

Marketplace National Regional Benefit Interpretation Document

Benefit Name	REHABILITATION (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) & HABILITATION SERVICES
Applicable State	California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, Nevada, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin
Benefit Definition	<p>This policy addresses outpatient habilitative services, including physical therapy, occupational therapy, post-cochlear implant aural therapy, cognitive habilitative therapy, manipulative treatment, and speech therapy. This policy also addresses rehabilitation services, including acute inpatient rehabilitation, outpatient physical and occupational therapy, and speech therapy.</p> <p>Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.</p> <p>Essential Health Benefits for Individual and Small Group</p> <p>For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> A. FEDERAL/STATE MANDATED REGULATIONS </div> <p>Note: The most current federal/state mandated regulations for each state can be found in the links below.</p> <p>CALIFORNIA:</p>

California Health and Safety Code, Title 28, [§ 1300.67](#). Scope of Basic Health Care Services.

The basic health care services required to be provided by a health care service plan to its enrollee's shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Director may approve:

- (c) Ambulatory care services, (outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate and those hospital services, which can reasonably be provided on an ambulatory basis. Such services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law
- (1) Home health services may also include such rehabilitation, physical, occupational, or other therapy, as the physician shall determine to be medically appropriate.

ILLINOIS:

[50 IAC 4521.130\(j\)](#): Outpatient Rehabilitative therapy (including but not limited to: speech therapy, physical therapy, and occupational therapy directed at improving physical functioning of the member) up to 60 treatments per year for conditions which are expected to result in significant improvement within two months as determined by the primary care physician and if required by the HMO, are authorized on a prospective and timely basis by the HMO's Medical Director

Habilitative Services for children under age 19

[P.A. 95-1049 \(SB 101\)](#): SB 101 provides coverage for habilitative services for children less than 19 years of age with a congenital, genetic, or early acquired disorder so long as specified conditions are met. This legislation sets general exclusions and limitations of the coverage. Provides that upon request of the reimbursing insurer, the provider under whose supervision the habilitative services are being provided shall furnish medical records, clinical notes, or other necessary data to allow the insurer to substantiate that initial or continued medical treatment is medically necessary and that the patient's condition is clinically improving.

SB 101 provides that the provisions concerning mental and emotional disorders shall not be interpreted to require coverage for speech

therapy or other habilitative services for those individuals covered under the provisions concerning habilitative services for children.

[215 ILCS 5/356z.15](#): Habilitative services for children

[215 ILCS 125/5-3](#): Insurance Code provisions

[215 ILCS 165/10](#): Application of Insurance Code provisions

P.A. 94-1076 [\[215 ILCS 5/356z.8\]](#): Multiple Sclerosis Preventative Physical Therapy

[HB 5087](#): Physical Therapy - Telehealth

KENTUCKY:

[SB 111](#): Coverage for the Treatment of Stuttering

SOUTH CAROLINA:

[SECTION 38-71-210](#)- Health insurance policies to include chiropractic services.

[§ 38-71-1730](#)

[45 CFR 156.115 \(5\)\(iii\)](#)

TEXAS:

TIC §§1367.201-1367.206

[Sec. 1367.201](#): Definition

In this subchapter, rehabilitative and habilitative therapies include:

- 1) Occupational therapy evaluations and services;
- 2) Physical therapy evaluations and services;
- 3) Speech therapy evaluations and services; and
- 4) Dietary or nutritional evaluations.

[Sec. 1367.204](#): Offer of Coverage Required

(a) A health benefit plan issuer must offer coverage that complies with this subchapter.

(b) The individual or group policy or contract holder may reject coverage required to be offered under this section.

