



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

DEC 20 2007

The Honorable Ulysses Currie  
Chairman, Senate Budget and Taxation Committee  
Miller Senate Office Building, 3 West Wing  
Annapolis, Maryland 21401-1991

The Honorable Norman H. Conway  
Chairman, House Appropriations Committee  
House Office Building, Room 121  
Annapolis, Maryland 21401-1991

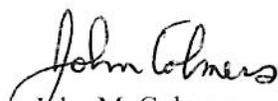
**RE: 2007\_JCR\_p127\_DHMH/MHCC\_Report on Habilitative Services**

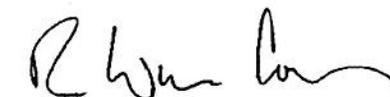
Dear Chairmen Currie and Conway:

The Department of Health and Mental Hygiene (DHMH) and the Maryland Health Care Commission (MHCC) are pleased to submit our joint report entitled *Habilitative Services in Maryland*.

The Joint Chairmen's Report for the 2007 session of the General Assembly requests that DHMH and the MHCC examine the provision of habilitative services in the State. The Department was to examine how habilitative services are provided through the Maryland Medical Assistance Program to individuals who are 19 and older and provide an estimate of how much these services cost the State annually. The Commission's charge was to examine how habilitative services are currently provided in the private insurance market, whether the Maryland Health Insurance Plan might serve as an alternative to the private insurance market to cover these types of services, and how much it would cost the private market to extend the State's current insurance mandate on habilitative services to individuals who are 19 or older.

Sincerely,

  
John M. Colmers  
Secretary, DHMH

  
Rex W. Cowdry, M.D.  
Executive Director, MHCC

Enclosure

cc: Simon G. Powell, Department of Legislative Services  
Cathy Kramer, Department of Legislative Services  
Anne Hubbard, DHMH

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Habilitative Services in Maryland  
A Report to the Senate Budget and Taxation Committee and the House  
Committee on Appropriations  
As required in the 2007 Joint Chairmen's Report

As required in the April 2007 Joint Chairmen's Report (page 127), the Maryland Health Care Commission (MHCC) has prepared a report on habilitative services in Maryland. Specifically, the Commission's charge was to address the following three issues:

- How are habilitative services currently provided in the private insurance market?
- How much would it cost the private market to extend the state's current insurance mandate on habilitative services to individuals 19 or older?
- Could the Maryland Health Insurance Program (MHIP) serve as an alternative to the private insurance market to cover these types of services?

The Commission engaged its consulting actuary, Mercer, to research these questions. Mercer based key parameters of its analysis on the interpretation of a mandate proposed in 2007 (which later failed) that addressed habilitative services for individuals. Mercer recognizes that substantial differences in interpretation of the proposed mandate's scope could yield significantly different results.

As presented, HB 1192/SB 944 (2007) would have required a health insurer, nonprofit health service plan, Medicaid managed care organization or HMO (further referred to as a "carrier") to provide coverage for habilitative services for persons of all ages who suffered "congenital or genetic birth defects" including but not limited to autism spectrum disorder (ASD) or cerebral palsy (CP). Guidance from the Maryland Department of Legislative Services (DLS) indicated that the intent of this proposed mandate was *to limit services to individuals who suffered developmental disabilities resulting from these conditions*. As defined in the proposed legislation, habilitative services are occupational, physical and speech therapy (OT, PT and ST) treatments that enhance the functioning ability of a person with the prescribed conditions. Mercer used this interpretation and definition for its analysis.

The state of Maryland currently mandates coverage of these services for children who are developmentally disabled by birth defects, ASD or CP through the age of 18 years. This proposed mandate would extend coverage to affected persons between 19 and 64 years of age.

- *How are habilitative services currently provided in the private insurance market?*

As part of the analysis, Mercer surveyed several carriers in Maryland. The wording of the proposed mandate concerns insurers. They worry that as currently drafted it may support an interpretation encompassing much farther-reaching services and may not limit such services to only those adults with developmental disabilities. Additionally, the definitions of “congenital or genetic birth defects” are proving to be more fluid and expansive as science continues to identify genes and mutations responsible for many conditions that may not manifest immediately at birth. This scientific reality significantly complicates the potential scope of the proposed mandate.

Insurance policies traditionally provide benefits for the medically necessary treatment of diseases and injuries. Opinions differ as to whether birth or congenital defects, including ASD and CP, are diseases and/or injuries in the traditional sense. There also are some questions regarding the necessity and efficacy of particular treatments for individuals who have passed age-defined developmental benchmarks. Finally, some of the proposed services may be classified as “maintenance” or custodial care, which historically has been excluded by insurance companies’ medical policies. Custodial care is provided under long-term care policies, an entirely different type of policy.

The extent to which insurance coverage is available depends somewhat on the inclusion of the word “habilitative” in the legislation. For most private insurers, “habilitative” refers to the development of age-appropriate skills that were never present due to genetic or birth defects.

Private insurance requires that services be medically necessary for the treatment of an illness or injury. Thus, insurance would cover rehabilitative services to the extent that such services result in continued and demonstrated improvement to recover skills that were lost due to an illness or injury. When these services no longer result in continued improvement, coverage is generally no longer available. In a previous study conducted by Mercer for the evaluation of habilitative services for children, it was found that about 60% of insurance companies provided these services in the absence of any mandate to enable, to some extent, the child to acquire as many age-appropriate skills as possible. Treatment plans would be required with periodic assessments to determine whether the therapies were working. If and when the therapies were no longer effective (and, therefore, no longer medically necessary) and/or continued treatment would no longer “enhance” the child’s ability to function, treatment would cease to be covered, as the services would then represent custodial care. Because of the requirement that services be medically necessary and not custodial in nature, private insurance coverage for habilitative services for people 19 to 64 with developmental disabilities from birth defects, ASD or CP is generally not available.

Of four major private insurers surveyed in Maryland, only one specifically provides habilitative services for developmentally disabled persons beyond the mandated limiting age, and that is in only about 5% of the insurer’s plan offerings. Additional data

regarding the enrollment and costs associated with such plans were not available. One insurer who does not differentiate between habilitative and rehabilitative services excludes OT and ST when the primary or only diagnosis for a member is mental retardation, perceptual handicaps, or developmental delay. This same insurer, however, will sometimes provide therapy when the primary diagnosis is CP.

