

Making Sense of Therapy: Physical, Occupational & Speech from Start to Claim

Molina Healthcare of Nebraska



AGENDA



- Therapies
- Therapy Limits
- Authorizations
- Corrected Claims
- EFT, ERA and Electronic claim submission
- Balance Billing

Therapies



Therapy Types

Physical Therapy (PT):

Physical therapy focuses on helping individuals improve their movement, strength, and physical function. It is often used to treat injuries, surgeries, or conditions that affect mobility. PT uses exercises, stretches, manual therapy, and modalities (like heat or cold) to promote healing, relieve pain, and restore normal function.

Occupational Therapy (OT):

Occupational therapy helps individuals develop, recover, or maintain skills necessary for daily living and work activities. This includes fine motor skills, hand-eye coordination, and the ability to perform tasks like dressing, cooking, and working. OT is often used for people with physical, mental, or developmental conditions.

Speech Therapy (ST):

Speech therapy focuses on helping individuals improve their communication skills, including speech, language, and swallowing. Speech therapists work with people who have difficulty speaking, understanding language, or swallowing due to injury, developmental disorders, or conditions like strokes, brain injuries, or speech disorders.

These therapies are often integrated into a rehabilitation program to help individuals achieve the best possible quality of life.

Therapy Limits



Therapy Limits

Therapy Visit Guidelines

- **Adults** are limited to **60 therapy visits per calendar year**. This includes a combined total across Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST).
- **Children under age 21** do **not** have a visit limit.
- The **first 12 visits per discipline do not require Prior Authorization**:
 - 12 visits for PT
 - 12 visits for OT
 - 12 visits for ST
- These initial 12 visits are shared across all therapy providers, including chiropractors. They are **not** per provider and **not** per episode of care.
 - *Example:* If a member breaks their ankle and later breaks their hip, the first 12 visits do not reset.
- The Authorization Team can view the number of visits requested and approved, but not the number of visits billed.



Therapy Limits continued

In 2025, we removed the SNF and Facilities from accumulating into the count for the first 12 therapies.

Home Health Services Overview

- Home Health services remain part of the 60-visit annual limit for adults, but they do not count toward the first 12 non-authorized visits
- Home Health providers must obtain a prior authorization after the 6th visit. Visits include evaluation, all home health care services, and therapy.
- All Home Health services—including evaluations, visits, and therapy—require prior authorization.
- Providers must bill Home Health services through Electronic Visit Verification (EVV).

Authorization Extensions & Support

•Extension Requests:

Members may request an extension if they need more time to use their existing approved visits.

Extensions are only granted if visits remain unused.

•Requesting Additional Visits:

If a member needs more visits beyond the approved amount, a new authorization is required.

•How to Request an Extension:

Providers can request an extension through the following methods:

Availability: www.availity.com

Fax: 833-832-1015

- For questions, please contact the Utilization Management (UM) team at:
NE_UM@MolinaHealthcare.com



Therapy Modifier Billing Guidelines

Molina complies with the CMS requirements related to therapy modifiers. CMS recognizes the services furnished under the outpatient therapy (OPT) services benefit as either “always” or “sometimes” therapy and publishes this list as an Annual Update on the Therapy Services Billing webpage at:

<https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>

Beginning with claims received 9/1/2025 and after, these claims will be denied or recouped if the appropriate modifier is not appended.

To assist providers with the reinforcement of this CMS requirement, please note that for professional claims, each code designated as “always therapy” must always be furnished under a speech-language pathology (SLP), occupational therapy (OT), or physical therapy (PT) plan of care, regardless of who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers.

- GO – Occupational Therapy
- GP – Physical Therapy
- GN – Speech Therapy

Therapy Modifier Billing Guidelines cont...

