Psychomotricity

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CNS
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To be entitled to a reimbursement from the National Health Fund (CNS) or the competent public sector fund, acts of psychomotor rehabilitation and relaxation performed by a psychomotor therapist must be prescribed by a doctor and authorised by the CNS, after a favourable opinion of the Medical Board of the Social Security (CMSS).

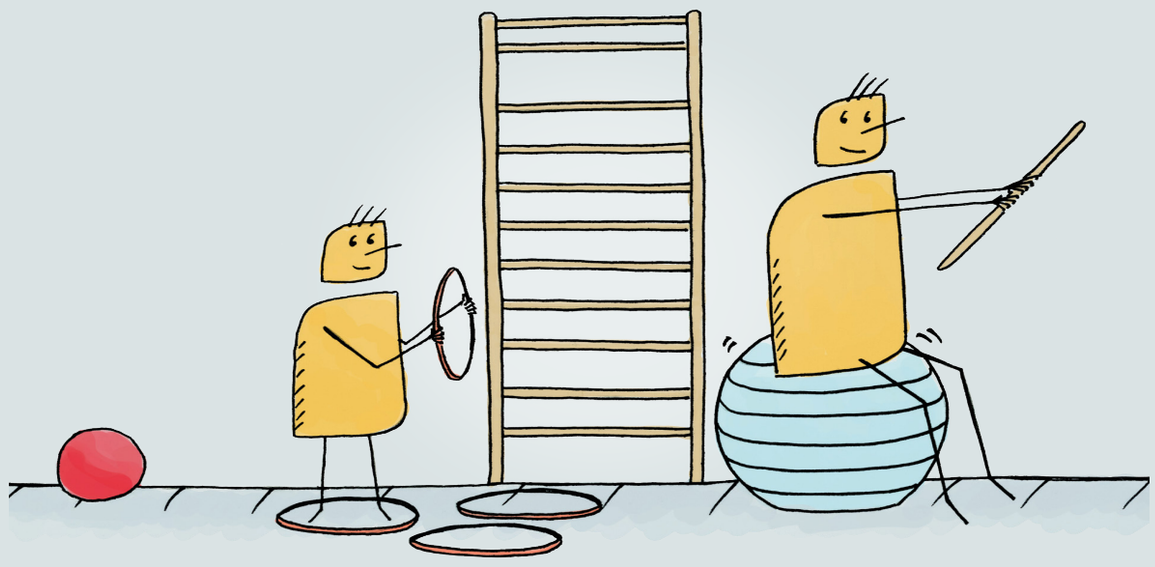
Conditions of coverage

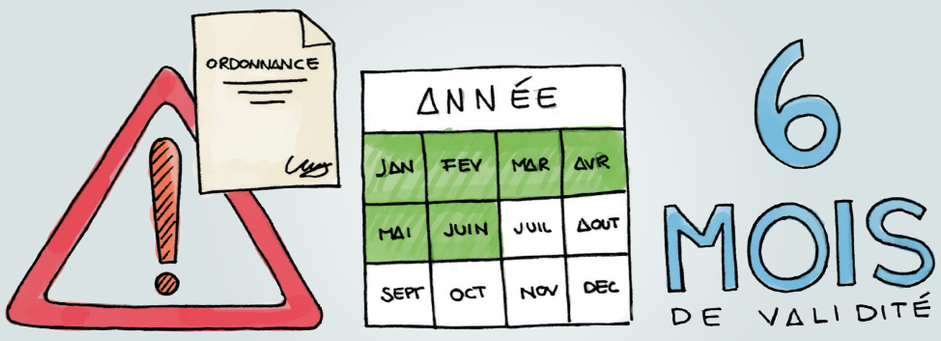
Medical prescription

Treatment prescription is made by means of a prior medical prescription. The insured person receives a medical prescription for psychomotor care from their attending/prescribing physician. The insured person may then present this prescription to a psychomotor therapist of their choice in Luxembourg.