One carrier indicated that long-term rehabilitative therapy is not a covered benefit. If significant improvement is not achievable within a two-month period, benefits for rehabilitative services will be denied.

In some cases, adults with developmental disabilities resulting from birth defects, ASD or CP, can receive a limited number of therapy treatments under the private insurer's umbrella of rehabilitative services. The services would be rendered in accordance with the effect of enhancing functional ability not in an effort to meet the habilitative criteria. If the member can be treated on an outpatient, short-term basis with expected, achievable improvement, the services are covered up to the treatment limits irrespective of diagnosis. While the proposed legislation did not limit the number of treatments an individual may receive, private plans do require a limit – usually by number of visits per condition per year. It is difficult to say what portion of the population targeted by this bill might receive like services under rehabilitation, but it should be assumed that it would be a subset of members and treatments covered.

While some data (case studies, small-scale trials, surveys, etc.) suggest that adults with developmental disabilities from birth defects, ASD and CP benefit from therapies that enhance their abilities for self-care, employment and quality of life, there is a lack of large-scale studies to support the conclusion that these services are necessary health care treatments.

Statistics for incidence and costs of habilitative services for adults disabled by birth defects, ASD and CP are not readily available.

One study estimated the incremental lifetime per capita costs of autism to be \$3.2 million (all statistics in 2003 dollars). Lost productivity and adult care are the largest components of costs. While the typical American spends about \$317,000 over his or her lifetime in direct medical costs, incurring 60% of those costs after age 65, a person with autism will incur an additional \$307,000 in direct medical costs, incurring 60% of these costs after age 21. Direct medical costs average about \$1,500 per year. These are incremental costs above and beyond the costs a normal adult would expect to incur.<sup>1</sup> Mercer assumes that a significant portion of these costs (50%) is attributable to therapies that would not be required for a person without this diagnosis, or \$750 per adult diagnosed with autism per year in 2003 dollars. If we assume a medical trend of 10% per year, this would equate to approximately \$1,100 per year in 2007 dollars.

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<sup>1</sup> Ganz, Michael L., PhD. "The Lifetime Distribution of the Incremental Societal Costs of Autism." *Arch Pediatrics Adolescent Medicine*, Vol. 161, Apr 2007. [www.archpediatrics.com](http://www.archpediatrics.com)

Testimony given by an activist in support of the failed mandate indicated that the annual therapy costs for him and his brother, who both have cerebral palsy, exceed \$17,000.<sup>2</sup> This equates to \$8,500 per individual per year. Based on the statistics inferred by his testimony, therapy sessions cost \$80 to \$90, and individuals would attend 100 sessions per year, or approximately two sessions per week.

Federal Medicaid defines “habilitative services” as those “designed to assist individuals in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.”<sup>3</sup>

Statistics specific to the costs of habilitative services for any Medicaid program are not readily available. However, some states currently have Home and Community-Based Services (HCBS) Waiver Programs with Medicaid, whose waivers are exclusively for adults and include habilitative services as part of the total services available. Three such states are Colorado, Oklahoma and Oregon.<sup>4</sup>

State	Annual Cost Per Mentally Disabled Adult Per Year	Fiscal Year	Annual Cap on Benefits
Colorado	\$16,383	2007	\$35,000
Oklahoma	\$13,167	2005	\$18,540
Oregon	\$8,675	2007	\$20,000

If we assume that Medicaid reimbursement levels are approximately 50% of the levels typically paid by commercial carriers and that habilitative services represent approximately 10% of all costs for this population, and adjust for the differences in costs associated with these states and Maryland, the average annual cost per adult ranges from \$2,100 to \$3,700 and averages \$3,100. Selected information on Maryland’s HCBS services is presented later in the report.

<sup>2</sup> Maryland Politics Watch. “District 18 Activist Aaron Kaufmann Testifies for Health Care.” March 23, 2007. <http://www.maryland-politics.blogspot.com/2007/03/district-18-activist-aaron-kaufmann.html>

<sup>3</sup> Centers for Medicare and Medicaid Services, (42 CFR §1915(c)), <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=413a73fc1cf054156badc5da8e8429b5&rgn=div5&view=text&node=42:4.0.1.1.9&idno=42>.

<sup>4</sup> Smith, Gary, et.al. "Gauging the Use of HCBS Support Waivers for People with Intellectual and Developmental Disabilities: Profiles of State Support Waivers." Human Services Research Institute. October 2006. <http://www.aspe.hhs.gov/daltcp/reports/2006/gauging.pdf>.

- *To what extent is the service covered by self-funded employers in the state who employ at least 500 employees?*

Mercer's survey of insurance companies participating in the self-funded market in Maryland indicated that most self-funded employers in the state do not follow Maryland's mandates. While the insurance companies did not provide specific data, they indicated it would be unlikely for self-funded plans to modify their current definitions.

Mercer estimates that only a very small number of self-funded employers with at least 500 employees provide habilitative services to those aged 19 to 64 with developmental disabilities resulting from birth defects, ASD, or CP. Only one of the major Maryland insurers even provides plans that cover habilitative services for adults, and these account for only 5% of their plan offerings.

- *How much would it cost the private market to extend the state's current insurance mandate on habilitative services to individuals 19 or older?*

Mercer surveyed four major carriers in Maryland to obtain information on current practices regarding habilitative services. Mercer also asked these companies to provide financial estimates as to how rates would be affected by the extension of habilitative services to adults.

As indicated previously, there is concern regarding the existing language contained in the current bill. Here are some examples of the responses received.

#### *Carrier A*

"It is very difficult to anticipate premium increases, but, in addition to costs of care, we anticipate programming and operational changes costing in the 10's of millions of dollars to include:

- Single benefit carve-outs within a product are difficult to administer and require costly system modifications – there could be a need to segregate these claims and process manually.
- The systems changes and administrative burden in terms of service training, enrollment and account implementation, medical management tracking, audit, etc. would run in the multi-millions to accommodate this type of policy (covering one specific medical condition for the life of the patient).
- New/unique identification cards would need to be created and generated to clearly identify that the individual has coverage limited to habilitative services only.
- Contract language and eligibility schedules would need to be created, filed and approved by the MIA.
- Enrollment issues – termination dates are automatically loaded when enrollment is processed.

- What happens when the parents are Medicare beneficiaries and they have individual Medicare Supplemental policies?
- What if the child is married, has other health coverage, resides in another state, etc.?
- How would we deal with retroactivity and re-adding individuals to parent's policies?
- There are potential IRS tax implications to members and employer groups."

