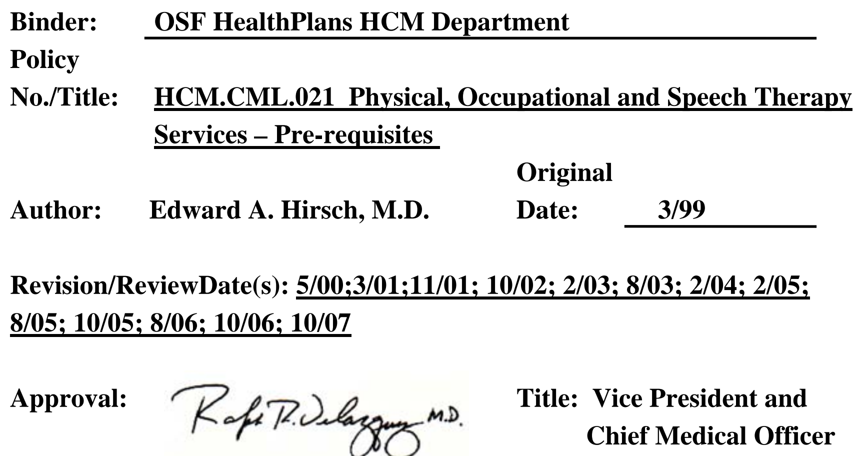

Binder: OSF HealthPlans HCM Department

Policy No./Title: HCM.CML.021 Physical, Occupational and Speech Therapy Services – Pre-requisites

Author: Edward A. Hirsch, M.D. **Original Date:** 3/99

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Approval: **Title:** Vice President and Chief Medical Officer

POLICY:

Coverage of physical, occupational and speech therapy services is a provisionally covered benefit. Coverage is limited to acute care where significant improvement can be expected. In context of efficient utilization of the service, physical, occupational and speech therapy is not intended, nor is it effective as a method of treating pain per se. Physical, occupational and speech therapy treatments and modalities are directed toward resolving the pathophysiologic causes of musculoskeletal pain problems, or toward restoring functional capabilities. Physical, occupational and speech therapy should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. The services must be restorative with the expectation the patient's condition will improve significantly in a reasonable and generally predictable period of time. Documentation in the medical record is essential for approval. Only one-on-one therapy is covered. Group therapy is not a covered benefit

PURPOSE:

To promote consistency in medical management and in defining coverage criteria for physical, occupational and speech therapy services.

PROCEDURE:

Physical Therapy Service Coverage Criteria

All physical, occupational and speech therapy services require a referral from an in-network PCP or an in-network sub-specialist.

Pre-approved physical, occupational and speech therapy service visits may be allowed for a specific medical diagnosis or condition as established by the Medical director through Therapeutic Associates, Inc. Clinical Practice Guidelines for Rehabilitation.

Documentation of objective findings is necessary for continued physical, occupational and speech therapy services beyond pre-approved limits. Medical re-evaluation is required prior to approval of additional visits beyond the pre-approved limits.

HCM Case Managers can approve 6 additional physical, occupational and speech therapy visits above pre-approved visits on Therapeutic Associates Rehabilitation protocols when documentation is received and goals have not been met according to protocols. All additional visits requested (above the additional six) must have progress notes and ordering physician re-evaluation

documentation submitted for additional review, or Medical Director Review for any non-covered services, such as work related, sports related, or chronic condition.

Required objective findings, when additional therapy visits requested:

Pain Level 0 is defined as no pain
10 is defined as severe pain.

ROM – Range of Motion needs to be quantified

Strength – Needs to be quantified

Goals – Need to be clearly defined.

Time-table of treatment plan needs to be set.

Home teaching program must be initiated within the first 3 visits and completed by the end of the approved visits.

Documentation of progress must be in objective terms.

ie: Pain level 8/10 down to 6/10
ROM increasing from 40 degrees to 65 degrees.
Strength at 3/5 now at 4/5

Primary Care Physicians who perform therapy in their office are subject to the above guidelines.

Guidelines for specific conditions not included in protocols.

1. Aquatic Therapy
   Covered only when one on one with the therapist when member cannot tolerate full weight bearing. It will also be covered for six visits for initial training or acute exacerbation of condition such as MS or fibromyalgia; again, must be one on one with therapist. Group exercise programs are not covered.

2. Lymphedema
   Six visits will be approved at participating provider for education and training. Any additional visit requests will require medical director review unless significant change in member condition, or other complication.

3. PT for conditions when there is no protocol
   head injury, conditions requiring multiple rehab services (PT, OT, ST). HCM will authorize twelve initial visits, then six additional as needed as long as member is making progress to meet goals, up to plan maximum.

4. Acute exacerbation of chronic conditions (MS, MD, fibromyalgia)
   HCM will authorize six initial visits and will be reviewed by the medical director as indicated in this policy.

5. Pregnancy
   PT for treatment of pregnancy discomforts is not rehabilitative services and will not be authorized for coverage. Benefit denial under EOC, Part VII, Section E, Number 3. PT will only be authorized for pregnant members when other medical conditions exist such as radiculopathy or other injury, authorize according to protocol for condition.

6. Vestibular clinic/vertigo
   HCM will authorize two PT visits for vertigo after confirming diagnosis with ENG study by neurology/ audiology using the Epley/Canolith or Semont maneuver. Two additional visits will be approved if needed to educate and initiate home program for member. Any additional visits requested will require medical director review.

7. IMS (Intra Muscular Stimulatus) treatment
   HCM will authorize three initial visits, then progress note are required for review for additional visits. Treatment visits are usually 7-10 days apart.

8. Finger fracture 12 visits

9. Post-op shoulder surgery 24 visits

10. Pelvic pain/pelvic dysfunction 6 visits for home program training. No additional visits will be approved.

11. Speech therapy for pervasive developmental disorders

    Effective 1/1/07 upon plan renewal:
    According to Illinois State Law, Public Act (PA) 94-0906, twenty additional outpatient speech therapy visits will be allowed for the treatment of pervasive developmental disorders (diagnosis codes 299-299.91)

Restrictions:

Maintenance programs that do not require the individual services of a physical therapist are not a covered service.

Referral or recommendations from a physical therapist is not sufficient for coverage of physical therapy services.

CHRONIC: a patient's condition is considered chronic when it is not expected to completely resolve. Once the functional status has remained stable (no significant change after two or three weeks of treatment), for a given condition, further physical therapy treatment is considered of no further benefit and therefore a maintenance therapy and is <u>no longer covered.</u>

General exercise programs, including aquatic exercise programs, to promote overall fitness, flexibility, or maintenance of a condition do not constitute physical therapy services and are therefore not a covered benefit.

The mere statement or diagnosis of pain is not sufficient to support medical necessity for treatments. Subjective impression that pain is improving is not sufficient to support medical necessity for continued treatments.

If the services provided can be carried out by non-skilled personnel then the services are not a covered benefit. Physical therapy services, which do not require the performance or supervision of a physical therapist, even if the are performed or supervised by a physical therapist, are not a covered service. Aquatic therapy will be covered only when one on one with the therapist and is subject to all the above policy requirements just as land therapy.

Massage Therapy is not a covered benefit.

Physical therapy is not covered for sports related activities. It is only covered to restore the patient to standard daily activities.

Work hardening programs to return to work, or any therapies related to employment are not covered.

References:

St. Anthony's Complete Guide to Medicare Coverage Issues C. March 1999.
Medicare Policy: http://www.wpsic.com/medicare/policy/pmed-002.html
2000 Therapeutic Associates, Inc., Guidelines for Physical Therapy.