Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter II, Section 85, Physical Therapy Services

ADOPTED RULE NUMBER: N/A

CONCISE SUMMARY: This emergency rule is being adopted in accordance with PL 2011, ch. 657, Part O. The changes made in this rule allow more Physical Therapy services, up to five (5) treatment visits and one (1) evaluation within twelve (12) months, when provided pursuant to a pain management care plan as described in the MaineCare Benefits Manual Section 80.07-5(D)(3).

See http://www.maine.gov/dhhs/oms/rules/index.shtml **for rules and related rulemaking documents.**

EFFECTIVE DATE: January 1, 2013

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SECTION 85 **PHYSICAL THERAPY SERVICES** ESTABLISHED 7/1/79
LAST UPDATED 3/10/10

TABLE OF CONTENTS

PAGE

85.01 **PURPOSE** 1

85.02 **DEFINITIONS** 1

85.02-1 Functionally Significant Improvement 1
85.02-2 Maintenance Care 1
85.02-3 Physical Therapy Practitioner 1
85.02-4 Physical Therapy Services 1
85.02-5 Rehabilitation Potential 1
85.02-6 Practitioner of the Healing Arts 1

85.03 **ELIGIBILITY FOR CARE** 1

85.04 **SPECIFIC ELIGIBILITY FOR CARE** 2

85.05 **DURATION OF CARE** 2

85.06 **COVERED SERVICES** 2

85.06-1 Evaluations or Re-evaluations 3
85.06-2 Modalities 3
85.06-3 Therapeutic Procedures 3
85.06-4 Tests 3
85.06-5 Supplies 3

85.07 **LIMITED SERVICES** 3

85.07-1 All Ages 3
85.07-2 Adults 4

85.08 **NON COVERED SERVICES** 4

85.09 **POLICIES AND PROCEDURES** 4

85.08-1 Qualified Professional Staff 4
85.08-2 Member's Records 5
85.08-3 Utilization Review 6
85.08-4 Program Integrity 6

85.10 **REIMBURSEMENT** 6

85.11 **COPAYMENTS** 6

85.12 **BILLING INSTRUCTIONS** 7

SECTION 85 **PHYSICAL THERAPY SERVICES** ESTABLISHED 7/1/79
LAST UPDATED ~~12/01/11~~1/1/13

85.01 PURPOSE

The purpose of this rule is to provide medically necessary physical therapy services to MaineCare members who are adults (age twenty-one (21) and over), who are not residing in a Nursing Facility (NF) or Intermediate Care Facility-Mental Retardation (ICF-MR), and who have rehabilitation potential; and to provide medically necessary physical therapy services to MaineCare members who are under age twenty-one (21).

85.02 DEFINITIONS

85.02-1 Functionally Significant Improvement: demonstrable, measurable increase in the member's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment.

85.02-2 Maintenance Care: physical therapy services provided to a member whose condition is stabilized after a period of treatment or for whom no further functionally significant improvement is expected.

85.02-3 Physical Therapy Practitioner: an individual who is licensed as a physical therapist or licensed as a physical therapy assistant working under the supervision of a licensed physical therapist.

85.02-4 Physical Therapy Services: services ordered by a practitioner of the healing arts, oral surgeon, or if the member is enrolled in MaineCare managed care, by the member's primary care provider (PCP), and provided by or under the supervision of a licensed physical therapist for the purposes of evaluating a member's condition, and planning and implementing a program of purposeful services to develop or maintain adaptive skills necessary to achieve the maximum physical and mental functioning of the member in his or her daily pursuits.

85.02-5 Rehabilitation Potential: documented expectation of measurable functionally significant improvement in the member's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan. The physician's documentation of rehabilitation potential must include the reasons used to support the physician's expectation.

85.02-6 Practitioner of the Healing Arts: physicians and all others registered or licensed in the healing arts, including, but not limited to, nurse practitioners, podiatrists, optometrists, chiropractors, physical therapists, occupational therapists, speech therapists, dentists, psychologists and physicians' assistants.

85.03 ELIGIBILITY FOR CARE

Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I.

85.04 SPECIFIC ELIGIBILITY FOR CARE

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Services for members of all ages must be medically necessary. The Department or its authorized agent has the right to perform eligibility determination, prior authorization -and/or utilization review to determine if services provided are medically necessary.

