



## Physical Therapy/Occupational Therapy/Speech Language Pathology (PT/OT/ST):

### Waiver Transition Frequently Asked Questions

#### Auditing

1. Could you speak to how providers will be audited and/or surveyed by Medicaid? Specifically, how individual therapy practitioners will be audited and surveyed?
  - Medicaid's Division of Program Integrity (PI) audits provider claims to identify possible fraud, waste, and abuse. PI's audits are conducted via desk review in which a letter is sent to the provider requesting members' records for specific timeframes, and/or by conducting unannounced onsite visits to the provider's office to obtain records needed for the audit. A record review is conducted by Nurse Consultant Inspectors (NCI) and Medicaid Specialist IIIs to determine if the documentation within the records support what the provider has billed, and to determine if there are any erroneous billing, coding, and usage errors resulting in an overpayment. If the audit reveals possible fraudulent activity, then a referral will be made to one of the following agencies for any action they deem necessary; Office of the Inspector General (OIG), The Attorney General's Office of Medicaid Fraud and Abuse (Medicaid Fraud Control Unit, MFCU), HHS OIG, and/or US Attorney's office.
2. Will Medicaid auditors be reassessing the original determination of medical necessity as they review records?
  - If there is a question concerning medical necessity, then the medical director for the Department for Medicaid Services will be asked to review.
3. What will Medicaid auditors be reviewing and looking for when they are performing audits? Will they be re-determining the determination of medical necessity and if they disagree with the original determination, then recouping? We know the things waiver auditors are looking for - but are there audit tools available that providers can see for Medicaid auditors?
  - Program Integrity can look for appropriate documentation up to 5 years (we do not always go back 5 years), and will, also, be looking for any erroneous billing, coding, and usage errors. If there is a question concerning medical necessity, then the medical director for the Department will be asked to review.

#### Billing, Reimbursement, and Fee Schedule

1. What CPT coding guidelines do we utilize? Do we follow Medicare guidelines?
  - Please refer to the Medicaid fee schedule. There are separate fee schedules for PT, OT and ST.
2. Will there be more information provided regarding how to complete billing? Most of us are familiar with how to bill Waiver therapies, however what is required for billing under individual practitioner numbers? Will there be a way to use the existing KYMMIS accounts?
  - Billing instructions will tell you how to bill under the state plan. You are able to access the billing instructions on [ky.mmis.com](http://ky.mmis.com), under Provider Relations there is a section titled Provider Billing Instructions. Providers will continue to use their existing KYMMIS accounts. The only change you are going to have are how you log in. Providers will need



- to log in with their new provider numbers in order to bill as the PT 76. You may also need to utilize different CPT codes, which are available on the Medicaid fee schedule.
- Contact your HP Provider representative if you have any additional questions.
3. How would ADH bill for therapies provided in their facility? Would a separate, state plan Medicaid provider number be required? What provider type would bill?
    - They'll have to enroll under the 76 multi-therapy group to bill for state plan services.
  4. Given the Final Rule for waiver providers, are there any guidelines regarding provision of therapies in day programs that can be provided?
    - No, the final rule doesn't prohibit provision of therapies in day programs.
  5. What form do you use to bill the state plan?
    - CMS 1500.
  6. Can you bill more than one episode per day for ST? My understanding is that an episode is one rate for the day regardless of how much therapy is provided in that day, is that not correct?
    - If it is medically necessary, you can request a Prior Authorization for the visit and bill the codes related to the medically necessary services you provided. Most speech therapy codes are episodic but providers should make sure they are complying with coding standards – standards are available in each of the CPT books.
  7. How many units per modality per day? What is the maximum number of units for the 90 day periods?
    - This depends on the individual and the services that they need, there is not a specific number.
  8. For Speech Therapy (ST) can you bill for swallowing and session as one episode?
    - The provider must follow correct NCCI coding. If the code billed is episodic and includes swallowing and session, then it may be billed as one episode. If not, then they must be billed separately.
  9. You said that speech episodes were an hour and then another 30 minutes for additional ones. Can you please verify this? I was under the impression that an episode was a 15 minute minimum but could go up to an hour?
    - Refer to the fee schedule, it will specify what a unit is for that specific code.
  10. For HCB, will the unit for therapies still be per episode? And will we continue to ask for units based on each being one episode?
    - For the HCB waiver, refer to the Medicaid PT/OT/ST fee schedule for codes. There are a couple speech codes that are an hour per unit or an additional 30 minutes. Please note that therapies may still be provided as Home Health Services, which are episodic.
    - Home Health agencies billing for therapy services that are a covered service in the Medicaid Home Health Program will continue to be reimbursed at a "per visit" or "per episode" rate in accordance with 907 KAR 1:031, Section 13 which has a fixed upper payment limit of \$85.05.
  11. What is the formula we use to break down the number of units, in cases of it not dividing equally, but having a number with decimals?
    - There should not be a need to break time or units down arithmetically. The unit for specific CPT codes is included in the fee schedule.
  12. Would the reimbursement rates continue under the current plan, or would they immediately change to the new state plan rates at that point?
    - Once the transition occurs, providers rendering and billing under the state plan would receive state plan rates.