[Sec. 1367.205](#): Coverage of Certain Therapies

- a) A health benefit plan that provides coverage for rehabilitative and habilitative therapies under this subchapter may not prohibit or restrict payment for covered services provided to a child and determined to be necessary to and provided in

accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

b) Rehabilitative and habilitative therapies described by Subsection (a) must be covered in the amount, duration, scope, and service setting established in the child's individualized family service plan.

c) A child is entitled to benefits under this subchapter if the child, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

Sec. 1367.206: Prohibited Actions

Under the coverage required to be offered under this subchapter, a health benefit plan issuer may not:

- 1) Apply the cost of rehabilitative and habilitative therapies described by Section 1367.205(a) to an annual or lifetime maximum plan benefit or similar provision under the plan; or
- 2) Use the cost of rehabilitative or habilitative therapies described by Section 1367.205(a) as the sole justification for:
 - A. Increasing plan premiums; or
 - B. Terminating the insured's or enrollee's participation in the plan.

Sec. 1271.156: Benefits for Rehabilitation Services and Therapies

(a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

WASHINGTON:

RCW 48.43.045: Health Plan Requirements - Annual Reports - Exemptions

(1) Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

- a) Permit every category of health care provider to provide health services or care included in the basic essential health benefits benchmark plan established by the commissioner consistent with RCW 48.43.715, to the extent that:

- i. The provision of such health services or care is within the health care providers' permitted scope of practice;
- ii. The providers agree to abide by standards related to:
 - a) Provision, utilization review, and cost containment of health services;
 - b) Management and administrative procedures; and
 - c) Provision of cost-effective and clinically efficacious health services;
- and
- iii. The plan covers such services or care in the essential health benefits benchmark plan.

The reference to the essential health benefits does not create a mandate to cover a service that is otherwise not a covered benefit.

b) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals, unless substantially similar information is filed with the commissioner or the national association of insurance commissioners. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a supplemental compensation exhibit in its annual statement as required by law.

(2) The requirements of subsection (1)(a) of this section do not apply to a licensed health care profession regulated under Title 18 RCW when the licensing statute for the profession states that such requirements do not apply.

[RCW 18.74.010](#): Definitions

(8) (a) "Physical therapist assistant" means a person who Meets all the requirements of this chapter and is licensed as a physical therapist assistant and who performs physical therapy procedures and related tasks that have been selected and delegated only by the supervising physical therapist. However, a physical therapist may not delegate sharp debridement to a physical therapist assistant.

(b) "Physical therapy aide" means an unlicensed person who receives ongoing on-the-job training and assists a physical therapist or physical therapist assistant in providing physical therapy patient care and who does not meet the definition of a physical therapist, physical therapist assistant, or other assistive personnel. A physical therapy aide may directly assist in the implementation of therapeutic interventions but may not alter or modify the plan of therapeutic interventions and may not perform any procedure or task which only a physical therapist may perform under this chapter.

(9) Physical therapy" means the care and services provided by or under the direction and supervision of a physical therapist licensed by the state. Except as provided in RCW 18.74.190, the use of Roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, and the use of spinal manipulation, or manipulative mobilization of the spine and its immediate articulations, are not included under the term "physical therapy" as used in this chapter.

(10) "Practice of physical therapy" is based on movement science and means:

- a. Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations in movement, and disability or other health and movement-related conditions in order to determine a diagnosis, prognosis, plan of therapeutic intervention, and to assess and document the ongoing effects of intervention;
- b. Alleviating impairments and functional limitations in movement by designing, implementing, and modifying therapeutic interventions that include therapeutic exercise; functional training related to balance, posture, and movement to facilitate self-care and reintegration into home, community, or work; manual therapy including soft tissue and joint mobilization and manipulation; therapeutic massage; assistive, adaptive, protective, and devices related to postural control and mobility except as restricted by (c) of this subsection; airway clearance techniques; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction;
- c. Training for, and the evaluation of, the function of a patient wearing an orthosis or prosthesis as defined in RCW 18.200.010. Physical therapists may provide those direct-formed and prefabricated upper limb, knee, and ankle-foot orthoses, but not fracture orthoses except those for hand, wrist, ankle, and foot fractures, and assistive technology devices specified in RCW 18.200.010 as exemptions from the defined scope of licensed orthotic and prosthetic services. It is the intent of the legislature that the unregulated devices specified in RCW 18.200.010 are in the public domain to the extent that they may be provided in common with individuals or other health providers, whether unregulated or regulated under Title 18 RCW, without regard to any scope of practice;
- d. Performing wound care services that is limited to sharp debridement, debridement with other agents, dry dressings, wet dressings, topical agents including enzymes, hydrotherapy, electrical stimulation, ultrasound, and other similar treatments. Physical therapists may not delegate sharp debridement. A physical therapist may perform wound

