Network Notifications

Massachusetts

WellSense HEALTH PLAN

formerly BMC HealthNet Plan

Date:	August 25 , 2023	Number: 242
To:	All WellSense Providers	
From:	WellSense Health Plan	
Subject:	**August Medical Policy Network Notification**	
Product:	☒ MassHealth ☒ Qualified Health Plans ☒ Senior Care Options	

August Medical Policy Network Notification

Effective October 28, 2023, the following WellSense Health Plan medical policies will include updates to our prior authorization requirements:

- Occupational Therapy in the Outpatient Setting, OCA 3.53 (MassHealth)
- Occupational Therapy in the Outpatient Setting, OCA 3.532 (Qualified Health Plans)
- Occupational Therapy in the Outpatient Setting, OCA 3.533 (Senior Care Options plan)
- Physical Therapy in the Outpatient Setting, OCA 3.54 (MassHealth)
- Physical Therapy in the Outpatient Setting, OCA 3.541 (Qualified Health Plans)
- Physical Therapy in the Outpatient Setting, OCA 3.545 (Senior Care Options plan)
- Speech Therapy in the Outpatient Setting, OCA 3.551 (MassHealth)
- Speech Therapy in the Outpatient Setting, OCA 3.552 (Qualified Health Plans)
- Speech Therapy in the Outpatient Setting, OCA 3.533 (Senior Care Options plan)

General Information

All medical policies are on the Provider page at wellsense.org.

Questions?

Network Notifications

Massachusetts

WellSense HEALTH PLAN

formerly BMC HealthNet Plan

If you have questions about this Network Notification, please contact your dedicated Provider Relations consultant or call the Provider Line at 888-566-0008. Providers can also email feedback to medicalpolicy@wellsense.org . Please include the medical policy title and policy number with your comments.

All WellSense Network Notifications and Reimbursement Policies are available at wellsense.org.

Medical Policy – Policy with InterQual® Criteria

Occupational Therapy in the Outpatient Setting

Policy Number: OCA 3.53
Version Number: 29
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers occupational therapy (OT) provided in the outpatient setting to be medically necessary, including for habilitative services and/or rehabilitative services, when InterQual® criteria are met for services requested for an adult or pediatric member or are required EPSDT services for a member age 20 or younger on the date of service (when applicable). Occupational therapy must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements. OT must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary.

Prior authorization is required according to the guidelines outlined below:

1. Prior authorization is NOT required for any service listed in items a through c:

   a. For a member age 20 or younger on the date of service (DOS), all outpatient OT, including initial evaluations, re-evaluations, and all treatment visits, when services are rendered by a participating OT provider; OR

   b. For a member age 21 or older, an initial evaluation for outpatient OT when rendered by a participating occupational therapist; OR

c. For a member age 21 or older on the DOS, outpatient OT provided in the first 20 treatment visits (and within 80 15-minute treatment units) per member per benefit/Plan year when rendered by a participating OT provider for an established plan of care and each DOS is billed on a separate claim (or prior authorization is necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

   a. All outpatient OT requested or rendered by an occupational therapist/OT provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; this applies to OT for adult and pediatric members; OR

   b. All outpatient OT requested or rendered by a provider who is NOT certified or licensed as an OT provider, as defined by scope of practice, license, and certification; this applies to OT for adult and pediatric members and includes all initial evaluations, re-evaluations, and treatments; OR

   c. For an adult member age 21 or older on the DOS, any re-evaluation of the established plan of care for outpatient OT rendered, including re-evaluations conducted by a participating occupational therapist; OR

   d. For an adult member age 21 or older on the DOS, outpatient OT beyond 20 treatment visits (or in excess of 80 15-minute treatment units) per member per benefit/Plan year rendered by any OT provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing occupational therapist/OT provider rendering OT to a Plan member must be certified in rendering OT, as defined by license, scope of practice, and certification. Untimed OT is typically billed as one (1) unit per modality, and timed modalities are billed in 15-minute treatment units.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. The Plan Medical Director will evaluate the member's individual needs and circumstances, including the factors in items 1 through 11 (when applicable) to determine the medical necessity of therapeutic services:

1. Symptoms specific to the member's deficits; AND

2. How the member's deficits are impacting the member's quality of life; AND

3. How therapeutic interventions would benefit the member (based on a formal treatment plan with objective and measurable goals specific to the member's deficit); AND

