Exhibit 14

OUTPATIENT THERAPY

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SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled outpatient therapy providers.

The primary objective of Medicaid is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services, recommended and supported by a pediatric subspecialist, with care coordination that relates to the CSHCS qualifying diagnosis. Policies are aimed at maximizing the health care services obtained for this population with the limited number of dollars available.

The term Medicaid throughout this chapter refers to both the Medicaid and CSHCS programs.

1.1 SERVICE PROVISION

Outpatient therapy may be provided by Medicaid-enrolled providers when performed by properly credentialed professionals in the following settings:

- Outpatient Occupational Therapy (OT) and Physical Therapy (PT)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - CARF-Accredited Outpatient Medical Rehabilitation Program
  - Physical Therapist or Occupational Therapist in Private Practice (Medicare coinsurance and deductible amounts only)
  - Physician's Office
  - Optometrist's Office
- Outpatient Speech Language Pathology (ST)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - CARF-Accredited Medical Rehabilitation Program
  - CAA-Accredited University Graduate Education Program

1.2 OUTPATIENT THERAPY DATABASE

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the Michigan Department of Health and Human Services (MDHHS) Outpatient Therapy Database on the MDHHS website. (Refer to the Directory Appendix for website information.) The database includes all covered outpatient therapy codes and applicable frequency limits.

1.3 Documentation in Beneficiary File

Outpatient therapy providers must maintain all applicable documentation in the beneficiary's file for seven years. For audit purposes, the patient's medical record must substantiate the medical necessity of the item or service supplied.

SECTION 2 – PROVIDER REQUIREMENTS

2.1 OUTPATIENT HOSPITALS

Outpatient OT, PT and ST services may be provided to beneficiaries of all ages in the outpatient hospital.

2.2 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Rehab Agencies may enroll with Medicaid for reimbursement of outpatient OT, PT and ST provided by qualified professionals. All CORFs and Rehab Agencies must provide proof of Medicare certification when enrolling in Medicaid.

2.3 COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES (CARF) ACCREDITED OUTPATIENT MEDICAL REHABILITATION PROGRAMS

CARF accredited outpatient medical rehabilitation programs may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. The program must be freestanding and not part of, or owned by, a hospital, CORF or Rehab Agency. All CARF accredited outpatient medical rehabilitation programs must provide proof of their current CARF accreditation when enrolling in Medicaid.

2.4 UNIVERSITY AFFILIATED SPEECH-LANGUAGE PATHOLOGY GRADUATE EDUCATION PROGRAMS

University graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation (CAA) in Audiology and Speech-Language Pathology may enroll with Medicaid for reimbursement of outpatient ST provided by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF or Rehab Agency. All university programs must provide proof of their current ASHA-CAA when enrolling in Medicaid.

2.5 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS IN PRIVATE PRACTICE

Medicaid enrolls physical therapists and occupational therapists in private practice only for reimbursement of the Medicare coinsurance and deductible on behalf of dual Medicaid/Medicare beneficiaries. These providers may not bill for services provided to beneficiaries with Medicaid or CSHCS only.

2.6 PHYSICIAN'S OFFICE OR CLINIC

OT and PT services may be provided to beneficiaries of all ages in a physician's office.

SECTION 3 - CSHCS REQUIREMENTS

As a condition to participate in the CSHCS program, the beneficiary's assigned pediatric subspecialist must coordinate treatment and services relating to the beneficiary's CSHCS-qualifying diagnosis. CSHCS beneficiaries must be referred by their pediatric subspecialist directly to the specified Medicaid-enrolled provider of therapy services. Documentation of this referral must remain in the beneficiary's medical record.

CSHCS diagnostic evaluations authorized by the local health department do not require a referral by the pediatric subspecialist.

CSHCS-covered outpatient therapy services must be directly related to the CSHCS-eligible diagnosis. Therapists providing or supervising services provided to CSHCS beneficiaries must have obtained at least one year of prior professional experience treating the health care needs of pediatric patients with physical disabilities. Professional resumes documenting pediatric experience, as well as a copy of the facility's program description and mission/vision statement, must be submitted to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.) CSHCS will make the determination, based on this documentation, of whether the provider is approved to provide therapy services to CSHCS beneficiaries.

Once approved to provide therapy services to CSHCS beneficiaries, the provider may accept referrals from the pediatric subspecialist. When a CSHCS beneficiary presents for services, the provider must check the beneficiary's CSHCS Client Eligibility Notice. Before billing for therapy services, the enrolled provider must be listed on the beneficiary's CSHCS Client Eligibility Notice. Providers may contact the MDHHS Program Review Division to request addition to a Client Eligibility Notice. (Refer to the Directory Appendix for contact information.)

These requirements do not apply to services provided to Medicaid-only or dual Medicaid/CSHCS beneficiaries.