care services only by referral from or after consultation with an authorized health care practitioner;

e. Reducing the risk of injury, impairment, functional limitation, and disability related to movement, including the promotion and maintenance of fitness, health, and quality of life in all age populations; and

f. Engaging in administration, consultation, education, and research.

[RCW 18.74.012](#): Consultation with health care practitioner no required for certain treatments

A consultation and periodic review by an authorized health care practitioner is not required for treatment of neuromuscular or musculoskeletal conditions

[RCW 48.44.450](#): Neurodevelopmental Therapies

(1) Each employer-sponsored group contract for comprehensive health care service, which is entered into, or renewed, on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individual's age six and under.

(2) Benefits provided under this section shall cover the services of those authorized to deliver occupational therapy, speech therapy, and physical therapy. Benefits shall be payable only where the services have been delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where covered services have been rendered by such licensee. Nothing in this section shall prohibit a health care service contractor from requiring that covered services be delivered by a provider who participates by contract with the health care service contractor unless no participating provider is available to deliver covered services. Nothing in this section shall prohibit a health care service contractor from negotiating rates with qualified providers.

(3) Benefits provided under this section shall be for medically necessary services as determined by the health care service contractor. Benefits shall be payable for services for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service. Benefits shall be payable to restore and improve function.

(4) It is the intent of this section that employers purchasing comprehensive group coverage including the benefits required by this section, together with the health care service contractor, retain authority to design and employ utilization and cost controls. Therefore,

benefits delivered under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the employer purchasing coverage and the health care service contractor. Benefits provided under this section may be subject to standard waiting periods for preexisting conditions and may be subject to the submission of written treatment plans.

(5) In recognition of the intent expressed in subsection (4) of this section, benefits provided under this section may be subject to contractual provisions establishing annual and/or lifetime benefit limits. Such limits may define the total dollar benefits available or may limit the number of services delivered as agreed by the employer purchasing coverage and the health care service contractor.

Note: Neurodevelopmental therapies are services rendered to children age six (6) and under, who have developmental delay due to diagnosable medical cause such as autism, prematurity, or cerebral palsy. Benefits provided will cover the services of those authorized to deliver occupational therapy, speech therapy and physical therapy. Benefits will be payable to restore and improve function and for the maintenance of a condition where significant deterioration in the child's condition would result without the service. Inpatient or residential neurodevelopmental programs in the absence of a medical condition requiring acute medical care are never covered.

For regulatory guidance, please refer to the Washington State Department of Social and Health Services' Division of Developmental Disabilities.

For specific visit limitations, refer to the member's Schedule of Benefits (SOB) or contact the Customer Service Department.

a. Habilitative Services: Short-term Habilitative Services are covered on an outpatient basis for members with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapists, Physician, licensed nutritionist, licensed social worker, or licensed psychologist.

☐ The initial or continued treatment must be proven and not an Experimental and/or Investigational Procedure, Item and Treatment.

Covered Services for Habilitative Services do not apply to those services that are solely educational in nature or otherwise paid under state or

federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training, and residential treatment are not Habilitative Services. A service that does not help the member meet functional goals in a treatment plan within a prescribed time frame is not a Habilitative Service. When the member reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate the initial or continued medical treatment is needed and that the member's condition is clinically improving as a result of the Habilitative Service. When the treating Provider anticipates that continued treatment is or will be required to permit the member to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment type, frequency the treatment plan will be updated.