4. Expected duration of therapy to meet the member's therapeutic treatment goals (with the duration consistent and reasonable when compared to professionally recognized standards of practice for the applicable therapeutic services); AND

5. Review of past therapy, the member's progress with treatment, and an evaluation of results; AND

6. Complications; AND

7. Progression of the member's condition, illness, or injury; AND

8. Comorbidities and relevant medical behavioral health/pharmacotherapy history; AND

9. Psychosocial circumstances; AND

10. Home environment; AND

11. Other applicable environmental factors.

Limitations and Exclusions

The following occupational therapy provided in the outpatient setting is NOT considered medically necessary:

1. Maintenance therapy provided in the outpatient setting; these services involve non-diagnostic, non-therapeutic, routine, and/or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed occupational therapist.

2. Therapy that is intended to restore or improve function after a temporary loss or reduction of function that could be reasonable expected to improve without such therapy when the individual resumes activities.

3. The therapy replicates services that are provided concurrently by any other type of therapy such as physical therapy and/or speech and language therapy, which should provide different treatment goals, plans, and therapeutic modalities.

4. The therapy documentation does not objectively verify progressive functional improvement over the specific time frames and therefore does not support the need for therapeutic services or continuing therapy.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification

of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	**Code Descriptions: Codes Covered When Medically Necessary**
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time

	or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

References

American Academy of Pediatrics (AAP). 2020 Recommendations for Preventive Pediatric Health Care. Committee on Practice and Ambulatory Medicine and Bright Futures Periodicity Schedule Workgroup. Pediatrics. 2020 Mar;145(3):e20200013. doi: 10.1542/peds.2020-0013.

American Occupational Therapy Association (AOTA). Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services. Am J Occup Ther. 2020 Nov-Dec;7413410020. doi: 10.5014/ajot.2020.74S3004.

American Occupational Therapy Association (AOTA). Occupational Therapy Using a Sensory Integration-Based Approach with Adult Populations.

American Occupational Therapy Association (AOTA). Official Documents: Accreditation, Concept Papers, Ethics, Guidelines, Specialized Knowledge and Skills, Position Papers, Standards, Statements, Societal Statements.

American Occupational Therapy Association (AOTA). Practice Guidelines.

American Occupational Therapy Association (AOTA). Scope of Practice: Questions & Answers.

Centers for Medicare & Medicaid Services (CMS). Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Medicaid.gov.

Centers for Medicare & Medicaid Services (CMS). EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. 2014 Jun.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 130 CMR 440.00. Division of Medical Assistance. Early Intervention Program Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 259 CMR 3.00. Occupational Therapists. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. Division of Insurance. Bulletin 2019-06. Guidelines for Pain Management Alternatives to Opiate Products. 2019 Aug 29.

Commonwealth of Massachusetts. Early Intervention Policies.

Commonwealth of Massachusetts. EPSDT and PPHSD Information and Resources.

Commonwealth of Massachusetts. MassHealth Guidelines for Medical Necessity Determination for Occupational Therapy.

Commonwealth of Massachusetts. MassHealth Provider Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Manuals.

Commonwealth of Massachusetts. MassHealth Therapist (THP) Manual.

Commonwealth of Massachusetts. MassHealth Transmittal Letters.

Commonwealth of Massachusetts. Policies, Regulations, and Statutes (Allied Health).

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 08.

Hayes. Health Technology Assessment. Occupational Therapy for Attention-Deficit/Hyperactivity Disorder (ADHD). Dallas, TX: Hayes; 2017 Mar 16. Annual Review 2021 May 12.

Massachusetts Association for Occupational Health Nurses (MaAOHN).

Massachusetts Department of Public Health. Early Intervention Operational Standards. 2013 Jul.