13. Could you please clarify the billing and provision of therapy services for patients who are dually covered? Regarding number of minutes required for a unit?
  - When Medicare is paying as primary and KY Medicaid is secondary, the provider bills KY Medicaid for the coinsurance and/or deductible after Medicare. The provider will follow Medicare's guidelines regarding units and KY Medicaid will process the claim. There will not be an additional bill to KY Medicaid for additional units.
14. Medicare B does not require a full 15 minutes for a unit (a Medicare unit can be 8 minutes). What does a provider need to do in order to be able to bill Medicare (primary) and then bill Medicaid in regards to the number of minutes provided to an individual? Can the provider balance bill Medicaid for the portion not covered even though the unit was only 8 minutes?
  - When Medicare is primary, bill Medicare as the primary and then Medicaid as the secondary as described in the response to the question immediately above. If Medicare denies the service, KY Medicaid will be billed, using KY Medicaid guidelines regarding units. The explanation of benefits from Medicare should be attached.

### **CMHC**

1. Can you please address the status of CMHCs providing these therapy services under their existing CMHC license? Will CMHCs be granted a multi-agency approval status?
  - OIG and Medicaid are updating reimbursement, primary care, and therapy services in the CMHC regulations, with tentative filing dates possibly in July. We are not sure at this time whether these regulations will be filed as emergency or ordinary regulations. OIG is in process of updating the CMHC licensure regulation and DMS is updating the CMHC regulation for Medicaid services and reimbursement
2. CMHCs – and providers are not credentialed, and in Provider Enrollment process. When a BH provider has a Medicaid Provider Number/ID, moves from CMHC setting to multi-specialty group, such as Therapy Group ABC, it is taking a long time to link to their group. This reduces access. Can Medicaid consider a uniform-out-of-network provider?
  - I do not understand the request to consider a "uniform-out-of-network provider." Medicaid has prioritized processing of BH and therapy providers. If it is taking more than 30 days, please escalate those to Kate Hackett.

### **Codes**

1. There are a couple speech codes that are incorrect, who do we contact?
  - Ann Hollen, [ann.hollen@ky.gov](mailto:ann.hollen@ky.gov)
2. Modality codes only show for PT, where are the modality codes for OT? What codes should OT use for modalities?
  - If there are codes for OT that are normally provided that you do not see on the fee schedule, please reach out to Ann Hollen.
3. Are all speech therapy codes going to be episode based or are some still time based like with Medicare?
  - Most speech therapy codes are episodic, some rely on time. Please refer to the Medicaid fee schedule to determine units for each CPT code.
4. Speech therapy services are going to be episode based. Can a speech therapist bill 2 different CPT codes on the same day and it be under 1 episode?



- As long as the treatment is deemed medically necessary and one code is not considered incidental or exclusive to the other code there is not limit on the number of codes that can be billed.
5. If unit is 15 minutes, can you bill for two or more CPT codes delivered during the same 15 minute increment?
    - No. If a provider is rendering two 15-minute unit services to an individual, the services cannot be done during the same 15 minutes.
  6. Do you need to specify how many units will be provided by each discipline?
    - You must specify how many units will be provided for each code.
  7. If OT and PT both ask for self-care, or other similar code, how will we know what number of codes go with each disciplines?
    - If the code is the same the Prior Authorization will be for the total of both.
  8. If OT is treating for self-care for instance for their specific treatment plan, and PT will also need to bill for self-care, will we get a separate PA/line for OT self-care versus PT self-care? Not a duplication of service, as they would be treating for different self-care issues, but same code would be used.
    - No, the lines will be combined.