B. STATE MARKET PLAN ENHANCEMENTS

None

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

Habilitative services help a person keep, learn, or improve skills and functioning for daily living. In contrast, **rehabilitative** services help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because of being sick, hurt, or disabled.

HABILITATION/REHABILITATION SERVICES

CALIFORNIA:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person with disabilities or chronic conditions to keep, learn, or improve skills and functioning for daily living. These include physical, speech and

occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitation Services: Molina covers Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily life usually requiring physical therapy, speech therapy, and occupational therapy in a setting appropriate for the level of disability or injury and include cardiac and pulmonary rehabilitation.

Acupuncture Services: Molina covers acupuncture services that are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

Massage Therapy: Massage therapy may be covered if it is medically necessary as part of a physical therapy treatment plan.

FLORIDA:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Outpatient rehabilitative services are limited to a total of 35 visits for any combination of the following therapies; however, only 26 of those visits can be for Spinal Manipulative Therapy:

- Cardiac Rehabilitation Therapy
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Massage Therapy by licensed massage therapist
- Spinal Manipulative Therapy

IDAHO:

Chiropractic Care (Limit 18 visits): Molina covers 18 chiropractic visits by a licensed professional, per Plan year.

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech, occupational therapy, aural therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitation Services (limit 20 visits): Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and aural therapy rehabilitation services (limited to 20 visits for the combined services per calendar year) in a variety of inpatient and/or outpatient settings.

ILLINOIS:

Diabetes Services: Molina covers the following diabetes related services:

- Acupuncture services

Chiropractic and Osteopathic Services: Molina cover Chiropractic and Osteopathic services for manipulation or adjustment of osseous or articular structures when a condition of an orthopedic or neurological nature necessitates treatment for which falls within the scope of a licensed chiropractor or osteopath. The benefit is limited to a maximum of 25 visits per calendar year.

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings and are provided up to 60 treatments per year for conditions which are expected to result in significant improvement within two months. Habilitative Services including Autism Spectrum Disorder for members under the age of 21 prohibits denial of benefits solely on location of where medically necessary services are rendered.

Preventative Physical Therapy: Molina covers Medically Necessary physical therapy that is prescribed by a Participating Provider licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or

impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Molina covers up to 60 treatments per calendar year for outpatient Rehabilitation Services which are expected to result in significant improvement within two months as determined by your PCP. Maintenance therapies are not covered.

KENTUCKY:

Habilitation Services: Passport covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitation Services include:

- Physical therapy (25 visit limit per calendar year)
- Speech therapy (25 visit limit per calendar year)
- Occupational therapy (25 visit limit per calendar year)

Rehabilitation Services: Passport covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Rehabilitation Services include:

- Physical therapy (25 visit limit per calendar year)
- Occupational therapy (25 visit limit per calendar year)
- Speech therapy (25 visit limit per calendar year)
- Pulmonary rehabilitation (25 visit limit per calendar year)
- Cardiac rehabilitation (36 visit limit per calendar year)
- Manipulation therapy (20 visit limit per calendar year)
- Post-Cochlear Implant Aural Therapy (30 visit limit per calendar year)
- Cognitive Rehabilitation Therapy (20 visit limit per calendar year)
- Inpatient Rehabilitative Services (60 visit limit per calendar year)

MICHIGAN:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitation Services include:

- Physical therapy and occupational therapy, chiropractic (combined 30 visit limit per calendar year)
- Speech therapy (30 visit limit per calendar year)

Please note that the visit limits for physical therapy (including chiropractic services), occupational therapy, and speech therapy in this Agreement and the Schedule of Benefits do not apply when those therapies are provided under the Autism Spectrum Disorder benefit.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, cardiac and pulmonary rehabilitation and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Rehabilitation Services include:

- Physical therapy, occupational therapy, chiropractic services (combined 30 visit limit per calendar year)
- Speech therapy (30 visit limit per calendar year)
- Cardiac/pulmonary rehabilitation (combined 30 visit limit per calendar year)

Please note that the visit limits for physical therapy (including chiropractic services), occupational therapy, and speech therapy in this Agreement and the Schedule of Benefits do not apply when those therapies are provided under the Autism Spectrum Disorder benefit.