*Carrier B*

This company's actuaries indicated that there was no way to estimate the increase in premium based on the language in the proposed mandate. With no defined scope of services, and with the wide variety of possible conditions and treatments, they felt they could not begin to quantify that information.

*Carrier C*

Company C's response was: "Long term rehabilitative therapy is not a covered benefit. If significant improvement is not achievable within a 2-month period, benefits for rehabilitative services will be denied.....This has the potential to be a significant benefit modification. Removing age limits would require a rate increase of between \$4.00 and \$8.00 pmpm." Our calculations indicate that this equates to 2% to 3% of premium.

*Carrier D*

This is the only carrier that did not express concerns regarding the claim cost and/or administrative complexities regarding the language in the failed mandate. This carrier estimated that premiums would increase by 0.7%.

In its Fiscal and Policy Note, the Maryland Department of Legislative Services (DLS) estimated that extending habilitative services to individuals with congenital or genetic birth defects regardless of age would increase the state plan expenditures by 2%. This translates into an increase of about \$11 million in Fiscal Year 2008 (FY2008) to almost \$16 million in FY 2012.<sup>5</sup>

Because of the very limited amount of data available on the use and cost of habilitative services for adults who suffer from developmental disabilities associated with congenital or genetic birth defects, Mercer is providing a range of estimates for the cost of this proposed mandate, outlined as Approach A and Approach B below.

All of these estimates assume that this mandate will impact 1% to 2% of the membership of the insured population.

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<sup>5</sup> Maryland Department of Legislative Services, Health Insurance – Habilitative Services – Covered Persons, HB 1192, 2007. [http://www.mlis.state.md.us/2007RS/fnotes/bil\\_0002/hb1192.pdf](http://www.mlis.state.md.us/2007RS/fnotes/bil_0002/hb1192.pdf).

Since these benefits are not generally covered under existing policies, Mercer assumes that the full cost and the marginal cost of providing these services would be the same.

Most policies have some type of cost-sharing provisions. Therefore, Mercer assumes that insuring entities would be responsible for 90% of the total costs.

Approach A assumes that, based on previously-referenced testimony, the average cost for therapy is between \$80 and \$90 per session. It is typical for policies to have limits on the number of therapy sessions that are eligible for payments within a year. These limits typically range from 30 to 100 sessions.

Approach B starts with the Medicaid experience in the three states that provide habilitative services for adults with developmental disabilities, adjusts for the differences in costs among these states and Maryland, adjusts for differences in reimbursement levels for Medicaid and commercial payers, and applies the range in prevalence.

Please note that the estimates in the following table only reflect the impact on claims costs. These estimates do *not* reflect any administrative costs associated with implementing this change. Based on the comments from the carriers, administrative costs could be very significant.

	Approach A		Approach B	
	Low	High	Low	High
Estimated cost of mandated benefits as a percentage of average cost per Maryland small employer policy	0.8%	5.1%	0.9%	1.9%
Estimated cost as a percentage of average wage	0.1%	0.4%	0.1%	0.2%
Estimated annual per-employee cost of mandated benefits for Maryland's small employer group policies	\$39	\$261	\$50	\$100

It is important to re-emphasize that these estimates are based on the interpretation of the meaning of "habilitative services." They also depend on the population eligible for these services. Again, Mercer based the analysis on guidance from DLS who indicated that the intent of this proposed mandate was to limit the analysis to services provided to individuals who suffered developmental disabilities resulting from the conditions outlined earlier in the report. Moreover, as defined in the proposed legislation, habilitative services are occupational, physical and speech therapy (OT, PT and ST) treatments that enhance the functioning ability of a person with the prescribed conditions. If, for any

reason, this interpretation is not correct or, if the population to whom these services would be extended is significantly different from that assumed, then these estimates would not be appropriate.

- *Could the Maryland Health Insurance Program (MHIP) serve as an alternative to the private insurance market to cover these types of services?*

Mercer interviewed a board member of the Maryland Health Insurance Plan (MHIP), the high-risk pool for individuals who cannot pass health underwriting in the nongroup market.<sup>6</sup> MHIP currently follows the mandates that have been adopted by MHCC for the Comprehensive Standard Health Benefit Plan (CSHBP) for the small group market. The CSHBP currently provides habilitative services for children with developmental disabilities attributable to congenital or birth defects. The CSHBP and MHIP generally adopt commercial insurers' interpretations of medically necessary services. Traditionally, these services for adults have not been viewed as insurable but have been defined as custodial-type care. MHIP probably would not extend habilitative coverage to adults.

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<sup>6</sup> Conversation with Dr. Rex Cowdry, board member of MHIP.

### *DHMH Analysis of Maryland Medicaid*

Maryland Medicaid covers OT, PT and ST. These services are commonly provided as adjunct therapies for rehabilitation in a hospital outpatient setting. In addition, home and community based services (HCBS) waivers cover certain habilitative services in the community for individuals who meet an institutional level of care. HCBS waivers are capped, so waiver services are not available to all Medicaid recipients.

Addendum B presents an analysis of Maryland Medicaid allowed costs on OT, PT, ST, and two habilitative services (day habilitation and supported employment) for adults with certain diagnoses. Day habilitation and supported employment are provided by Medicaid only through home and community based services waivers. The analysis excludes individuals dually eligible for Medicare and Medicaid. There may be some dual eligibles getting HCBS waiver services who do not show up in the analysis. The total amount for the cohort was over \$4.1 million.

Cost data are also available by program from Maryland's two HCBS waivers for individuals with developmental disabilities. For the New Directions waiver, FY 2007 average annual enrollee costs were approximately \$47,300. Costs for the Community Pathways waiver can be broken out by major service types. Average annual user costs for FY 2007 were \$65,000 for residential services, \$15,300 for day services, \$13,300 for supported employment services, and \$34,900 for community supported living arrangement services.

## Addendum A

Mercer also assessed the medical, social and financial impacts of the habilitative services mandate, in addition to the three questions required to be addressed in the Joint Chairmen's Report.

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*The medical, social and financial impacts of this proposal follow.*

### Medical Impact

- *To what extent is the service generally recognized by the medical community as being effective and efficacious in the treatment of patients?*

Both the American Occupational Therapy Association (AOTA) and the American Speech-Language Hearing Association (ASHA) have position statements and practice guidelines endorsing their therapies for the target population.