Discipline Specific	CPT Code	Modifier	Notes
Occupational Therapy	97003	GO	Not currently covered by NE Medicaid
Occupational Therapy	97004	GO	Not currently covered by NE Medicaid
Occupational Therapy	97165	GO	
Occupational Therapy	97166	GO	
Occupational Therapy	97167	GO	
Occupational Therapy	97168	GO	
Physical Therapy	97161	GP	
Physical Therapy	97162	GP	
Physical Therapy	97163	GP	
Physical Therapy	97164	GP	
Speech Therapy	92521	GN	Only covered on Physician Fee Schedule
Speech Therapy	92522	GN	Only covered on Physician Fee Schedule
Speech Therapy	92523	GN	Only covered on Physician Fee Schedule
Speech Therapy	92524	GN	Only covered on Physician Fee Schedule
Speech Therapy	92597	GN	Only covered on Physician Fee Schedule
Speech Therapy	92607	GN	Only covered on Physician Fee Schedule

Authorizations



Authorizations

- Molina has a code look up tool on the landing page of the website to determine if a code requires an authorization or not.
Authorizations can be requested online via Availity (www.availity.com) or on our Molina website (www.molinahealthcare.com/NEproviders)

For Molina Members | About Molina | Showing Information For Nebraska | Nebraska | Medicaid | Type Size - +

MOLINA HEALTHCARE | Availity Essentials Portal | Find a Doctor or Pharmacy | Search | Go | Sign in Register

Home | Provider Resources | Claims & Authorizations | Health Resources | Communications | Join Our Network

Learn More About Mental Health | Psych HUB

EXPLORE EVIDENCE-BASED EDUCATION OPPORTUNITIES FROM PSYCH HUB.

Click here

Need a Prior Authorization? | Code LookUp Tool

Home Health Services (RN/LPN/HHA): PA required after eval + 6 visits per calendar year. (For Home Health PT/OT/ST, see PT/OT/ST therapy PA requirements.)

Hospice: PA Required after initial 60 day period.

PT/OT/ST: PA required after 12 visits of each therapy type (PT/OT/ST) per calendar year (includes Home Health therapies). Therapy benefit limit is 60 visits per calendar year cumulative of PT/OT/ST for members aged 21 and older.

LTSS: All services are carved out to MLTC.

DME: DME requests over \$750 require PA.

Healthcare Administered Drug Requests:
Medicaid: Fax to 877-281-5364
Medicare: via Novologix Provider Portal or fax to 800-391-6437

State: Nebraska | Health Plan Benefit: Molina Healthcare of Nebraska | LOB: Medicaid

CPT / HCPCS Code: | Lookup

Authorizations continued...

- Providers utilizing the Molina website (<https://www.molinahealthcare.com/providers/ne/m/medicaid/home.aspx>) will navigate to the 'Claims & Authorization' tab and drop down to 'Authorizations'.
- For additional information regarding the PA of specialized clinical services, please refer to the authorization tools highlighted in teal.
- The PA auth form can be faxed to Molina at: (833) 832-1015.
- PA can be initiated by contacting Molina's Provider Services department and pressing option 3 at (844) 782-2678. They are available 8am-5pm CT M-F.

Home > Claims & Authorizations > Authorizations

Authorizations

Utilization Management (UM)

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina, Molina may choose contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the prior authorization tools:

- [Prior Authorization Code Look-up Tool](#)
- [Prior Authorization Code Matrix](#)
- [Prior Authorization Guide](#)

Availity Essentials portal: Participating Providers are encouraged to use the Availity Essentials portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