SECTION 4 – PRIOR AUTHORIZATION REQUESTS

PA is required for certain services before the services are rendered. To determine which services require PA, refer to the Standards of Coverage and Service Limitations Section of this chapter or the MDHHS Outpatient Therapy Database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Requests for PA for all services must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Required medical documentation must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including the appropriate HCPCS procedure codes, must be provided on the form. The form and all documentation must include the beneficiary name and Medicaid identification (ID) number, provider name, address and the provider's NPI number.

PA request forms for all eligible Medicaid beneficiaries must be sent or faxed to the MDHHS Program Review Division. To check the status of a PA request, contact the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for contact information.)

4.1 EMERGENCY PRIOR AUTHORIZATION [CHANGE MADE 4/1/16]

A provider may contact MDHHS to obtain a verbal PA when the physician/physician assistant **(revised 4/1/16)** providing the medical clearance has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain verbal PA, providers may call or fax a request. If the provider faxes a request, the request must state, "verbal prior authorization required." (Refer to the Directory Appendix for contact information.)

If a service is required during MDHHS nonworking hours, providers must contact the Program Review Division the next working day.

The following steps must still be completed before a PA number is issued for billing purposes:

- The verbal authorization date must be entered on the MSA-115.
- The MSA-115 must be submitted to the Program Review Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted along with the PA request.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible when the service was provided.
- The Program Review Division does not receive the completed MSA-115 and required documentation within 30 days of the verbal authorization.
- The required documentation is dated after the date of service.

4.2 Retroactive Prior Authorization

Services provided before PA is requested are not covered unless the beneficiary was not eligible on the date of service (DOS) and a subsequent eligibility determination was made retroactive to the DOS. If the MDHHS record does not show that retroactive eligibility was approved, then the request for retroactive PA is denied.

4.3 Beneficiary Eligibility

Approval of a service on the MSA-115 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible. To assure payment, the provider must verify eligibility for fee-for-service (FFS) Medicaid or CSHCS before initiating services.

4.4 Reimbursement Amounts

Outpatient therapy services are processed through the MDHHS Outpatient Prospective Payment System (OPPS) utilizing Medicare fee screens with an MDHHS reduction factor applied. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized PA request.

4.5 Billing Authorized Services

After authorization is issued, the information (e.g., PA number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the claim form. (Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.)

The copy of the PA request returned to the provider must be retained in the beneficiary's medical record.

SECTION 5 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

5.1 OCCUPATIONAL THERAPY

MDHHS uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled outpatient therapy provider when performed by:

- A licensed occupational therapist (OT);
- A licensed occupational therapy assistant (OTA) under the supervision of an OT (i.e., the OTA's services must follow the evaluation and treatment plan developed by the OT, and the OT must supervise and monitor the OTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising OT; or
- A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OT. All documentation must be reviewed and signed by the supervising OT.

OT is considered an all-inclusive charge and MDHHS does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDHHS expects OTs and OTAs to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

For CSHCS beneficiaries	OT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing care.
For beneficiaries 21 years of age and older	OT is only covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDHHS anticipates OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable. MDHHS does not cover therapy that does not have an impact on the beneficiary's ability to perform age-appropriate tasks.

OT must be skilled (i.e., require the skills, knowledge and education of an OT). MDHHS does not cover interventions provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [PT], family member, or caregiver).

OT may be covered for one or more of the following:	▪ Therapeutic use of occupations*. ▪ Adaptation of environments and processes to enhance functional performance in occupations*. ▪ Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*. ▪ Design, fabrication, application, or training in the use of assistive technology or orthotic devices. ▪ Skilled services that are designed to set up, train, monitor, and modify a maintenance or prevention program to be carried out by family or caregivers. Routine provision of the maintenance/prevention program is not a covered OT service. * Occupations are goal-directed activities that extend over time (i.e., performed repeatedly), are meaningful to the performer, and involve multiple steps or tasks. For example, doing dishes is a repeated task. Buying dishes happens once; therefore, does not extend over time and is not a repeated task.
OT is not covered for the following:	▪ When provided by an independent OT**. ▪ For educational, vocational, or recreational purposes. ▪ If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services). ▪ If therapy requires PA and service is rendered before PA is approved. ▪ If therapy is habilitative. Habilitative treatment includes teaching someone how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. This may include teaching a child normal dressing techniques or cooking skills to an adult who has not performed meal preparation tasks in the past. **Note:** Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services. ▪ If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes. ▪ For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered. ▪ Continuation of therapy that is maintenance in nature. ** An independent OT may enroll in Medicaid to provide Medicare-covered therapy and bill Medicaid only for Medicare coinsurance and/or deductible.

5.1.A. Duplication of Services

Some therapy areas (e.g., dysphagia, assistive technology, hand therapy) may be appropriately addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDHHS does not cover duplication of service (i.e., where two disciplines are working on similar goals/areas). The OT is responsible to communicate

with other therapists and coordinate services. MDHHS requires any related documentation to include coordination of services.

