Injection, triamcinolone acetonide, preservative free, 1 mg	Per Encounter	n/a	6 per year
J3302					Injection, triamcinolone diacetate, per 5mg	Per Encounter	n/a	6 per year
J3303					Injection, triamcinolone hexacetonide, per 5mg	Per Encounter	n/a	6 per year
J3304					Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Per Encounter	n/a	6 per year
J0670					Injection, mepivacaine hydrochloride, per 10 ml	Per Encounter	n/a	6 per year
J0702					Injection, betamethasone acetate 3mg and betamethasone sodium phosphate 3mg	Per Encounter	n/a	6 per year
J1885					Injection, ketorolac tromethamine, per 15 mg	Per Encounter	n/a	6 per year
J2001					Injection, lidocaine hcl for intravenous infusion, 10 mg	Per Encounter	n/a	6 per year
J2400					Injection, chloroprocaine hydrochloride, per 30 ml	Per Encounter	n/a	6 per year
J2795					Injection, ropivacaine hydrochloride, 1 mg	Per Encounter	n/a	6 per year
J3301					Injection, triamcinolone acetonide, not otherwise specified, 10 mg	Per Encounter	n/a	6 per year
J1000					Injection, depo-estradiol cypionate, up to 5 mg	Per Encounter	n/a	6 per year