### **EPSDT**

1. Is EPSDT coverage for therapy services ending or going into the waiver program?
  - If a service is otherwise available through the state plan, it should not be covered through EPSDT. A few years ago, we transitioned payment for therapy for waiver children from the waivers to EPSDT. We communicated with EPSDT providers that payment will need to transition from EPSDT to the state plan therapy benefit. That transition should occur soon; DMS will notify providers of the specific date.
2. Is this just for the waivers or does it also include EPSDT with kids on these waivers?
  - At present, the transition is from waiver to state plan. Payment for therapy for children will need to transition from EPSDT to the state plan therapy benefit. That transition should occur soon; DMS will notify providers of the specific date.

### **First Steps**

1. Will First Steps be impacted with these regulation changes as well?
  - First Steps is a totally separate program, and at this time, DMS does not anticipate revisions.

### **InterQual**

1. Can you speak to the diagnosis codes required by InterQual, if any, in relation to determining medical necessity?
  - No, a recipient does not need to have a specific diagnosis to meet medical necessity for therapies under the InterQual guidelines.
2. Where can providers access InterQual to see criteria required for approval?
  - 907 KAR 3:130, medical necessity and clinically appropriate determination basis, provides contact information for McKesson Health Solutions.



- InterQual is a propriety product of McKesson Health Solutions and users are required to have a license in order to access their product.
- 3. For new waiver clients who begin waiver services/therapy after transition, will they immediately be measured against InterQual standards or given the 2 - 90 day periods as the transitioning waiver clients are going to be given?
  - InterQual standards will be utilized immediately to determine medical necessity for therapy services for new waiver clients; they will not have a transition period.
- 4. Does the Home Care Module of InterQual take into account the high therapy needs of a participant with a brain injury?
  - InterQual has a module specific to brain injury clients, this module is part of InterQual and will be used for ABI recipients.

### **Licensure**

1. Who is the person to call at OIG to answer specific questions related to individual practitioners and licensure?
  - Robin Rowe 502-564-7963
  - Stephanie Brammer-Barnes 502-564-2888
2. With the change in OT/SLP license numbers should each individual notify Medicaid individually to update these numbers?
  - Yes, if your license number has changed you can fill out a maintenance form on the DMS Provider Enrollment website. The Department is trying to work with licensure boards to identify changes through an automated process. Currently, it is necessary for providers to fill out the form to ensure we are not missing any.
3. Do I have to get a license for each office or just 1 license for all offices?
  - 902 KAR 20:275, Section 2(1) allows a mobile health licensee to provide services in various locations, which may include settings such as the office of the licensee, another health facility licensed under KRS Chapter 216B, or a home- or community-based setting. Therefore, one license will satisfy the requirement for any therapy practice that seeks licensure under 902 KAR 20:275 to provide PT, OT, and/or SP at various locations.
4. The OTs are not sent a license verification form so they have to send the number in letter form?
  - If they go to the Office of Occupations and Professions, Kentucky (O&P, <http://dop.ky.gov/Pages/default.aspx>) on their license they will have their legacy number and the new number. A copy of that document can be sent.
5. Both the Legacy (old) and new therapist license numbers appear on the current license.
  - Turn in license to provider enrollment and the change will be made in the system.

### **MAP 347**

1. How do you complete a MAP 347 to link to a provider number when you don't have a provider number until you send in the MAP 811 and receive the number?
  - On the MAP 811, you would put N/A under Medicaid Provider number because you do not have one yet.
2. When you submit a MAP 347 with MAP 811 and a few months later add another therapist, can the MAP 347 go out by itself or does a new MAP 811 have to be attached?



- Initially, the set needs to come in together (MAP 347 and MAP 811). If you add another therapist later, the MAP 347 can be submitted independently once the first set has been received.
3. I was told we could add MAP 347 forms for our additional OT's, is that true?
    - The new OTs who have joined the practice will need to complete and submit a MAP 347 form to be linked with the practice.

