MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 23, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

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SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1700 - THERAPY

BACKGROUND AND EXPLANATION

Changes are being made to Medicaid Services Manual (MSM) Chapter 1700 – Therapy to clarify prior authorization requirements for children and adults, all non-covered therapy services and provider responsibilities regarding the provision of services and added language for therapy for developmental delay disorders.

The Definitions and References and Cross References sections have been removed to be consistent with the MSM Chapters.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These policy changes are effective August 24, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 16/11 CHAPTER 1700 – THERAPY	MTL 31/03, 06/06 CHAPTER 1700 – THERAPY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1700	**Introduction**	Reworded policy for clarity. Added references to 42 CFR 440.110 and 440.20.
1702	**Definitions**	Removed all Definitions.
1703.1	**Policy Overview**	Reworded policy overview for clarity.
1703.2	**Coverage and Limitations**	Added Coverage and Limitations title.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Covered Services	Included all services covered under the outpatient therapy program. Reference to MSM Chapter 2000 for Cochlear Implant policy coverage. Added language for therapy for developmental delay disorders.
	Prior Authorization Requirements	Moved Prior Authorization requirements into this section. Reference Cochlear Implant to MSM Chapter 2000 for protocol. Referred authorization protocol for speech generating devices to MSM Chapter 1300, Appendix B. Deleted/moved children and adults to appropriate chapter sections.
	Non Covered Services	Included all therapy and related therapy services Medicaid does not cover.
	Provider Responsibility	Clarified provider responsibilities for the provisions of therapy services.
	Recipient Responsibility	Refer to MSM Chapter 100.
1703.3	**Lymphedema Therapy Policy**	Added subsection titles and references to MSM Chapter 100.
1703.4	**Respiratory Therapy Policy**	Clarified non covered respiratory services.
1705	**References and Cross References**	Removed References.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

THERAPY

1700 INTRODUCTION

Nevada Medicaid reimbursement for outpatient Physical Therapy (PT), Occupational Therapy (OT), Speech/Communication Therapy (ST) and Respiratory Therapy/Care (RT) is based on the provision of medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time. Therapy services must be prescribed by a physician, physician's assistant or an advanced practitioner of nursing (APN).

Services related to activities for the general health and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute restorative or rehabilitative therapy services for Medicaid purposes.

Outpatient Physical, Occupational and Speech therapy under 42 Code of Federal Regulations (CFR) 440.110 is an optional service under State Medicaid Programs.

Therapy services provided by the Home Health Agency (HHA) Program is a mandatory home health care benefit provided to recipients in his/her residence. See Medicaid Service Manual, Chapter 1400 for HHA Therapy coverage.

Therapy services provided by an outpatient hospital under 42 CFR 440.20 is a mandatory service under State Medicaid Programs.

All Medicaid policies and requirements are the same for Nevada Check Up (NCU), with the exception of those listed in the NCU Manual, Chapter 1000.

1701 AUTHORITY

1701.1 The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulations (CFR), Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Act.

1701.2 The State Legislature grants authority to the relevant professional licensure boards to set the standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

a. NRS Chapter 640 Physical Therapy (PT).

b. NRS Chapter 640A Occupational Therapy (OT).

c. NRS Chapter 637B Audiologists and Speech Pathologists.

d. NRS Chapter 630 Practice of Respiratory Care.

1702 RESERVED

1703 POLICY

1703.1 Medicaid will reimburse physical, occupational, speech therapy services rendered to eligible Medicaid recipients and eligible participants in the Nevada Check Up (NCU) Program. Therapy must be medically necessary (Reference Medicaid Services Manual (MSM) Chapter 100; section 103.1) to restore or ameliorate functional limitations that are the result of an illness or injury which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time. It must be rendered according to the written orders of the physician, physician's assistant or an advanced practitioner of nursing (APN) and be directly related to the active treatment regimen designed by the therapist and approved by the professional who wrote the order.

Requests for therapy must specify the functional deficits present and include a detailed description assessing the measurable degree of interference with muscle and/or joint mobility of persons having congenital or acquired disabilities, measurable deficits in skills for daily living, deficits of cognitive and perceptual motor skills and integration of sensory functions. Identify measurable speech and/or communication deficits through testing, identification, prediction of normal and abnormal development, disorders and problems, deficiencies concerning the ability to communicate and sensorimotor functions of a person's mouth, pharynx and larynx.

A written individualized plan addressing the documented disabilities needs to include the therapy frequency, modalities and/or therapeutic procedures and goals of the planned treatment. The primary diagnosis must identify the functional deficit which requires therapeutic intervention for the related illness or injury diagnosis.

Medicaid will reimburse contracted practitioners of respiratory care for individual services provided in the outpatient setting. Prior authorization is not required. The term "respiratory care" includes inhalation and respiratory therapy, diagnostic testing, control and care of persons with deficiencies and abnormalities associated with the cardiopulmonary system.

