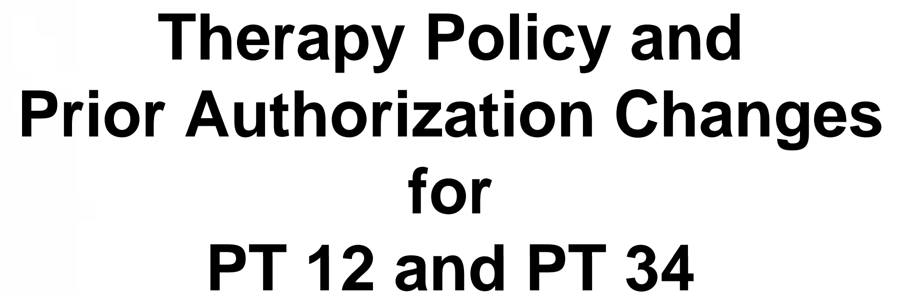
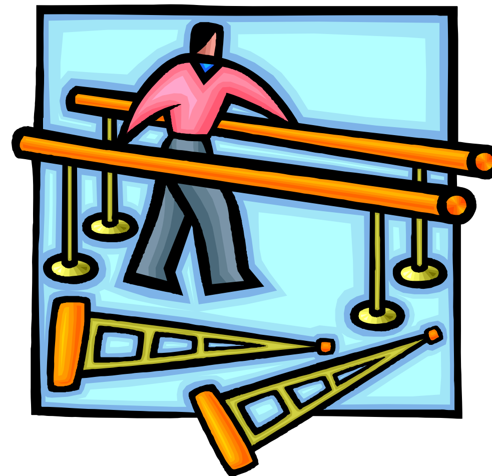


Therapy Policy and Prior Authorization Changes for PT 12 and PT 34

Colleen Boltman, Magellan Medicaid Administration, Inc. and
Carol Tilstra, Division of Health Care Financing and Policy (DHCFP)
Health Care Management
December 2010

Agenda

- Policy
- Prior Authorization Process
- Questions and Answers



PT 12 and 34 PA Changes

Beginning January 1, 2011

- Prior authorization will be required for all initial and concurrent therapy services

- Exceptions to PA for Evaluations:
  - ✓ 92506 Speech/Language evaluation
  - ✓ 97001 Physical Therapy evaluation
  - ✓ 97003 Occupational Therapy evaluation
  - ✓ 97002 Physical Therapy re-evaluation
  - ✓ 97004 Occupational Therapy re-evaluation

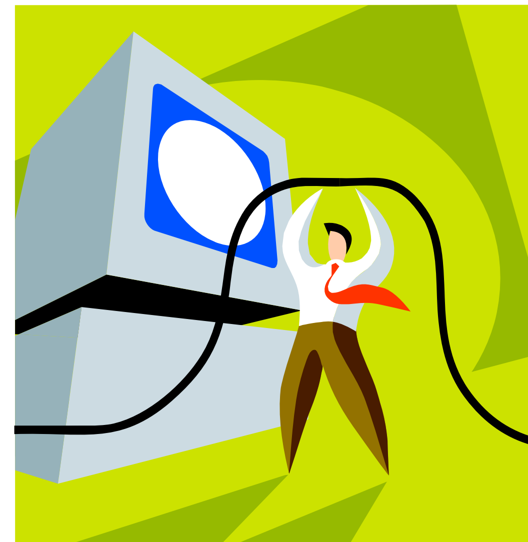
Benefits of Therapy Changes

- Medical necessity is established at the onset of service

- Prior authorizations modify the claims payment process to ensure timely and accurate payment to providers

State Policy References

- Medicaid Services Manual (MSM) Chapter 1700 contains State policy for all therapy services
- 42 CFR 440.110: Outpatient therapy is an optional service under State Medicaid Programs (PT 34)
- 42 CFR 440.20: Outpatient hospital therapy is a mandatory service under State Medicaid Programs (PT 12)



Highlights of Therapy Policy

"For therapy to be medically necessary, it must 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."*

Highlights of Therapy Policy

- Requests for therapy must include the following documentation:
  - ✓ Description of functional deficits
  - ✓ Assessment of:
    - ✓ Measurable degree of interference with muscle and joint mobility
    - ✓ Measurable deficits in skills for daily living
    - ✓ Measurable deficits in speech and/or communication
  - ✓ Individualized plan:
    - ✓ Addresses documented disabilities
    - ✓ Needs to include the therapy frequency, modalities and/or therapeutic procedure
    - ✓ Short- and long-term goals of the planned treatment
    - ✓ How the plan will measure and report progress
  - ✓ Each PA is for an independent period of time indicated by the start and end dates of the service period

Highlights of Therapy Policy

- Restorative services not covered if:
  - ✓ Potential expected improvement in function would be insignificant in relation to the extent and duration of therapy required to achieve such potential
  - ✓ At any point in an illness it is determined that the expectations will not materialize then the services would no longer be considered medically necessary
  - ✓ Failure to progress toward goals after a reasonable period of time

