

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1700 - THERAPY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1700 are being proposed to comply with the transition to International Classification of Disease 10th Revision, Clinical Modification (ICD 10-CM) as required by the Health Insurance Portability and Accountability Act (HIPAA) mandate. In order to be in compliance with this mandate, the Division of Health Care Financing and Policy (DHCFP) is proposing the removal of ICD 9-CM codes and adding verbiage regarding current diagnosis code(s).

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED

MTL 28/15
CHAPTER 1700 - THERAPY

MATERIAL SUPERSEDED

MTL 16/11, 04/14
CHAPTER 1700 - THERAPY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1703.1	Policy	Added the word Registered to Advanced Practitioner of Nursing to now read Advanced Practitioner of Registered Nursing (APRN).
1703.2A.7	Covered Services	Removed ICD-9-CM reference and added with "current"
1703.3A.1	Coverage and Limitations	Removed ICD-9-CM reference and added "coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs".

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

THERAPY

1700	INTRODUCTION	1
1701	AUTHORITY	1
1702	RESERVED.....	1
1703	POLICY	1
1703.2	COVERAGE AND LIMITATIONS	1
1703.2A	COVERED SERVICES.....	1
1703.2B	PRIOR AUTHORIZATION REQUIREMENTS.....	3
1703.2C	NON- COVERED SERVICES.....	3
1703.2D	PROVIDER RESPONSIBILITY.....	4
1703.2E	RECIPIENT RESPONSIBILITY.....	4
1703.3	LYMPHEDEMA THERAPY POLICY.....	4
1703.3A	COVERAGE AND LIMITATIONS	5
1703.3B	PRIOR AUTHORIZATION REQUIREMENTS.....	5
1703.3C	NON- COVERED SERVICES.....	5
1703.3D	PROVIDER RESPONSIBILITIES	6
1703.3E	RECIPIENT RESPONSIBILITIES.....	6
1703.4	RESPIRATORY THERAPY POLICY	6
1703.4A	COVERAGE AND LIMITATIONS	6
1703.4B	PRIOR AUTHORIZATION REQUIREMENTS.....	6
1703.4C	NON- COVERED SERVICES.....	6
1703.5	MAINTENANCE THERAPY POLICY	7
1703.5A	DEFINITIONS.....	7
1703.5B	COVERAGE AND LIMITATIONS	7
1703.5C	PRIOR AUTHORIZATION REQUIREMENTS.....	8
1703.5D	NON- COVERED SERVICES.....	9
1704	HEARINGS	1

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1700
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

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 (MSM), Chapter 1400 for HHA Therapy coverage.

Nevada Medicaid provides therapy services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

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.

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1701
MEDICAID SERVICES MANUAL	Subject: AUTHORITY

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

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1702
MEDICAID SERVICES MANUAL	Subject: RESERVED

1702 RESERVED

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

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 **Registered** Nursing (APRN) 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 (SBCHS) Program are covered under MSM 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 two to four individuals) may be covered up to a max of 90 minutes per session when the service is provided to the

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

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 may be ordered under an EPSDT referral by a physician, physician's assistant or an APN. The examination must identify a functional limitation to either acquire or correct/ameliorate a functional deficit/condition based upon medical necessity, not withstanding in relation to illness or injury which includes realistic and obtainable 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 MSM 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.

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

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 **current** 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 Quality Improvement Organization (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 (Section 1703.2A).

1703.2C NON-COVERED SERVICES

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

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

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 Physical Therapist (PT) or Occupational Therapist (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 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 MSM Chapter 100.

1703.2E RECIPIENT RESPONSIBILITY

For Recipient Responsibilities refer to MSM 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

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

Network for primary and secondary lymphedema.

1703.3A COVERAGE AND LIMITATIONS

1. Complete or Combined Decongestive Physiotherapy (CDP) **coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs** 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 (six units) per session, three to five times per week for a maximum of three 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 (Section 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);

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

- 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 MSM Chapter 100.

1703.3E RECIPIENT RESPONSIBILITIES

For Recipient Responsibilities, refer to MSM 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 MSM 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. (Section 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.

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

1703.5 MAINTENANCE THERAPY POLICY

The DHCFP will reimburse for skilled therapy necessary to develop and safely implement a maintenance program. During the last visits of a rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program are to maintain functional status at a level consistent with the patient’s physical or mental limitations or to prevent decline in function. Maintenance therapy is a covered service when the specialized skill, knowledge and judgment of a therapist are required to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make necessary reevaluations of the plan.

1703.5A DEFINITIONS

Skilled activities include:

1. Ongoing evaluation of patient performance.
2. Adjustments to the maintenance program that help the patient achieve appropriate functional goals.

Unskilled activities are:

1. Repetitive tasks or exercises that do not involve any variation in complexity, level of cueing or progressive independence.
2. Observations of a patient or caregivers’ performance of a learned activity with no feedback and/or modification of the plan.

1703.5B COVERAGE AND LIMITATIONS

1. Evaluation and development of a maintenance plan without rehabilitative treatment- An initial evaluation of the extent of the disorder, illness or injury is required. If the treating skilled therapist determines after the initial evaluation the potential for rehabilitation is insignificant, prior to discharge an appropriate maintenance program may be established. Services are covered when the skills of the therapist are required for the development of the maintenance program and training of the patient or caregivers.
2. Skilled maintenance therapy for safety- Due to the severity or complexity of the therapy procedures to maintain function, the judgment and skill of a therapist may be necessary to implement the safe and effective delivery of the maintenance program. When the patient’s safety is at risk, those reasonable and necessary services will be covered for the initiation of the maintenance program, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

3. Maintenance therapy must meet at least one of the following:
 - a. Prevent decline of function;
 - b. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; or
 - c. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

4. Maintenance therapy must have expected outcomes that are:
 - a. Functional;
 - b. Realistic;
 - c. Relevant;
 - d. Transferable to the recipients current or anticipated environment; and
 - e. Consistent with best practice standards and accepted by the professional community as being safe and effective treatment for the purpose used.

5. Documentation requirements
 - a. Plan of care must address a condition for which therapy is an accepted method of treatment as defined by standards of medical practice.
 - b. Plan of care must be for a condition that establishes a safe and effective skilled maintenance program.

6. Management of a maintenance program is covered only when provided by a skilled therapist (reference MSM Section 1701.2).

1703.5C PRIOR AUTHORIZATION REQUIREMENTS

1. All Maintenance therapy services require prior authorization.
2. Services are limited to ten sessions every three years per each recipient, from the date of initial visit. EPSDT is exempt from service limitations.

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1703
MEDICAID SERVICES MANUAL	Subject: POLICY

1703.5D NON-COVERED SERVICES

1. Services which are not authorized.
2. Services, which do not require the management of a skilled therapist for the oversight of the maintenance program, will no longer be considered reasonable and necessary and are excluded from coverage.
3. Maintenance program is not safe and/or effective.

	MTL 28/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1704
MEDICAID SERVICES MANUAL	Subject: HEARINGS

1704 HEARINGS

1704.1 Please reference Medicaid Services Manual (MSM) Chapter 3100 for hearings procedures.