GUIDELINE NOTE 5, OBESITY

Line 325

Medical treatment of obesity is limited to accepted intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss. Maintenance visits are covered no more than monthly after this intensive counseling period. Pharmacological treatments are not intended to be included as services on this line.

GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

Lines 34,50,61,72,75,76,78,85,95,96,135,136,140,154,157,164,182,187,188,199,200,204,205,211,258,260,275,290,292,297,305, 306,315,322,345,349,351,358,359,362,374,380,381,391,410,412,420,422,427,435,447,459,468,471,472,484,492,504,515,533, 545,560,577,579,588,597,616

A total of 30 visits per year of rehabilitative therapy (physical, occupational and speech therapy, and cardiac and vascular rehabilitation) are included on these lines when medically appropriate. Additional visits, not to exceed 30 visits per year, may be authorized in exceptional circumstances, such as in cases of rapid growth/development.

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included on these lines when the following criteria are met:

1. therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide the therapy,
2. there is objective, measurable documentation of clinically significant progress toward the therapy plan of care goals and objectives,
3. the therapy plan of care requires the skills of a medical provider, and
4. the client and/or caregiver cannot be taught to carry out the therapy regimen independently.

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.

Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.

GUIDELINE NOTE 7, ERYTHROPOIESIS-STIMULATING AGENT (ESA) GUIDELINE

Lines 12,63,97,99,116-120,130,137,139,161,162,165,167,183,195,203,204,212,214,218,219,221,233,238,241,242,262-266,274, 279,291-293,299,300,319-321,333,401,402,424,439,533,600

A) Indicated for anemia (Hgb < 10gm/dl or Hct < 30%) induced by cancer chemotherapy given within the previous 8 weeks or in the setting of myelodysplasia.
   1) Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, ESAs should be discontinued once the hemoglobin level reaches 10, unless a lower hemoglobin level is sufficient to avoid the need for red blood cell (RBC) transfusion.

B) Indicated for anemia (Hgb < 10gm/dl or HCT < 30%) associated with HIV/AIDS.
   1) An endogenous erythropoietin level < 500 IU/L is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200 mg/week.
   2) Reassessment should be made after 8 weeks. If no response, treatment should be discontinued. If response is demonstrated, the lowest ESA dose sufficient to reduce the need for RBC transfusions should be used, and the Hgb should not exceed 11gm/dl.

C) Indicated for anemia (Hgb < 10 gm/dl or HCT <30%) associated with chronic renal failure, with or without dialysis.
   1) Reassessment should be made after 12 weeks. If no response, treatment should be discontinued. If response is demonstrated, the lowest ESA dose sufficient to reduce the need for RBC transfusions should be used, and the Hgb should not exceed 11gm/dl. In those not on dialysis, the Hgb level should not exceed 10gm/dl.

GUIDELINE NOTE 8, BARIATRIC SURGERY

Lines 30,594

Bariatric surgery for is included under the following criteria:

A) Age ≥ 18
B) The patient has
   1) a BMI ≥ 35 with co-morbid type II diabetes for inclusion on Line 30 TYPE II DIABETES MELLITUS; OR.
   2) BMI >=35 with at least one significant co-morbidity other than type II diabetes (e.g., obstructive sleep apnea, hyperlipidemia, hypertension) or BMI >= 40 without a significant co-morbidity for inclusion on Line 594
C) No prior history of Roux-en-Y gastric bypass or laparoscopic adjustable gastric banding, unless they resulted in failure due to complications of the original surgery.
D) Participate in the following four evaluations and meet criteria as described.
   1) Psychosocial evaluation: (Conducted by a licensed mental health professional)
      a) Evaluation to assess potential compliance with post-operative requirements.

Rehabilitation Guideline

Question: What type of restrictions should be placed on physical and occupational therapies and other rehabilitative therapies?

Question source: HERC staff

Issues:

1) The current guideline with different visit numbers based on age without medical justification is not allowed under the ACA
2) At the May, 2014 meeting, the VBBS adopted a modified guideline without any visit limits
3) Medical Director feedback indicates that some type of numerical limits are strongly desired. The modified guideline shown in the recommendations section has been reviewed by the Medical Directors and they have no objections or comments.
4) HERC staff are concerned about lack of coverage for neurologic injuries, which may take longer to rehab and may vary on when rehab can begin

Current guideline:

GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

Lines 37,50-52,64,74-76,78,80,85,89,90,94,95,98-101, 108, 109, 115, 116, 122, 129, 139, 141-143,145,146,158,161,167,179,184-185,189, 190, 192, 194, 195, 201, 202, 208, 209,216,226,237,239,270,271,273,274,279,288,289,293,297,302,304,307-309, 318, 336,342,349, 350, 363, 367, 369, 375,376,378, 382,384,385,387, 400,406, 407, 434, 441,443,448,455,467,478,489,493,507,516,535,549,562, 580, 597,619,638

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation, are covered for diagnoses paired with the respective CPT codes, depending on medical appropriateness, for up to 3 months immediately following stabilization from an acute event.