Highlights of Therapy Policy*

- Diagnosis:
  - ✓ Primary diagnosis must identify the functional deficit which requires therapeutic intervention & the related illness or injury diagnosis
  - ✓ Therapy for Developmental Delay Disorders may be covered for:
    - ✓ Speech and language
    - ✓ Fine and/or gross motor skills development when the functional deficit(s) are identified by ICD-9-CM diagnosis code(s) and meet all medical necessity requirements

* Policy highlights do not address section 1703-Lymphedema Therapy

Medically Necessary Therapy

- Service must be acceptable standard of medical practice to treat recipient’s functional deficits and medical condition
- Service can only be safely and effectively performed by a qualified therapist or qualified assistant under the therapist’s supervision
- Expectation that the functional deficit/condition will improve in a reasonable and predictable period of time
  - ✓ Physician must determine the realistic rehabilitative/restorative potential in consultation with the qualified therapist
- Amount, frequency and duration of therapy must be appropriate and reasonable based upon best practice standards for the illness or injury being treated

Therapy Coverage Guidelines

- Outpatient therapy is limited to twenty-four (24) sessions per discipline, per calendar year for individual and/or group therapy services

- Exceptions to annual therapy limits may be covered if medically necessary and the following conditions are met:
  - ✓ Presentation of a new acute condition
  - ✓ Therapist intervention is critical to the realistic/restorative goal

- Individual therapy session may be covered up to a max of one hour provided to:
  - ✓ Same recipient
  - ✓ By same therapist
  - ✓ On same day

Therapy Coverage Guidelines

- Group therapy (comprised of no more than 2-4 individuals) may be covered up to a max of 90 minutes per session when the service is provided to:
  - ✓ Same recipient
  - ✓ By same therapist
  - ✓ On same day

- An evaluation which requires 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

- Covered codes for therapy providers can be found in Table 34A in the Provider Type 34 Billing Guide at @cq] •KKD ^åã&aã.} ç.*[ç (see “Provider Billing” under the “Providers” tab)

Medicare

Qualified Medicare Beneficiary (QMB) Coverage

Benefit Plan (Plan Coverage Desc)	Begin-End (Date Time Period)	Eligibility or Benefit Info	Patient Pay (Benefit Amt)	NPI/API (Benefit Related Entity ID)	Phone Number Communication Number
MED CO & DED	05/01/2009-05/31/2009	1		0000000000	000-000-0000

- Prior Authorization requests are unnecessary for recipients in the “QMB Only” program
- Medicaid pays only co-pay and deductible up to the Medicaid allowable amount