MISSISSIPPI:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the Member was sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitation services are limited to the following:

- Cardiac rehabilitation therapy (36-visit limit per calendar year).
- Chiropractic services (limited to 20 visits per calendar year combined for physical therapy, occupational therapy, and chiropractic services).
- Occupational Therapy (limited to 20 visits per calendar year combined for physical therapy, occupational therapy, and chiropractic services).
- Physical Therapy (limited to 20 visits per calendar year combined for physical therapy, occupational therapy, and chiropractic services).
- Speech Therapy (20-visit limit per calendar year).

Benefits can be denied or shortened for Members who are not progressing in goal-directed rehabilitation services. Benefits can also be denied or shortened if rehabilitation goals have previously been met.

Please note that Covered Services include speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from injury, stroke, cancer, or congenital anomaly. For speech therapy with relation to Autism Spectrum Disorder, please refer to the services described in the Benefit Policy titled Pervasive Developmental Disorder and Autism Disorder.

NEW MEXICO:

Acupuncture/Acupressure Services: Molina covers acupuncture services when furnished by licensed Participating Providers that is determined to be Medically Necessary and appropriate for the treatment of the Member's conditions. Acupuncture is a treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the member's provider. It is recommended that acupuncture be part of a coordinated plan of care approved by the member's provider. Cost Sharing applicable to outpatient services will apply. The acupuncture/acupressure benefit is limited to 20 visits per plan year unless the service is prescribed by a provider for Habilitative or Rehabilitative purposes.

Chiropractic Services: Chiropractic services are available for specific medical conditions and are not available for maintenance therapy such as routine adjustments. Chiropractic services are subject to the following:

- The practitioner/provider determines in advance that chiropractic treatment can be expected to result in significant improvement in the member's condition within a period of two months.
- Chiropractic treatment is specifically limited to treatment by means of manual manipulation, i.e., by use of hands and other methods of treatment approved by the plan, including, but not limited to, ultrasound therapy.
- Subluxation must be documented by chiropractic examination and documented in the chiropractic record. Molina will not require radiologic (X-ray) demonstration of subluxation of chiropractic treatment.
- Biofeedback is only covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

Limited to 20 visits per calendar year unless associated to Habilitative and Rehabilitative services.

Habilitation Services: Molina covers healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical, speech and occupational therapy services in a variety of inpatient and/or outpatient settings. Molina covered service include short-term for physical therapy and occupation therapy, provided in a rehabilitation facility, skilled nursing facility, home health agency, or outpatient setting. Rehabilitation Services are offered at PCP cost share.

Short-term rehabilitation services and physical therapy is provided in those instances where the member's primary care provider or other appropriate treating health care professional determines that such services and therapy can be expected to result in the significant improvement of a member's physical condition within a period of two months. Such services may be extended beyond the two-month period upon recommendation by the primary care provider in consultation with Molina prior authorization.

Rehabilitation services include covered services with a chiropractor and acupuncturist with no visit limit. 20 visit limits for complementary.

NEVADA:

Chiropractic Services: Molina covers chiropractic services when furnished by licensed Participating Providers that is determined to be Medically Necessary and appropriate for the treatment of the Member's conditions. Please consult the Schedule of Benefits for Chiropractic Services to determine applicable Member Cost Sharing and visit limits.

CW: Chiropractic Services: Limit of 20 visits/year.

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings. All inpatient and outpatient habilitative services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per calendar year. When the member reaches their maximum level of improvement

or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer considered habilitative.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. All inpatient and outpatient short term rehabilitation are subject to a combined maximum benefit of one hundred twenty (120) days or visits per Member per calendar year.