5.1.B. Services to School-aged Beneficiaries

School-aged beneficiaries may be eligible to receive OT through multiple sources. MDHHS expects educational OT to be provided by the school system, and it is not covered by MDHHS or CSHCS. (Example: OT coordination for handwriting, increasing attention span, identifying colors and numbers.)

MDHHS only covers medically necessary OT when provided in the outpatient setting. Coordination between all OT providers must be continuous to ensure a smooth transition between sources.

Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school is considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.

If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file.

5.1.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool would be reimbursed when billed using the HCPCS code describing the covered procedure as long as the service met all Medicaid coverage requirements.

5.1.D. Group Therapy

OT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) patient contact by the therapist.

5.1.E. Serial Casting

Serial casting is a process in which a joint(s) which normally lacks full range of motion, is immobilized with a rigid cast. During this procedure, the affected joint(s) is gradually and repeatedly set in more anatomically correct alignment to improve joint alignment and/or to achieve a decrease in abnormal tone and increased muscle length, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, over a specified period of time. Upon removal of each cast, the limb is stretched and a new cast is applied immediately to hold the limb in place.

Serial casting is a covered Medicaid/CSHCS benefit when performed by or under the direct supervision of a qualified therapist and defined in a treatment plan as medically necessary rehabilitation services for improving range of motion and/or reducing abnormal tone. Either the referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence of any treatment plan, including serial casting. For CSHCS beneficiaries without dual Medicaid eligibility, the service must be directly related to the CSHCS-eligible diagnosis and must be referred by the beneficiary's assigned pediatric subspecialist.

5.1.F. Prescription Requirements [Change Made 4/1/16]

MDHHS requires a prescription from a physician/physician assistant **(revised 4/1/16)** for an OT evaluation and preparation of the treatment plan. The prescription must include beneficiary name, prescribed therapy, and diagnosis(es) or medical conditions(s). MDHHS requires a new prescription if OT is not initiated within 30 days of the prescription date. An evaluation may be provided for the same medical diagnosis without PA twice in a 365-day period with a prescription. PA is required if an evaluation is needed more frequently.

Evaluations	Evaluations must include standardized tests and/or measurable functional baselines. OT evaluations must be completed by an OT and include the following: ▪ Treatment diagnosis and medical diagnosis, if different from the treatment diagnosis(es) (e.g., medical diagnosis of cerebral palsy with contractures being treated); ▪ OT provided previously, including facility/site, dates, duration, and summary of change; ▪ Current therapy being provided to the beneficiary in this or other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
Treatment Plan	The OT treatment plan that results from the evaluation must consist of the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's life goals; ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy; ▪ Anticipated frequency and duration of treatment required to meet short- and long-term goals;

	▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs; ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational); and ▪ Prescribing provider signature verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring specialty physician.
Initiation of Services	OT may be initiated without PA upon completion of the assessment and development of a treatment plan that is reasonable and medically necessary as documented in the patient record. The outpatient setting allows up to 144 units of OT services provided in the initial 12-month treatment period. If therapy is not initiated within 30 days of the prescription date, a new prescription is required. PA is not required for the initial period of skilled therapy for the first 12 consecutive calendar months in the outpatient setting for a new treatment diagnosis or new medical diagnosis if: ▪ The beneficiary remains Medicaid-eligible during the period therapy is provided. ▪ A copy of the signed and dated (within 30 days of initiation of services) prescription for OT is on file in the beneficiary's medical record. Providers may initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability. OT must be provided by the evaluating discipline. (Example: A speech-language pathologist cannot provide treatment under an occupational therapist's evaluation.) Cosigning of evaluations and sharing treatments require PA. MDHHS does not cover the service when Medicare determines that the service is not medically necessary.
Requirements of Continued Therapy	The OT must request PA to continue therapy beyond the initial 12 months. When requesting PA, providers must complete the MSA-115. MDHHS returns a copy of the PA to the provider, and it must be retained in the beneficiary's medical record. Requests to continue active therapy must be supported by the following: ▪ Treatment summary of previous OT period, including measurable progress on each short- and long-term goal. This must include the treating OT's analysis of the therapy provided during the previous month, rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ Progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ Statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate.

	▪ A copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring provider and dated within 30 days prior to initiation of the continued service. ▪ A discharge plan. When a beneficiary completes 144 units of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.
Maintenance/ Monitoring Services	In some cases, the beneficiary does not require active treatment, but the skills of an OT are required for training or monitoring of maintenance programs being carried out by family and/or caregivers, or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is not required for these types of service for up to four times per 12-month period in the outpatient setting. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. The OT must complete an MSA-115 and include the following: ▪ Service summary, including a description of the skilled services being provided (to include the treating OT'S analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period for which PA is being requested. ▪ A comprehensive description of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (medical and educational) if appropriate. ▪ The anticipated discharge plan. ▪ The anticipated frequency and duration of continued maintenance/monitoring.

5.2 PHYSICAL THERAPY

MDHHS uses the terms physical therapy, PT and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled outpatient therapy provider and performed by a licensed Physical Therapist (PT) or an appropriately supervised licensed Physical Therapy Assistant (PTA).

