Acentra HEALTH

Accelerating Better Outcomes

Habilitative and Rehabilitative Therapy – Frequently Asked Questions

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Benefit Limitations

Do we have to start the year with a prior authorization or do recipients automatically get visits before an authorization is needed?

Each recipient is eligible 14 PT or 24 OT visits without an authorization at the start of every calendar year.

Will MN-Its or Atrezzo show how many of the 14 PT or 24 OT visits were used in 2026 for Medicaid patients?

MN-Its is being updated to show this as of January 2026

Is a prior authorization required for evaluations?

Yes, if the patient has used the allowable visits for the year, an authorization is required for all evaluations.

If a patient has exhausted all 14 visits for the year prior to presenting to us for care, will the initial evaluation be covered without authorization?

No. The provider may submit an authorization request for the evaluation.

Are units the same as the number of visits?

No. See above billing threshold notes for visit versus unit definitions.

If that evaluation is not approved, do we charge the patient for the evaluation?

Please follow your internal processes for billing non-approved services for Medical Assistance recipients.

Is there a maximum visit limit that can be approved at one time?

No maximum visit limit; however, authorizations are approved for up to 90 days at a time.

Some of our patients are seen 3 times a week, can we ask for 40-45 visits at a time?

Yes. Submit a request for the total number of units you estimate you will need for those 40-45 visits.

If we use all units of a CPT code, but have remaining units on another code, do we need to update the request?

Yes. Send a message to the clinical review team indicating the requested change, and include supporting documentation for the change.

If a facility only bills under the facility NPI does the request have to be submitted under a specific provider (NPI)

Submit the authorization request under the facility providing services.

If patients started therapy in 2025 and will continue into 2026, do visit counts start fresh in 2026?

Yes. This is a calendar-year benefit for all MA recipients.

What is the timeline for a retro authorization? How many days back can I go?

There is no limit to how many days back, as long as it follows timely billing guidelines. Submit authorization requests as soon as possible.

What is the normal time frame for receiving a response back on our requests?

Reviewers have 7 calendar days to provide an initial response.

When Medicare is primary and crosses over to MN Medicaid, will auth be required after the visit limits are met?

Yes. See Authorizations - Medicare and TPL section in the MHCP provider manual.

What is the process for any denials?

Please review the resource “How to Request a Reconsideration” found here https://mhcp.acentra.com/provider-resources/ and the How-To guide “Submitting a Medical Assistance Reconsideration Request for Providers” found here under the Forms and How-To Guides Section: https://mhcp.acentra.com/physical-and-occupational-therapy/

What is the DHS contact to find out the number of PT or OT visits used?

MHCP Provider Resource Center:
Hours: 8 a.m. to 4:15 p.m. (closed from noon to 12:45 for lunch), Monday - Friday
Voice: 651-431-2700 or 800-366-5411
TTY: 711 or 800-627-3529

https://mn.gov/dhs/partners-and-providers/contact-us/minnesota-health-care-programs/providers/

Does Medicaid follow the AMA substantial portion methodology or Medicare rules for billing?

Please contact DHS for any billing questions.

Billing Before Meeting the Threshold

I keep hearing confusing information about visits and units. What's the difference?

The threshold is based on visits (dates of service), not units. The first 14 or 24 visits are counted based on date of service, not the number of units.

> Example: If a provider bills one evaluation code, that counts as one visit. Additionally, if a provider bills four different CPT/HCPCS codes on the same day, that still counts as one visit.

Billing After Meeting the Threshold

What are the billing requirements with an authorization (PA)?

Authorization is based on procedure codes and units, because claims process by exact match to the PA. Once the threshold is met, prior authorization (PA) is required.

- The PA must include:
  - Procedure codes the provider plans to use.
  - Estimated number of units per code (based on anticipated treatment plan).

Providers may request authorization early but should not use it until the threshold is met. The authorization must be included on the claim.