AOTA's 2005 "Statement: The Scope of Occupational Therapy Services for Individuals with Autism Spectrum Disorders Across the Lifespan" addresses the value of the association's therapies for both children and adults with ASD:

Occupational therapy intervention helps individuals with autism develop or improve appropriate social, play, learning, community mobility, and vocational skills. The occupational therapy practitioner aids the individual in achieving and maintaining normal daily tasks such as getting dressed, engaging in social interactions, completing school activities, and working or playing.<sup>7</sup>

A 2005 feature article from AOTA's publication *OTPractice Online* advocates the role of OT for adults with developmental disabilities. It discusses specific ways OT can enhance employment, residential living and quality-of-life issues for adults with developmental disabilities.<sup>8</sup>

ASHA's 2005 "Principles for Speech-Language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders Across the Life Span" states:

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<sup>7</sup> American Occupational Therapy Association, "Statement: The Scope of Occupational Therapy Services for Individuals with Autism Spectrum Disorders Across the Lifespan," *American Journal of Occupational Therapy*, (2005): 59, 680-683.

<sup>8</sup> Laura Vogtle and Bethany Brooks, "Common Issues for Adults with DD," *OTPractice Online*, <http://www.aota.org/Pubs/OTP/Features/2005/f-090505.aspx>.

The broad-based challenges in social communication experienced by individuals with ASD and their families may make them eligible to receive the services of a qualified speech-language pathologist regardless of intellectual status, age, or presumed prerequisites.<sup>9</sup>

Similarly, ASHA's 2005 "Principles for Speech-Language Pathologists Serving Persons with Mental Retardation/Developmental Disabilities" recommends ST to meet the special communication needs of adults with developmental disabilities. It notes the importance of developing and nurturing the socialization skills of this adult population for improved quality of life.<sup>10</sup>

Although the American Physical Therapy Association (APTA) does not offer any position statements or policy guidelines regarding the treatment of developmentally disabled adults, these individuals are included in its Physical Fitness for Special Populations (PFSP) program. This recently developed program targets individuals with acute and chronic impairments, functional limitations, and disabilities related to movement, function, and health. PFSP encourages physical therapists to work closely with these individuals to improve their physical fitness and their access to traditional and non-traditional programs and venues promoting their fitness, as described below.

Physical therapy positively influences an individual's overall health, wellness, and fitness by providing services that positively impact physical fitness. Improving an individual's level of physical fitness can prevent, remediate, improve, maintain, slow the decline of, or lower the risk of impairments, functional limitations, and disabilities. Physical therapy services that impact physical fitness include: interventions that affect cardiovascular/pulmonary endurance; muscle strength, power, endurance and flexibility; relaxation; and body composition.<sup>11</sup>

In May 2006, APTA delivered public comments to the federal Medicaid Commission reiterating the role of physical therapists to "prevent, diagnose, and treat movement dysfunction and enhance the physical health and functional abilities of individuals in all age populations ... [and] with disabilities."<sup>12</sup>

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<sup>9</sup> American Speech-Language Hearing Association, "Principles for Speech-Language Pathologists in Diagnosis, Assessment, and Treatment of Autism Spectrum Disorders Across the Life Span," (2006) <http://www.asha.org/docs/html/TR2006-00143.html#sec1.5>.

<sup>10</sup> American Speech-Language Hearing Association, "Principles for Speech-Language Pathologists Serving Persons with Mental Retardation/Developmental Disabilities," (2005) <http://www.asha.org/docs/html/TR2005-00144.html#sec1.2>.

<sup>11</sup> American Physical Therapy Association, "Physical Fitness for Special Populations," (2007) [http://www.apta.org/AM/Template.cfm?Section=Physical\\_Fitness\\_for\\_Special\\_Populations1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=267&ContentID=30270](http://www.apta.org/AM/Template.cfm?Section=Physical_Fitness_for_Special_Populations1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=267&ContentID=30270).

<sup>12</sup> American Physical Therapy Association, "Public Comments before the Medicaid Commission," (May 2006). [http://www.apta.org/AM/Template.cfm?Section=Medicaid\\_Resource\\_Center&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=30994](http://www.apta.org/AM/Template.cfm?Section=Medicaid_Resource_Center&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=30994)

- *To what extent is the service generally recognized by the medical community as demonstrated by a review of scientific and peer review literature?*

In the last 10 to 15 years, the benefits of OT, PT and ST for child populations that are affected by developmentally disabling birth defects, ASD and CP have been investigated quite thoroughly; however, the benefits for like adult populations have been researched significantly less. Mercer was unable to find any recent, large-scale studies supporting or disproving the effectiveness of these therapies to improve functional ability in developmentally disabled adults. However, there are some smaller-scale studies, case studies and anecdotal evidence that support therapeutic benefits and suggest the need for expanded research with adult populations.

A 1993 study published in the *American Journal of Mental Retardation* examined the effect of independent living training on 1,498 developmentally disabled adults living in their own homes. The study found that, by the end of the seven-year study period, individuals who had received greater amounts of independent living services and had improved or maintained their independent living skills were more likely to still live independently. However, there was no significant relation between the receipt of such services and the probability of improving or maintaining one's skills.<sup>13</sup>

A 2004 study by the American Association on Mental Retardation examined the effect of introducing a physical activity project into a day habilitation setting for a group of 12 older adults with intellectual disability and a variety of physical and behavioral conditions. Their findings indicated that, after 12 weeks, 92% of the participants had experienced improvement in at least one domain of physical function. Many participants sustained functional gains one year after habilitation staff assumed responsibility for sessions.<sup>14</sup>

Although there are many studies and articles about the positive outcomes of the various therapies, the studies and articles do not access the cost of these therapies nor the cost benefit that results.

- *To what extent is the service generally available and utilized by treating physicians?*

Data that track the use of these services by treating physicians for the target population were not available. The limited number of published studies and the limited amount of scientific literature indicate that some physicians are using these treatments for developmentally disabled adults, but it is not widespread.

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<sup>13</sup> B Lozano, "Independent Living: Relation among Training, Skills, and Success," *American Journal of Mental Retardation*, 1993 Sep: 98(2): 249-62.