## **MCO**

1. We currently have our OT and ST group State Plan provider numbers and NPI numbers. However, when adding our new NPI numbers to the MCOs, they are not aware of this State Plan change. When will the MCOs be notified of this change?
  - We notified MCOs of the changes in therapies some time ago. We will share information with them again. From an enrollment stand point, if you are enrolling in the state plan, it does not impact the MCO. The MCO will not see differences between you and another provider.
2. Is the expectation that providers need to enroll in all the MCOs?
  - If you want to serve non-waiver clients, you need to enroll in one or more MCOs. If you want to be broadly open, you may choose to enroll in all.
3. There have been past roadblocks, such as claims denied by MCOs due to maxing-out of benefits of the soft limit of 20 per discipline, although the federal mandate affords medically necessity. Currently, MCOs are using this claim-rule or flag, stopping at 20. How is Medicaid explaining or translating Provider Type 76 to MCOs, for example, with EPSDT, there is a maximum number of 20 services? How does Provider Type 76 translate this? When enrolled with MCO, are they recognizing this, services to children, and not denying claims? For example, when a provider has a prior authorization to provide necessary services, and in the middle of prior-off period, and now on the 21st visit, and claims start to be denied, this goes against the federal mandate?
  - MCOs may not put arbitrary limits on the therapies. An MCO may allow for therapies to be provided up to a certain number with or without prior authorization, and require the provider to request additional services. The MCO must make determinations of medical necessity on an individual basis, case by case. Members should appeal service denials and follow the process to ensure the MCO is appropriately denying (or limiting in whole or in part) the request for services. A provider may notify DMS if there is a concern the MCO is placing an arbitrary limitation on a service. Specific examples would need to be provided.

## **Medicare**

1. Many waiver recipients also have Medicare. Will they receive therapies under the state plan or will they need to access therapy under their Medicare benefits? In addition, if the provider is not Medicare certified, can they bill under Medicaid?
  - By law, Medicaid is a payer of last resort, meaning that if a Medicaid-eligible individual has another form of insurance (for example, Medicare), that insurance entity is responsible to pay for medical costs before Medicaid pays. If you are not already enrolled with Medicare, you may need to enroll as a Medicare provider and bill Medicare for these services first, if you provide therapy services to individuals who are covered by both Medicaid and Medicare (dual-eligible). Medicare does not recognize all provider types that Medicaid recognizes, and therefore, some HCBS waiver providers



will not be able to enroll as a Medicare provider. As a general rule, if Medicare recognizes the provider type in which you are licensed as a Medicaid provider, then you will need to enroll as a Medicare provider and bill Medicare for these services. It is the provider's responsibility to determine if they need to enroll as a Medicare provider.

2. Is provider type 76 recognized by Medicare?
  - Provider type 76 is not specifically mentioned in the Medicare documentation.
3. Has there been discussion of how payment by Medicaid will be handled when a person has reached their Medicare cap for therapies? Or does anyone know how this will work?
  - Once the individual has reached their Medicare cap, the provider will receive a denial notice from Medicare, and then the provider should bill Medicaid for the services.

### **Mobile Health Service**

1. If we are an ADHC, need we only enroll as a Mobile Health Service to provide therapies in participants' homes and in our facility? Or do we need to enroll as a Multi-Therapy Group as well as a Mobile Health Service?
  - Mobile Health Services is a licensure and you must obtain this licensure if you want to provide services outside of your ADHC. In addition you will need to enroll as a Multi-Therapy group so you are enrolled as a Medicaid provider type that is not solely a waiver provider type.
2. If there is an OT Group that has a Medicaid number that plans to work with a mobile health service, does the OT group link to the mobile health service or does each individual therapist have to link to the mobile health service?
  - Mobile Health Service is a licensure rather than a Medicaid provider type. If you're an OT group, meaning you are a private practice owned entirely by OTs and only providing OT services, you do not require special licensure. With respect to Medicaid provider type, if you are an OT group or a multi-therapy group, the individual OTs within your group must link to the group provider number.
3. Does an OT group have to have mobile health service licensure?
  - Same response as provided in question 2 and question 4; if you are a private practice owned exclusively by an OT (or group of OTs) and your practice provides OT services only, you are not required to be licensed by the Office of Inspector General.
  - If you're an OT group, meaning you are a private practice owned entirely by OTs and only providing OT services, you do not require mobile health services licensure.
4. Where can OT be provided? Does the individual have to be homebound to receive services in the home?
  - For private OT practices, OT groups, and mobile health services, services can be provided at the provider's location or in the home. For other types of therapy providers, the place of service will depend on what the provider's licensure allows, as well as the Medicaid rules governing their services.
5. What if OIG is not able to do a survey and issue licensure for a mobile health service quickly enough to allow enough time to process the application for the Multi-Therapy Agency?
  - Ultimately you cannot enroll as a Medicaid provider if the licensure is not in place. When you do enroll, it can be retroactive for up to a year to the date of licensure. If you have not attained the proper licensures, you should move forward with that first.



