PROVIDER POLICIES & PROCEDURES

REHABILITATION SERVICES

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for rehabilitation services performed in outpatient settings. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Rehabilitation Services means medical and remedial services provided to an individual located outside of an inpatient setting, the purpose of which is the maximum reduction of physical or mental disabilities and restoration of individuals to their best possible functional level. The services are performed under the direction of a licensed physician (MD), Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA). For the purposes of this policy, the term rehabilitation service refers to physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services as well as audiology services.

CLINICAL GUIDELINE

HUSKY Health uses Change Healthcare's InterQual® Criteria when reviewing prior authorization requests for coverage of rehabilitation services. In instances where the requested frequency or duration of services exceeds InterQual recommendations, an individualized review will be performed by a therapist reviewer (i.e., physical therapist, occupational therapist) to determine if the request meets all of the following criteria:

1. The member has an ongoing illness, injury or condition resulting in decreased level of function;
2. Rehabilitation potential indicates the expectation that a member's condition will improve with skilled intervention;
3. The plan of care includes appropriate objective and subjective measurements to demonstrate the medical necessity of the proposed treatment;
4. Objective measurements show continued deficits and functional impairments compared to normal values and the member's prior level of function;
5. The documentation includes physical and functional improvement compared to prior measurements and assessments submitted;
6. The documentation includes the medical need for continued skilled intervention;
7. The plan of care includes updated/progressed objective and measurable short- and long-term goals compared to prior goals submitted;
8. The plan of care includes a frequency and duration of proposed ongoing therapy services; and
9. The documentation demonstrates the member's compliance with the treatment plan and established home exercise program.

If the above criteria are not met, the request will be reviewed by a physician reviewer to determine the medical necessity of the requested services.

Coverage guidelines for rehabilitation services performed in outpatient settings are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the criteria conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail.

PRIOR AUTHORIZATIONREQUIREMENTS FOR REHABILITATION SERVICES

Independent therapists (setting), rehabilitation clinics and outpatient hospitals:

- Prior authorization is NOT required for an initial evaluation.
- Prior authorization is required for greater than one evaluation per calendar year per provider and two visits per calendar week per provider for PT/ST/Audiology (NOTE: the prior authorization requirements for audiology services do not apply to outpatient hospitals)
- Prior authorization is required for greater than one evaluation per calendar year per provider and one visit per calendar week per provider for OT performed in a rehabilitation clinic.
- Prior authorization is required for greater than one evaluation per calendar year per provider and two visits per calendar week per provider for OT performed by an independent therapy provider or in an outpatient hospital.
- Prior authorization is also required for PT/ST/OT services greater than nine visits per calendar year, per provider for the following diagnoses*:
    1. A mental disorder including an intellectual disability or a specific delay in development;
    2. A musculoskeletal system disorder involving the spine;
       Or
    3. A symptom related to nutrition, metabolism, or development.

  *****For a list of corresponding ICD-10 CM diagnosis codes, please visit the DSS Fee Schedule Instructions located at www.ctdssmap.com →Provider → Provider Fee Schedule Download →Provider Fee Schedule Instructions (Table 15).

Physician therapy providers:

- Prior authorization is NOT required for an initial evaluation
- Prior authorization is required for greater than two visits per calendar week per provider for PT.
- Prior authorization is also required for PT services greater than nine visits per calendar year, per provider for the following diagnoses*:
    1. A mental disorder including an intellectual disability or a specific delay in development;
    2. A musculoskeletal system disorder involving the spine; or
    3. A symptom related to nutrition, metabolism or development.

  *****For a list of corresponding ICD-10 CM diagnosis codes, please visit the DSS Fee Schedule Instructions located at www.ctdssmap.com →Provider → Provider Fee Schedule Download →Provider Fee Schedule Instructions (Table 15).

Home Health Agencies:

- Prior authorization is NOT required for an initial evaluation.
- Prior authorization is required for PT/ST services for greater than the two visits per week.
- Prior authorization is required for OT services for greater than one visit per week
- Prior authorization is also required for PT/ST/OT services greater than nine visits per therapy, per calendar year, per provider for the following diagnoses*:
    1. A mental disorder including an intellectual disability or a specific delay in development;
    2. A musculoskeletal system disorder involving the spine; or
    3. A symptom related to nutrition, metabolism or development.