The PT must supervise and monitor the PTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the supervising PT.

PT must be medically necessary and reasonable for the maximum reduction of physical disability and restoration of a beneficiary to his/her best possible functional level.

For CSHCS beneficiaries	PT must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the beneficiary's care. Functional progress must be demonstrated and documented.
For beneficiaries 21 years of age and older	PT is covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant to the beneficiary's life roles despite impairments, activity limitations or participation restrictions.

MDHHS anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to his chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). PT making changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

PT must be skilled (i.e., require the skills, knowledge and education of a PT). MDHHS does not cover interventions provided by another practitioner (e.g., teacher, RN, OT, family member, or caregiver).

MDHHS covers the physical therapist's initial evaluation of the beneficiary's needs and design of the PT program. The program must be appropriate to the beneficiary's capacity, tolerance, treatment objectives, and include the instructions to the beneficiary and support personnel (e.g., aides or nursing personnel) for delivery of the individualized treatment plan. MDHHS covers infrequent reevaluations, if appropriate.

The cost of supplies and equipment used as part of the therapy program is included in the reimbursement for the therapy. MDHHS only covers a clinic room charge in addition to PT if it is unrelated.

PT services may be covered for one or more of the following reasons:

- PT is expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills;
- PT service is diagnostic;
- PT is for a temporary condition that creates decreased mobility and/or function; or
- Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDHHS does not reimburse for routine provision of the maintenance/prevention program.

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility);
- Stretching for improved flexibility;
- Instruction of family or caregivers;
- Modalities to allow gains of function, strength, or mobility; and/or
- Training in the use of orthotic/prosthetic devices.

MDHHS requires a new prescription if PT is not initiated within 30 days of the prescription date.

PT is not covered for the following:

- When PT is provided by an independent PT. (An independent PT may enroll in Medicaid if they provide Medicare-covered therapy and intend to bill Medicaid for Medicare coinsurance and/or deductible only.)
- When PT is for educational, vocational, or recreational purposes.
- If PT services are required to be provided by another public agency (e.g., CMHSP services, school-based services [SBS]).
- If PT requires PA and services are rendered prior to approval.
- If PT is habilitative therapy. Habilitative treatment includes teaching a beneficiary how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously.

  Note: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services.
- If PT is designed to facilitate the normal progression of development without compensatory techniques or processes.
- If PT is a continuation of PT that is maintenance in nature.
- If PT services are provided to meet developmental milestones.
- If PT services are not covered by Medicare as medically necessary.

Only medically necessary PT may be provided in the outpatient setting. Coordination between all PT providers must be continuous to ensure a smooth transition between sources.

5.2.A. Duplication of Services

MDHHS recognizes some areas of therapy (e.g., dysphagia, assistive technology, hand therapy) may also be addressed appropriately by multiple disciplines (e.g., OT, PT, speech therapy) in more than one setting. MDHHS does not cover two disciplines working on similar areas/goals. The PT is responsible for coordinating/communicating with other therapists and providing documentation in the medical record.

5.2.B. Services to School-Aged Beneficiaries

MDHHS recognizes school-aged beneficiaries may be eligible to receive PT through multiple sources. MDHHS expects educational PT (e.g., strengthening to play school sports) to be provided by the school system and is not covered by MDHHS or CSHCS.

Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school is considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.

If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file.

5.2.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool would be reimbursed when billed using the HCPCS code describing the covered procedure as long as the service met all Medicaid coverage requirements.

5.2.D. Group Therapy

PT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) patient contact by the therapist.

5.2.E. Serial Casting

Serial casting is a process in which a joint(s), which normally lacks full range of motion, is immobilized with a rigid cast. During this procedure, the affected joint(s) is gradually and repeatedly set in more anatomically correct alignment to improve joint alignment and/or to achieve a decrease in abnormal tone and increased muscle length, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, over a specified period of time. Upon removal of each cast, the limb is stretched and a new cast is applied immediately to hold the limb in place.

Serial casting is a covered Medicaid/CSHCS benefit when performed by or under the direct supervision of a qualified therapist and defined in a treatment plan as medically necessary rehabilitation services for improving range of motion and/or reducing abnormal tone. Either the referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence of any treatment plan, including serial casting. For CSHCS beneficiaries without dual Medicaid eligibility, the service must be directly related to the CSHCS-eligible diagnosis and must be referred by the beneficiary's assigned pediatric subspecialist. This may be met by the referring provider's dated signature on the PT plan of care.

5.2.F. Prescription Requirements [Change Made 4/1/16]

MDHHS requires a prescription from a physician/physician assistant **(revised 4/1/16)** for a PT evaluation and preparation of the treatment plan. It must include the beneficiary's name, prescribed therapy and diagnosis(es) or medical condition. A new prescription is required if PT is not initiated within 30 days of the prescription date.