6. Can you speak more to how an individual therapist provides services under the state plan? Is there a need to be licensed as a mobile health services to provide services in an individual's home and in the community?
  - If you are an individual therapy practitioner, an additional license is not necessary. You are not subject to Certificate of Need (CON) or health facility licensure, however you may elect to be licensed. If the individual therapy practitioner is not already enrolled in the state plan, go to the provider enrollment website, find the provider type on the website, and download the same MAP-811 Form to get enrolled.
  - Call the Office of Health Policy for clarification or if you have additional questions about Certificate of Need.

### **Multi-Therapy Agency**

1. What is the difference from the Occupational Therapists Group and Multi-Therapy Agency?
  - An OT Group is a group entirely owned by OTs, composed entirely of OTs and only OT services provided by those individuals. A Multi-Therapy Agency may have more than one type of therapist and provides more than one type of therapy (OT/PT/ST services can be provided by the Multi-Therapy Agency).
2. We have already received our individual Medicaid numbers for our PTs, OTs, and STs. We have also received our PT group number, OT group number, and ST group number. Do we need to get a Multi Therapy Group Number to link the groups? We are licensed as a CORF.
  - CORF is a Medicaid provider type. You can enroll as a CORF and you do not need to get a multi-therapy group number.
3. If the provider has already set up the OT/PT/ST groups and linked providers, can we still provide therapy services in a home and community based setting, or does it have to be in a facility?
  - This depends on how you are licensed. If the licensure category only allows services to be provided within the provider's four walls, then the provider would need to obtain special licensure to provide mobile therapy (in home and community).
4. In transition of therapy providers that might have 4 or 5 different Medicaid groups, specific to the different disciplines, e.g., AC Therapy, has 5 groups:
  1. OT
  2. PT
  3. ST
  4. EPSDT
  5. Multi-specialty behavioral health

What is the process to submit for prior authorization for Provider Type 76 for all these different disciplines?

- When your provider type 76 is enrolled, you should terminate your OT Group, PT Group and ST Group as they will no longer be needed. Any PA issued under those provider numbers can be transferred upon request to the new provider number. Keep in mind that all your individual therapists (PTs, OTs and STs) have to link to the PT-76 number as well. PT-76 should be used to provide therapies to waiver members. It can also be used to provide services to members in managed care but you would have to be in the network of the managed care organization.
- EPSDT should only be utilized if providing an EPSDT service which means a medically necessary service either not already covered under our State Plan or which exceeds any limitation in the State Plan. Because the therapies have soft limits, PAs should be



requested under the regular provider number and not the EPSDT provider number. In the near future, Medicaid will be notifying providers who are providing State Plan services under an EPSDT number that the EPSDT number will be terminated unless the Department has determined it is necessary for the provider to maintain it for other services.

- The Behavioral Health Multi-Specialty Group (BHMSG) number should be used to provide non-waiver behavioral health services to both waiver and managed care members. BHMSGs, however, have to be careful not to duplicate services being provided in a 1915(c) waiver.

