



CENTERS for MEDICARE & MEDICAID SERVICES

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Region II
26 Federal Plaza Rm. 37-100
New York, N.Y. 10278

September 14, 2011

Jason Helgersen, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
Corning Tower, Room 1441
Empire State Plaza
Albany, New York 12237

Dear Mr. Helgersen:

We have completed our review of New York's State Plan Amendment (SPA) submittal 11-37 and find it acceptable for incorporation into the State's Medicaid Plan, effective October 1, 2011. This SPA makes changes to the utilization limits for physical therapy services, occupational therapy services, and speech-language therapy services. Each service will be limited to 20 visits in a twelve-month period. The pages originally submitted by the State have been replaced by the revised pages submitted by the State via e-mail on August 12, 2011, August 15, 2011, and August 18, 2010.

We would like to thank Karla Knuth, Constance Donahue, Ronald Bass, and other staff members who were involved in the discussions and the informal responses that enabled CMS to process this SPA. If you have any questions, please contact Nicole McKnight at 212-616-2429.

Sincerely, _____

Michael Melendy
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosures: SPA # 11-37
CMS-179 Form

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: #11-37	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2011	
5. TYPE OF PLAN MATERIAL (Check One): ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/11-09/30/11 \$0 b. FFY 10/01/11-09/30/12 (\$4.90) million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A Supplement: Pages 6, 7 Attachment 3.1-B Supplement: Pages 6, 7		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A Supplement: Pages 6, 7 Attachment 3.1-B Supplement: Pages 6, 7	
** SEE REMARKS			
10. SUBJECT OF AMENDMENT: Establish Utilization Limits for Physical Therapy, Occupational Therapy, and Speech Therapy/Pathology (FMAP = 50% 7/1/11 forward)			
11. GOVERNOR'S REVIEW (Check One): ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: Jason A. Helgeson		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health			
15. DATE SUBMITTED: June 17, 2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: September 14, 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 01, 2011		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Michael Melendez		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS: Utilization limits for physical therapy services, occupational therapy services, and speech- language therapy services			

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**Attachment 3.1-A
Supplement
(04/11)**

9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

Physical Therapy Services

- 11a. [Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provisions of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.] Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

Occupational Therapy Services

- 11b. [Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess or prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.] Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

TN #11-37 _____

Approval Date SEP 14 2011

Supersedes TN #06-61 _____

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**Attachment 3.1-A
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Speech-Language Therapy Services

- 11c. [Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.] Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.
- 12a. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Pharmacy Provider Manual. Such threshold requirements are applicable to specific provider service types including pharmacy for prescription items and their refills, over the counter medications, and medical/surgical supplies dispensed by a community or outpatient pharmacy. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipient per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

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Physical Therapy Services

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Speech-Language Therapy Services

- 11c. [Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization for the provision of services based on medical necessity in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.] Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.
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