Evaluation	MDHHS does not require PA for evaluations. An evaluation is formalized testing in the early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate the disposition of the beneficiary's treatment. Evaluations may be provided for the same diagnosis without PA twice in a 365-day period with a prescription. PA is required for more frequent evaluations. PT evaluations must be completed by a PT, include standardized tests and/or measurable functional baselines, and include: ▪ Treatment and medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with gait treatment); ▪ PT previously provided, facility/site, dates, duration, and summary of change; ▪ Current therapy provided in this or other settings; ▪ Medical history as it relates to current PT; ▪ Beneficiary's current functional status (i.e., functional baseline); ▪ Standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory, visual, and comprehensive).
Treatment Plan	MDHHS requires a PT treatment plan immediately follow the evaluation. The treatment plan must include: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function and/or mobility; ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from therapy; ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals; ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs; ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational); and ▪ Prescribing provider signature verifying acceptance of the treatment plan. CSHCS beneficiaries must have a treatment plan signed by the referring specialty physician.

Initiation of Services	MDHHS requires PT be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA. For the initial period, PT may be provided up to 144 units in 12 months in the outpatient setting. PT must be provided by the evaluating discipline (e.g., OT cannot provide treatment under a PT's evaluation). Cosigning evaluations and sharing treatment requires PA. MDHHS does not require PA for the initial period of skilled therapy the first 12 consecutive calendar months in the outpatient setting for a new treatment diagnosis or new medical diagnosis if: ▪ Beneficiary remains Medicaid-eligible during the period therapy is provided; and ▪ A copy of the signed and dated (within 30 days of initiation of services) prescription for PT is on file in the medical record. MDHHS does not require PA when PT services are initiated when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.
Continued Active Treatment	MDHHS requires providers to obtain PA to continue PT beyond the initial 12 months. Providers must complete the MSA-115. MDHHS returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record. Requests to continue Active Therapy must contain: ▪ A treatment summary of the previous period of PT, including measurable progress on each short-term and long-term goal. This should include the treating PT's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of PT. ▪ Documentation related to the period no more than 30 days prior to that time period for which PA is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A copy of the prescription, hand-signed by the referring provider and dated within 30 days prior to initiation of continued service, must be provided for each request. ▪ A discharge plan. When a beneficiary completes 144 units of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.

Maintenance / Monitoring Services	MDHHS recognizes that, in some cases, a beneficiary does not require active treatment but the skills of a PT are necessary for training, modifying, or monitoring of maintenance programs being performed by family and/or caregivers. PA is not required for these types of services for up to four times in 12 months for the outpatient setting. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required for up to 90 consecutive calendar days in the outpatient setting. The PT must complete an MSA-115 and include: ▪ A service summary, including a description of the skilled services being provided (including the treatment PT's analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period for which PA is requested. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ A discharge plan.

5.2.G. Discharge Summary

MDHHS requires the PT to document a discharge summary to identify the completion of PT services and the discharge status. This must include:

- Dates of service (i.e., initial and discharge dates);
- Description of services provided;
- Functional status related to treatment areas/goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

5.3 Speech Therapy

The terms speech therapy, speech-language pathology, speech-language therapy, and therapy are used to mean speech and language rehabilitation services and speech-language therapy.

MDHHS covers speech-language therapy provided in the outpatient setting. MDHHS only reimburses services for speech-language therapy when provided by:

- A speech-language pathologist (SLP) with a current license.

- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY]) or having completed all requirements but has not obtained a license. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current license. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

MDHHS expects that all SLPs will utilize the most ethically appropriate therapy within their scope of practice as defined by Michigan law and/or the appropriate national professional association.

Speech therapy must relate to a medical diagnosis, and is limited to services for:

- Articulation
- Language
- Rhythm
- Swallowing
- Training in the use of an speech-generating device
- Training in the use of an oral-pharyngeal prosthesis
- Voice

For CSHCS beneficiaries (i.e., those not enrolled in Medicaid; only enrolled with CSHCS), therapy must be directly related to the CSHCS-eligible diagnosis(es) and prescribed by the specialty physician who is overseeing the care of the beneficiary.

Therapy must be reasonable, medically necessary and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time (i.e., when treatment is due to a recent change in medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status without therapy).

Speech therapy services must be skilled (i.e., require the skills, knowledge and education of a licensed SLP to assess the beneficiary for deficits, develop a treatment program and provide therapy). Interventions that could be provided by another practitioner (e.g., teacher, registered nurse [RN], licensed physical therapist [PT], licensed occupational therapist [OT], family member, or caregiver) would not be reimbursed as speech therapy by MDHHS.

Therapy is **not** covered:

- When provided by an independent SLP.
- For educational, vocational, social/emotional, or recreational purposes.
- If services are required to be provided by another public agency (e.g., PIHP/CMHSP provider, SBS).
- When intended to improve communication skills beyond premorbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status).

- If it requires PA but is rendered before PA is approved.
- If it is habilitative. Habilitative treatment includes teaching someone communication skills for the first time without compensatory techniques or processes. This may include syntax or semantics (which are developmental) or articulation errors that are within the normal developmental process.

