***Commonwealth of Massachusetts***
***Executive Office of Health and Human Services***
***Office of Medicaid***
*600 Washington Street*
*Boston, MA 02111*
*www.mass.gov/masshealth*

MASSHEALTH
TRANSMITTAL LETTER THP-22
June 2005

**TO:** Therapists Participating in MassHealth

**FROM:** Beth Waldman, Medicaid Director BW

**RE:** *Therapist Manual* (Prior Authorization Policy for Rehabilitative Therapy Services)

This letter transmits revisions to the therapist regulations. The revisions reflect the policy changes that MassHealth announced under Therapist Bulletin 13, dated December 2004.

**Increase in Number of Payable Visits Before PA Is Required**

The revised regulations increase the number of medically necessary physical therapy (PT), occupational therapy (OT), and speech therapy (ST) visits that are payable by MassHealth within a 12-month period before prior authorization (PA) is required. The number of medically necessary visits payable by MassHealth without PA is now **20 PT visits**, **20 OT visits**, and **35 ST visits** within a 12-month period.

**Therapy Evaluations**

MassHealth no longer requires PA for comprehensive evaluations, and no longer counts them as part of the therapy visits that are payable without PA within a 12-month period. In addition, MassHealth no longer requires PA for a second comprehensive evaluation within a 12-month period.

**Please Note:** Although the attached regulations are revised July 1, 2005, the increase in the number of payable therapy visits and the elimination of the PA requirement for therapy evaluations have been in effect since January 1, 2005, as stated in the above-mentioned bulletin.

**Maintenance Programs**

The attached revisions also provide a revised definition of maintenance program and change the policy on coverage for maintenance programs. See 130 CMR 432.414(D).

MassHealth defines maintenance programs as “repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed therapist for safety and effectiveness.”

130 CMR 432.414(D) states:

> (D) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service.
>
> (1) The MassHealth agency does not pay a therapist for performance of a maintenance program, except as provided in 130 CMR 432.414(D)(2).
>
> (2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

**Revised Definitions**

MassHealth has also revised the definitions for Occupational Therapy, Physical Therapy, and Speech/Language Therapy to make them consistent with industry standards.

**Adaptive Devices**

The revised regulations also amend 130 CMR 432.417(A)(5) and remove references to 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. This revision reflects changes communicated to providers in Transmittal Letter THP-20. MassHealth covers the design, fabrication, and fitting of an adaptive device for members under age 21 as part of a member's therapy treatment. If the design, fabrication, and fitting of an adaptive device require additional time beyond the maximum one-hour visit, the provider can refer the member to an orthotic provider.

**Tips on Requesting PA**

MassHealth encourages providers to use its Web-based Automated Prior Authorization System (APAS) at www.masshealth-apas.com when requesting PA for therapy services in excess of 20 PT visits, 20 OT visits, or 35 ST visits, within a 12-month period. To receive more information about requesting PA using APAS, including training and access to APAS, call 1-866-378-3789.

A number of PA requests for therapy services have been returned to providers or delayed in processing because of confusion about how to request PA. The following are guidelines for completing PA requests for PT, OT, and ST.

***General Instructions***

When requesting PA, whether on the Automated Prior Authorization System (APAS), or on the paper Request for Prior Authorization, you must:

- submit a complete, legible Request and Justification for Therapy Services form (R&J);
- submit a current (within 60 days) physician prescription for initial requests, and a physician's order for renewal for subsequent requests;
- submit a copy of the most recent comprehensive evaluation or reevaluation;
- summarize the member's medical necessity in Section VII of the R&J form and submit all appropriate information for substantiating medical necessity for the requested service;
- use the most appropriate code for the service (see below for more information about service codes); and
- make sure that the services on the PA request are consistent with the services shown on the R&J.

***Service Codes***

Service codes are listed in Subchapter 6 of the *Therapist Manual*. To view Subchapter 6 on the Web, go to www.mass.gov/masshealthpubs. Click on "Provider Library," then on "MassHealth Service Codes and Descriptions."

***Calculating Units***

To calculate the total number of units, identify the number of:

- visits needed per week;
- weeks for which you will need to schedule visits; and
- units needed for each visit to enable you to provide all modalities of service.

**Example:** If the R&J form indicates that you plan to see the member twice a week, for one hour each visit, for a four-week period, the number of units is as follows:

- 2 visits x 4 15-minute units = 8 15-minute units per week
- 8 15-minute units x 4 weeks = 32 15-minute units over the course of four weeks.