Therapy services provided in the community-based and/or hospital outpatient setting are subject to the same coverage and therapy limitations.

Services that are provided within the School Based Child Health Services Program are covered under Chapter 2800.

1703.2 COVERAGE AND LIMITATIONS

1703.2A COVERED SERVICES

1. Medicaid covers outpatient therapy for individual and/or group therapy services administered by the professional therapist within the scope of their license for the

following:

a. An individual therapy session may be covered up to a max of one hour when service is provided to the same recipient by the same therapist on the same day.

b. Group therapy (comprised of no more than 2-4 individuals) may be covered up to a max of ninety minutes per session when the service is provided to the same recipient by the same therapist on the same day. The leader of the group must be a Medicaid provider. Documentation in the medical record is expected to be available on each Medicaid recipient in the group.

2. Therapy services ordered as a result of a comprehensive Healthy Kids evaluation. The examination must identify the functional deficits to ameliorate and establish medical necessity which includes realistic rehabilitative/restorative therapy goals.

3. The application of a modality that does not require direct (one-on-one) patient contact by the licensed therapist may be provided by a licensed therapy assistant under the supervision of the licensed Medicaid therapist.

4. Evaluations administered per therapy discipline within the scope of their license and meets the following criteria:

a. Initial evaluations.

b. Re-evaluations may be covered when there is a break in service greater than 90 days.

5. To be considered reasonable and medically necessary all of the following conditions must be met:

a. Meet the definition of medical necessity in Chapter 100.

b. The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's functional deficit/condition.

c. The services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or qualified assistant under the therapist's supervision.

d. There must be an expectation that the functional deficit/condition will improve in a reasonable, and generally predictable, period of time based on the assessment

made by the physician of the patient's realistic rehabilitative/restorative potential in consultation with the qualified therapist.

e. The amount, frequency, and duration for restorative therapy services must be appropriate and reasonable based on best practice standards for the illness or injury being treated.

6. Cochlear Implant Therapy: Speech and language pathologist's services are covered under cochlear implantation protocol for speech evaluation and therapy services. Codes used by speech therapists will require the appropriate therapy modifier. (Refer to MSM Chapter 2000 for comprehensive cochlear policy.)

7. Therapy for Development Delay disorders may be covered for speech and language, fine motor and/or gross motor skills development when the functional deficit(s), identified by ICD-9-CM diagnosis code(s) meet all medical necessity requirements.

8. Respiratory therapy is considered reasonable and necessary for the diagnosis and/or treatment of an individual's illness or injury when it is:

   a. Consistent with the nature and severity of the recipient's medical symptoms and diagnosis;

   b. Reasonable in terms of modality, amount, frequency and duration of the treatment; or

   c. Generally accepted by the professional community as being safe and effective treatment for the purpose used.

9. Exception to annual therapy limitations may be covered if medically necessary criteria are met for the following:

   a. Presentation of new acute condition; or

   b. Therapist intervention is critical to the realistic rehabilitative/restorative goal.

10. In certain circumstances the specialized knowledge and judgment of a qualified therapist may be covered when medically necessary to establish a safe and effective home maintenance therapy program in connection with a specific disease state.

11. Speech and Language Pathologist (SLP) evaluation may be covered according to MSM Chapter 1300, Appendix B for a dedicated speech generating device evaluation and therapeutic services.

1703.2B PRIOR AUTHORIZATION REQUIREMENTS

1. Nevada Medicaid provides coverage for recipients who meet all medical necessity criteria for physical, occupational and speech/language therapeutic interventions without prior authorization for:

   a. children under age 21, for the first twenty-four (24) sessions per discipline, per calendar year. Prior authorization is required without exception for therapy services which exceed this limitation.

   b. adults age 21 or older, for the first twelve (12) sessions per discipline, per calendar year. Prior authorization is required without exception for therapy services which exceed this limitation.

2. To obtain an authorization request the therapist must have completed an initial evaluation, identify the medical/physical functional deficits and establish a plan of treatment to ameliorate functional limitations. The plan will establish amount, frequency and duration of treatment, identify short/long term goals and state how the progress will be measured and reported. Progress reports need to document the increments of progress specific to the goal of the plan treatment and reflect the detailed information along with any treatment modifications in the authorization request.

3. See MSM Chapter 2000 for Cochlear Implant prior authorization protocol.

4. See MSM Chapter 1300, Appendix B for speech generating device prior authorization requirements.

1703.2C NON COVERED SERVICES

1. Services which do not meet Nevada Medicaid medical necessity requirements.

2. Personal comfort items, which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body part.

3. Services that do not require the performance or supervision of a licensed therapist, even if they are performed or supervised by a licensed therapist.

4. Wound care requested by a therapist or a hospital based therapy department unless it is part of a comprehensive therapy treatment plan, (e.g., whirlpool with debridement & ROM exercises etc.).

