TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #14-337(F)

DIGEST

Amends 405 IAC 5-22-1 to amend the definition of maintenance therapy and add a definition for rehabilitative services and applied behavioral analysis therapy services. Amends 405 IAC 5-22-6 to make changes to coverage requirements for medically necessary occupational therapy services, physical therapy services, respiratory therapy services, and speech pathology services for individuals under 21 years of age. Amends 405 IAC 5-22-8 to make changes to physical therapy services provided in an outpatient setting. Amends 405 IAC 5-22-10 to make changes to when respiratory therapy services will be reimbursed. Amends 405 IAC 5-22-11 to update the licensure and supervision requirements for occupational therapy assistants in accordance with IC 25-23.5-1-6 and IC 25-23.5-3. Adds 405 IAC 5-22-12 to add applied behavioral analysis therapy services as a reimbursable component. Effective 30 days after filing with the Publisher.

405 IAC 5-22-1; 405 IAC 5-22-6; 405 IAC 5-22-8; 405 IAC 5-22-10; 405 IAC 5-22-11; 405 IAC 5-22-12

SECTION 1. 405 IAC 5-22-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-1 Definitions

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. The following definitions apply throughout this rule:
(1) "Acute medical condition" means a condition with an onset within the preceding fourteen (14) days, and sequelae of a temporary nature, including, but not limited to, sprains, spasms, infection, or joint inflammation.
(2) "Acute rehabilitation condition" means medical injury or insult, onset occurring within one (1) year, which results in impaired functioning. These conditions may include, but are not limited to, head injury, cerebrovascular accident (CVA), or fracture.
(3) "Applied behavioral analysis therapy services" or "ABA therapy services" means the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.
~~(3)~~ **(4)** "Chronic medical condition or rehabilitation condition" means any injury or insult with onset and sequelae extending past one (1) year.
~~(4)~~ **(5)** "Educational in nature" means instruction or training that develops the general abilities of the mind and results in learning new material, as opposed to restoring or establishing a normal condition.
~~(5) "Maintenance~~ **(6) "Habilitative** therapy" means therapy addressing chronic medical conditions where further progress can no longer be expected ~~or where progress is minimal in relation to the time needed in therapy to achieve that progress. The recipient's inability to maintain previous therapy gains, despite an unchanging medical diagnosis or condition, would indicate that further therapy intervention would be of limited value to the recipient.~~ **to lessen the deterioration of function over time. Habilitative therapy includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology services, and audiology services provided to recipients for the purpose of maintaining a level of functionality, but not the improvement of functionality. Although the development of a habilitation plan is considered part of rehabilitation services, the services furnished under a habilitation plan are not skilled therapy.**
(7) "Licensed or board certified behavior analyst" means a behavior analyst with credentialing as a:
(A) board certified behavior analyst - doctoral (BCBA-D);
(B) board certified behavior analyst (BCBA); or
(C) board certified assistant behavior analyst (BCaBA).
~~(6)~~ **(8)** "Medically necessary therapy" means therapy for the restoration of an impaired level of function caused by an acute change in medical condition.
~~(7)~~ **(9)** "Outpatient therapy services" means services provided to a recipient outside the recipient's primary place of residence.
(10) "Rehabilitative services" refers to the federal definition of rehabilitative services in 42 CFR 440.130(d) and includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services provided to recipients.

~~(8)~~ **(11)** "Respiratory therapy" or "RT" means the adjunctive treatment, management, and preventive care of patients with acute and chronic cardiac pulmonary problems.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 2. 405 IAC 5-22-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-6 Occupational, physical, and respiratory therapy and speech pathology; criteria for prior authorization

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. (a) Prior authorization is required for all therapy services with the following exceptions:
(1) Initial evaluations.
(2) Emergency respiratory therapy.
(3) Any combination of therapy ordered in writing prior to a recipient's discharge from an inpatient hospital that may continue for a period not to exceed thirty (30) units in thirty (30) calendar days.
(4) The deductible and copay for services covered by Medicare, Part B.
(5) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators.
(6) Therapy services provided by a nursing facility or large private or small intermediate care facility for the mentally retarded (ICF/MR), which are included in the facility's per diem rate.
(7) ~~Physical therapy, occupational therapy, and~~ Respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in ~~sections 8,~~ **section** 10 ~~and 11~~ of this rule.