  Note: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services.
- If it is designed to facilitate the normal progression of development without compensatory techniques or processes.
- If continuation is maintenance in nature.
- If provided to meet developmental milestones.
- If Medicare does not consider the service medically necessary.

5.3.A. Duplication of Services

Some areas (e.g., dysphagia, assistive technology) may appropriately be addressed by more than one discipline (e.g., OT, PT, speech therapy) in more than one setting. MDHHS does not cover duplication of services, i.e., where two disciplines are working on similar areas/goals. It is the treating therapist's responsibility to communicate with other practitioners, coordinate services, and document this in his reports.

5.3.B. Services to School-Aged Beneficiaries

School-aged beneficiaries may be eligible to receive speech-language therapy through multiple sources. Educational speech is expected to be provided by the school system and is not covered by MDHHS or CSHCS. Examples of educational speech include enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, and identifying colors and numbers. Only medically necessary therapy may be provided in the outpatient setting. Coordination between all speech therapy providers should be continuous to ensure a smooth transition between sources.

Outpatient therapy provided to school-aged children during the summer months in order to maintain the therapy services provided in the school are considered a continuation of therapy services when there is no change in beneficiary diagnosis or function. Prior authorization is required before initiating a continuation of therapy.

If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file.

5.3.C. Referral for Speech Therapy [Change Made 4/1/16]

A referral from a physician/physician assistant **(revised 4/1/16)** is required for Medicaid coverage of speech therapy. The referral for speech therapy must be documented in the beneficiary's medical record and must include the following:

- Beneficiary name;
- Beneficiary date of birth;
- Diagnosis for referral (for CSHCS beneficiaries, this must be the CSHCS-qualifying diagnosis); and
- A statement indicating that the beneficiary is being referred for speech therapy.

If therapy is not initiated within 30 days of the referral date, a new referral is required. A new referral must be made at least annually for continuing treatment lasting longer than 12 months. Whenever a beneficiary is discharged from speech therapy treatment, a new referral must be made and an evaluation and treatment plan must be completed before therapy may resume.

A copy of the referral must be attached to all PA requests for speech therapy.

Evaluation	Does not require PA. This is formalized testing in early stages of a beneficiary's treatment program followed by periodic testing and reports to indicate measurable functional change resulting from the beneficiary's treatment. These may be provided for the same diagnosis without PA twice in a 365-day period with a referral. If an evaluation is needed more frequently, PA is required. Evaluations must include standardized tests and/or measurable functional baselines. The speech-language evaluation must be completed by an SLP and include: ▪ The disorder and the medical diagnosis, if different than the treatment diagnosis (e.g., medical diagnosis of cerebral vascular accident with dysphasia as the speech disorder being treated). ▪ Speech therapy provided previously, including facility/site, dates, duration and summary of measurable change. ▪ Current rehabilitation services being provided to the beneficiary in this or other settings. ▪ Medical history as it relates to the current course of therapy. ▪ Beneficiary's current functional communication status (functional baseline). ▪ Standardized and other evaluation tools used to establish the baseline and to document progress. ▪ Assessment of the beneficiary's functional communication skill level, which must be measurable. ▪ Medical, physical, intellectual deficits that could interfere with the beneficiary's improvement in therapy.

	Evaluations must include, but are not limited to: ▪ Articulation – standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication and a medical diagnosis. ▪ Language – standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm – standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication and a medical diagnosis. ▪ Swallowing – copy of a video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment and a standardized cognitive assessment. ▪ Voice – copy of the referring provider's medical assessment of the beneficiary's voice mechanism and medical diagnosis.
Treatment Plan	Is the immediate result of the evaluation and consists of: ▪ Time-related short-term goals that are measurable, functional and significant to the beneficiary's communication needs. ▪ Long-term goals that identify specific functional maximum reasonable achievement, which serve as indicators for discharge from speech-language therapy services. ▪ Anticipated frequency and duration of treatment required to meet short-term and long-term goals. ▪ Plan for discharge from service, including the development of follow-up activities/maintenance programs. ▪ Statement detailing coordination of services with other therapies (e.g., medical and educational). ▪ Documentation of acceptance by referring provider of stated treatment plan. The treatment plan must be accepted by the referring specialty physician for CSHCS beneficiaries. Referring provider acceptance of the speech therapy treatment plan must be documented by one of the following processes: ▪ Phone call to the referring provider (document date and time). ▪ Copy of the plan to the referring provider (document date sent and method sent). ▪ Referring provider's sign-off on the treatment plan. Documentation of the referring provider's acceptance of the speech therapy treatment plan must be placed in the beneficiary's medical record.