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/16/05	10/16/05 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

* Effective date for MassHealth product: 10/16/05
* Effective date for MA QHP product: 01/01/12 to 05/31/23
* Effective date for MA Senior Care Options product: 01/01/16 to 05/31/23

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
02/07/06	Added definitions for modality and visit. Defined coverage for visits, evaluations and units billed.	Version 2	02/07/06: Q&CMC
07/06/06	Removed verbiage regarding reimbursement for evaluation and modality services.	Version 3	07/06/06: Q&CMC
03/27/07	Policy archived.	Not applicable	Not specified
10/14/08	Clinical criteria updated, effective date of revised policy is 12/16/08.	12/16/08 Version 4	11/10/08: MPCTAC 12/16/08: Quality Improvement Committee (QIC)
09/22/09	No changes.	Version 5	09/22/09: MPCTAC 10/28/09: QIC
10/01/10	Updated template and references, no changes to criteria	Version 6	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	Added Commercial benefit limitations. Updated references and coding.	Version 7	10/19/11: MPCTAC 11/29/11: QIC
08/01/12	Off cycle review for NH Medicaid product, revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory paragraph, updated code list, revised Limitations, deleted references to contracts and EOCs that are not applicable.	Version 8	08/13/12: MPCTAC 09/06/12: QIC
11/01/12	Review for effective date 03/01/13. Updated references and revised Summary section. Moved medical criteria from Summary section to Clinical Guidelines Statement section.	03/01/13 Version 9	11/21/12: MPCTAC 12/20/12: QIC

	Moved services not considered medically necessary from the Clinical Guidelines Statement section to the Limitations section. Updated applicable coding list and references. Removed duplicate text in the Clinical Background Information section. Referenced Plan reimbursement policy 4.609 for occupational therapy reimbursement guidelines. Updated language in introductory paragraph of Applicable Coding section. Removed "Guideline" from title.		
08/14/13 and 08/15/13	Off cycle review for NH Medicaid product and merged policy format. Incorporate policy revisions dated 11/01/12 (as specified above) for the NH Medicaid product; these policy revisions were approved by MPCTAC on 11/21/12 and QIC on 12/20/12 for applicable Plan products.	Version 10	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
11/01/13, 12/01/13, 01/01/14, and 02/01/14	Review for effective date 05/01/14. Updated code definitions, introductory paragraph in Applicable Coding section, and the applicable code lists for the MA products and the NH Medicaid product. Updated references. Removed prior authorization waiver for the first 32 units of OT for the NH Medicaid product. Add criterion in the Medical Policy Statement sections for the MA products and NH Medicaid product requiring an updated physician prescription and supporting clinical documentation after 20 OT visits per treatment episode. Revised limitations.	05/01/14 Version 11	02/11/14: MPCTAC 02/18/14: QIC
10/01/14	Review for effective date 01/11/15. Policy reformatted to include MA products only. References updated.	01/11/15 Version 12	10/15/14: MPCTAC 11/12/14: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Administrative changes made to the Medical Policy Statement section and Limitations section without changing criteria. Updated Summary and References sections. Revised language in the Applicable Coding section.	01/01/16 Version 13	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
12/01/15	Review for effective date 02/01/16. Clarified text in the Medical Policy and Limitations section without changing criteria. Updated the Summary and Definitions sections.	02/01/16 Version 14	12/16/15: MPCTAC 01/13/16: QIC

12/01/16	Review for effective date 02/01/17. Industry-wide revisions made to applicable codes. Plan note added to the Applicable Coding section. Clarified existing criteria in the Medical Policy Statement section. Updated Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	02/01/17 Version 15	12/21/16: MPCTAC 01/11/17: QIC
12/01/17	Review for effective 01/01/18. Industry-wide updates to codes included in the Applicable Coding section. Annual review of policy with administrative changes made to the Definitions and Reference sections.	01/01/18 Version 16	12/20/17: MPCTAC
11/01/18	Review for effective date 12/01/18. Administrative changes made to the Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	12/01/18 Version 17	11/21/18: MPCTAC
07/01/19	Review for effective date 10/01/19. Updated applicable code list to be consistent with the Plan's reimbursement guidelines.	10/01/19 Version 18	07/17/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide updates to codes included in the Applicable Coding section.	01/01/20 Version 19	Not applicable because industry-wide code changes.
11/01/19	Review for effective date 02/01/20. Revised criteria in the Medical Policy Statement and Limitations sections. Updated the applicable code list. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	02/01/20 Version 20 Renumbered to version 20 to implement industry-wide code updates effective 01/01/20 included in version 19	11/20/19: MPCTAC
12/01/19	Review for effective 02/01/20. Industry-wide updates to codes effective 01/01/20 included in the Applicable Coding section of the policy version effective 02/01/20.	02/01/20 Version 21	Not applicable because industry-wide code changes
12/01/19	Review for effective date 03/01/20. Revised in the Medical Policy Statement section the number of units/visits of outpatient occupational therapy waived for prior authorization when the service is rendered by a provider who is certified in rendering OT services defined by scope of practice and certification.	03/01/20 Version 22	12/18/19: MPCTAC