Assessment report

During the first consultation with the patient, the psychomotor therapist establishes a treatment plan, which will be included in the assessment report. This report must be presented to the doctor who issued the medical prescription, as he must give his written consent in the form of a treatment prescription, with which the insured person can start treatment after prior authorisation from the CMSS. The assessment report is mandatory in order for the treatment to be authorised.





Prior authorisation by the Medical Board of the Social Security

Psychomotor rehabilitation and relaxation care must be previously authorised by the CMSS before the treatment is provided. However, the assessment reports provided for in the nomenclature are exempt from prior authorisation.

However, treatment may be started fifteen days after an assessment report has been sent to the attending physician and, where applicable, to the CNS, if there is no response or return notice from the CMSS in a timely manner.

The treatment once begun ceases to be covered by health insurance as soon as the assessment report is cancelled by the attending physician or as soon as the CMSS's decision to refuse authorisation of the treatment is acquired. However, treatment costs already incurred before the authorisation/refusal is obtained will be covered by the CNS.

For psychomotor rehabilitation treatments, the CMSS initial agreement can only be made on the basis of the first psychomotor examination and assessment report before treatment (Y11). In the case of a long-term treatment, the CMSS may require an intermediate assessment report (Y12).

Beginning of treatment

Unless specified otherwise by the doctor on the psychomotor care medical prescription, the prescribed treatment must be started within six months of the prescription's issue date. In the event of waiting periods exceeding six months, certified by the healthcare provider, this provision shall not apply.

Practical approach

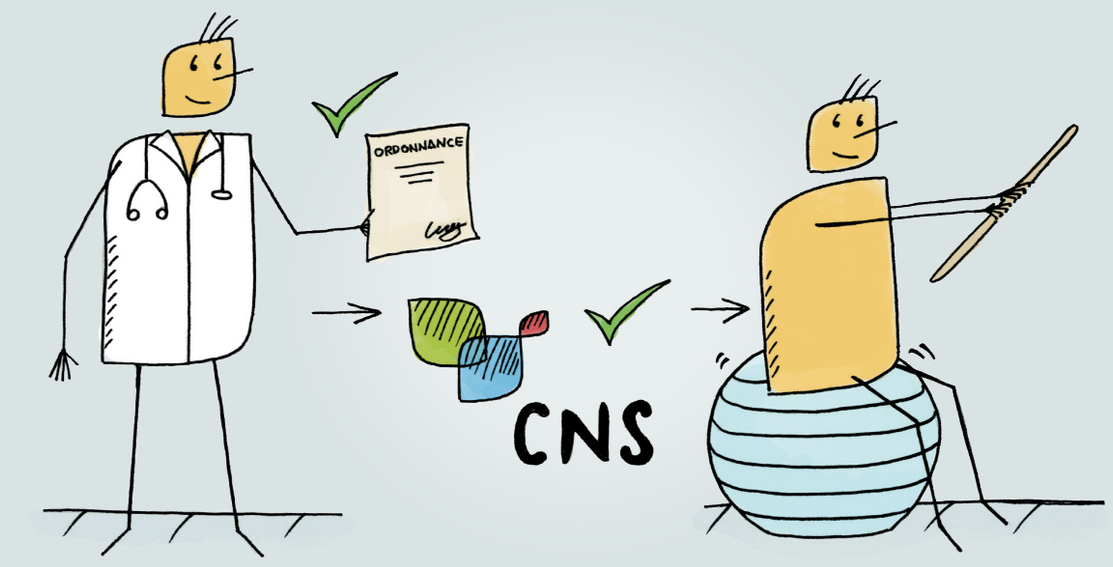
The insured person receives a prescription from their attending physician for a first visit to a psychomotor therapist of their choice.