*****For a list of corresponding ICD-10 CM diagnosis codes, please visit the DSS Fee Schedule Instructions located at www.ctdssmap.com →Provider → Provider Fee Schedule Download → Provider Fee Schedule Instructions (Table 15).

LIMITATIONS

Physical, occupational, and speech therapies and audiology services are typically not covered for individuals 21 years of age and older when provided in an independent setting. Individuals must receive these services in a clinic setting. This limitation applies only to therapy providers and therapy groups. Physicians and physician groups are not subject to this limitation.

NOTE: EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

The following information is needed to review initial requests for rehabilitation services:

1. Fully completed State of Connecticut, Department of Social Services Outpatient Prior Authorization Request form **OR** fully completed authorization request via on-line web portal;
2. Clinical evaluation;
3. Treatment plan;
4. Documentation of rehab potential;
5. Treatment goals; and
6. Other pertinent information as requested by CHNCT.

The following information is needed to review requests for the continuation of rehabilitation services:

1. Fully completed State of Connecticut, Department of Social Services Outpatient Prior Authorization Request Form **OR** fully completed authorization request via on-line web portal;
2. Detailed listing of requested services including frequency and duration;
3. Clinical information supporting the need for requested services;
4. Documentation of rehab potential;
5. Treatment goals;
6. Updated progress report;
7. A minimum of four days of encounter notes; and
8. Other pertinent information as requested by CHNCT.

Review Process:

Initial authorization requests for rehabilitation services will be reviewed within two business days. Re-authorization requests for rehabilitation services will be reviewed within 14 calendar days.

Requesting Authorization

Independent therapists, rehabilitation clinics and physician therapy providers:

- Requests for the prior authorization of rehabilitation services performed in independent settings, rehabilitation clinics and physician offices must be made using a code grouping (see below) as opposed to individual CPT codes.
  Example: When requesting an initial authorization for the first 3 months of physical therapy provided in an independent therapy setting, prior authorization request would be made using code group INPTI.
  Example: When requesting re-authorization for an additional 3 months of physical therapy provided in an independent setting, prior authorization request would be made using code group INPTR.
- Authorization requests for rehabilitation services must include a number of units. Units DO NOT equal visits. Providers must submit the full amount of units they will submit claims for during the full authorization period.
  Example: The individual needs to be seen by a physical therapist twice a week for 1 month, a total of 8 visits. During *each visit* the individual will have 30 minutes of electrical stimulation (97032-2 units), an application of a hot pack (97010 – 1 unit) and 30 minutes of manual manipulation (97140 – 2 units). The total number of units of physical therapy services provided PER VISIT is five (2 units of 97032, 1 unit of 97010 and 2 units of 97140). Five multiplied by the total number of visits during the initial authorization period (8) is 40. For the initial authorization, provider would request INPTI with 40 units. Claim would be submitted with CPT Code(s), modifier(s) and number of units.

Outpatient hospitals:

- Requests for prior authorization of rehabilitation services performed in an outpatient hospital clinic setting must be made using the applicable revenue center code(s).
- Authorization requests for rehabilitation services must include the number of units. The number of units equals the number of visits.

Home health agencies:

- Requests for prior authorization of rehabilitation services performed by a home health agency must be made using the applicable revenue center code as identified on the DSS Home Health Fee Schedule.
- Authorization requests for rehabilitation services must include the number of units. The number of units equals the number of visits.

EFFECTIVE DATE

This Policy is effective for prior authorization requests for rehabilitation services for individuals covered under the HUSKY Health Program on or after July 1, 2012.