**Note:** Most therapy codes are expressed in 15-minute units, but there are exceptions. The following codes that require PA are billed with a different unit structure (one unit per visit allowed).

| | | | |
|---|---|---|---|
| 97010 | 97016 | 97020 | 97026 |
| 97012 | 97018 | 97024 | 97028 |

Units must be distributed among the services being provided. If you are requesting PA to provide four different services (for example, ultrasound (97035), manual therapy techniques (97140), therapeutic exercise (97110), and gait training (97116)) during each of two visits per week for a one-month period, the breakdown of units for the duration of the PA might look like this:

| Service Code | Units per Week | No. of Days |
|---|---|---|
| 97035 | 8 | 30 |
| 97140 | 8 | 30 |
| 97110 | 8 | 30 |
| 97116 | 8 | 30 |
| | **32** | **30** |

If you are requesting to provide therapy services to a member for an hour two times a week for a one-month period, but plan to provide more of one service (for example, therapeutic exercise (97110), and not provide another (for example, gait training), the breakdown of units for the duration of the PA might look like this:

| Service Code | Units per Week | No. of Days |
|---|---|---|
| 7035 | 8 | 30 |
| 97140 | 8 | 30 |
| 97110 | 16 | 30 |
| | **32** | **30** |

**Revised R&J**

MassHealth has revised the R&J form to reflect the revised regulations. In addition, the sites of service delivery have been expanded to include rehabilitation centers and "other" locations. The revised form also clarifies that a summary of the member's medical necessity must be provided in Section VII of the R&J. This requirement is in addition to the requirement to attach supporting documentation to the form. The revised form is available on the MassHealth Web site at www.mass.gov/masshealthpubs. Click on "Provider Library," then on "Provider Forms." You may continue to submit PA requests with the previous version of the R&J form, but you should make note of the new language.

To order supplies of the new form, send a written request to MassHealth Customer Service or call them at

MassHealth
P.O. Box 9118
Hingham, MA 02043
Telephone: 1-800-841-2900
E-mail: publications@mahealth.net
Fax: 617-988-8973.

Include your provider number, mailing address, contact name, and desired quantity with all requests for forms.

**MassHealth Guidelines**

To provide additional assistance to MassHealth providers requesting prior authorization for therapy services, MassHealth has developed Guidelines for Medical Necessity Determination for Physical Therapy, for Occupational Therapy, and for Speech and Language Therapy. These Guidelines are intended to clarify the specific medical information that MassHealth needs to determine medical necessity. They are not intended to replace or supersede program regulations. All MassHealth Guidelines for Medical Necessity Determination are available at www.mass.gov/masshealth/guidelines. From this site, you can also sign up to receive e-mail notification of updates to the MassHealth Guidelines.

**Effective Date**

These regulations are effective July 1, 2005.

**Questions**

If you have any questions about the information in this transmittal letter before July 1, 2005, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231. If you will be making your inquiry on or after July 1, 2005, please call MassHealth Customer Service at 1-800-841-2900 or e-mail your inquiry to providersupport@mahealth.net.

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

Therapist Manual

Pages 4-1 through 4-10

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

Therapist Manual

Pages 4-1 through 4-10 — transmitted by Transmittal Letter THP-21

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. The MassHealth agency 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 services, required to maintain or prevent the worsening of function, that do not require the judgment of a licensed therapist for safety and effectiveness.

Occupational Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

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 – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

Speech/Language Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

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 by the American Occupational Therapy Association (AOTA) or is a graduate of a program in occupation therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by AOTA.

(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 (ASHA) or have obtained a statement from ASHA 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. The MassHealth agency 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

The MassHealth agency pays for the following therapist services subject to the conditions and limitations of 130 CMR 432.000:

(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 MassHealth agency 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; and

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

432.413: Nonpayable Circumstances

The MassHealth agency 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 the MassHealth agency and is paid by the facility to provide that service, whether or not the cost of the service is included in the MassHealth agency’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) The MassHealth agency pays a therapist for no more than one individual treatment and one group therapy session per member per day.

(B) The MassHealth agency 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) The MassHealth agency 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.

(D) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service.

(1) The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 432.414(D)(2).

(2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

432.415: Medical Referral Requirements

(A) The MassHealth agency pays for only those treatments and evaluations for which the therapist has obtained written referral from a licensed physician or a licensed nurse practitioner. 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 or nurse practitioner's signature and address.

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

(C) A referral from a physician or nurse practitioner 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 or nurse practitioner;

(C) a detailed treatment plan prescribing the type, amount, frequency, and duration of therapy and indicating the diagnosis, prognosis, 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 clinician, 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. The MassHealth agency 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-therapy visits or 20 physical-therapy visits, including group-therapy visits for a member in a 12-month period;

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

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

(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, the MassHealth agency 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, the MassHealth agency 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 the MassHealth agency if it denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 30 days after the date of receipt of the notice of denial or modification. The MassHealth 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 or licensed nurse practitioner'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 the MassHealth agency'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; and
(3) the name of the referring physician.

(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 the MassHealth agency.

REGULATORY AUTHORITY

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

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