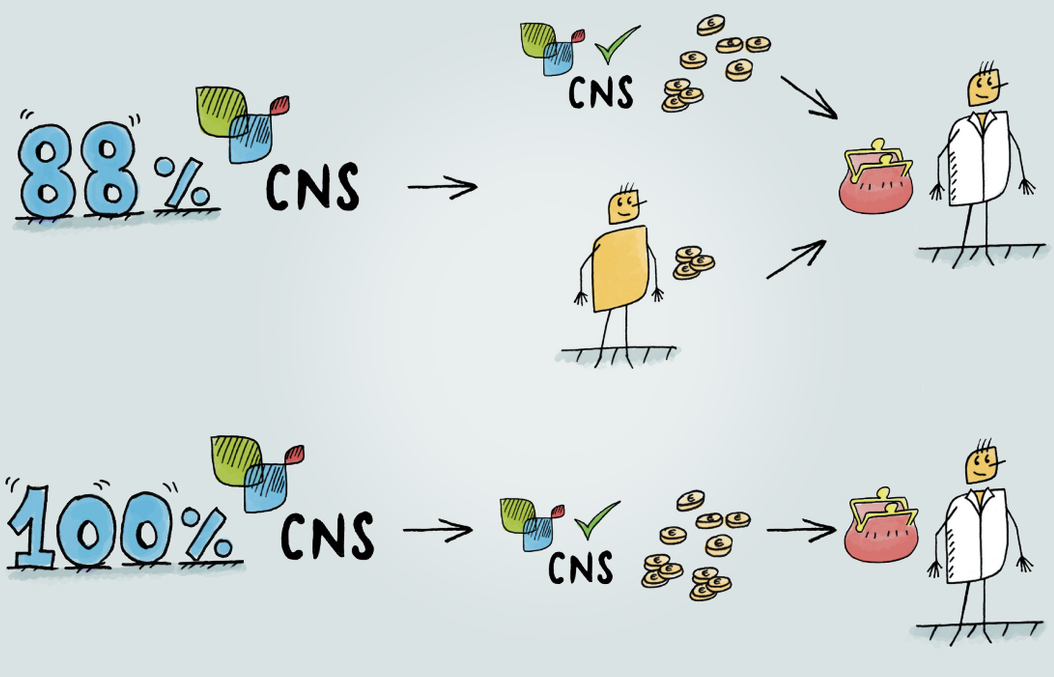
The insured person visits the psychomotor therapist with the medical prescription. The latter carries out an initial examination and draws up an assessment report containing a treatment plan.

The insured person presents the report to the attending doctor. The doctor must give his prior consent to the report by issuing a treatment prescription, with which the insured person will be able to report again to his psychomotor therapist in order to start treatment after a certificate of coverage has been issued.

In general, the psychomotor therapist forwards the request for prior authorisation to the competent department of the CNS with the supporting documents (medical prescription of the prescribing doctor, assessment report of the psychomotor therapist). The CNS verifies whether the administrative conditions are met. If the conditions are fulfilled, the request is forwarded by the CNS to the CMSS.

Following a favourable opinion of the CMSS, the CNS issues a certificate of coverage and sends it to the psychomotor therapist or the insured person, if the latter initiated the request for prior authorisation.





Payment method

Third-party payment

In general, psychomotricity services are covered directly by health insurance through the third-party payment system. Under the third-party payment system, the insured person pays the psychomotor therapist only the portion at their own expense.

The insured person pays the fees upfront

If the third-party payment system has not been applied, the psychomotor therapist presents to the insured person an invoice at the end of the treatment showing the total amount to be paid, i.e. the portion of the costs covered by health insurance as well as any portion to be paid by the insured person. After payment, the insured person requests a reimbursement of the portion covered by health insurance from their competent fund (CNS or public sector health insurance fund).

In order to be refunded for an invoice issued by a psychomotor therapist, the invoice must:

- display the insured's identification number, surname and first name;
- be validly paid;
- be submitted with the medical prescription and the certificate of coverage of the CNS.

Coverage rate

Acts and services listed in the nomenclature of psychomotor therapists, duly authorised in advance by the CMSS, as well as the assessment reports, are covered at the rate of 88 % of the tariffs applicable at the time of their delivery.

The coverage rate is 100 % if the insured person has not reached the age of 18 years at the time the prescription is issued.

The health insurance coverage rate is 80 % for acts of relaxation.

More information:
www.cns.lu > Insured person > Private life > Reimbursed services > Paramedical services > Psychomotricity

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