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-21
January 2004

TO: Therapists Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: *Therapist Manual* (Prior Authorization for Certain Therapy Visits)

This letter transmits revisions to the independent therapist regulations. Effective February 1, 2004, a provider must obtain prior authorization from MassHealth before providing more than **eight** physical-therapy visits, **eight** occupational-therapy visits, and **15** speech/language therapy visits (including group therapy and evaluation) to a member within a 12-month period.

The 12-month period for the initial eight or 15 visits begins on the date of the first therapy visit on or after February 1, 2004. For example, if a member's first therapy visit is February 20, 2004, the 12-month period is February 20, 2004, through February 19, 2005. To simplify accounting of therapy visits, and to allow time for providers to request prior authorization without interrupting an established regimen of therapy to members currently receiving therapy services, MassHealth will begin counting therapy visits for dates of service on or after February 1, 2004. Regardless of the number of therapy visits a member has had before February 1, MassHealth will count the first visit occurring on or after February 1, 2004, as the first visit toward the eight or 15 visits that are allowed without prior authorization. No payment is made for services in excess of eight physical therapy, eight occupational therapy, and 15 speech/language therapy visits to a provider in a 12-month period, unless prior authorization has been obtained from MassHealth.

Examples:

1. If a member's first physical-therapy visit after February 1, 2004, is March 22, 2004, then the 12-month period for physical therapy is March 22, 2004, through March 21, 2005. MassHealth will pay the provider for seven additional physical-therapy visits before March 22, 2005, without prior authorization. To avoid disruption in treatment, providers are encouraged to request prior authorization as soon as they believe that medically necessary therapy will exceed the number of visits allowed without prior authorization.

2. If the same member receives occupational therapy in addition to physical therapy, and the first occupational-therapy visit is April 29, 2004, then the 12-month period for occupational therapy is April 29, 2004, through April 28, 2005. MassHealth will pay the provider for seven additional occupational-therapy visits before April 29, 2005, without prior authorization.

Exception: If a member is receiving therapy under a prior authorization given by MassHealth before February 1, 2004, MassHealth will not count visits authorized by that prior authorization toward the initial eight or 15 visits allowed without prior authorization. Rather, after the number of visits approved before February 1, 2004, are provided, or after the prior authorization expires, whichever is sooner, a member may receive eight or 15 therapy visits, as allowed under these new regulations, within a 12-month period before the provider must request another prior authorization.

> **Example:** If a member is receiving speech/language therapy under a prior authorization that was issued before February 1, 2004, and that expires on May 15, 2004, then the 12-month period for speech/language therapy begins on the date of the first visit after the date the prior authorization expires. If this member's next speech/language therapy visit is May 20, 2004, then the 12-month period in this example begins on May 20, 2004. MassHealth will pay for a total of 15 speech/language therapy visits between May 20, 2004, and May 19, 2005, without prior authorization.

Requesting Prior Authorization

To request prior authorization, the provider must complete the Request for Prior Authorization form as instructed in MassHealth's billing instructions, or use the Web-based Automated Prior Authorization System (APAS), which is available at www.masshealth-apas.com.

In addition, the provider must complete a Request and Justification for Therapy Services form and attach it to the prior-authorization request, whether the request is submitted on paper or using APAS. If you are using APAS, you can either download this MassHealth form, or complete it on line and submit it electronically as part of the request.

You can also download the Request and Justification form from the MassHealth Provider Services Web site at www.mahealthweb.com. Click on Publications and Forms. If you prefer, you can also request supplies of this form from this Web site or by submitting a written request to the following address or fax number.

MassHealth
Attn: Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 703-917-4937

When requesting forms, include the name and quantity of the form, your MassHealth provider number, street address (no post office boxes), and contact name and telephone number.

Billing for Services with Prior Authorization

MassHealth will notify the provider and member in writing of its decision on the request for prior authorization. When billing for services, you must enter the prior-authorization number on the claim as indicated below. This prior-authorization number is printed on the approval letter, and if you used APAS to request prior authorization, it is also listed on APAS. When billing for authorized services:

- Enter the six-character prior-authorization number in Item 4 of claim form no. 9 or its electronic equivalent. If you are billing in the 837P format, refer to the Detail Data section of the *MassHealth 837P Companion Guide* for correct placement of this number on the claim.

- Do not include on the same claim form (or electronic equivalent) any therapy services that are part of the original eight or 15 that do not require prior authorization.

- Submit a separate claim form (or its electronic equivalent) for each type of therapy (physical, occupational, or speech/language) for members who have received authorization for more than one type. (**Note:** Each type of therapy will have a separate prior-authorization number.)

Maintenance Program

The attached revisions to the home health agency regulations also clarify that MassHealth does not pay for performance of a maintenance program. A maintenance program is defined as repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist. MassHealth pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

Effective Date

These regulations are effective January 1, 2004.