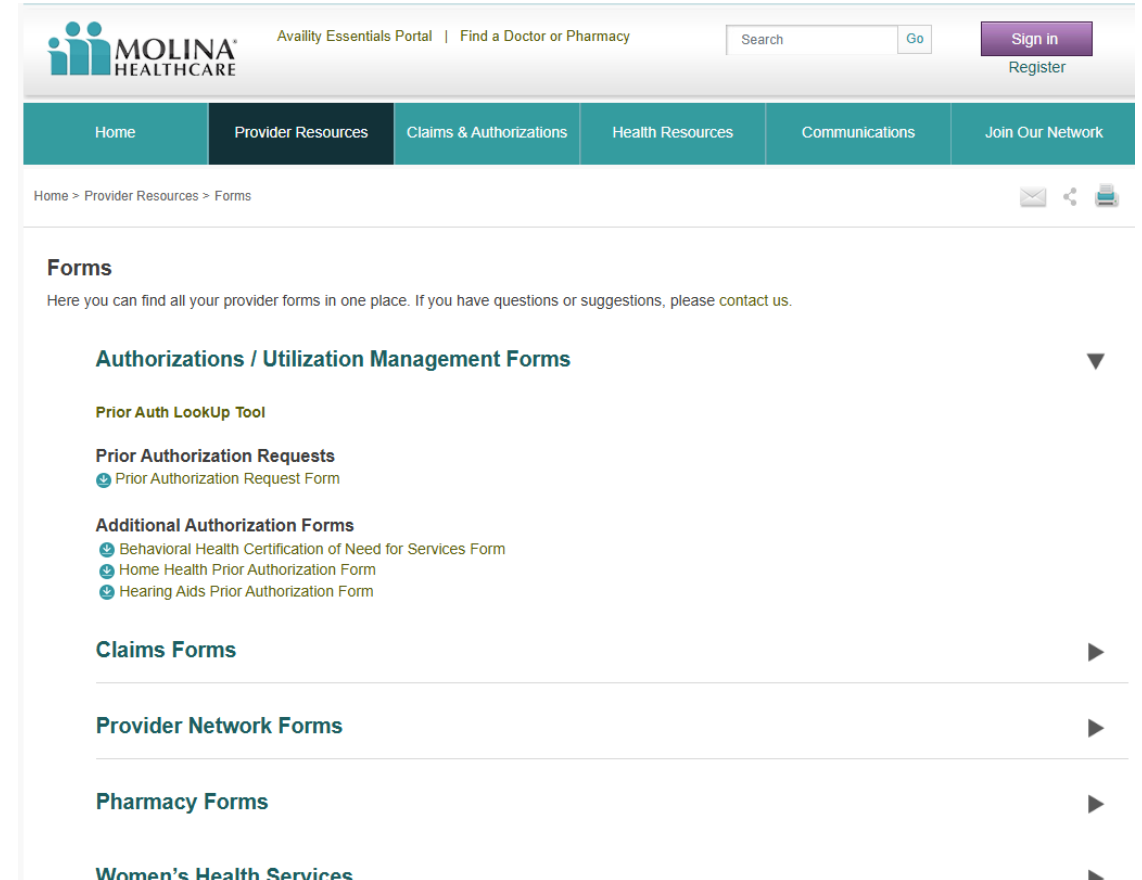
- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

Fax: The Prior Authorization Request Form can be faxed to Molina at: (833) 832-1015.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at (844) 782-2678. It may be necessary to submit additional documentation before the authorization can be processed.

Authorizations continued...