<sup>14</sup> Carol Podgorski et al., "Physical Activity Intervention for Older Adults with Intellectual Disability: Report on a Pilot Project," *Mental Retardation*: Vol. 42, No. 4, 272-283, [http://aaidd.allenpress.com/aamronline/?request=get-abstract&doi=10.1352%2F0047-6765\(2004\)42%3C272:PAIFOA%3E2.0.CO%3B2](http://aaidd.allenpress.com/aamronline/?request=get-abstract&doi=10.1352%2F0047-6765(2004)42%3C272:PAIFOA%3E2.0.CO%3B2).

Efforts to use data from the Maryland Medicaid program as a proxy proved problematic because claims data focus on the primary diagnosis being treated, not any underlying conditions that may have been present at birth. Therefore, a search of the claims data by diagnosis would yield a very modest return, especially for services rendered to adults. There is no clear identifier or reasonable proxy for sorting the Medicaid claims data.

### Social Impact

- *To what extent is the service generally utilized by a significant portion of the population?*

While there are multiple sources for national and state disability statistics, developmental disabilities as a subset seem to be less extensively tracked. The best source for estimating developmentally disabled populations by age appears to be the 1994 to 1995 Disability Supplement to the National Health Interview Survey (NHIS-D), which gathered specific information about civilian and non-institutionalized individuals with mental retardation and/or developmental disabilities (MR/DD). It is estimated that those with MR/DD account for 0.9% of the adult population between the ages of 17 and 64.<sup>15</sup> Of the *total* population (including children under the age of 17), it is estimated that those who have MR/DD and are between the ages of 17 and 64 account for 0.6% of the population.<sup>16</sup>

Although it tracks developmental disability in children, the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), initiated by the Centers for Disease Control and Prevention (CDC) in 1984, is widely referenced as the best and most current source for prevalence rates. Its most recent prevalence rates from 1994 (for mental retardation and CP) and 1996 (for ASD) are shown in the following table:<sup>17</sup>

<b>Developmental Disability</b>	<b>Prevalence Rate per 1,000 Children</b>
Mental Retardation	9.7
Cerebral Palsy	2.8
Autism	3.4
Total	15.9 (or 1.6%)

The National Institutes of Health suggests using a prevalence rate of 0.50% for autism, which means that at any one time, 0.50% of the population could be diagnosed with

<sup>15</sup> Sheryl Larson, Ph.D. et al., "Demographic Characteristics of Persons with MR/DD Living in Their Own Homes or With Family Members: NHIS-D Analysis," *MR/DD Data Brief*, Research and Training Center on Community Living and Institute on Community Integration (UAP), College of Education and Human Development, University of Minnesota (June 2001), <http://rtc.umn.edu/docs/dddb3-2.pdf>.

<sup>16</sup> See footnote 17.

<sup>17</sup> National Center on Birth Defects and Developmental Disabilities, "Metropolitan Atlanta Developmental Disabilities Surveillance Program: Prevalence Rates," (October 2004), <http://www.cdc.gov/ncbddd/dd/maddsp.htm#prev>.

autism.<sup>18</sup> The Association for Science in Autism Treatment states that ASD may occur in as many as one in 160 people, or at a rate of 0.625%.<sup>19</sup>

Estimates for the prevalence rate of cerebral palsy vary from a low of 0.15% to a high of 0.3%.<sup>20</sup>

The CDC estimates the prevalence of mental retardation at 1.2%.

Combining all of these sources, we generate a range of prevalence for mental retardation, cerebral palsy and autism ranging from 1.25% to 2.125%.

Considering these sources, Mercer estimates the prevalence of developmentally disabling birth defects, ASD and CP among people age 19 to 64 to be between 1% and 2%. Due to the low prevalence rates, it can be presumed that only a small portion of the population generally uses these services.

- *What is the level of public demand for the service?*

The level of public demand for the services is relatively small and generally limited to those affected by the developmental disability (and their families) and organizations that advocate on their behalf, such as the American Congress of Community Support & Employment Services (ACSES) and the national and affiliated state chapters of The Arc of the United States, United Cerebral Palsy (UCP), and Autism Society of America (ASA). At the same time, lengthy waiting lists for both community-based and federally funded programs indicate that demand for services still outpaces supply.

- *How interested are collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts?*

Most collective bargaining agents that Mercer surveyed indicated that their existing benefits provide for habilitative services for children but do not extend coverage to adults. Most unions do not place the extension of habilitative services high on their priority list of collective bargaining issues. Most funds already extend coverage for disabled dependents beyond age 19, although habilitative services may not be covered. Unions understand that increased mandates and/or benefits translate into increased costs, and that makes collective bargaining more difficult because there are generally only so many dollars available for higher wages and benefits combined. Most unions are focusing on retaining existing benefits and/or contributions to health care funds.

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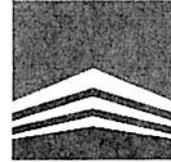
<sup>18</sup> Jacobson, John W. Ph.D., "Is Autism on the Rise?" originally published in *Science in Autism Treatment*, Vol. 2, No. 1, Spring 2002, available on Association for Science in Autism.  
[http://www.asatonline.org/about\\_autism/ontherise.htm](http://www.asatonline.org/about_autism/ontherise.htm), Accessed November 2007.

<sup>19</sup> *About Autism: Defining Autism Spectrum Disorder*. Association for Science in Autism Treatment.  
[http://www.asatonline.org/about\\_autism/about\\_autism.htm](http://www.asatonline.org/about_autism/about_autism.htm), Accessed October 2007.

<sup>20</sup> Low estimate: "Cerebral Palsy," by Christine Thorogood, MS, July 2005; High estimate: "Reaching for the States, a Foundation of Hope for Children with Cerebral Palsy."

## Addendum B

# CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT



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**To:** Susan Tucker  
Ann Volpel

**From:** Asher Mikow / David Idala

**Date:** 11/20/2007

**Re:** **OT, PT, ST, Day Habilitation, and Supported Employment for Certain Adults in Medicaid**

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Enclosed please find data for your request for habilitative services for select Medicaid participants in calendar year 2006 (CY06). The data include service utilization and Medicaid payments for a cohort of participants with ten conditions that you identified, enrolled in Medicaid at any time during CY06. The cohort was comprised of anyone in the Medicaid claims files (fee-for-service), aged 19-64, who had any of the primary diagnoses listed in Table 1. Primary diagnoses were captured from all claims in CY06 only; claims from prior years were not included. The data exclude dual Medicaid/Medicare eligible participants. The data that follow include both the total unique count of participants with the conditions identified in Table 1, as well as those who did not utilize habilitative services in CY06.