(b) Unless specifically indicated otherwise, the following criteria for prior authorization of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology:
(1) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. Therapy must be ordered by a physician (doctor of medicine or doctor of osteopathy). A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization request and available for audit purposes.
(2) Therapy must be provided by a qualified therapist or qualified assistant under the direct supervision of the therapist as appropriate.
(3) Therapy must be of such a level of complexity and sophistication and the condition of the recipient must be such that the judgment, knowledge, and skills of a qualified therapist are required.
(4) Medicaid reimbursement is available only for medically reasonable and necessary therapy.
(5) Therapy rendered for **a** diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities, or for developmental activities that can be conducted by nonmedical personnel, is not covered by Medicaid.
(6) **This subdivision applies to services for recipients twenty-one (21) years of age and older.** Therapy for rehabilitative services will be covered for a recipient **twenty-one (21) years of age and older for** no longer than two (2) years from the initiation of the therapy unless there is a significant change in **the recipient's** medical condition requiring longer therapy. Habilitative ~~services for a recipient under eighteen (18) years of age may be prior authorized for a longer period on a case-by-case basis.~~ **therapy is not a covered service for recipients twenty-one (21) years of age and older.** Respiratory therapy services ~~may be prior authorized for a longer period of time on a case-by-case basis.~~ **are covered for recipients twenty-one (21) years of age and older but for no longer than two (2) years from the date of initiation of the therapy. Respiratory therapy may be covered for a longer period of time on a case-by-case basis subject to prior authorization.**
(7) ~~Maintenance therapy is not a covered service.~~ **This subdivision applies to services for recipients under twenty-one (21) years of age. Therapy for rehabilitative services will be covered for a recipient under twenty-one (21) years of age when determined to be medically necessary. Habilitative therapy services for recipients under twenty-one (21) years of age will be covered on a case-by-case basis and are subject to prior authorization. Educational services, including, but not limited to, the remediation of learning disabilities, are not covered by Medicaid.**
(8) When a recipient is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. Ongoing evaluations are not separately reimbursed under the Medicaid

program.

(9) One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.

(10) ~~Therapy services will not be approved for more than~~ **Reimbursement for therapy services is limited to** one (1) hour per day per type of therapy. **Additional therapy services must be medically necessary and requires prior authorization.**

(11) A request for therapy services, which would duplicate other services provided to a ~~patient,~~ **recipient,** will not be prior authorized. Therapy services will not be authorized when such services duplicate nursing services required under 410 IAC 16.2-3.1-17.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; filed Sep 27, 1999, 8:55 a.m.: 23 IR 318; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 3. 405 IAC 5-22-8 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-8 Physical therapy services

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. Physical therapy services are subject to the following restrictions:

(1) The physical therapy service must be performed by a licensed physical therapist or certified physical therapist's assistant under the direct supervision of a licensed physical therapist or physician as defined in ~~844 IAC 6-1-2(e)~~ **844 IAC 6-1-2(g)** for reimbursement. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified physical therapist's assistant who must be under the direct supervision of a licensed physical therapist. Payment for the following services is included in the Medicaid allowance for the modality provided by the licensed therapist and may not be billed separately to Medicaid:

(A) Assisting patients in preparation for and, as necessary, during and at the conclusion of treatment.

(B) Assembling and disassembling equipment.

(C) Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient.

(D) Following established procedures pertaining to the care of equipment and supplies.

(E) Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas.

(F) Transporting:

(i) patients;

(ii) records;

(iii) equipment; and

(iv) supplies;

in accordance with established policies and procedures.

(G) Performing established clerical procedures.

(2) Certified physical therapists' assistants may provide services only under the direct supervision of a licensed physical therapist or physician as defined in ~~844 IAC 6-1-2(e).~~ **844 IAC 6-1-2(g).**

(3) Evaluations and reevaluations are limited to three (3) hours of service per recipient evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include physical therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.

~~(4) Physical therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) hours, sessions, or visits in thirty (30) calendar days without prior authorization. This exception includes the provision of splints, crutches, and canes. Prior authorization must be obtained for additional services.~~

~~(5)~~ **(4)** Physical therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3341; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1902; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.:

20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 4. 405 IAC 5-22-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-10 Respiratory therapy services

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. Respiratory therapy services are subject to the following restrictions:
(1) ~~The~~ Respiratory therapy ~~service~~ **services** will ~~only~~ be reimbursed **only** when performed by a licensed respiratory therapist or a certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic.
(2) The equipment necessary for rendering respiratory therapy will be considered part of the provider's capital equipment.
(3) Oxygen provided in a nursing facility does not require prior authorization if oxygen is ordered in writing by a physician.
(4) Respiratory therapy given on an emergency basis does not require prior authorization.
(5) Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection may be provided without prior authorization for a period not to exceed fourteen (14) hours on fourteen (14) calendar days. If additional services are required after that date, prior authorization must be obtained.
(6) Respiratory therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