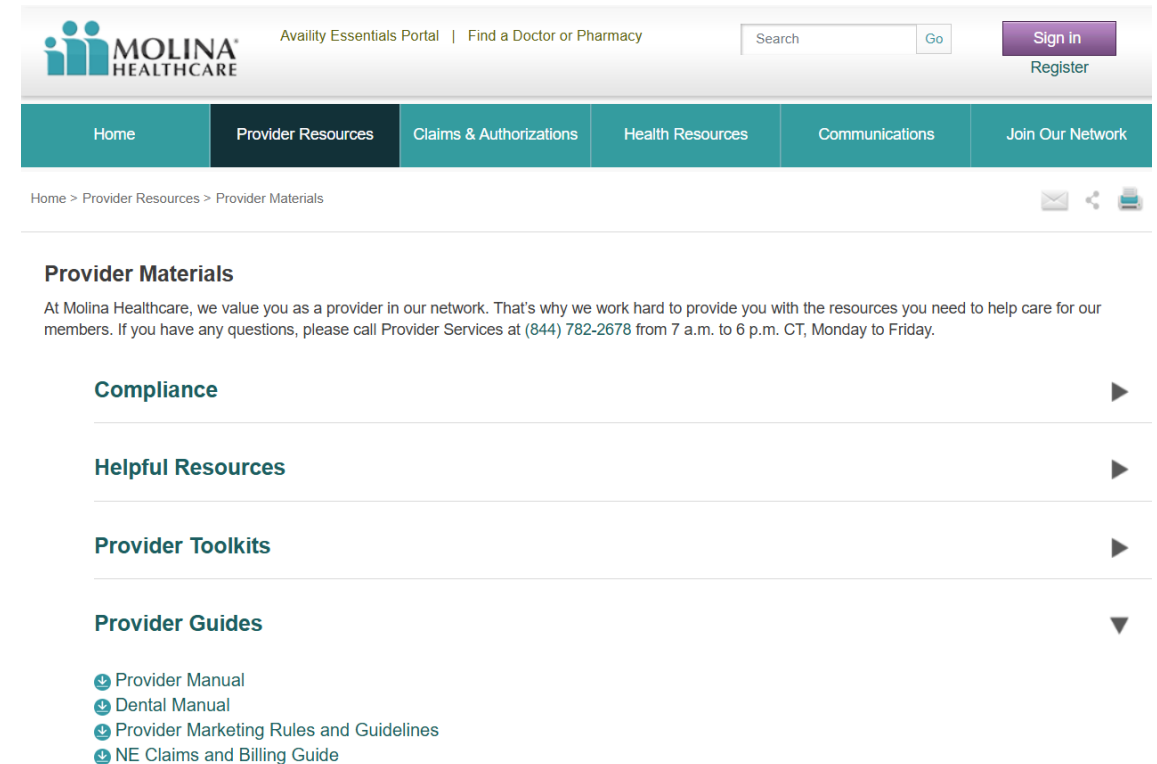
- Prior Authorization forms are located on our website https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ne/NE_PA-Request-Form.ashx
- All prior authorization requests require clinical information.
- Please reach out to the UM team with any authorization related question via email: NE_UM@MolinaHealthcare.Com



The screenshot displays the Molina Healthcare website interface. At the top, the logo for Molina Healthcare is visible alongside navigation links for 'Availity Essentials Portal' and 'Find a Doctor or Pharmacy'. A search bar and 'Sign in / Register' buttons are also present. The main navigation menu includes 'Home', 'Provider Resources', 'Claims & Authorizations', 'Health Resources', 'Communications', and 'Join Our Network'. The 'Forms' page is currently active, showing a breadcrumb trail: 'Home > Provider Resources > Forms'. The page content is organized into sections: 'Forms' (with a sub-header and a note about contacting support), 'Authorizations / Utilization Management Forms' (with a dropdown arrow), 'Prior Auth LookUp Tool', 'Prior Authorization Requests' (with a link to the 'Prior Authorization Request Form'), 'Additional Authorization Forms' (with links for 'Behavioral Health Certification of Need for Services Form', 'Home Health Prior Authorization Form', and 'Hearing Aids Prior Authorization Form'), 'Claims Forms', 'Provider Network Forms', 'Pharmacy Forms', and 'Women's Health Services'.

PT/OT/ST Claims and Reimbursement

- Comprehensive information for submitting claims to Molina is available on our Provider website:
<https://www.molinahealthcare.com/providers/ne/medicaid/home.asp>
- To ensure claims are submitted in accordance with Molina's policies, please refer to the Provider Manual. This document is accessible via the Provider Resources tab > Provider Guides > Provider Manual.
- Additionally, our Claims and Billing Guide offers a concise reference for all claim and billing-related inquiries. It can be found under the Provider Resources tab > Provider Guides > NE Claims and Billing Guide



The screenshot shows the Molina Healthcare website's Provider Resources page. At the top, there is a navigation bar with the Molina Healthcare logo, a search bar, and a 'Sign in Register' button. Below the navigation bar is a menu with tabs for Home, Provider Resources (which is highlighted), Claims & Authorizations, Health Resources, Communications, and Join Our Network. The main content area is titled 'Provider Materials' and includes a welcome message for providers. Below this, there are four expandable sections: Compliance, Helpful Resources, Provider Toolkits, and Provider Guides. The Provider Guides section is expanded, showing a list of documents: Provider Manual, Dental Manual, Provider Marketing Rules and Guidelines, and NE Claims and Billing Guide.