Adult members age twenty-one (21) and over in an outpatient setting must have rehabilitation potential documented by a physician or PCP. Adult members are specifically eligible only for:

1. Treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities; and/or

2. Treatment after a surgical procedure performed for the purpose of improving physical function; and/or

3. Treatment in those situations in which a physician or PCP has documented that the patient has at some time during the preceding thirty (30) days, required extensive assistance in the performance of one or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility;

4. Medically necessary treatment for other conditions including maintenance and palliative care, subject to the limitations in Section 85.07; and/or

Eff. 1/1/13

5. Maintenance care required to prevent deterioration in functions that would result in an extended length of stay or placement in an institutional or hospital setting, as documented by a physician or PCP.

~~5.~~6. Up to five (5) treatment visits and one (1) evaluation within twelve (12) months when visits are in conjunction with a prescribed pain management plan, pursuant to the MaineCare Benefits Manual Section 80.07-5(D)(3). The treatment must be:

a. Ordered by the practitioner prescribing the Opioid medication and

~~a.~~b. Approved through a prior authorization. Prior authorization forms, which include applicable requirements can be found at: https://mainecare.maine.gov/ProviderHomePage.aspx

85.05 DURATION OF CARE

Covered services must be medically necessary and must not exceed the limitations set in Section 85.07. The Department or its authorized agent reserves the right to request additional information to evaluate medical necessity.

85.06 COVERED SERVICES

MaineCare will reimburse for covered medically necessary services in all outpatient settings, including the home. Services must be of such a level, complexity, and sophistication that the judgment, knowledge, and skills of a licensed therapist are required. All services must be in accordance with acceptable standards of medical practice and be a specific and effective

85.06 **COVERED SERVICES (cont.)**

treatment for the member's condition. Services related to activities for the general good and welfare of members (for example, general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation) are not MaineCare covered physical therapy services.

Pursuant to 42 CFR §440.110,MaineCare physical therapy services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under Maine law and must be provided by or under the direction of a qualified licensed physical therapist.

MaineCare reimburses providers for the following physical therapy services:

85.06-1 Evaluations or re-evaluations: For adults, one evaluation or re-evaluation per member per condition is a covered service.

85.06-2 Modalities: Modalities are any physical agents applied to produce therapeutic changes to biologic tissues; including but not limited to thermal, acoustic, light, mechanical, or electric energy. Except when performing supervised modalities, the therapist is required to have direct (one-on-one) continuous patient contact.

85.06-3. Therapeutic Procedures: Therapeutic procedures effect change through the application of clinical skills and/or services that attempt to improve function.

85.06-4 Tests and measurements: The therapist is required to have direct (one-on-one) continuous patient contact in performing testing and measurement.

85.06-5 Supplies: Providers may bill for supplies necessary for the provision of physical therapy services. Covered supplies under this section include items such as splinting. Providers may not bill for supplies under other Sections of the MaineCare Benefits Manual, unless they are enrolled as providers and comply with the appropriate Section requirements. Covered supplies under this Section must be billed at acquisition cost and be documented by an invoice in the member's file. Routine supplies used in the course of treatment are not separately reimbursable. Take-home supplies are not reimbursable.

85.07 **LIMITED SERVICES**

85.07-1 All ages:

A. MaineCare will not reimburse for more than two (2) hours of physical therapy services per day.

Eff. 1/1/13

B. Supervised modalities (those without direct one-to-one continuous contact) that are provided on the same day as modalities requiring constant attendance or on the same day as any other therapeutic procedure are not billable. Billing for supervised modalities as stand-alone treatment is limited to one (1) unit per modality per day.

85.07 **LIMITED SERVICES (cont.)**

Members receiving physical therapy in conjunction with a pain management plan, pursuant to the MaineCare Benefits Manual Section 80.07-5(D)(3), may not receive more than up to five (5) treatment visits and one (1) evaluation within twelve months (12), and reimbursement for such visits is conditional on prior authorization based on a demonstration that the service is medically necessary. Prior authorization forms and applicable requirements can be found at: https://mainecare.maine.gov/ProviderHomePage.aspx

85.07-2 Adults (age twenty-one (21) and over):

A. Services for adults who meet the specific eligibility requirements in Section 85.04 must be initiated within sixty (60) days from the date of physician or PCP certification.

B. Services for palliative care and maintenance care are limited to one (1) visit per year to design a plan of care, to train the member or caretaker of the member to implement the plan, or to reassess the plan of care, except that this limitation does not apply to maintenance care for members who would experience deterioration in function as described in 85.04(5).

C. Services for adults with documented rehabilitation potential who do not meet the criteria in 85.04(1)-(3) must be medically necessary as documented by a certification by a physician or PCP. Such treatment is limited to no more than one (1) visit per condition by qualified staff.

D. Services for sensory integration are limited to a maximum of two (2) visits per year.

85.08 **NON-COVERED SERVICES**

Refer to Chapter I of the MaineCare Benefits Manual for additional non-covered services, including academic, vocational, socialization or recreational services.

