Clinical Policy: Occupational Therapy

Reference Number:IL.CP.MP.525 Coding Implications
Last Review Date: 09/21 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Definitions:

Occupational Therapy (OT)	Involves the use of purposeful activities to help develop performance skills or regain those lost through injury or illness. Individual programs are designed to improve quality of life by developing or restoring competence, maximizing independences, and teaching skills to prevent further injury or disability.
Rehabilitative Services	Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because member became ill, hurt, or disabled.
Habilitative Services	Service that help a person keep, learn or improve skills and functioning for daily living. 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. Includes teaching a beneficiary how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously.

Policy/Criteria

I. It is the policy of MeridianHealth affiliated with Centene Corporation® that occupational therapy is medically necessary for the following indications:

A. Utilization Management Care Coordinators can approve up to 24 therapy visits
B. Following the initial 24 visits nurse reviewers can approve an additional 12 therapy visits if the member is making documented progress towards goals per this policy
C. Any requests for therapy beyond 36 visits need to be reviewed by a medical director
D. All services must be provided under the written order of a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), or other qualified health professional as defined by law according to a written treatment plan established by that provider.
E. ALL OON requests require Prior Authorization

II. Occupational Therapy:

A. OT is only covered if it can be reasonably expected to result in a meaningful improvement in the beneficiary's ability to perform functional day-to-day activities that are significant in the beneficiary's life roles despite impairments, activity limitations or participation restrictions.
B. OT must be medically necessary, reasonable and required to:

i. Return the beneficiary to the functional level prior to illness or disability
ii. Return the beneficiary to a functional level that is appropriate to a stable medical status; or
iii. Prevent a reduction in medical or functional status had the therapy not been provided.
iv. Functional improvements must be achieved in a reasonable amount of time and must be maintainable.

C. The skills of an OT are required for training or monitoring of maintenance programs being carried out by family and/or caregivers, or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is not required for these types of services for up to four times per 12-month period in the outpatient setting.

The OT request must include the following:

i. Service summary, including a description of the skilled services being provided (to include the treating OT'S analysis of the rate of progress, and justification for any change in the treatment plan). Documentation must relate to the period immediately prior to that time period for which PA is being requested.
ii. A comprehensive description of the maintenance/activity plan.
iii. A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
iv. A statement detailing coordination of services with other therapies (medical and educational) if appropriate.
v. The anticipated discharge plan.
vi. The anticipated frequency and duration of continued maintenance/monitoring.

III. Specific Diagnosis:

A. General Information Required for Continued Therapy (applies OT requests beyond 36 visits). Requests to continue active therapy must be supported by the following:

i. Treatment summary of previous therapy period, including measurable progress on each short-and long-term goal. This must include the treating provider's analysis of the therapy provided during the previous month, rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes.
ii. Progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
iii. Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
iv. Statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
v. Statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate.
vi. A copy of the prescription must be provided with each request. The prescription must be signed by the referring provider and dated within 30 days prior to initiation of the continued service. A signature stamp is not acceptable.
vii. A discharge plan. The discharge plan must include:
    1. Dates of service (i.e., initial and discharge dates);
    2. Description of services provided;

3. Functional status related to treatment areas/goals at discharge;
4. Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
5. Description or copy of follow-up or maintenance program put into place, if appropriate;
6. Identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate; ***and***
7. Recommendations/referral to other services, if appropriate

IV. Services to School-aged Beneficiaries:

A. Meridian expects educational OT to be provided by the school system and it is not a covered benefit. An example of education OT includes, but is not limited to:
   i. Coordination for handwriting, increasing attention span, identifying colors and numbers (Educational OT)

B. Only medically necessary OT will be covered when provided in the outpatient setting
   i. Coordination between all providers must be continuous to ensure a smooth transition between sources
   ii. **A copy of member's IEP should be submitted with initial requests**

C. Summer months
   i. When OT is provided to school-aged children during the summer months in order to maintain the therapy services provided in school, this is considered a continuation of therapy services when there is no change in beneficiary diagnosis or function
   ii. Prior Authorization is required before initiating a continuation of therapy
   iii. Coordination of therapy between providers is required if the school-aged beneficiary receives medically necessary therapy services in both a school setting (part of an Individualized Education Plan [IEP]) and in an outpatient hospital setting. Providers are to maintain documentation of coordination in the beneficiary's file

V. Absolute Contraindications:

A. The following therapy services are excluded from coverage:
   i. The type of therapy does not require the skills of a therapist in an outpatient hospital setting or free standing clinic
   ii. Therapy which is long-term in patients with cerebral palsy for adults 21 or older
   iii. Work hardening/conditioning programs, including vocational rehabilitation program
   iv. Strength training and exercise programs

B. Occupational Therapy is not covered for the following:
   i. For educational, vocational, or recreational purposes
   ii. If services are required to be provided by another public agency (e.g., community mental health services provider, school-based services)
   iii. If therapy requires PA and services is rendered before PA is approved
   iv. If therapy is habilitative
      1. **Note:** Federal EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) regulations require coverage of medically necessary

treatment for children under 21 years of age, including medically necessary habilitative therapy services

v. If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes

vi. For development of perceptual motor skills and sensory integrative functions to follow a normal sequence. If the beneficiary exhibits severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function, OT may be covered

vii. Continuation of therapy that is maintenance in nature

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Revision		9/26/18
Annual Review	08/27/21	09/2021

References:

1. Illinois DHFS, Handbook for Practitioners of Therapy Services. Section J-203.2. Version Date: July 1, 2016.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.