### **Prior Authorization**

1. Can you request 20 visits for speech and 20 visits for swallowing?
  - This is determined based on the individual's needs. If the service is medically necessary it can be approved and provided.
2. Where are these forms located? Will you be providing the fax numbers or other contact information for where to send Prior Authorization requests?
  - You are able to find Prior Authorization forms (MAP – 9) on the DMS website under the Medicaid Assistance Program (MAP) Forms section on the left panel of the screen. Fax numbers are included in the presentation (<http://www.kymmis.com/kymmis/pdf/MAP-9%207-10rev.pdf>)
3. What does systematically ended mean?
  - Prior Authorizations will automatically be end dated in the MMIS system with the date of the therapy transition for each waiver once the end date is determined.
4. Is there appropriate infrastructure currently to handle the expected volume for 3 month Prior Authorization requests?
  - Yes, we anticipate that HPE and Carewise have the infrastructure able to handle it.
5. Please review again the transition period from Waiver to InterQual standards, time frame for period, amount of units approved, etc. Does the 20 session period and two 90 day time periods apply for both?
  - Initial 20 visits per year for each type of therapy (PT, OT, or ST) do not require Prior Authorization.
  - First 2 therapy requests:
    - If they are a waiver member that is transitioning they may receive the exact same therapies that they had received under the waiver, but the provider needs to specify codes and units from the therapy fee schedule on the PA request. The 3rd therapy request is when InterQual standards go into effect.
    - New members will receive Prior Authorization using InterQual from the beginning.
    - Under the state plan, anyone can receive 20 visits per year for each type of therapy (PT, OT, or ST) without Prior Authorization. A client who already had Medicaid and just transitioned into the waiver may have already received 20 visits through Medicaid and then you would need to request a Prior Authorization.



6. How does a provider check to see how many visits a patient has used during a year or if another agency has provided any of the 20 unauthorized visits? Is there a record of service that the patient has access to of all the services billed to that individual?
  - As of now, there is no centralized record of therapy services that providers can check. One option is to talk to the member to determine whether they have received therapy services, and to follow up with the previous provider. If a provider is unsure whether a member has received prior state plan therapy services, he or she may request PA prior to providing services.
7. Is the year based on calendar year or state fiscal year?
  - Calendar year.
8. Do the 20 visits include any visits already billed under the waiver? Or will the clock "reset" after the transition?
  - The clock will reset after the transition. Prior therapy services billed under the waiver do not count towards the 20 state plan therapy visits that may be provided without PA.
9. Does the 90 day period start from the date the doctor's order is signed or from the date of the first visit?
  - It starts with the date when you request the Prior Authorization.
10. If the 20 visits per year starts with the date of the Prior Authorization, then when does the clock reset?
  - The individual gets 20 visits per calendar year without Prior Authorization.
11. Are you saying the 20 visits begin on July 1, or do previous visits count towards the 20?
  - 20 visits are state plan visits available without Prior Authorization. If the individual is receiving services under the waiver, the 20 visits begin once the waiver therapy services are transitioned to the state plan.
12. The first 20 visits are part of the two 90 day requests? Not 20 days and then two more 90 days?
  - 20 visits are allowed per calendar year without Prior Authorization; that is not within the first two PA request periods.
13. If the initial 20 visits do not require a Prior Authorization, will therapists be able to use any discipline specific codes/quantities for a visits?
  - During the initial 20 visits, the therapist may provide any services deemed medically necessary which are included on the Medicaid fee schedule, and are allowable within their discipline.
14. Does PTA service need to be on the MD order? Or does PT eval and treatment cover those services?
  - Eval and treatment covers these services. It is expected that the correct rate would be billed by the provider based on who provides the service, a PT or PTA.
15. When you request Prior Authorization by units, do you have to divide by PT and PTA like SCL?
  - No. Please see above response for further information (#18).

### **Visits and Visit Clock**

1. What is considered a "visit"? Is there a unit limit? For community reintegration goals to be addressed current waiver participants may be seen for 8-12 units per visit to accomplish community goals, will this type of visit be allowed on state plan?
  - A visit is a date of service, regardless of the number of modalities or units that are billed. Medical necessity determines the unit limit.
2. Can you verify that 20 visits is a "soft" limit?



- Yes, 20 visits may be exceeded with medical necessity.
- 3. Is the 20 days of therapy in a calendar year or in the past so many days?
  - The 20 days of therapy is based on the calendar year.
- 4. Do the initial 20 visits have to be used within a specific time frame?
  - No.

### **Misc.**

1. Where can case managers find a current list of therapy providers?
  - There is a link on the program integrity website that shows available providers. It is also included in the case manager provider letter. You are also able to access the current list of therapy providers through the following link:  
<http://www.kymmis.com/Provider%20Directory/>
2. Who completes the Home Care module?
  - Carewise completes this.
3. How will you let providers know information needed to review the Prior Authorization request that you do not have?
  - They will receive a lack of Information form.
4. With the state plan can a client receive services by two separate facilities at the same time?
  - Yes. However it cannot be a duplication of services. For example, 2 STs cannot bill for services rendered to the same client on the same day, but 1 ST and 1 OT can bill individually for services rendered on the same day.