CODES AND CODE GROUPINGS

Rehabilitation Clinics:

Code Group	Benefit	CPT Codes/Modifiers
RCSTI	ST Initial	92507, 92508, , 92521, 92522, 92523, 92524, 92526
RCSTR	ST Re-authorization	
RCPTI	PT Initial	29125, 29126, 29131, 29260, 29280, 29540, 64550, 90901, 97001, 97002, 97010-97022, 97026, 97032-97035, 97110-97124, 97140-97535, 97542, 97597-97602, 97760-97762 (all with modifier GP or all with modifiers GP and 59)
RCPTR	PT Re-authorization	
RCOTI	OT Initial	29125, 29126, 29131, 29260, 29280, 29540, 64550, 90901, 97003, 97004, 97010 – 97022, 97026, 97032-97035, 97110-97124, 97140-97535, 97542, 97597-97602, 97760-97762 (all with modifier GO or all with modifiers GO and 59)
RCOTR	OT Re-authorization	

For services performed in a rehabilitation clinic not included in the table above request authorization using the applicable CPT or HCPCS code.

Audiology evaluations in excess of one per year will require prior authorization. Please submit authorization requests using the applicable CPT codes as listed on the DSS Rehabilitation Clinic Fee Schedule.

Independent Therapists:

Code Group	Benefit	CPT Codes
INSTI	ST Initial	92507, 92508, 92521, 92522, 92523, 92524, 92526
INSTR	ST Re-authorization	
INPTI	PT Initial	97002, 97010-97150, 97530, 97542, 97760, 97761
INPTR	PT Re-authorization	
INOTI	OT Initial	97004, 97010-97150, 97530, 97542, 97760, 97761
INOTR	OT Re-authorization	

Physician Therapy Providers:

Code Group	Benefit	CPT Codes
MDPTI	Physician Therapy Initial	97010-97530, 97533-97546

MDPTR	Physician Therapy Re-authorization	

DEFINITIONS

1. **Audiology or Audiological Services**: The application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and the determination and use of appropriate amplification related to hearing and disorders of hearing, for the purpose of modifying communicative disorders involving speech, language, auditory function or other aberrant behavior related in hearing loss. Services are performed by an audiologist.
2. **Current Procedural Terminology (CPT):** The most recent edition of a listing, published by the American Medical Association, of descriptive terms and identifying codes for reporting medical services performed by providers.
3. **Healthcare Common Procedure Coding System (HCPCS):** A system of national health care codes that includes the following: Level I is the American Medical Association Physician's Common Procedural Terminology (CPT codes). Level II covers services and supplies not covered in CPT. Level III includes local codes used by state Medicare carriers
4. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
5. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
6. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
7. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
8. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
9. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
10. **HUSKY Plus Physical Program (or HUSKY Plus Program):** A supplemental physical health program pursuant to Conn. Gen. Stat. § 17b-294, for medically eligible members of HUSKY B in Income Bands 1 and 2, whose intensive physical health needs cannot be accommodated within the HUSKY Plan, Part B.
11. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration

and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

12. **Occupational therapy:** Services prescribed by a physician for the evaluation, planning, and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by physical illness or injury, emotional disorder, congenital or development disability, using (1) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual, (2) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped, (3) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities. Services are performed by an occupational therapist to evaluate the individual's level of functioning and develop a plan of treatment. The implementation of the plan may be carried out by an occupational therapy assistant functioning under the general supervision of the occupational therapist.
13. **Physical therapy:** (1) diagnostic services to determine an individual's level of functioning, employing such performance tests as measurements of strength, balance, endurance, and range of motion; (2) treatment services which utilize therapeutic exercises and modalities of heat, cold, water, and electricity, for the purpose of preventing, restoring, or alleviating a lost or impaired physical function. Services are performed by a licensed physical therapist who develops a written individual program of treatment. The term "physical therapy" does not include the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes.
14. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.
15. **Speech therapy or Speech Pathology Services**: The application of principles, methods and procedures for the measurement, testing, diagnosis, prediction, counseling or instruction relating to the development and disorders of speech, voice or language for the purpose of diagnosing, preventing, treating, ameliorating or modifying such disorders and conditions. Services are provided by a speech pathologist.