Questions

If you have any questions about the information in this letter, please call 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 iv, vii, and 4-1 through 4-10

OBSOLETE MATERIAL

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

Therapist Manual

Pages iv, 4-1, 4-2, 4-9, and 4-10 — transmitted by Transmittal Letter THP-15

Pages vii, 4-5, and 4-6 — transmitted by Transmittal Letter THP-11

Pages 4-3, 4-4, 4-7, and 4-8 — transmitted by Transmittal Letter THP-19

4. PROGRAM REGULATIONS

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Each manual in the series contains administrative regulations, billing regulations, program regulations, service codes and descriptions, billing instructions, and general information. MassHealth's regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. Regulations promulgated by MassHealth are assigned Title 130 of the Code. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other provider manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For speech and hearing centers, those matters are covered in 130 CMR Chapter 413.000, reproduced as Subchapter 4 in the *Therapist Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which provide instructions for making changes by hand ("pen-and-ink" revisions), and by substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth's effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and with MassHealth members.

432.401: Introduction

All therapists participating in MassHealth must comply with MassHealth regulations, including but not limited to 130 CMR 432.000 and in 130 CMR 450.000. MassHealth pays only for those therapist services that reduce the member's physical disability.

432.402: Definitions

The following terms used in 130 CMR 432.000 have the meanings given in 130 CMR 432.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 432.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 432.000 and in 130 CMR 450.000.

Adaptive Device — an orthotic self-help device, such as a splint.

Group Therapy — therapy provided to at least one member in a group of not more than six persons.

Maintenance Program — repetitive activities intended to maintain function that can be performed safely and effectively without the skilled assistance of a qualified therapist.

Occupational Therapy — evaluation and treatment of a member in his or her own environment to minimize the debilitation of, improve, or restore impaired physical functions. Such treatment includes improvement of skills for activities of daily living; improvement of sensory motor skills; evaluation and training of upper extremities; evaluation of the need for and training in the use of prostheses; and the design, fabrication, and fitting of adaptive devices.

Office Visit — a therapy visit provided in the therapist's office (whether an individual practice, a group practice, or an association of practitioners). If the therapist has an office at home that is used for treatment of patients, services provided there are office visits.

Out-of-Office Visit — a therapy visit provided in a nursing facility, the member's home, or other out-of-office setting to which the therapist travels from his or her usual place of business.

Physical Therapy — evaluation, treatment, and restoration to normal or optimum functioning levels of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems. Such treatment includes the use of therapeutic exercise, mobilization, functional training, and traction; the physical application of heat, cold, water, radiant energy, or electricity; and the design, fabrication, and fitting of adaptive devices.

Speech/language Therapy — evaluation and treatment of speech, language, voice, and fluency disorders. Such treatment includes improvement of receptive and expressive language abilities, articulation, oral motor function, rate, rhythm, and vocal quality.

Therapy Visit – a personal contact with a member provided by a licensed physical, occupational, or speech and language therapist for the purpose of providing a covered service.

432.403: Eligible Members

(A) (1) MassHealth Members. MassHealth covers therapist services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. 130 CMR 450.105 specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services. (2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

432.404: Provider Eligibility: In State

Payment for the services described in 130 CMR 432.000 will be made only to therapists who are participating in MassHealth on the date of service. To participate in MassHealth, a therapist must meet the applicable requirements below.

(A) Physical Therapist. A physical therapist must be currently licensed by the Massachusetts Division of Registration in Allied Health Professions. If the therapist was registered under the laws of the Commonwealth prior to January 1, 1966, without having graduated from an approved educational program, he or she must have been certified by the proficiency process sponsored by the Social Security Administration's Bureau of Health Insurance on or before December 31, 1977.

(B) Occupational Therapist. An occupational therapist must be currently licensed by the Massachusetts Division of Registration in Allied Health Professions and be currently registered with the American Occupational Therapy Association.

(C) Speech/Language Therapist (Speech/Language Pathologist). A speech/language therapist must be currently licensed by the Massachusetts Division of Registration in Speech-Language Pathology and Audiology and either have a Certificate of Clinical Competence (CCC) from the American Speech, Language, and Hearing Association (ASLHA) or have obtained a statement from ASLHA of certification equivalency.

(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. MassHealth pays 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.

(130 CMR 432.406 through 432.410 Reserved)

432.411: Payable Services

MassHealth pays 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

MassHealth does 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) performance of a maintenance program. MassHealth pays for designing a maintenance program and instructing the member, member's family, or other persons in its use as part of a regular treatment visit, not as a separate service.

432.413: Nonpayable Circumstances

MassHealth does not pay a therapist for services provided under any of the following circumstances.

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

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

(C) The therapist receives compensation from the state, county, or municipality, unless he or she is supplementing his or her income by providing services during off-duty hours.

(D) Under comparable circumstances, the therapist does not customarily bill private patients who do not have health insurance.