11/01/20	Review for effective date 12/01/20. Administrative changes made to the Medical Policy Statement, Applicable Coding, References, and Reference to Applicable Laws and Regulations sections.	12/01/20 Version23	11/18/20: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made to the Policy Summary and References sections. Medical policy criteria retired and InterQual® criteria will continue to be used to determine medical necessity.	12/01/21 Version 24	11/17/21: MPCTAC
08/01/22	Review for effective date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Revised the prior authorization guidelines and criteria updated in the Clinical Criteria and Limitations and Exclusions sections.	11/01/22 Version 25 Version 25 NOT implemented	08/26/22: MPCTAC (electronic vote)
09/01/22	Review for effective date 12/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Revised the prior authorization guidelines and criteria updated in the Clinical Criteria and Limitations and Exclusions sections.	12/01/22 Version 26 Version 26 NOT implemented	09/23/22: MPCTAC (electronic vote)
10/24/22	Review for effective date 11/01/22. Revisions made to version 25 and version 26 will not be implemented. Medical policy guidelines effective in version 24 will remain in effect. Administrative changes made to the Clinical Criteria and Limitations and Exclusions section for this policy's annual review.	11/01/22 Version 27	10/24/22: MPCTAC (electronic vote)
04/01/23	Review for effective date 06/01/23. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections. Removed the Variations section. Removed QHP and SCO as applicable products for this policy and established new policies for QHP and SCO without changing criteria and/or coding for those products. Removed prior authorization requirement for all outpatient OT provided to a MassHealth ACO or MassHealth	06/01/23 Version 28	04/19/23: MPCTAC

	MCO member age 20 or younger when rendered by a licensed, appropriately qualified participating OT provider.		
08/24/23	Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section. Administrative change made to the Clinical Criteria section.	10/28/23 Version 29	08/24/23: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual® Criteria

Occupational Therapy in the Outpatient Setting

Policy Number: OCA 3.532
Version Number: 2
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers occupational therapy (OT) provided in the outpatient setting to be medically necessary, including habilitative services and/or rehabilitative services, when InterQual® criteria are met for an adult or pediatric member. OT must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements. OT must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary.

Prior authorization is required according to the guidelines outlined below.

1. Prior authorization is NOT required for any service listed in item a or item b:

   a. An initial evaluation for outpatient OT for an adult or pediatric member when rendered by a participating occupational therapist; OR

   b. Outpatient OT provided in the first 20 treatment visits (and within 80 15-minute treatment units) per member (adult or pediatric) per benefit/Plan year when rendered by a participating OT provider for an established plan of care and each DOS is billed on a separate claim (or prior

authorization is necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

   a. All outpatient OT requested or rendered by an occupational therapist/OT provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; this applies to OT for adult and pediatric members; OR

   b. All outpatient OT requested or rendered by a provider who is NOT certified or licensed as an OT provider, as defined by scope of practice, license, and certification; this applies to OT for adult and pediatric members and includes all initial evaluations, re-evaluations, and treatments; OR

   c. Any re-evaluation of the established plan of care for outpatient OT for an adult or pediatric member, including re-evaluations conducted by a participating occupational therapist; OR

   d. Outpatient OT beyond 20 treatment visits (or in excess of 80 15-minute treatment units) per member per benefit/Plan year for an adult or pediatric member rendered by an OT provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing occupational therapist/OT provider rendering OT to a Plan member must be certified in rendering OT, as defined by license, scope of practice, and certification. Untimed OT is typically billed as one (1) unit per modality, and timed modalities are billed in 15-minute treatment units.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. The Plan Medical Director will evaluate the member's individual needs and circumstances, including the factors in items 1 through 12 (when applicable) to determine the medical necessity of therapeutic services:

1. Chronological age; AND

2. Symptoms specific to the member's deficits; AND

3. How the member's deficits are impacting the member's quality of life; AND

4. How therapeutic interventions would benefit the member (based on a formal treatment plan with objective and measurable goals specific to the member's deficit); AND

5. Expected duration of therapy to meet the member's therapeutic treatment goals (with the duration consistent and reasonable when compared to professionally recognized standards of practice for the applicable therapeutic services); AND

6. Review of past therapy, the member's progress with treatment, and an evaluation of results; AND

7. Complications; AND

8. Progression of the member's condition, illness, or injury; AND

9. Comorbidities and relevant medical behavioral health/pharmacotherapy history; AND

10. Psychosocial circumstances; AND

11. Home environment; AND

12. Other applicable environmental factors.

Limitations and Exclusions

The following occupational therapy provided in the outpatient setting is NOT considered medically necessary:

1. Maintenance therapy provided in the outpatient setting; these services involve non-diagnostic, non-therapeutic, routine, and/or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed occupational therapist.