Initiation of Services	Therapy may only be initiated upon completion of an evaluation and development of a treatment plan that supports the reasonableness and medical necessity of therapy without PA. For the initial period, speech may be provided up to a maximum of 36 times during the 12 consecutive calendar months in the outpatient setting. If therapy is not initiated within 30 days of the referral, a new referral is required. No more than one encounter for individual speech therapy and one encounter for group speech therapy may be billed on the same date of service. Each encounter must represent a minimum of 25 minutes of therapy provided on the date of service. Therapy must be provided by the evaluating discipline. (An OT cannot provide treatment under a SLP's evaluation.) Cosigning of evaluations and sharing treatments require PA. PA is not required for the first 12 consecutive calendar months in the outpatient setting for a new treatment diagnosis or new medical diagnosis if: ▪ The beneficiary remains Medicaid-eligible and enrolled during the period services are provided; and ▪ A copy of the referring provider's signed and dated (within 30 days of initiation of services) referral for speech-language therapy is on file in the beneficiary's medical record. Providers may also initiate services without PA when there is a change in the treatment diagnosis and/or medical diagnosis resulting in decreased functional ability.
Continued Active Treatment	MDHHS requires providers to request PA for therapy beyond the initial 12 months. The SLP must complete the MSA-115. MDHHS returns a copy of the PA to the provider after processing the request. The PA must be retained in the beneficiary's medical record. Requests to continue active treatment must be accompanied by: ▪ Treatment summary of the previous service period, including measurable progress on each short-term and long-term goal. This must include the treating SLP's analysis of the therapy provided during the previous month, the rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes. ▪ A progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy. ▪ Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested. ▪ A statement of the beneficiary's treatment response, including factors that have affected progress during this interim. ▪ A statement detailing coordination of services with other therapies (e.g., medical and educational), if appropriate. ▪ Anticipated frequency and duration of maintenance/monitoring. ▪ A discharge plan.

	▪ A copy of the referral, hand-signed by the referring provider and dated within 30 days prior to initiation of continued service, must be provided with each request. When a beneficiary completes 36 visits of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.
Maintenance / Monitoring Services	A beneficiary may not require active treatment, but the skills of an SLP are required for training or monitoring of maintenance programs that are being carried out by a family member and/or caregiver. In the outpatient setting, these types of service may be provided without PA up to four times per 12-month period. If continued maintenance therapy is needed after the initial period specified in the paragraph above, PA is required. The SLP must complete the MSA-115 and include: ▪ A service summary, including a description of the skilled services being provided. This should include the treating SLP's analysis of the rate of progress and justification for any change in treatment plan. Documentation must relate to the period immediately prior to that time period for which PA is requested and can cover up to three months. ▪ A comprehensive description or copy of the maintenance/activity plan. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim. ▪ A statement detailing coordination of service with other therapies (e.g., medical and educational) if appropriate. ▪ The anticipated frequency and duration of continued maintenance/monitoring. ▪ A discharge plan.

5.3.D. DISCHARGE SUMMARY

When the beneficiary is discharged from therapy services, the SLP must maintain a discharge summary on file as a mechanism for identifying completion of services and beneficiary status at discharge. The discharge summary should include:

- Dates of service (initial and discharge);
- Description of services provided;
- Functional status related to treatment areas/goals at discharge;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- Description or copy of follow-up or maintenance program put into place, if appropriate;
- Identification of adaptive equipment provided and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

5.3.E. Evaluations and Follow-Up for Speech-Generating Devices

Up to six hours of face-to-face time spent by the SLP evaluating or re-evaluating a beneficiary to determine the need for a specified Speech-Generating Device (SGD) may be billed once in three years without PA. The results of this evaluation must be shared with the prescribing provider.

SGD follow-up care that requires the skills of an SLP, as is identified by the evaluating SLP, may be billed up to two times per year before PA is required. This service includes training or set-up services (including programming and modification) that are not provided by the SGD vendor.

An SLP evaluation for the use and/or fitting of a voice prosthetic device to supplement oral speech is only to be billed if the evaluation was done to determine the need for an electro-larynx. This service may be billed once in three years without PA.

PA is required for all SGDs. MSA-1653-B must be submitted for all original and replacement/upgrade SGDs. In addition, specific SGD documentation, described in the table below, must be included with the MSA-1653-B.

	Original Device	Replacements and Upgrades
Demographic Information		
Beneficiary Name	X	X
Beneficiary Medicaid Identification Number	X	X
Referring Provider	X	X
Referring Physician Specialty	X	X
Medical Diagnosis	X	X
Medical Diagnosis Onset Date	X	X
SLP Evaluation		
SLP Name and Credentials	X	X
Current Level of Therapy or Support Services (Include Frequency and Duration)	X	
Cognitive Level (Include Assessments and Testing Used, Results, Evaluator, Date)	X	X
Communication (Include Assessment Tools and Testing, Evaluator, Date)	X	X
▪ Both Expressive and Receptive Testing Results	X	X

