Date: 08/16/06

Web Announcement 98

Policy and Billing Updates for Therapy Services Providers:

Chapter 1700-Therapy Services of the Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual (MSM) has been updated, along with the Billing Guidelines for Therapy Providers. Provider Type (PT) 12 (Hospital, Outpatient), PT 17 (Special Clinics) and PT 34 (Therapy) are affected by the updates.

Changes to Chapter 1700 that are critical for all therapists providing services as hospital outpatient therapists (PT 12), special clinics therapists (PT 17) and individual therapy providers (PT 34) include:

- Changes in the prior authorization requirements.
- New policy for lymphedema therapy.
- Update to Cochlear implantation therapy policy.

New Billing Guidelines for Therapy effective 09/01/06

Claims for services provided on or after 09/01/06 must be billed according to the new guidelines, which include the following:

- Updated code list with required provider specific modifiers for each code.
- Number of units allowed per recipient, per day, by the same provider.
- Specification that these procedures must be billed by the same provider by individual days (on a HCFA/CMS 1500 claim form per line item and on a UB-92 claim form by individual revenue lines).
- Instructions for occurrence-based and time-based codes.
- Special instructions for therapy codes used for lymphedema therapy.

Special notations regarding provider modifiers:

- Claims submitted for services provided on or after 09/01/06 will deny without the provider specific modifier.
- Provider modifiers are only to be used on the claim form. Do not indicate the modifier when requesting Prior Authorization.

Review updated policy in Chapter 1700 of the Medicaid Services Manual posted on the Division's website (http://dhcfp.state.nv.us) and updated billing instructions in the Billing Guidelines for Therapy Providers posted on the First Health Services website (https://medicaid.nv.gov).