OHIO:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Habilitation Services include:

- Treatment of Autism Spectrum Disorder for children ages 0-21
- Outpatient physical rehabilitation services including:
 - Speech and language therapy performed by a licensed therapist: 20 visits per year;
 - Occupational therapy performed by a licensed therapist: 20 visits per year; and
 - Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the State of Ohio to perform the services in accordance with a treatment plan: 20 hours per week.
- Outpatient mental health services performed by a licensed psychologist, psychiatrist, or physician to provide consultation, assessment, development, and oversight of treatment plans

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Rehabilitation Services include:

- Physical therapy (20 visit limit per calendar year)
- Speech therapy (20 visit limit per calendar year)

- Occupational therapy (20 visit limit per calendar year)
- Manipulation therapy (12 visit limit per calendar year)
- Cardiac rehabilitation (36 visit limit per calendar year)
- Pulmonary rehabilitation (20 visit limit per calendar year)

Rehabilitation services may be subject to limitations, Prior Authorization requirements, and exclusions.

SOUTH CAROLINA:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, psychiatric rehabilitation, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, and spinal manipulative therapy services in a variety of inpatient and/or outpatient settings. Outpatient physical therapy, speech therapy, and occupational therapy are limited to 30 visits per therapy type per year.

Additional: Molina covers chiropractic and has chiropractors in the network. Molina is required by SC Code of Laws § 38-71-210 to cover chiropractic services. Molina is required by SC Code of Laws § 38-71-1730 not to discriminate against chiropractors but to cover their services within the scope of their license that are otherwise covered services. There are no visit limits for chiro. Cost sharing is per office visit.

Chiropractic Manipulation should be covered.

Osteopathic Manipulation should be covered for a chiropractor 1) if they are considered Chiropractic Services or 2) if they are otherwise covered services and they are within the scope of the chiropractor's license.

TEXAS:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Services include certain therapies for children with developmental delays in accordance with state law and an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

CW: Habilitative Services: Limited to 35 visits per year

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the Member was sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Services include certain therapies for children with developmental delays in accordance with state law and an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

Additional: CW: The 35 visits per plan year, including covered chiropractor services. The chiropractor must provide services in connection with outpatient rehabilitation, speech therapy, occupational therapy, and physical therapy. Member cost-share applies in any place of service.

UTAH:

Habilitation Services: Molina covers healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Habilitative services may include physical therapy, occupational therapy, speech-language pathology, and other services (limited to 20 visits for the combined services per calendar year) in a variety of inpatient and/or outpatient settings.

Rehabilitation Services: Molina covers services for the treatment of disease, injury, developmental delay, or other cause, by physical agents and methods to assist in the rehabilitation of normal physical bodily function, which is goal-oriented and where the person has potential for functional improvement and ability to progress. These services may include physical and occupational therapy, speech-language pathology, and aural therapy rehabilitation services (limited to 20 visits for the combined services per calendar year) in a variety of inpatient and/or outpatient settings.

WASHINGTON:

Habilitation Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 days): Molina covers healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. These include physical, speech, occupational therapy, aural therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Molina covers Medically Necessary neurodevelopmental therapy. Services are limited to 25 visits per calendar year (This limitation does not apply to Covered Services for autism spectrum disorders).

Rehabilitation Services (Outpatient limitation of 25 visits/Inpatient limitation of 30 days): Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Massage therapy is covered when provided as part of Physical therapy and/or Chiropractic care in connection with rehabilitation and/or habilitation services. Eligible providers include contracted Physical Therapists, Chiropractors, Naturopathic providers and Massage Therapists or any other provider acting within the scope of their licensure. All services provided during the same session count as one visit. Members have direct access to a chiropractor without referral.