Following the 3 month stabilization after an acute event, or, in the absence of an acute event, the following number of combined physical and occupational therapy visits are allowed per year, depending on medical appropriateness:

- Age < 8: 24
- Age 8-12: 12
- Age > 12: 2

And the following number of speech therapy visits are allowed per year, depending on medical appropriateness (with the exception of swallowing disorders, for which limits do not apply):

- Age < 8: 24

- Age 8-12: 12
- Age > 12: 2

Whenever there is a change in status, regardless of age, such as surgery, botox injection, rapid growth, an acute exacerbation or for evaluation/training for an assistive communication device, the following additional visits are allowed:

- 6 visits of speech therapy and/or
- 6 visits of physical or occupational therapy

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.

Guideline adopted in May, 2014

GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

Lines 37,50-52,64,74-76,78,80,85,89,90,94,95,98-101,108,109,115, 116,122, 129, 139,141-143,145,146,158,161,167,179,184,185,189,190,192,194, 195,201, 202, 208,209,216,226,237,239,270,271,273,274,279,288,289,293,297,302,304,307-309,318,336,342,349,350,363,367,369,375,376,378, 382,384,385,387,400, 406, 407,434,441,443,448,455,467,478,489,493,507,516,535,549,562,580,597,619,638

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included on these lines when the following criteria are met:

1) therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy,
2) there is objective, measurable documentation of progress toward the therapy plan of care goals and objectives,
3) the therapy plan of care requires the skills of a therapist, and
4) the client and/or caregiver cannot be taught to carry out the therapy regimen independently.

Rehabilitation Guideline

HERC staff recommendation:

1) Adopt the modified rehabilitation guideline as shown below
    a. Consider adding a clause excepting neurologic injuries from visit limits

GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

Lines 37,50-52,64,74-76,78,80,85,89,90,94,95,98-101, 108, 109, 115, 116, 122, 129, 139, 141-143,145,146,158,161,167,179,184,185,189, 190, 192, 194, 195, 201, 202, 208, 209,216,226,237,239,270,271,273,274,279,288,289,293,297,302,304,307-309, 318, 336,342,349, 350, 363, 367, 369, 375,376,378, 382,384,385,387, 400,406, 407, 434, 441,443,448,455,467,478,489,493,507,516,535,549,562,580, 597,619,638

A total of 30 visits per year of rehabilitative therapy (physical, occupational and speech therapy, and cardiac and vascular rehabilitation) are included on these lines when medically appropriate. Additional visits, not to exceed 30 visits per year, may be authorized in exceptional circumstances, such as in cases of rapid growth/development. Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included on these lines when the following criteria are met:

1) therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide the therapy,
2) there is objective, measurable documentation of clinically significant progress toward the therapy plan of care goals and objectives,
3) the therapy plan of care requires the skills of a medical provider, and
4) the client and/or caregiver cannot be taught to carry out the therapy regimen independently.

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.

Possible additional wording:
Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.

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Scope of Music Therapy Practice

2015

Preamble

The scope of music therapy practice defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Such practice also is governed by requirements for continuing education, professional responsibility and accountability. This document is designed for music therapists, clients, families, health and education professionals and facilities, state and federal legislators and agency officials, private and public payers, and the general public.

Statement of Purpose

The purpose of this document is to define the scope of music therapy practice by:

1. Outlining the knowledge, skills, abilities, and experience for qualified clinicians to practice safely, effectively and ethically, applying established standards of clinical practice and performing functions without risk of harm to the public;
2. Defining the potential for harm by individuals without formalized music therapy training and credentials; and
3. Describing the education, clinical training, board certification, and continuing education requirements for music therapists.

Definition of Music Therapy and Music Therapist

Music therapy is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. A music therapist is an individual who has completed the education and clinical training requirements established by the American Music Therapy Association (AMTA) and who holds current board certification from The Certification Board for Music Therapists (CBMT).

Assumptions

The scope of music therapy practice is based on the values of non-maleficence, beneficence, ethical practice; professional integrity, respect, excellence; and diversity. The following assumptions are the foundation for this document:

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music

intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.

- **Evidence-Based Practice.** A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

Music Therapy Practice

Music therapy means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups. Music therapy treatment plans are individualized for each client. The goals, objectives, and potential strategies of the music therapy services are appropriate for the client and setting. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. Music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas. Standards of practice in music therapy include:

- Accepting referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conducting a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client;
- Developing an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the assessed needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
- Implementing an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluating the client's response to music therapy and the music therapy treatment plan, documenting change and progress, and suggesting modifications, as appropriate;
- Developing a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimizing any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborating with and educating the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilizing appropriate knowledge and skills to inform practice including use of research, reasoning, and problem solving skills to determine appropriate actions in the context of each specific clinical setting.

Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context of the interdisciplinary team, supporting the treatment goals and co-treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implementation consider diagnosis and history, are performed in a manner congruent with the client's level of functioning, and address client needs across multiple domains.

Potential for Harm

Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices. The music therapist implements ongoing evaluation of client responses and adapts the intervention accordingly to protect the client from negative outcomes.

Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients. These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. Music therapists, therefore, participate in continued education to remain competent, know their limitations in professional practice, and recognize when it is appropriate to seek assistance, advice, or consultation, or refer the client to another therapist or professional. In addition, music therapists practice safely and ethically as defined by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws. Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs. Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary. Individuals attempting to provide music therapy treatment interventions without formalized music therapy training and credentials may pose risks to clients.

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).
- Recognize the client populations and health conditions for which music experiences are contraindicated.
- Comply with safety protocols with regard to transport and physical support of clients.

Definition of Governing Bodies

AMTA's mission is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA strives to improve and advance the use of music, in both its breadth and quality, in clinical, educational, and community settings for the betterment of the public health and welfare. The Association serves as the primary organization for the advancement of education, clinical practice, research, and ethical standards in the music therapy profession.

AMTA is committed to:

- Promoting quality clinical treatment and ethical practices regarding the use of music to restore, maintain, and improve the health of all persons.
- Establishing and maintaining education and clinical training standards for persons seeking to be credentialed music therapists.
- Educating the public about music therapy.
- Supporting music therapy research.

The mission of the CBMT is to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice. CBMT is an independent, non-profit, certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer.

CBMT is committed to:

- Maintaining the highest possible standards, as established by the Institute for Credentialing Excellence (ICE) and NCCA, for its national certification and recertification programs.
- Maintaining standards for eligibility to sit for the National Examination: Candidates must have completed academic and clinical training requirements established by AMTA.
- Defining and assessing the body of knowledge that represents safe and competent practice in the profession of music therapy and issuing the credential of Music Therapist Board Certified (MT-BC) to individuals that demonstrate the required level of competence.
- Advocating for recognition of the MT-BC credential and for access to safe and competent practice.
- Maintaining certification and recertification requirements that reflect current practice in the profession of music therapy.
- Providing leadership in music therapy credentialing.

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

Education and Clinical Training Requirements

A qualified music therapist:

- Must have graduated with a bachelor's degree (or its equivalent) or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA); and
- Must have successfully completed a minimum of 1,200 hours of supervised clinical work through pre-internship training at the AMTA-approved degree program, and internship training through AMTA –approved National Roster or University Affiliated internship programs, or an equivalent.

Upon successful completion of the AMTA academic and clinical training requirements or its international equivalent, an individual is eligible to sit for the national board certification exam administered by the Certification Board for Music Therapists (CBMT).

Board Certification Requirements

The Music Therapist – Board Certified (MT-BC) credential is granted by the Certification Board for Music Therapists (CBMT) to music therapists who have demonstrated the knowledge, skills, and abilities for competence in the current practice of music therapy. The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT, an independent, nonprofit corporation fully accredited by the National Commission for Certifying Agencies (NCCA).

The board certified music therapist credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the American Music Therapy Association (or an international equivalent) and successful completion of an objective written examination demonstrating current competency in the profession of music therapy. The CBMT administers this examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

Once board certified, a music therapist must adhere to the CBMT Code of Professional Practice and recertify every five years through either a program of continuing education or re-examination.

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual. The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

The recertification program contributes to the professional development of the board certified music therapist through a program of continuing education, professional development, and professional service opportunities. All three recertification categories are reflective of the Practice Analysis Study and relevant to the knowledge, skills and abilities required of the board certified music therapist. Documentation guidelines in the three categories require applying learning outcomes to music therapy practice and relating them to the CBMT Board Certification Domains. Integrating and applying new knowledge with current practice, developing enhanced skills in delivery of services to clients, and enhancing a board certified music therapist's overall abilities are direct outcomes of the recertification program. To support CBMT's commitment of ensuring the competence of the

board certified music therapist and protecting the public, certification must be renewed every five years with the accrual of 100 recertification credits.

NCCA accreditation demonstrates that CBMT and its credentialing program undergo review to demonstrate compliance with certification standards set by an impartial, objective commission whose primary focus is competency assurance and protection of the consumer. The program provides valuable information for music therapists, employers, government agencies, payers, courts and professional organizations. By participating in the CBMT Recertification Program, board certified music therapists promote continuing competence and the safe and effective clinical practice of music therapy.

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AMTA and CBMT created this document as a resource pertinent to the practice of music therapy. However, CBMT and AMTA are not offering legal advice, and this material is not a substitute for the services of an attorney in a particular jurisdiction. Both AMTA and CBMT encourage users of this reference who need legal advice on legal matters involving statutes to consult with a competent attorney. Music therapists may also check with their state governments for information on issues like licensure and for other relevant occupational regulation information. Additionally, since laws are subject to change, users of this guide should refer to state governments and case law for current or additional applicable materials.

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