Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER THP-19
December 2002

TO: Therapists Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *Therapist Manual* (Age Limitation for Adaptive Devices)

Beginning January 1, 2003, MassHealth will no longer cover the design, fabrication, or fitting of an adaptive device for adult MassHealth members who are 21 years of age or older. The Division's current budget appropriation requires these changes, at a minimum, to cover expected deficiencies.

The attached regulations, which describe these changes, are effective January 1, 2003.

This letter transmits revised regulations at 130 CMR 432.412 to reflect this age limitation. The Division has also modified its regulations at 130 CMR 432.417 to clarify that the prior-authorization requirement for the design, fabrication, and fitting of an adaptive device that requires more than 60 minutes by a physical or occupational therapist is for MassHealth members under age 21.

Service-Specific Prior Authorizations Approved or Appealed Prior to January 1, 2003

If MassHealth approved a prior-authorization (PA) request for a member aged 21 or older on or before October 25, 2002, and the request was for any of the services listed above, MassHealth will continue to pay for those services through the authorized period. Until December 31, 2002, MassHealth will approve medically necessary PA requests for members aged 21 and older for a 90-day period from the date the PA request is approved or changed. After December 31, 2002, MassHealth will no longer approve PA requests for members aged 21 and older for the services listed above.

If a member appeals any prior-authorization decision made prior to January 1, 2003, the Division will pay for the service if the Board of Hearings or a court does not uphold the Division's decision.

DMA Web Site

This transmittal letter and the attached regulations are available at the Division's Web site at www.mass.gov/dma.

Questions

If you have any questions about this transmittal letter, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Therapist Manual

Pages 4-3, 4-4, 4-7, and 4-8

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Therapist Manual

Pages 4-3 and 4-4 — transmitted by Transmittal Letter THP-11

Pages 4-7 and 4-8 — transmitted by Transmittal Letter THP-17

(D) Group Practice. A group practice may claim payment under these regulations only if it has a group practice organization identification number and is composed of physical, occupational, or speech/language therapists (or any combination of the three), each of whom has an individual provider number.

432.405: Provider Eligibility: Out of State

An out-of-state therapist who is licensed or registered to practice in his state and who meets the appropriate certification requirements of 130 CMR 432.404 is eligible to participate in MassHealth. The Division will pay an out-of-state therapist for services only in the following circumstances.

(A) The therapist provides services to an eligible MassHealth member living in a community near the border of Connecticut, New Hampshire, New York, Rhode Island, or Vermont.

(B) The therapist provides services to an eligible MassHealth member who is a foster child or an adopted child placed with a family out of state, or who is a child placed in an out-of-state residential school as the result of a 766 Team evaluation.

(106 CMR 432.406 through 432.410 Reserved)

432.411: Payable Services

The Division will pay for the following therapist services subject to the conditions and limitations of these regulations:

(A) individual treatment, including the design, fabrication, and fitting of an adaptive device;

(B) comprehensive evaluation; and

(C) group therapy.

432.412: Nonpayable Services

The Division will not pay a therapist for any of the following services:

(A) services provided by any person under the therapist's supervision;

(B) indirect services such as staff meetings, staff supervision, member screening, and development or use of instructional texts and reusable treatment materials;

(C) nonmedical services such as vocational, social, and recreational services;

(D) research or experimental treatment;

(E) mental health services;

(F) the design, fabrication, or fitting of an adaptive device provided to a MassHealth member aged 21 or older; and

(G) maintenance therapy. Designing a maintenance program and instructing the member, member's family, or other persons in its use is considered part of a regular treatment visit and is not reimbursable as a separate service.

432.413: Nonpayable Circumstances

The Division will not pay a therapist for services provided under any of the following circumstances.

(A) The therapist furnished the service in a facility approved by MassHealth and is paid by the facility to furnish that service, whether or not the cost of the service is included in the Division's rate of payment for that facility.

(B) The therapist furnished the service in a facility that is organized to provide primarily nonmedical services and is paid by the facility to furnish the service.

432.417: Prior Authorization

(A) Services that Require Prior Authorization. The Division requires that the therapist obtain prior authorization as a prerequisite to payment for the following services to eligible MassHealth members:

(1) more than 20 occupational or physical therapy (including group therapy) visits for a member in a 12-month period;

(2) more than 35 speech/language therapy (including group therapy) visits for a member in a 12-month period;

(3) continuing therapy when payment has been discontinued by Medicare or any other third-party payer;

(4) a second comprehensive evaluation in a 12-month period for a member whose level of functioning has decreased significantly or whose diagnosis has changed; and

(5) the design, fabrication, and fitting of an adaptive device that requires more than 60 minutes by a physical or occupational therapist for MassHealth members under age 21.

(B) Submission Requirement. The therapist must submit all prior-authorization requests in accordance with the billing instructions in Subchapter 5 of the *Therapist Manual*. Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

(C) Notice of Approval or Denial of Prior Authorization.

(1) Notice of Approval. For all approved prior-authorization requests for therapy services, the Division sends written notice to the member and the therapist regarding the frequency, duration, and intensity of care authorized, and the effective date of authorization.

(2) Notice of Denial or Modification and Right of Appeal.

(a) For all denied or modified prior-authorization requests, the Division notifies both the member and the therapist of the denial or modification, reason, right to appeal, and appeal procedure.

(b) A member may request a fair hearing from the Division if the Division denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 60 days after the date of the notice of denial or modification. The Division's Board of Hearings will conduct the hearing in accordance with 130 CMR 610.000.

432.418: Recordkeeping Requirements

Payment for any service listed in 130 CMR 432.000 is conditioned upon its full and complete documentation in the member's medical record. The therapist must keep a record of all services furnished to a member for at least four years following the date of service. The therapist is responsible for the complete documentation of services he or she provides, including services provided to members whose records are kept in nursing facilities or adult day health facilities. The record must include the following:

(A) a licensed physician's written referral for evaluation, referral for treatment, and renewal of referral (if applicable) every 60 days (see 130 CMR 432.415);

(B) the written comprehensive evaluation report (see 130 CMR 432.416);

(C) the name, address, and telephone number of the member's primary physician; and

(D) at least weekly documentation of the following:
(1) the date or dates on which therapy was provided;
(2) the specific therapeutic procedures and methods used;
(3) the member's response to treatment;
(4) any changes in the member's condition;
(5) the problems encountered or changes in the treatment plan or goals, if any;
(6) the location where the service was provided, if different from that in the evaluation report;
(7) the amount of time spent in treatment; and
(8) the therapist's signature.

432.419: Maximum Allowable Fees

The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for therapist services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 432.000. Payment for a service is the lower of the following:

(A) the therapist's usual and customary fee; or

(B) the maximum allowable fee listed in the applicable DHCFP fee schedule.