The information requested includes data on services that you had identified as "habilitative" for the conditions listed in Table 1. It should be noted that these data include procedures that could potentially be classified as either habilitative or rehabilitative. The claims data records from which this information is derived do not allow one to determine whether the therapy services (physical, occupational, speech) were strictly habilitative or rehabilitative. Therefore, no assumptions were made as to whether the therapies should be classified as habilitative or rehabilitative. The revenue codes and procedure codes listed in Table 2 were used to define the three therapies.

Table 1  
Primary Diagnosis Codes Utilized to Define Selected Health Conditions

HEALTH CONDITION	PRIMARY DIAGNOSIS <sup>21</sup>
Childhood Autism	299.0x
Infantile Cerebral Palsy	343.0x
Down's Syndrome	758.0x
Mental Retardation	319.0x
Mental Retardation: Mild	317.0x
Mental Retardation: Moderate	318.0x
Mental Retardation: Profound	318.2x
Mental Retardation: Severe	318.1x
Hydroencephelocele	742.0x
Spina Bifida	741.0x, 741.90, 741.91, 741.92, 741.93, 756.17

Table 2  
Revenue Codes and Procedure Codes Used to Define Therapy Services

TYPE OF THERAPY	REVENUE CODES	PROCEDURE CODES
Physical Therapy	0420-0429	<ul style="list-style-type: none"> <li>• PT Only Codes: 28890, 38611, 90810, 90811, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829, 97139, S8990, S9131</li> <li>• PT/ST/OT Codes identified as PT if combined with a PDX of Physical Therapy<sup>22</sup> or the Physical Therapy Revenue Codes: 97001, 97002, 97010, 97012, 97014, 97016, 97018, 97022, 97026, 97028, 97033, 97034, 97035, 97039, 97113, 97116, 97124, 97140, 97750, 97799, 4018F, G0151</li> </ul>

<sup>21</sup> Where "x" is shown for ICD-9 codes, pick up any code beginning with the four starting digits, up to and including a 5 digit code.

<sup>22</sup> *Physical Therapy primary diagnoses are defined as ICD-9 CM codes 93, 93.09, 93.1, 93.2, 93.35, 93.38, 93.39, or V57.1.*

Occupational Therapy	0430-0439	<ul style="list-style-type: none"> <li>OT Only Codes: 97003, 97004, 97005, 97006, 97024, 97032, 97036, 97110, 97112, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97545, 97546, 97760, 97761, 97762, 98925, 98926, 98927, 98928, 98929, 99509, G0129, G9041, G9042, G9043, G9044, H2000, S0250, S9129</li> <li>PT/ST/OT Codes identified as OT if combined with a PDX of Occupational Therapy<sup>23</sup> or the Occupational Therapy Revenue Codes:</li> </ul>
Speech Therapy	0440-0449	<ul style="list-style-type: none"> <li>ST Only Codes: 92506-92508, 92601-92604, 92626, 92627, 92630, 92633, S9128, S9152</li> <li>PT/ST/OT Codes identified as ST if combined with a PDX of Speech Therapy<sup>24</sup> or the Speech Therapy Revenue Codes: G0151, G0152, G0153, G0154, G0155, G0156</li> </ul>

Data is presented by each individual health condition identified in Table 1 and includes the following information for all claims where the health condition diagnoses are primary:

1. Total number of unduplicated recipients for each diagnosis or condition as defined in Table 1
2. Revenue Codes and Procedure codes in descending order of frequency for therapy services
  - Number of occurrence for each revenue code or procedure code
  - Medicaid allowed charge for each revenue code or procedure code

In your initial request you asked for cost per procedure code. The data do not allow us to provide a “cost” per code because the payment reflects only the Medicaid allowable charge per code. This said, we were able to separate out the Medicaid allowed charge for each individual revenue code or procedure code. And while not necessarily reflective of “cost,” it is representative of Maryland Medicaid payments for habilitative services for non-dual eligible Medicaid participants.

The count of service per revenue code or procedure is based on the reported revenue code or procedure code, respectively. Services from some data files included only revenue codes, while others included only procedure codes. Your request asked that each therapy be defined by mutually exclusive procedure codes. This required developing a hierarchy

<sup>23</sup> Occupational Therapy primary diagnoses are defined as ICD-9 CM codes 93.8, 93.83, 91.39, V57.2, or V57.21.

<sup>24</sup> Speech Therapy primary diagnoses are defined as ICD-9 CM codes 93.7, 93.74, 93.75, or V57.3.

for categorization because some procedures may be linked to revenue codes indicating either physical therapy or occupational therapy. The hierarchy of categorization of codes was first based on revenue code, where available, and then procedure code. As such, services with both revenue code and procedure code were categorized by revenue code. Assignment of procedure codes where revenue code was absent was based on the description of the procedure code<sup>25</sup>. This hierarchy resulted in mutually exclusive codes. As mentioned above, Table 2 contains the list of revenue codes and procedure codes for each therapy.

Data is also provided for day habilitation programs and supported employment services for members in the cohort. Revenue codes are not available for these services. Table 3 below provides a list of the procedure codes that were used to identify these two services:

Table 3  
Day Habilitation Programs and Supported Employment Services

TYPE OF SERVICE	PROCEDURE CODE
Day Habilitation Programs	W2101, W2102, W9306, W9307, W9311, Z9300, Z9301, W2121, W0037, W0038, W0039, W0054, W0055, W0056
Supported Employment Services	W2103, W0057, W0058, W0059

Results

Table 4 includes data from the entire cohort. For three conditions, Mental Retardation, Mental Retardation: Mild, and Hydroencephalocoele, the cohort was too small to be reported individually. However, the data for these conditions are included in the total found in Table 4. Also note that the therapy categorization for each procedure code follows the procedure code number.