85.09 **POLICIES AND PROCEDURES**

85.09-1 Qualified Professional Staff

All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure. The following professionals are qualified professional staff:

Physical therapist
Physical therapy assistant

A physical therapist may be self-employed or employed by an agency or business. Agencies or businesses may enroll as a provider of service and bill directly for

85.09 **POLICIES AND PROCEDURES (cont.)**

services provided by qualified staff. A physical therapy assistant may not enroll as an independent billing provider.

85.09-2 Member Records

Providers must maintain a specific record for each member, which shall include, but not necessarily be limited to:

A. Member's name, address, birthdate, and MaineCare ID number

B. The member's social and medical history and medical diagnoses indicating the medical necessity of the service or services

C. A personalized plan of service including (at a minimum):

1. Type of physical therapy needed;

2. How the service can best be delivered, and by whom the service shall be delivered;

3. Frequency of services and expected duration of services;

4. Long and short range goals;

5. Plans for coordination with other health service agencies for the delivery of services;

6. Medical supplies for which a Practitioner of the Healing Arts' order is necessary; and

7. Practitioner of the Healing Arts' orders including, for adults, their documentation of the member's rehabilitation potential.
The physician or primary care provider must review, sign and date the member's plan of care at least once every three (3) months for adult members (age twenty-one (21) and over). The plan of care must be kept in the member's record and is subject to Departmental review along with the contents of the member's record.

D. Written progress notes each day the member is seen (also referred to as the treatment or session note) shall contain:

1. Identification of the nature, date, and provider of any service given;

2. The start time and stop time of the service, indicating the total time spent delivering the service;

85.09 **POLICIES AND PROCEDURES (cont.)**

3. Any progress toward the achievement of established long and short range goals;

4. The signature of the service provider for each service provided; and

5. A full account of any unusual condition or unexpected event, including the date and time when it was observed and the name of the observer.

Entries are required for each service billed. When the services delivered vary from the plan of care, entries in the member's record must justify why more, less, or different care than that specified in the plan of care was provided.

85.09-3 Utilization review

The Department or its authorized agent has the right to perform utilization review. If at any point of an illness or disabling condition, it is determined that the expectation for measurable functionally significant improvement will not be realized, or if they are already realized and no more services are needed, the services are no longer considered reasonable and necessary, and will not be covered.

85.09-4 Program Integrity

Requirements of Program Integrity are detailed in Chapter I of the MaineCare Benefits Manual.

85.10 **REIMBURSEMENT**

The amount of payment for services rendered shall be the lowest of the following:

1. The amount listed in Chapter III, Section 85, and "Allowances for Physical Therapy Services" of the MaineCare Benefits Manual.

2. The lowest amount allowed by the Medicare carrier.

3. The provider's usual and customary charge.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of a rendered service prior to billing MaineCare.

85.11 **COPAYMENTS**

Note: Requirements regarding copayment disputes and exemptions are contained in Chapter I of the MaineCare Benefits Manual.

A. A copayment will be charged to each MaineCare member receiving services, with the exception of those exempt, as specified in the MaineCare Eligibility Manual, such as

85.11 **COPAYMENTS (cont.)**

children. The amount of the copayment shall not exceed $2.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 or more	$2.00

B. The member is responsible for copayments up to $20.00 per month whether the co-payment has been paid or not. After the $20.00 cap has been reached, the member will not be required to make additional copayments and the provider will receive full MaineCare reimbursement for covered services.

85.12 **BILLING INSTRUCTIONS**

A. Providers must bill in accordance with the Department's billing instructions for the CMS 1500 claim form.

B. All services provided on the same day must be submitted on the same claim form.

BASIS STATEMENT

MAINECARE BENEFITS MANUAL

CHAPTER II, SECTION 85

PHYSICAL THERAPY SERVICES

Pursuant to Public Law 2011, ch. 477, LD 1746, section L-1 of the Department of Health and Human Services Supplemental Budget, the Department is adopting this emergency rule in order to implement the Maine State Legislature's directive in section A, without the necessity of making the emergency findings as required in 5 M.R.S. §8054.

This emergency rule is being adopted in accordance with LD 1746, the DHHS 3rd Supplemental Budget, Part O. The changes made in this rule allow more Physical Therapy Services, up to five (5) treatment visits and one (1) evaluation within twelve (12) months, when provided pursuant to a pain management care plan as described in the MaineCare Benefits Manual Section 80.07-5(D)(3).

Statutory Authority

22 M.R.S.A. §§ 42, 3173; 5 MRSA § 8054; PL 2011, ch. 657, Part O and section L-1.

Effective date

January 1, 2013