Rehabilitation services are limited to 25 combined speech, physical and occupational visits per calendar year, however, there is no limit when medically necessary services are received due to a Mental Health condition. Spinal manipulation services are limited to 10 treatments per calendar year. Acupuncture services are limited to 12 visits without referral per calendar year. Acupuncture services provided for the treatment of chemical dependency are not subject to any visit limits. (There are no limitations if there is a diagnosis of Substance Use Disorder-CW).

WISCONSIN:

Habilitation Services: Molina covers healthcare services and authorized devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Manipulative Treatment Services: We cover Medically Necessary manipulative treatment services. Manipulative treatment is the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function in the management of an identifiable neuromusculoskeletal condition.

Rehabilitation Services: Molina covers services that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation

services in a variety of inpatient and/or outpatient settings and are considered short term.

Rehabilitation Service visit limits are as follows:

- 20 visits of physical therapy.
- 20 visits of occupational therapy.
- 20 visits of speech therapy.
- 20 visits of pulmonary rehabilitation therapy.
- 36 visits of cardiac rehabilitation therapy.
- 30 visits of post-cochlear implant aural therapy.
- 20 visits of cognitive rehabilitation therapy.
- 60 days per year for Inpatient Rehabilitative Facility.

Visit limits do not apply to Manipulative Therapy.

Product Clarification: WI only: OT and ST therapy when provided with a primary diagnosis of autism spectrum disorder will be excluded from the regular hab/rehab benefit (to not limit according to the rehab limits) and will be included in the non-intensive level benefit to be limited per EOC language.

MORE INFORMATION

After 12 visits + eval for PT/OT (not including modality), PA will be required for all MP States. Each state has a hard limit based on Benchmarks.

ST is a separate benefit with PA required after 6 visits + eval

Refer to Benefit Interpretation Policies titled **Cardiac Rehabilitation Services**, **Complementary Alternative Medicine** and **Pain Management (for Acupuncture Services)**.

D. NOT COVERED

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

Massage therapy unless mandated by State or Federal law and/or Market Plan Enhancements (Refer to Sections A and B)

NON-COVERED SERVICES

CALIFORNIA:

Aquatic Therapy: Aquatic therapy and other water therapy are not covered, unless Medically Necessary as part of a physical therapy treatment plan covered under the "Covered" section of this policy. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

Chiropractic Services: Chiropractic services are not covered. This exclusion does not apply to any services specifically covered in any section of this Agreement, including the Habilitation and Rehabilitation Services sections for California.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services and treatment options relating to a condition – for which these excluded therapies have been developed – is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Massage Therapy: Massage therapy is not covered, unless Medically Necessary as part of a physical therapy treatment plan covered under the “Covered” section of this policy.

FLORIDA:

Acupuncture Services: Acupuncture services are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Massage Therapy: Massage therapy is not covered.

IDAHO:

Acupuncture: Acupuncture is not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, and Rolf therapy are not covered.

ILLINOIS:

Acupuncture Services: Acupuncture services are not covered except related to diabetes.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services and treatment options relating to a condition - for which these excluded therapies have been developed - is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered

Maintenance Therapy: Maintenance therapies are not covered.

Massage Therapy: Massage therapy is not covered.

KENTUCKY:

Acupuncture Services: Acupuncture services are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Chiropractic Services: Chiropractic services are not covered, except when provided in connection as manipulative therapy outlined in the Habilitation and Rehabilitation Services section of this agreement. Manipulation Therapy includes both osteopathic and chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. Chiropractic therapy focuses on the joints of the spine and the nervous system. Osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered.

Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered

Massage Therapy: Massage therapy is not covered.

MICHIGAN:

Acupuncture Services: Acupuncture services are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Chiropractic Services: Chiropractic services are not covered. This exclusion does not apply to any services specifically “Covered” in section of this policy.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies is not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

MISSISSIPPI:

Acupuncture Services: Acupuncture services are not covered.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies, are not covered. Coverage for other health care services and treatment options relating to a condition - for which these types of excluded therapies have been developed - is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Massage Therapy: Massage therapy is not covered.