PA Process

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Health Care Management
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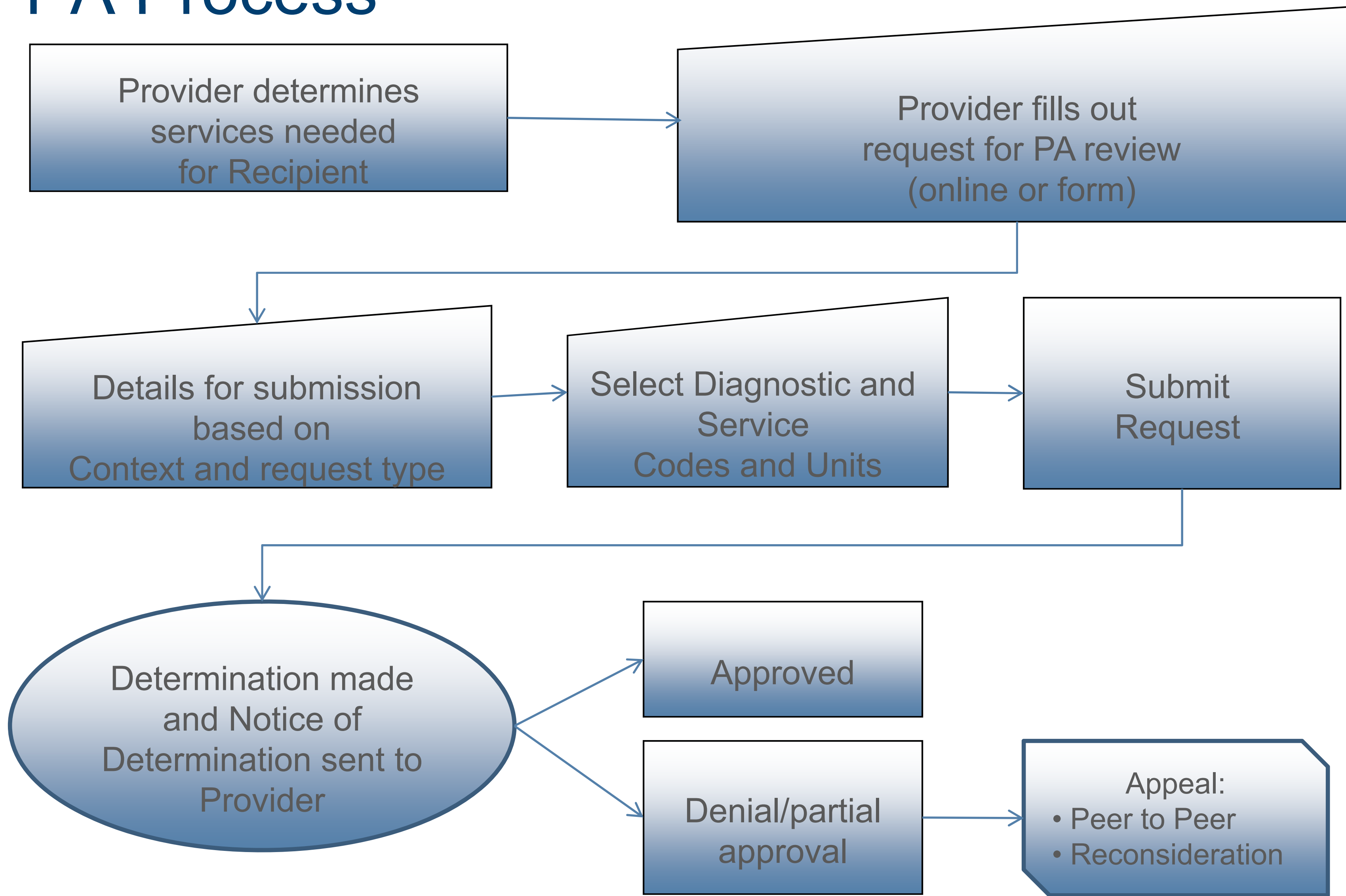
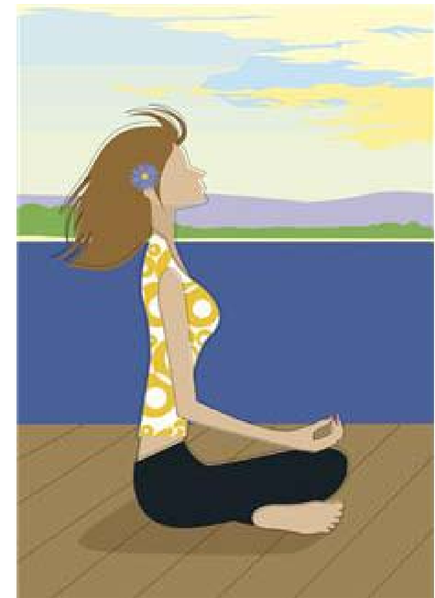
PA Process



Prior Authorization

- See Chapter 4 of the Billing Manual for PA guidelines
- PA may be requested online via FirstHCM/OPAS or by fax via form FA-7



Time Frames

- Prior authorizations can be requested up to fifteen (15) days prior to services for eligible recipients
- Request PA within ninety (90) days from the date of decision-retro eligible recipients
- Respond within five (5) days for requests for additional clinical information

How NPI and PA are Used

NPI of the Provider serving the Recipient must be used for the PA

- Group NPI:
  - ✓ When the PA is requested under the group/billing number, this number must be used when billing the claim
- Individual NPI:
  - ✓ When the PA is requested under the individual/servicing number, place this number in field 24J (CMS-1500) when billing the claim
- Authorization errors occur:
  - ✓ When eligibility isn't verified
  - ✓ When NPIs are not valid
- Data correction avoidance:
  - ✓ Due diligence to above
  - ✓ Due diligence to PA process

Adverse Determination

- Technical Denial
  - ✓ PA not completed by required time frame
  - ✓ Inadequate clinical information to make a determination

- Complete Denial
  - ✓ Lack of medical necessity based on available clinical information submitted

- Partial Approval
  - ✓ PA approved for portion of requested services and denied for remaining services based upon clinical documentation

PA Appeal Process

- Peer to Peer Review
  - ✓ Provider requested within ten (10) calendar days of date of adverse determination
  - ✓ 1-800-525-2395 to request an appointment
  - ✓ Peer review conducted with Magellan Medicaid Administration physician who rendered original determination

- Reconsideration
  - ✓ Provider requested in writing within thirty (30) calendar days of date of adverse determination
  - ✓ Reconsideration reviewed by an alternate Magellan Medicaid Administration physician to MD who generated the original determination

Resources

- User Administration Console (UAC)
  - ✓ Access to Online Prior Authorization System application
- PA fax form FA-7
  - ✓ 1-800-480-9903
- PA phone
  - ✓ 1-800-525-2395
- Website: https:medicaid.nv.gov
  - ✓ UAC
  - ✓ Billing Manual (“Providers” tab)
  - ✓ CMS-1500 Claim Form Instructions
  - ✓ Provider Type 34 Billing Guide
  - ✓ Medicaid Services Manual (“Quick Links” tab)
- Eligibility Verification System (EVS)