5. Reimbursement for licensed nurses when wound care is ordered as a PT or OT service.

6. Outpatient therapy provided to patients admitted in an acute or rehabilitation hospital.

7. Reimbursement for an all inclusive Respiratory Rehabilitation Program.

8. Medicaid does not reimburse or require re-evaluations to update other third party payer plans of progress for outpatient rehabilitation.

1703.2D PROVIDER RESPONSIBILITY

1. All therapy services require a physician's, physician's assistants, or advanced nurse practitioners order to initiate services.

2. To initiate therapy services, the therapist must complete an initial evaluation to clearly identify the medical and/or physical function deficits which may improve through therapeutic intervention established in a written plan of treatment.

3. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both) of the current authorization, the provider is responsible for the submittal of a new prior authorization request. It is recommended that the new request be submitted fifteen (15) days prior to the end date of the existing service period, so the newly authorized service may start immediately following the expiration of the existing authorization. Reference MSM Chapter 100, section 103.2.

   All providers shall maintain patient treatment records and physician's orders in accordance with Chapter 100.

4. The provider will allow, upon request of proper representatives of the Division of Health Care Financing and Policy (DHCFP), access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.

5. The provider will adhere to prior authorization requirements to include but not limited to submitting appropriate documentation timely.

6. The provider will verify the recipient's eligibility and address for any changes each encounter.

7. Once an approved prior authorization request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.

8. For Provider Responsibilities refer to Chapter 100.

1703.2E RECIPIENT RESPONSIBILITY

For Recipient Responsibilities refer to Chapter 100.

1703.3 LYMPHEDEMA THERAPY POLICY

Nevada Medicaid will reimburse a qualified lymphatic therapist (OT or PT) for a combination of therapy techniques recommended by the American Cancer Society and the National Lymphedema Network for primary and secondary lymphedema.

1703.3A COVERAGE AND LIMITATIONS

1. Complete or Combined Decongestive Physiotherapy (CDP) therapy is covered by Medicaid for ICD-9 codes 457.0, 457.1, and 757.0 when all of the following conditions are met:

   a. A treating or consulting practitioner (MD, DO, DPM, APN, and PA), within their scope of practice, documents a diagnosis of lymphedema due to a low output cause and specifically orders CDP therapy;

   b. The lymphedema causes a limitation of function related to self-care, mobility, and/or safety;

   c. The recipient or recipient caregiver has the ability to understand and provide home-based CDP;

   d. CDP services must be performed by a health care professional who has received CDP training;

   e. The frequency and duration of the services must be necessary and reasonable; and

   f. Lymphedema in the affected area is not reversible by exercise or elevation.

2. A CDP course of treatment by either OT or PT is considered a once in a lifetime benefit consisting of 90 minutes (6 units) per session, 3-5 times per week for a maximum of 3 consecutive weeks with prior authorization.

1703.3B PRIOR AUTHORIZATION REQUIREMENTS

1. Prior authorization is required without exception for the following:

   a. Initial/Original Combined Decongestive Physiotherapy Treatment consisting of 9-15 (6 units) sessions within a 3 week period; and

b. Any treatment requested by either OT or PT which exceeds the initial/original treatment plan.

1703.3C NON COVERED SERVICES

1. Non-covered services include the following:

a. Therapy limited to exercise or elevation of the affected area;

b. Other services such as skin care and the supplies associated with the compressions wrapping. (they are included in the services and are not paid separately);

c. OT and PT services performed concurrently for the therapeutic exercise portion of the session is duplicative (Only one service type per therapeutic session is allowed); and

d. Therapy designed principally for temporary benefit/without ongoing patient education.

1703.3D PROVIDER RESPONSIBILITIES

For Provider Responsibilities, refer to Chapter 100.

1703.3E RECIPIENT RESPONSIBILITIES

For Recipient Responsibilities, refer to Chapter 100.

1703.4 RESPIRATORY THERAPY POLICY

1703.4A COVERAGE AND LIMITATIONS

Medicaid will reimburse contracted practitioners of respiratory care for individual services provided in the outpatient setting. See Chapter 600 for outpatient services general limitations. The term “respiratory care” includes inhalation and respiratory therapy, diagnostic testing, control and care of persons with deficiencies and abnormalities associated with the cardiopulmonary system.

1703.4B PRIOR AUTHORIZATION REQUIREMENTS:

1. Outpatient diagnostic and treatment services do not require prior authorization but must be the result of a physician, PA or APN order, relative to the service provided.

2. The twenty-four (24) session limitations do not apply.

1703.4C NON-COVERED SERVICES:

1. Reimbursement for an all inclusive Respiratory Rehabilitation Program is not a Medicaid covered benefit, which may include the following:

   a. Psychological monitoring.

   b. Therapeutic procedures to increase strength or endurance.

   c. Procedures to improved respiratory function, increase strength or endurance of respiratory muscles.

1704 HEARINGS

1704.1 Please reference MSM Chapter 3100, for hearings procedures.