MOLINA HEALTHCARE Availability Essentials Portal | Find a Doctor or Pharmacy Search

Home Provider Resources **Claims & Authorizations** Health Resources Communications Join Our Network

Home > Provider Resources > Provider Materials

Provider Materials

At Molina Healthcare, we value you as a provider in our network. That's why we work hard to provide you with the resources you need to help care for our members. If you have any questions, please call Provider Services at (844) 782-2678 from 7 a.m. to 6 p.m. CT, Monday to Friday.

- Compliance** ▶
- Helpful Resources** ▶
- Provider Toolkits** ▶
- Provider Guides** ▼
 - Provider Manual
 - Dental Manual
 - Provider Marketing Rules and Guidelines
 - NE Claims and Billing Guide

PT/OT/ST Claims and Reimbursement continued...

- The Billing Guide is located on our website and includes resources about Coordination of Benefits, Submitting Prior Authorizations, Rejections, Denials, Claim Dispute Process, Sample Claim forms and more.
- Another helpful resource on the website is the Payment Integrity Policies. This can be found under the Provider Resources Tab>Other Resources and Policies>Payment Integrity Policies.
- The Payment Integrity Policies contains policies for Molina of Nebraska including Modifier Use Policies, PT/OT Initial Evaluations, PT/OT/ST yearly limits, Clinical Policies, DME Policies, ABNs, Corrected Claims, CMS replacement Claims, and more.



Corrected Claims



Timely Filing

- Providers must submit all claims, corrected claims and encounters within 180 calendar days of the date of service. The filing limit may be extended where the eligibility has been retroactively received by Molina, up to a maximum of 180 calendar days.
- If Molina is not the primary payer under coordination of benefits or third-party liability, the provider must submit claims to Molina within 180 calendar days after final determination by the primary payer. Claim disputes and appeals must be received within 90 calendar days from the date of notification of payment or denial is issued



Corrected Claims

- Molina utilizes corrected claims to obtain additional information necessary for claim processing, such as EOBs from primary payers, medical records, invoices, and similar documentation.
- Please do not submit a reconsideration for these scenarios. Instead, submit a corrected claim to ensure the information is appropriately reviewed.
- Corrected claims may also be used to update essential claim data, including diagnosis codes, provider NPIs, CPT codes, and other relevant details.
- Providers must submit corrected claims within 180 calendar days from the date of service.