432.414: Service Limitations

(A) MassHealth pays a therapist for no more than one individual treatment and one group therapy session per member per day.

(B) MassHealth does not pay for a treatment claimed for the same date of service as a comprehensive evaluation, since the evaluation fee includes payment both for a written report and for any treatment provided at the time of the evaluation.

(C) MassHealth pays a therapist for providing services in a Medicare-certified long-term-care facility only in the following circumstances.

(1) The member is not covered under Medicare Part A or B.

(2) The member is covered under Medicare, the facility has submitted the claim to Medicare, and Medicare has denied payment.

432.415: Medical Referral Requirements

(A) MassHealth pays for only those treatments and evaluations for which the therapist has obtained written referral from a licensed physician. The referral must include the following information:

(1) a complete diagnosis of the member;
(2) the date of onset of the disability for which therapy is recommended;
(3) a statement of previous treatment, if any;
(4) the date of the member's last physical examination;
(5) the reason for the referral;
(6) the date of referral; and
(7) the physician's signature and address.

(B) MassHealth pays for continuing physical or occupational therapy only when the physician's referral is renewed in writing every 60 days.

(C) A referral from a physician does not authorize payment. The therapy prescribed by a therapist pursuant to the comprehensive evaluation described in 130 CMR 432.416 must constitute appropriate and effective treatment, within accepted medical standards, for the member's condition.

432.416: Comprehensive Evaluation

A comprehensive evaluation is an in-depth assessment of a member's medical condition, disability, and level of functioning to determine the need for treatment and, when treatment is indicated, to develop a treatment plan. A comprehensive evaluation must include preparation of a written report for the member's medical record that contains at least the following information:

(A) the member's name and address;

(B) the name of the referring physician;

(C) a detailed treatment plan prescribing the type, amount, frequency, and duration of therapy and indicating the diagnosis, anticipated goals, and location where therapy will take place, or the reason treatment is not indicated;

(D) a description of any conferences with the member, member's family, member's physician, or other interested persons;

(E) other health care evaluations, as indicated;

(F) a description of the member's psychosocial and health status that includes:
(1) the present effects of the disability on the member and the member's family;
(2) a brief history, the date of onset, and any past treatment of the disability;
(3) the member's level of functioning, both current and before onset of the disability, if applicable; and
(4) any other significant physical or mental disability that may affect therapy;

(G) for speech/language therapy only:
(1) assessments of articulation, stimulability, voice, fluency, and receptive and expressive language;
(2) documentation of the member's cognitive functioning; and
(3) a description of the member's communication needs and motivation for treatment;

(H) for physical or occupational therapy only: a description of the member's physical limitations; and

(I) the therapist's signature and the date of the evaluation.

432.417: Prior Authorization

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

(1) more than eight occupational-therapy visits or eight physical-therapy visits, including an evaluation and group-therapy visits for a member in a 12-month period;

(2) more than 15 speech/language therapy visits, including an evaluation and group-therapy visits for a member in a 12-month period;

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

(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. See 130 CMR 450.303 for additional information about prior authorization.

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

(1) Notice of Approval. For all approved prior-authorization requests for therapy services, MassHealth sends written notice to the member and the therapist about 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, MassHealth notifies both the member and the therapist of the denial or modification and the reason. In addition, the member will receive information about the member's right to appeal and the appeal procedure.

(b) A member may request a fair hearing from MassHealth if MassHealth denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 30 days after the date of the notice of denial or modification. MassHealth'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 provided 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.

432.420: Individual Consideration

(A) Some services listed in the service codes and descriptions in Subchapter 6 of the *Therapist Manual* are designated "I.C.," an abbreviation for individual consideration. Individual consideration means that a fee could not be established. The rate of payment for an individual consideration service will be determined by MassHealth's professional advisors, based on the therapist's descriptive report of the service provided.

(B) In order to receive payment for an individual consideration service, the therapist must attach to the claim form a detailed report of the service performed and his usual and customary charge for the service. The report must include at least the following information:

(1) a detailed description of the service provided;
(2) the diagnosis of the member's disability;
(3) the name of the referring physician; and
(4) for an adaptive device requiring more than 60 minutes to design, fabricate, and fit:
    (a) the amount of time spent constructing the device; and
    (b) a photocopy of the invoice that shows the actual cost of materials used in constructing the device.

(C) Determination of the appropriate payment for an individual consideration service is made in accordance with the following criteria:

(1) the time required to provide the service;
(2) the degree of skill required for the service;
(3) the severity or complexity of the member's disorder or disability;
(4) the policies, procedures, and practices of other third-party purchasers of care;
(5) prevailing professional ethics and accepted practice; and
(6) such other standards and criteria as may be adopted from time to time by DHCFP or MassHealth.

REGULATORY AUTHORITY

130 CMR 432.000: M.G.L. c. 118E, §§ 7 and 12.

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