MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 11, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1700 - THERAPY

BACKGROUND AND EXPLANATION

Revisions to (MSM) Chapter 1700 were made to remove language contained in other policies and replaced with references to said policies. In addition, duplicative language was removed as it is already contained in the Billing Manual. The prior authorization requirements for therapy services are being changed to require prior authorization at the initiation of treatment, with the exception of initial evaluations and reevaluations.

Capitalization changes were made, duplications removed, acronyms used and standardized.

These changes are effective January 1, 2013.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 28/12 CHAPTER 1700 - THERAPY	MTL 16/11 CHAPTER 1700 - THERAPY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1703	**Policy**	Section addressing prior authorization and utilization management for respiratory services has been removed. This is duplicate language from MSM 103.
1703.2A	**Covered Services**	Removed subsection 9 as it is no longer required. Section established policy for additional services beyond annual limitations (i.e., 12 units for adults and 24 units for children).
1703.2B	**Prior Authorization Requirements**	Removed subsection 1 as it is no longer required. As a result of a public workshop on August 1, 2012, the core therapy services will require prior

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		authorizations (see changes below.) Subsection 2 removed. References included in MSM 1703.1 and 1703.2A. Subsections 3 and 4 removed. References to MSM Chapters 1300 and 2000 are included within the Table of Contents for MSM and on page 11 of the Billing Manual for Nevada Medicaid and Nevada Check Up. Changed language to require all other therapy services (with the exception of initial evaluations and reevaluations) to require prior authorization. Changed language to state all therapy service must meet Coverage and Limitations requirements apply (MSM 1703.2A).
1703.2D	**Provider Responsibilities**	Subsection 1 removed. References regarding written orders to initiate therapy services are addressed in MSM 1703.1. Subsection 2 removed. References regarding initial evaluations, functional deficits, and treatment plans are addressed in MSM 1703.1. Subsection 3, paragraph 1 removed. References regarding prior authorizations for therapy services are addressed in MSM 103. Subsection 3, paragraph 2 removed. References regarding the maintenance of patient records are addressed in MSM 102. Subsection 5 removed. References regarding prior authorization requirements are addressed in MSM 103. Subsection 6 removed. Requirements to verify recipient eligibility is addressed in Chapter 3 of the Billing Manual for Nevada Medicaid and Nevada Check Up.
1703.3B	**Prior Authorization**	Subsection 1 removed as it is no longer needed because of authorization requirement.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Requirements	
		Changed language to require all lymphedema therapy services to require prior authorization. Also noted that all therapy service must meet Coverage and Limitations requirements apply (MSM 1703.2A).
1703.4B	**Prior Authorization Requirements**	Subsection 1 removed as it is no longer required. Requirements for "written orders" are addressed in MSM 1703.1. Subsection 2 removed as it is no longer required, due to health requirement changes. Added language that respiratory therapy services must be prior authorized. Add language that all Coverage and Limitations requirements apply.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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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.

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 (SLP) 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. 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.

10. SLP evaluations 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. With the exception of initial therapy evaluations and re-evaluations, all therapy services must be prior authorized by the QIO-like vendor.

2. Initial and re-evaluations do not require prior authorization. Appropriate therapy evaluations must be accomplished and submitted with prior authorization requests.

3. To obtain prior authorization for therapy services, all Coverage and Limitations requirements must be met (MSM 1703.2A).

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. Providers must comply with prior authorization requirements set forth in the Medicaid Services Manual (MSM), Chapter 100 (Medicaid Program), Section 103.2 (Authorization).

2. 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.

3. 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.

4. 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. All lymphedema therapy services must be prior authorized by the QIO-like vendor.

2. To obtain prior authorization for therapy services, all Coverage and Limitations requirements must be met (MSM 1703.2A).

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. Respiratory therapy services must be prior authorized by the QIO-like vendor.

2. To obtain prior authorization for respiratory therapy services, all Coverage and Limitations requirements must be met. (MSM 1703.2A).

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.