EFT, ERA and Electronic Claim Submission

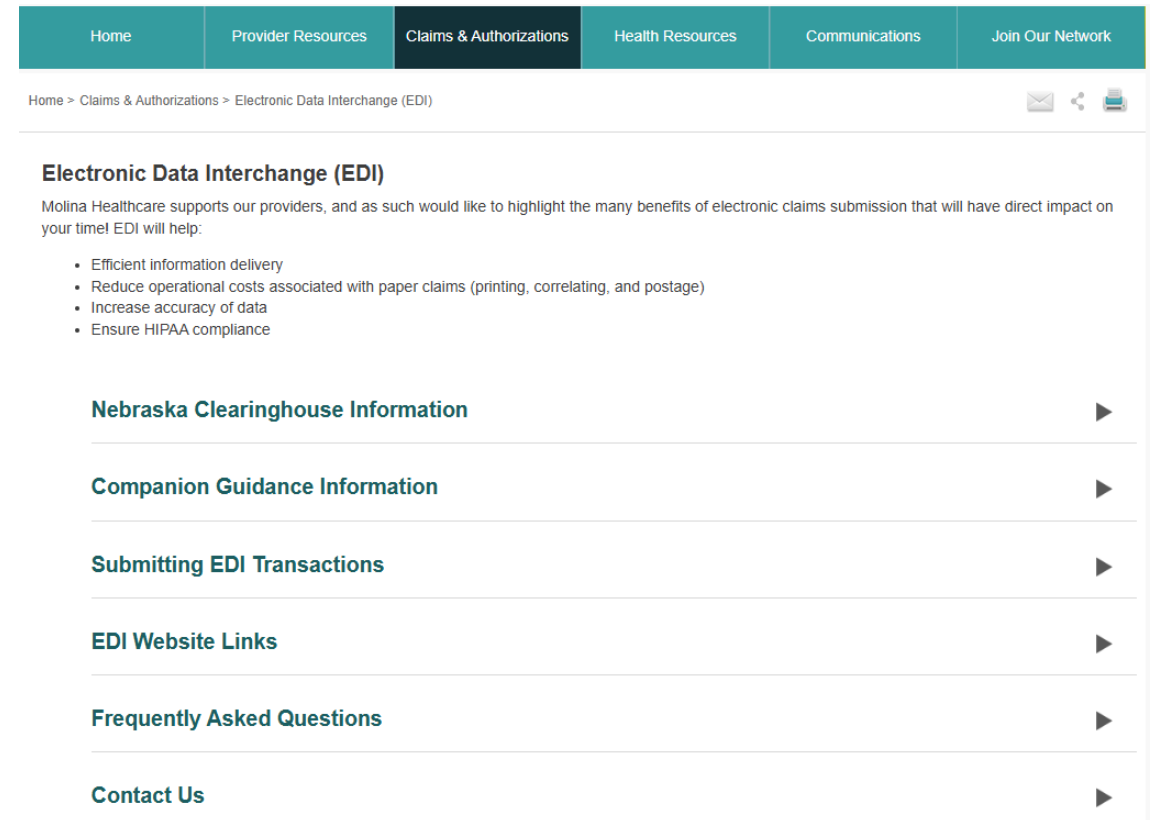


Electronic Payments, Remittances, Electronic Claim submission

Detailed information for submitting electronic claims to Molina of Nebraska is available on our website under:

Claims and Authorizations > Electronic Data Interchange (EDI)

- To receive electronic payments (EFT), providers can enroll through Echo Health.
- Enrollment details for this service can be found under: Claims and Authorizations > Electronic Remittance Advice / Electronic Funds Transfer (ERA/EFT)



The screenshot shows a navigation menu with the following items: Home, Provider Resources, Claims & Authorizations (highlighted), Health Resources, Communications, and Join Our Network. Below the menu is a breadcrumb trail: Home > Claims & Authorizations > Electronic Data Interchange (EDI). The main content area is titled "Electronic Data Interchange (EDI)" and includes a paragraph: "Molina Healthcare supports our providers, and as such would like to highlight the many benefits of electronic claims submission that will have direct impact on your time! EDI will help:". Below this are four bullet points: "Efficient information delivery", "Reduce operational costs associated with paper claims (printing, correlating, and postage)", "Increase accuracy of data", and "Ensure HIPAA compliance". At the bottom of the page is a list of links with right-pointing arrows: "Nebraska Clearinghouse Information", "Companion Guidance Information", "Submitting EDI Transactions", "EDI Website Links", "Frequently Asked Questions", and "Contact Us".

Balance Billing



Balance Billing / Member Acknowledgement Statement

Providers may not balance bill Molina members for any reason for covered services. Detailed information regarding the billing requirements for non-covered services is available in the Provider Manual. Providers must inform the member of their responsibility for payment of non-covered services prior to services being rendered. Additionally, providers may not bill members for missed appointments.

The provider must obtain a written acknowledgment from the member to bill the member for non-covered services. Please have the member sign the following Member Acknowledgment Statement:

I understand that the services or items that I have requested to be provided to me on [dates of service] may not be covered by Molina Healthcare of Nebraska, and in the opinion of [Provider's Name] they are reasonable and medically necessary for my care. I understand that Molina, through its contract with Nebraska Medicaid, determines medical necessity for the services and items I receive. The cost of services to be rendered are estimated to be [price]. I understand that I am responsible for the payment of non-covered services and items that I request and receive if those services are not medically necessary or reasonable.

QUESTIONS