ADDITIONAL RESOURCES AND REFERENCES:

- Connecticut Medical Assistance Program Freestanding Clinic Services Regulation/Policy Chapter 7, dated January 1, 2008
- Connecticut Medical Assistance Program Therapy Services Regulation/Policy Chapter 7, dated January 1, 2008
- DSS Provider Bulletin 2012-28: Changes to Authorization Process and New Authorization Portal for Requesting Rehabilitation Therapy, dated June 2012

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	September 2012	
Reviewed	September 2013	Clinical Quality Sub-Committee Review. References updated. Added Advanced Practice Registered Nurse (APRN) and Physician Assistant (PA) to the provider types able to oversee the provision of therapy services. Clarified PA requirement for physician therapy providers under HUSKY A, C and D Programs. These changes approved at the September 16, 2013 Clinical Quality Sub-Committee meeting.
Reviewed	September 2014	Clinical Quality Subcommittee review. Reference updated. Updated CPT codes based on 2014 changes. Further defined documentation requirements for initial and continuing reviews. These changes approved at the September 15, 2014 Clinical Quality Subcommittee meeting.
Revised	August 2015	Updated definitions for HUSKY A, B, C and D programs at request of DSS.
Reviewed	September 2015	Clinical Quality Subcommittee Review. Reference updated. This change approved at the September 21, 2015 Clinical Quality Subcommittee meeting. Added ICD 10 codes. Updates to language in introductory paragraph pertaining to purpose of policy. Updates to Clinical Guideline section pertaining to definition of Medical Necessity. Changes approved by DSS on October 14, 2015
Updated	March 2016	Updated to reflect importance of person centeredness when reviewing requests for rehabilitation services. Updates related to the change in prior authorization requirements for audiology services provided in outpatient hospital settings. Changes approved at the March 21, 2016 Clinical Quality Subcommittee meeting. Removed reference to the specific criteria used to review requests for rehab services at request of DSS. Changes approved by DSS on June 14, 2016.
Updated	April 2017	Update to Procedure section. Added language clarifying the information needed to review requests for rehabilitation services and requests for the continuation of rehabilitation services. Changes approved at the May 10, 2017 Medical Policy Review Committee meeting. Changes approved at the June

		20, 2017 Clinical Quality Subcommittee meeting. Changes approved by DSS on July 14, 2017.
Updated	June 2018	Update to Additional Resources and References section. Change approved at the June 13, 2018 Medical Policy Review Committee meeting. Change approved by the CHNCT Clinical Quality Subcommittee on June 18, 2018. Approved by DSS on June 20, 2018.
Updated	April 2019	Update to Additional Resources and References section. Change approved at the April 24th, 2018 CHNCT Medical Reviewer meeting. Change approved by the CHNCT Clinical Quality Subcommittee on June 19, 2019. Approved by DSS on June 21, 2019.
Updated	April 2020	Update to Additional Resources and References section. Changes approved at the March 11, 2020 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 16, 2020. Approved by DSS on April 16, 2020.
Updated	March 2021	Removed ICD 9 diagnosis codes from policy section. Added navigation instructions to list of ICD 10 diagnosis codes on DSS website. Changes approved at the February 10, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on March 22, 2021.
Updated	March 2022	Updated Procedure section: removed need for submission of MD order or signed treatment plan. Change approved at the March 9, 2022 CHNCT Medical Reviewer meeting. Change approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022.
Updated	March 2022	Updated language related to HUSKY B and HUSKY Plus coverage. Changes approved by DSS on March 25, 2022.
Reviewed	March 2023	Reviewed and approved without changes at the February 8, 2023, CHNCT Medical Reviewer Meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
Updated	February 2024	Clinical Guidelines updated to include criteria for rehab requests that exceed InterQual recommendations. Prior authorization requirements updated to align policy language with Benefit Grid. Procedure updated to include documentation of rehab potential and minimum of four days of encounter notes. Code section updated to include 92526 within the ST code groups for independent therapists. Change approved at the

		February 14, 2024 CHNCT Medical Reviewer meeting. Change approved by the CHNCT Clinical Quality Subcommittee on March 18, 2024. Approved by DSS on March 28, 2024.