	Original Device	Replacements and Upgrades
▪ Developmental Age in Years	X	X
▪ Prognosis for Functional Oral Speech	X	X
Current Communication Skills (With and Without SGD)	X	
Oral Examination (Include Test Results, Evaluator, Date)	X	
Status of the Patient	X	
▪ Current Hearing Status	X	
▪ Current Vision Status	X	
▪ Current Educational Status	X	
▪ Current Employment Status	X	
List of Interactive Settings in Which SGD Will Be Used	X	
Daily Functional Communication Needs	X	
▪ To enable the meeting of physical needs	X	
▪ To carry out family and community interactions	X	
▪ To obtain necessary medical care and participate in medical decision making	X	
Treatment Plan, which includes:	X	
▪ Follow-Up Training in Use of the Device	X	
▪ Communication Goals	X	
▪ Timeline	X	
▪ Acknowledgement of Caregiver Participation and Support	X	
Reassessment Report		X
Assessment and Effectiveness of Currently Used Device		X
Purchaser of Currently Used Device		X
OT/PT Evaluation/Report		
OT/PT Name and Credentials	X	X
Functional Ambulation/Mobility	X	
SGD Positioning Requirements	X	

	Original Device	Replacements and Upgrades
Description of Physical Change Since Last Device Recommendation		X
Patient Ability to Directly Access Currently Used SGD		X
Experience with Communication Technology		
Chronological listing by Date, Device and Experience	X	X
Device Trials and Outcomes		
Evaluator Name(s) and Credentials	X	X
Evaluation of Experience by Device (Include With and Without Modifications and Accommodations)	X	X
Device Recommendation and Reasoning		
Make and Model of Recommended Device	X	X
Reasoning for Recommendation Based on Evaluations, Trials and Outcomes	X	X
Functional Benefit of Upgrade		X

5.3.F. SUPPLIES AND EQUIPMENT

The cost of supplies and equipment used as part of the speech therapy is included in the reimbursement for the therapy services.

Exhibit 15

Life | Fri Mar 13, 2015 2:32pm EDT

Related: HEALTH

Transgender people face discrimination in healthcare

BY ANDREW M. SEAMAN

(Reuters Health) - Many transgender men face discrimination in U.S. healthcare settings, according to a new study.

About 42 percent of female-to-male transgender adults reported verbal harassment, physical assault or denial of equal treatment in a doctor's office or hospital, the researchers report.

"Over a third of participants in the study were blatantly mistreated when they tried to get healthcare," said Deirdre Shires of Wayne State University in Detroit.

She and co-author Kim Jaffee write in the journal Health and Social Work that past research found transgender people often face discrimination or harassment in various areas of life, including healthcare.

The little research that does exists tends to focus on male-to-female transgender people, they write. For this study, they focused instead on female-to-male people.

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Their data came from a 2008-2009 survey of 1,711 female-to-male transgender people from the U.S. and its territories. Most were ages 25 to 44.

Over three quarters lived full-time as their nonbirth gender. A similar proportion reported some type of medical gender transition.

Asked about experiences in doctors' offices or hospitals, 28 percent said they'd been denied equal treatment, about 32 percent reported verbal harassment, and about 1 percent reported physical assaults.

Shires emphasized that it's not clear who discriminated against the participants. Additionally, she said, the results may not apply to the entire transgender community.

One researcher not involved with the study told Reuters Health by email that she wasn't surprised by the findings.

If anything, the study may underestimate the problem, "because the sample was skewed towards young, white, college-educated people with jobs and private health insurance," said Dr. Laura Erickson-Schroth, a psychiatrist at New York University in New York City.

"If 42 percent of that group is reporting discrimination, the number may be even higher for others," said Erickson-Schroth, who is the editor of the book Trans Bodies, Trans Selves.

A next step, Shires said, would be to find ways to improve healthcare experiences for transgender people.

For example, she said, it's still difficult for many transgender people to identify themselves on medical forms as anything other than male or female.

"At every point in the healthcare system if you're transgender there is no place for you," she said. "There is no way to identify yourself and it's a vicious cycle."

Erickson-Schroth pointed out that 65 survey participants said they never accessed care at a doctor's office or hospital.

"Though this is a small number, I can't help but wonder if they avoided care completely because they feared harassment or discrimination," she said.

While the medical community is beginning to make changes to improve care for transgender people, Erickson-Schroth said progress is slow.

"The most important step the medical community needs to take toward ending discrimination against transgender people in clinical settings is educating providers," she said.

Previous research found that medical schools only spend an average of five hours on lesbian, gay, bisexual and transgender issues. Some schools never discuss the topic at all.

The education of healthcare providers should start in school, said Erickson-Schroth, but shouldn't end there.

"It should happen in hospitals and clinics as well," she said.

The World Professional Association for Transgender Health (WPATH) and GLMA: Health Professionals Advancing LGBT Equality have searchable databases of providers with an interest or expertise in working with transgender people, Erickson-Schroth said.

Also, she pointed out, people can often report discrimination to clinics and hospitals, or they can contact organizations such as the National Center for Transgender Equality or the Transgender Law Center.

SOURCE: bit.ly/1x1ube1 Health and Social Work, online March 3, 2015.

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