SECTION 5. 405 IAC 5-22-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-22-11 Occupational therapy services

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 11. Occupational therapy services are subject to the following restrictions:
(1) ~~The~~ Occupational therapy ~~service~~ **services** must be performed by a ~~registered~~ **licensed** occupational therapist or by a ~~certified~~ **licensed** occupational therapy assistant under the ~~direct on-site~~ supervision of a ~~registered~~ **licensed** occupational therapist. **An** evaluation must be performed by ~~the registered~~ **a licensed** occupational therapist **in order** for reimbursement **to be made.**
(2) Evaluations and reevaluations are limited to three (3) hours of service per evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include occupational therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the ~~patient's~~ **recipient's** condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(3) General strengthening exercise programs for recuperative purposes are not covered by Medicaid.
(4) Passive range of motion services are not covered by Medicaid as the only or primary modality of therapy.
(5) Medicaid reimbursement is not available for occupational therapy psychiatric services.
~~(6) Occupational therapy services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) hours, sessions, or visits in thirty (30) calendar days without prior authorization. This exception includes the provision of splints, crutches, and canes. Prior authorization must be obtained for additional services.~~
~~(7)~~ **(6)** Occupational therapy services provided by a nursing facility or large private or small ICF/MR, which are included in the facility's established per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Jan 7,

SECTION 6. 405 IAC 5-22-12 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-22-12 Applied behavioral analysis therapy services

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. (a) ABA therapy services shall be available to an individual who:
(1) is eligible for Medicaid services;
(2) has been diagnosed as having autism spectrum disorder by a qualified provider; and
(3) has a completed diagnostic evaluation. A qualified provider, when completing such evaluation, shall:
(A) utilize a standardized assessment tool approved by the office; and
(B) include a recommended treatment referral for ABA therapy services, including projected length of treatment.

(b) Services shall be available from the time of initial diagnosis through twenty (20) years of age.

(c) The following providers may provide ABA therapy services:
(1) A health services provider in psychology (HSPP).
(2) A licensed or board certified behavior analyst.
(3) A credentialed registered behavior technician (RBT).

(d) Services shall be reimbursed subject to the following restrictions:
(1) Services performed by a bachelor-level board certified behavior analyst (BCaBA) or a credentialed RBT shall be supervised by a master's (BCBA) or doctoral level board certified behavior analyst (BCBA-D), or an HSPP.
(2) Services provided by a credentialed RBT shall be reimbursed at seventy-five percent (75%) of the rate on file.

(e) A provider described in subsection (c) shall develop a treatment plan for each recipient eligible for services under this section. The treatment plan shall be based on criteria such as the individual's:
(1) needs;
(2) age;
(3) school attendance; and
(4) other daily activities as documented in the treatment plan not otherwise excluded from coverage under subsection (i).

(f) All covered ABA therapy services shall be subject to prior authorization. A provider shall abide by the prior authorization requirements under 405 IAC 5-3, with the exception that a BCBA may also submit a prior authorization request to the office for review and approval. Each prior authorization request shall include, at a minimum, the following:
(1) The individual's treatment plan and supporting documentation.
(2) The number of therapy hours requested and supporting documentation.
(3) Other documentation as requested by the office.

(g) Prior approval for the initial course of treatment may be approved for up to six (6) months. In order to continue providing ABA therapy services, a provider shall submit a new prior authorization request and receive approval. The prior authorization request shall include an updated treatment plan along with the documentation specified in subsection (f)(2) and (f)(3).

(h) ABA therapy services shall only be available to a recipient for a period of three (3) years and shall not exceed a period of forty (40) hours per week. The office shall not approve any prior authorization request that provides ABA therapy services for a period longer than six (6) months.

(i) As follows, coverage under this section shall not be available for services that:
(1) Focus solely on recreational outcomes.
(2) Focus solely on educational outcomes.
(3) Are duplicative, such as services rendered under an individualized educational plan.
(4) Are provided by a registered behavior technician in the home or school setting.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-12; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA)

LSA Document #14-337(F)
Notice of Intent: 20140820-IR-405140337NIA
Proposed Rule: 20150819-IR-405140337PRA
Hearing Held: September 10, 2015
Approved by Attorney General: December 1, 2015
Approved by Governor: January 6, 2016
Filed with Publisher: January 7, 2016, 8:00 a.m.
Documents Incorporated by Reference: None Received by Publisher
Small Business Regulatory Coordinator: Amanda Alvey, Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning, Indiana Government Center South, 402 West Washington Street, Room W374, Indianapolis, IN 46204, (317) 234-5551, amanda.alvey@fssa.in.gov

Posted: 02/03/2016 by Legislative Services Agency
An html version of this document.