NEVADA:

Acupuncture Services: Acupuncture services are not covered.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services and treatment options relating to a condition – for which these excluded therapies have been developed – is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Massage Therapy: Massage therapy is not covered.

NEW MEXICO:

Aquatic Therapy: Aquatic therapy and other water therapy are not covered.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services and treatment options relating to a condition – for which these excluded therapies have been developed – is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Massage Therapy: Massage therapy is not covered, unless provided by a licensed physical therapist and as part of prescribed short-term rehabilitation physical therapy program.

OHIO:

Acupuncture Services: Acupuncture services are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Chiropractic Services: Chiropractic services are not covered, except when provided in connection as manipulative therapy outlined in the Habilitation and Rehabilitation Services section of this agreement. Manipulation Therapy includes both osteopathic and chiropractic manipulation therapy used for treating problems associated with bones, joints, and the back. Chiropractic therapy focuses on the joints of the spine and the nervous system. Osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons, and ligaments.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Massage Therapy: Massage therapy is not covered.

Pulmonary rehabilitation in the acute inpatient rehabilitation setting is not a Covered Service

SOUTH CAROLINA:

Acupuncture Services: Acupuncture services are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services and treatment options relating to a condition - for which these types of excluded therapies have been developed - is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Massage Therapy: Massage therapy is not covered.

TEXAS:

Acupuncture Services: Acupuncture services or supplies are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services and treatment options relating to a condition – for which these excluded therapies have been developed – is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Massage Therapy and Alternative Treatments: We do not cover alternative treatments including, but not limited to, massage therapy, aromatherapy, or hypnotherapy.

UTAH:

Acupuncture Services: Acupuncture services are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Chiropractic Services: Chiropractic services are not covered, except when provided in connection with occupational therapy and physical therapy.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Massage Therapy: Massage therapy is not covered.

WASHINGTON:

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available is in accordance with this Agreement and any limit outlined in applicable medical policy. As such, certain services may be subject to subject to Prior Authorization.

Homeopathic and Holistic Services: Non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki and Rolf therapy are not covered.

WISCONSIN:

Acupuncture Services: Acupuncture services are not covered.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy, and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services relating to a condition, for which these types of treatments are available, is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization.

Homeopathic and Holistic Services: Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

Massage Therapy: Massage therapy is not covered.

E. DEFINITION

[See Glossary](#)

F. REFERENCES

MCG™ Care Guidelines, 24th edition, 2020

G. POLICY HISTORY/REVISION INFORMATION

	Date	Action/Description		
	4/15/2021	<ul style="list-style-type: none">Added KY 2022 Drafted Language		
	5/14/2021	<ul style="list-style-type: none">Added IL 2022 EOC Language		
	6/7/2021	<ul style="list-style-type: none">Added RPM Clarification around OT and ST limits for WI from 2020 BBRD		
	6/30/2021	<ul style="list-style-type: none">Added ID 2022 EOC Language		
	7/1/2023	<ul style="list-style-type: none">Added NV 2024 EOC Language		
Codification	Marketplace Benefit Interpretation Policies Codification			
Prior Authorization	<p>For the MHI PA Matrix, if a code is NOT listed, it could EITHER be:</p> <ul style="list-style-type: none">a. Covered and No PA Requiredb. Not Covered <p>You cannot use the MHI PA Matrix to make coverage determinations.</p> <p>PA Lookup Tool</p>			
Approval	Departments	Product	CIM	Clinical Management
	Date	4/6/2021	6/16/2021	5/12/2021
	Revised (for 1/1/2022)	11/16/2021	3/28/2022	11/29/2021
	Revised (for 1/1/2023)	12/13/2022	4/5/2023	12/13/2022
	Revised (for 1/1/2024)	11/30/2023	4/1/2024	12/8/2023
	Revised (for 1/1/2025)	11/12/2024	-	11/12/2024