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<sup>25</sup> EncoderPro Expert online coding application. Ingenix, 2525 Lake Park Boulevard, Salt Lake City, UT 84120. <http://www.ingenix.com/>

Table 4

Total of All Medicaid Only Habilitative Services and Allowed Charges for Selected Conditions, CY06

Habilitative Services for Selected Conditions, CY06	Count of Service	Allowed Charges
Day Habilitation Programs	40495	\$ 3,244,822.76
Supported Employment Services	6373	\$ 443,168.47
Physical Therapy	1274	\$ 209,273.86
Speech Therapy	1631	\$ 142,872.35
Occupational Therapy	922	\$ 106,485.84
Total	50695	\$ 4,146,623.28

Table 5

Counts of Medicaid Only Participants with a Diagnosis of Childhood Autism, Habilitative Service Utilization, and Medicaid Allowed Charges, CY06

Childhood Autism		Total
Count of Medicaid Only Recipients		163
Not Receiving Habilitative Services		69
Habilitative Service	Count of Service	Medicaid Allowed Charges
Day Habilitation Programs	6245	\$ 616,068.68
Supported Employment Services	2156	\$ 188,858.57
Speech Therapy	586	\$ 43,302.64
Occupational Therapy	282	\$ 15,592.84
Physical Therapy	22	\$ 4,533.17
Grand Total	9291	\$ 868,355.90
Procedure Code or Revenue Code	Count of Service	Medicaid Allowed Charges
W2102 - Day Habilitation, DD Waiver	6245	\$ 616,068.68
W2103 - Supported Employment Services, DD Waiver	2156	\$ 188,858.57
92507 - Speech Therapy	584	\$ 42,940.00
97003 - Occupational Therapy	277	\$ 14,404.00
97001 - Physical Therapy	19	\$ 1,159.00
420 - Physical Therapy General Classification	3	\$ 3,374.17
430 - Occupational Therapy General Classification	3	\$ 511.34
434 - Occupational Therapy Evaluation	2	\$ 677.50
92610 - Speech Therapy	2	\$ 362.64
Grand Total	9291	\$ 868,355.90

Table 6  
 Counts of Medicaid Only Participants with a Diagnosis of Infantile Cerebral Palsy,  
 Habilitative Service Utilization, and Medicaid Allowed Charges, CY06

Infantile Cerebral Palsy		Total
Count of Medicaid Only Recipients		120
Not Receiving Habilitative Services		44
Service	Count of Service	Medicaid Allowed Charges
Day Habilitation Programs, DD Waiver	6633	\$ 617,385.32
Physical Therapy	544	\$ 85,190.35
Supported Employment Services, DD Waiver	339	\$ 24,366.86
Occupational Therapy	199	\$ 18,827.13
Speech Therapy	164	\$ 15,725.69
Grand Total	7879	\$ 761,495.35
Procedure Code or Revenue Code	Count of Service	Medicaid Allowed Charges
W2102 - Day Habilitation, DD Waiver	6633	\$ 617,385.32
W2103 - Supported Employment Services, DD Waiver	339	\$ 24,366.86
97001 - Physical Therapy	255	\$ 14,128.40
97003 - Occupational Therapy	155	\$ 7,020.00
420 - Physical Therapy General Classification	143	\$ 37,663.20
92507 - Speech Therapy	139	\$ 10,564.00
421 - Physical Therapy Visit Charge	77	\$ 19,537.44
97110 - Physical Therapy	29	\$ 4,231.98
424 - Physical Therapy Evaluation	29	\$ 7,133.98
434 - Occupational Therapy Evaluation	18	\$ 3,880.00
440 - Speech Pathology General Classification	16	\$ 3,316.02
430 - Occupational Therapy General Classification	14	\$ 4,582.67
444 - Speech Pathology Evaluation	6	\$ 1,056.23
Z0005 - Physical Therapy	5	\$ 589.35
439 - Occupational Therapy Other Restorative	5	\$ 2,557.00
97755 - Occupational Therapy	3	\$ 369.46
429 - Physical Therapy Other	3	\$ 1,217.00
97113 - Physical Therapy	2	\$ 600.00
431 - Occupational Therapy Visit Charge	2	\$ 418.00
433 - Occupational Therapy Group Rate	2	\$ -
441 - Speech Pathology Visit Charge	2	\$ 473.32
423 - Physical Therapy Group Rate	1	\$ 89.00
442 - Speech Pathology Hourly Charge	1	\$ 316.12
Grand Total	7879	\$ 761,495.35

Table 7

Counts of Medicaid Only Participants with a Diagnosis of Down's Syndrome,  
 Habilitative Service Utilization, and Medicaid Allowed Charges, CY06

Down's Syndrome		Total
Count of Medicaid Only Recipients		56
Not Receiving Habilitative Services		29
Service	Count of Service	Medicaid Allowed Charges
Day Habilitation Programs	3101	\$ 172,700.27
Supported Employment Services	457	\$ 26,088.06
Speech Therapy	45	\$ 3,812.31
Physical Therapy	13	\$ 2,247.37
Occupational Therapy	10	\$ 1,085.20
Grand Total	3626	\$ 205,933.21
Procedure Code or Revenue Code	Count of Service	Medicaid Allowed Charges
W2102 - Day Habilitation, DD Waiver	3101	\$ 172,700.27
W2103 - Supported Employment Services, DD Waiver	457	\$ 26,088.06
92507 - Speech Therapy	35	\$ 2,660.00
440 - Speech Pathology General Classification	10	\$ 1,152.31
H0005 - Physical Therapy	8	\$ 799.36
H0006 - Occupational Therapy	6	\$ 599.82
420 - Physical Therapy General Classification	4	\$ 1,212.27
430 - Occupational Therapy General Classification	3	\$ 367.51
421 - Physical Therapy Visit Charge	1	\$ 235.74
431 - Occupational Therapy Visit Charge	1	\$ 117.87
Grand Total	3626	\$ 205,933.21

Table 8

Counts of Medicaid Only Participants with a Diagnosis of Mental Retardation: Moderate, Habilitative Service Utilization, and Medicaid Allowed Charges, CY06

