Connecticut interChange MMIS

Provider Manual

Chapter 7 - Independent Therapy

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Requirements for Payment of Services Provided by Independent Licensed Audiologists, Physical Therapists, Occupational Therapists and Speech Pathologists

Sec. 17b-262-630. Scope

Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of services provided by independent licensed audiologists, physical therapists, occupational therapists and speech pathologists for clients who are determined eligible to receive services under Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes. Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies shall not apply to therapy services provided by home health agencies, clinics, rehabilitation centers, hospitals or other health care providers.

Sec. 17b-262-631. Definitions

For the purposes of sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Advanced practice registered nurse" or "APRN" means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;

(2) "Audiologist" means a person licensed to practice audiology pursuant to chapter 397a of the Connecticut General Statutes and who meets the definition of "qualified audiologist" in 42 CFR 440.110(c)(3);

(3) "Audiology" means evaluation and treatment provided by an audiologist;

(4) "Border provider" has the same meaning as provided in section 17b-262-523 of the Regulations of Connecticut State Agencies;

(5) "Chronic disease hospital" has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;

(6) "Client" means a person eligible for goods or services under Medicaid;

(7) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;

(8) "Department" means the Department of Social Services or its agent;

(9) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services that are not otherwise covered under Medicaid but which are nevertheless covered as EPSDT services for Medicaid-eligible children

pursuant to 42 USC 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider and the service is a type of service that may be covered by a state Medicaid agency and qualifies for federal reimbursement under 42 USC 1396d;

(10) "Home" means the client's place of residence, which includes a boarding home or residential care home. Home does not include a hospital or long-term care facility;

(11) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies. It shall also include an out-of-state hospital or a hospital that is a border provider;

(12) "Independent therapist" means an audiologist, physical therapist, occupational therapist or speech pathologist practicing in the community independently and not associated with a hospital, long-term care facility, clinic, home health agency or any other health care provider;

(13) "Independent therapy" means those services provided by an independent therapist, a physical therapy assistant or an occupational therapy assistant;

(14) "Intermediate Care Facility for the Mentally Retarded" or "ICF/MR" means a residential facility for individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(15) "International Classification of Diseases" or "ICD" means the most recent system of disease classification established by the World Health Organization or such other disease classification system that the department requires providers to use when submitting Medicaid claims;

(16) "Licensed practitioner" means a physician, a physician assistant, an advanced practice registered nurse or a podiatrist providing services within the licensed practitioner's scope of practice under state law;

(17) "Long-term care facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities;

(B) inpatient chronic disease hospitals; and

(C) intermediate care facilities for the mentally retarded;

(18) “Medicaid” means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(19) “Medical necessity” or “medically necessary” have the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(20) “Nursing facility” has the same meaning as provided in 42 USC 1396r(a) and is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or a rest home with nursing supervision;

(21) “Occupational therapist” has the same meaning as provided in section 20-74a(2) of the Connecticut General Statutes;

(22) “Occupational therapy” means services provided by an occupational therapist or an occupational therapy assistant and that meet the definition of occupational therapy in 42 CFR 440.110(b);

(23) “Occupational therapy assistant” has the same meaning as provided in section 20-74a(3) of the Connecticut General Statutes;

(24) “Physical therapist” has the same meaning as provided in section 20-66 of the Connecticut General Statutes;

(25) “Physical therapy assistant” has the same meaning as provided in section 20-66 of the Connecticut General Statutes;

(26) “Physical therapy” means the evaluation and treatment provided by a physical therapist or physical therapy assistant in accordance with 42 CFR 440.110(a);

(27) “Physician” means a person licensed pursuant to section 20-13 of the Connecticut General Statutes;

(28) “Physician assistant” has the same meaning as provided in section 20-12a(5) of the Connecticut General Statutes;

(29) “Podiatrist” means a person licensed to practice podiatric medicine pursuant to chapter 375 of the Connecticut General Statutes;

(30) “Prior authorization” means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(31) “Provider” means an independent therapist enrolled with Medicaid;

(32) “Provider agreement” means the signed, written agreement between the department and the provider for enrollment in Medicaid;

(33) “Speech pathologist” means a “licensed speech and language pathologist” as defined in section 20-408 of the Connecticut General Statutes;

(34) “Speech pathology services” means the evaluation and treatment provided by a speech pathologist in accordance with 42 CFR 440.110(c); and

(35) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, “usual and customary” means the median charge. Token charges for charity patients and other exceptional charges shall be excluded when calculating the usual and customary charge.

Sec. 17b-262-632. Provider participation

In order to participate in Medicaid and receive payment from the department, providers shall:

(a) Comply with all applicable licensing, accreditation and certification requirements;

(b) comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(c) comply with sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies; and

(d) have a valid provider agreement on file with the department.

Sec. 17b-262-633. Eligibility

Payment for independent therapy services prescribed by a licensed practitioner is available on behalf of all clients who have a need for such services and which are medically necessary subject to the conditions and limitations which apply to such services.

Sec. 17b-262-634. Services covered and limitations

Subject to the limitations and exclusions in this section, the department shall pay for independent therapy which conforms to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental or cosmetic nature; for services in excess of those deemed medically necessary by the department to treat the client’s condition; or for services not directly related to the client’s diagnosis, symptoms or medical history.

(a) The department shall pay for the following:

(1) Services provided in the provider's office or the client's home; and

(2) EPSDT Special Services.

(b) Limitations on covered services shall be as follows:

(1) Evaluation services for physical therapy, speech therapy, occupational therapy and audiology shall be limited to one of each type per day, per client regardless of the length of time it takes to complete the evaluation;

(2) for physical therapy and occupational therapy services, the department shall pay per modality as listed on the fee schedule;

(3) for speech therapy and audiology services, the department shall not pay for more than one and one half hours of treatment per day;

(4) the fee for evaluation shall include all treatment when evaluation and treatment are provided on the same day; and

(5) group speech therapy services shall include a maximum of three persons per group, per session regardless of each participant's payment source.

(c) The department shall not pay for the following independent therapy:

(1) Independent therapy when the client is concurrently receiving the same therapy services from a hospital, chronic disease hospital, clinic, rehabilitation clinic, home health agency or any other health care provider;

(2) services provided to clients who are residents of a hospital, long-term care facility or any other facility that is required to include independent therapy in its rates;

(3) cancelled office visits or appointments not kept; and

(4) information or services provided to a client by a provider electronically or over the telephone.

Sec. 17b-262-635. Need for service

(a) The department shall pay for independent therapy that is medically necessary when a licensed practitioner prescribes the client's need for the service.

(b) A licensed practitioner shall reestablish the need for service by performing an evaluation not more than twelve months after the previous evaluation.

(c) The provider shall document the initial and subsequent need for service in the client's record.

Sec. 17b-262-636. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) All audiology, physical therapy, occupational therapy and speech pathology evaluation services in excess of one evaluation per calendar year, per client, per provider;

(2) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of nine treatments per calendar year per provider per client, involving the following primary diagnoses:

(A) All mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the ICD;
(B) cases involving musculoskeletal system disorders of the spine covered by the ICD; and

(C) cases involving symptoms related to nutrition, metabolism and development covered by the ICD;

(3) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of two services per calendar week, per client, per provider;

(4) EPSDT Special Services, as follows:

(A) EPSDT Special Services are determined medically necessary on a case-by-case basis; and

(B) the request for EPSDT Special Services shall include:

(i) A written statement from a licensed practitioner justifying the need for the item or services requested; and

(ii) any other documentation required by the department in order to render a decision; and

(5) any service that is not on the department's fee schedule.

(b) The length of the initial authorization period is at the department's discretion, but shall be for no longer than three months;

(c) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six

months per request or longer if determined appropriate by the department on a case- by-case basis.

(d) For services requiring prior authorization, a provider shall provide pertinent medical or social information adequate to evaluate the client's medical need for the services.

(e) In order to receive payment from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met.

Sec. 17b-262-637. Billing procedures

Providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment.

Sec. 17b-262-638. Payment

(a) Payment rates shall be the same for in-state, border and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the independent therapy fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(c) Notwithstanding the provisions of subsection (b)(5) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual without affecting the amount paid by the department for the same or substantially similar goods or services.

Sec. 17b-262-639. Payment rates

The commissioner shall establish the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

Sec. 17b-262-640. Documentation

(a) Providers shall maintain a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the provider, documentation of services provided and the dates the services were provided.

(b) The provider shall maintain all required documentation in its original form, paper or electronic, for at least five years or longer, as required by applicable statutes and regulations in the provider's file, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation until the end of the dispute or five years, whichever is greater.

(c) The department may disallow and recover any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(d) The department may audit any relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with all regulatory and statutory requirements.