Mental Retardaton: Moderate		Total
Count of Medicaid Only Recipients		326
Not Receiving Habilitative Services		193
Service	Count of Service	Medicaid Allowed Charges
Day Habilitation Program, DD Waiver	8964	\$ 594,059.82
Suupported Employment Services, DD Waiver	2055	\$ 132,814.64
Speech Therapy	730	\$ 56,697.75
Occupational Therapy	142	\$ 11,836.49
Physical Therapy	131	\$ 12,791.44
Grand Total	12022	\$ 808,200.14
Procedure Code or Revenue Code	Count of Service	Medicaid Allowed Charges
W2102 - Day Habilitation, DD Waiver	8964	\$ 594,059.82
W2103 - Supported Employment Services, DD Waiver	2055	\$ 132,814.64
92507 - Speech Therapy	722	\$ 54,872.00
97003 - Occupational Therapy	125	\$ 6,500.00
97001 - Physical Therapy	84	\$ 5,161.40
420 - Physical Therapy General Classification	30	\$ 5,090.07
97110 - Physical Therapy	9	\$ 882.00
430 - Occupational Therapy General Classification	9	\$ 2,003.84
424 - Physical Therapy Evaluation	6	\$ 1,304.77
434 - Occupational Therapy Evaluation	6	\$ 2,308.65
440 - Speech Pathology General Class	4	\$ 824.54
444 - Speech Pathology Evaluation	4	\$ 1,001.21
97112 - Physical Therapy	1	\$ 88.20
429 - Physical Therapy Other	1	\$ 265.00
431 - Occupational Therapy Visit Charge	1	\$ 278.00
439 - Occupational Therapy Other Restorative	1	\$ 746.00
Grand Total	12022	\$ 808,200.14

Table 9

Counts of Medicaid Only Participants with a Diagnosis of Mental Retardation: Profound, Habilitative Service Utilization, and Medicaid Allowed Charges, CY06

Mental Retardation: Profound		Total
Count of Medicaid Only Recipients		348
Not Receiving Habilitative Services		261
Service	Count of Service	Medicaid Allowed Charges
Day Habilitation Program, DD Waiver	9278	\$ 768,745.10
Occupational Therapy	52	\$ 5,204.04
Physical Therapy	138	\$ 12,483.04
Speech Therapy	32	\$ 4,784.88
Supported Employment Services	0	\$ -
Grand Total	9500	\$ 791,217.06
Procedure Code or Revenue Code	Count of Service	Medicaid Allowed Charges
W2102 - Day Habilitation, DD Waiver	9278	\$ 768,745.10
97001 - Physical Therapy	112	\$ 6,593.00
97003 - Occupational Therapy	29	\$ 1,508.00
92507 - Speech Therapy	22	\$ 1,672.00
420 - Physical Therapy General Classification	15	\$ 3,137.80
430 - Occupational Therapy General Classification	14	\$ 1,197.04
424 - Physical Therapy Evaluation	7	\$ 1,828.24
434 - Occupational Therapy Evaluation	4	\$ 1,233.00
440 - Speech Pathology General Classification	4	\$ 960.60
429 - Physical Therapy Other	3	\$ 590.00
439 - Occupational Therapy Other Restorative	3	\$ 710.00
444 - Speech Pathology Evaluation	3	\$ 1,610.00
92610 - Speech Therapy	2	\$ 394.14
431 - Occupational Therapy Visit Charge	2	\$ 556.00
92611 - Speech Therapy	1	\$ 148.14
421 - Physical Therapy Visit Charge	1	\$ 334.00
Grand Total	9500	\$ 791,217.06

Table 10

Counts of Medicaid Only Participants with a Diagnosis of Mental Retardation: Severe, Habilitative Service Utilization, and Medicaid Allowed Charges, CY06

Mental Retardaton: Severe		Total
Count of Medicaid Only Recipients		134
Not Receiving Habilitative Services		85
Service	Count of Service	Medicaid Allowed Charges
Day Habilitation Program, DD Waiver	4637	\$ 356,750.18
Physical Therapy	212	\$ 44,041.96
Occupational Therapy	74	\$ 14,794.44
Speech Therapy	50	\$ 6,080.32
Supported Employment Services	0	\$ -
Grand Total	4973	\$ 421,666.90
Procedure Code or Revenue Code	Count of Service	Medicaid Allowed Charges
W2102 - Day Habilitation, DD Waiver	4637	\$ 356,750.18
97001 - Physical Therapy	79	\$ 4,819.00
420 - Physical Therapy General Classification	79	\$ 29,037.96
92507 - Speech Therapy	43	\$ 3,268.00
431 - Occupational Therapy Visit Charge	41	\$ 8,704.00
421 - Physical Therapy Visit Charge	26	\$ 6,524.00
423 - Physical Therapy Group Rate	21	\$ 1,785.00
433 - Occupational Therapy Group Rate	13	\$ 1,445.00
97003 - Occupational Therapy	10	\$ 520.00
424 - Physical Therapy Evaluation	7	\$ 1,876.00
440 - Speech Pathology General Classification	7	\$ 2,812.32
439 - Occupational Therapy Other Restorative	4	\$ 2,521.00
430 - Occupational Therapy General Classification	3	\$ 865.44
434 - Occupational Therapy Evaluation	3	\$ 739.00
Grand Total	4973	\$ 421,666.90

Table 11

Counts of Medicaid Only Participants with a Diagnosis of Spina Bifida, Habilitative Service Utilization, and Medicaid Allowed Charges, CY06

Spina Bifida		Total
Count of Medicaid Only Recipients		133
Not Receiving Habilitative Services		66
Service	Count of Service	Medicaid Allowed Charges
Day Habilitation Program, DD Waiver	1608	\$ 116,923.99
Suported Employment Services, DD Waiver	1366	\$ 71,040.34
Physical Therapy	214	\$ 47,986.53
Occupational Therapy	163	\$ 39,145.70
Speech Therapy	24	\$ 12,468.76
Grand Total	3375	\$ 287,565.32
Procedure Code or Revenue Code	Count of Service	Medicaid Allowed Charges
W2102 - Day Habilitation, DD Waiver	1608	\$ 116,923.99
W2103 - Supported Employment Services, DD Waiver	1366	\$ 71,040.34
420 - Physical Therapy General Classification	104	\$ 31,897.53
430 - Occupational Therapy General Classification	71	\$ 26,408.56
434 - Occupational Therapy Evaluation	51	\$ 9,893.62
424 - Physical Therapy Evaluation	48	\$ 9,660.15
97001 - Physical Therapy	39	\$ 2,614.45
97003 - Occupational Therapy	33	\$ 1,866.16
421 - Physical Therapy Visit Charge	18	\$ 3,127.37
440 - Speech Pathology General Classification	9	\$ 10,236.74
444 - Speech Pathology Evaluation	9	\$ 1,776.02
431 - Occupational Therapy Visit Charge	8	\$ 977.36
92507 - Speech Therapy	6	\$ 456.00
97110 - Physical Therapy	4	\$ 409.03
429 - Physical Therapy Other	1	\$ 278.00
Grand Total	3375	\$ 287,565.32