2. Therapy that is intended to restore or improve function after a temporary loss or reduction of function that could be reasonable expected to improve without such therapy when the individual resumes activities.

3. The therapy replicates services that are provided concurrently by any other type of therapy such as physical therapy and/or speech and language therapy, which should provide different treatment goals, plans, and therapeutic modalities.

4. The therapy documentation does not objectively verify progressive functional improvement over the specific time frames and therefore does not support the need for therapeutic services or continuing therapy.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified

in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is

	performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

References

American Academy of Pediatrics (AAP). 2020 Recommendations for Preventive Pediatric Health Care. Committee on Practice and Ambulatory Medicine and Bright Futures Periodicity Schedule Workgroup. Pediatrics. 2020 Mar;145(3):e20200013. doi: 10.1542/peds.2020-0013.

American Occupational Therapy Association (AOTA). Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services. Am J Occup Ther. 2020 Nov-Dec;7413410020. doi: 10.5014/ajot.2020.74S3004.

American Occupational Therapy Association (AOTA). Occupational Therapy Using a Sensory Integration-Based Approach with Adult Populations.

American Occupational Therapy Association (AOTA). Official Documents: Accreditation, Concept Papers, Ethics, Guidelines, Specialized Knowledge and Skills, Position Papers, Standards, Statements, Societal Statements.

American Occupational Therapy Association (AOTA). Practice Guidelines.

American Occupational Therapy Association (AOTA). Scope of Practice: Questions & Answers.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations. 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations. 259 CMR 3.00. Occupational Therapists. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. Division of Insurance. Bulletin 2019-06. Guidelines for Pain Management Alternatives to Opiate Products. 2019 Aug 29.

Commonwealth of Massachusetts. Massachusetts General Laws (MGL). Chapter 71B. Children with Special Needs.

Commonwealth of Massachusetts. Massachusetts General Laws (MGL). Chapter 721. Early Intervention.

Commonwealth of Massachusetts. Policies, Regulations, and Statutes (Allied Health).

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 08.

Hayes. Health Technology Assessment. Occupational Therapy for Attention-Deficit/Hyperactivity Disorder (ADHD). Dallas, TX: Hayes; 2017 Mar 16. Annual Review 2021 May 12.

Massachusetts Association for Occupational Health Nurses (MaAOHN).

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 04/19/23: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	06/01/23 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC

* QHP product included in the *Occupational Therapy in the Outpatient Setting* medical policy, OCA 3.53 from 01/01/12 to 05/31/23.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
08/24/23	Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section.	10/28/23 Version 2	08/24/23: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual® Criteria

Occupational Therapy in the Outpatient Setting

Policy Number: OCA 3.533
Version Number: 2
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers occupational therapy (OT) provided in the outpatient setting to be medically necessary, including habilitative services and/or rehabilitative services, when InterQual® criteria are met for services requested for a member. OT must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements. OT must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary.

Prior authorization is required according to the guidelines outlined below:

1. Prior authorization is NOT required for any service listed in item a or item b:

   a. An initial evaluation for outpatient OT for a member when rendered by a participating occupational therapist; OR

   b. Outpatient OT provided in the first 20 treatment visits (and within 80 15-minute treatment units) per member per benefit/Plan year when rendered by a participating OT provider for an established plan of care and each DOS is billed on a separate claim (or prior authorization is

necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

    a. All outpatient OT requested or rendered by an occupational therapist who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; OR

    b. All outpatient OT requested or rendered by a provider who is NOT certified or licensed as an OT provider, as defined by scope of practice, license, and certification; this includes all initial evaluations, re-evaluations, and treatments; OR

    c. Any re-evaluation of the established plan of care for outpatient OT for a Plan member, including re-evaluations conducted by a participating occupational therapist; OR

    d. Outpatient OT beyond 20 treatment visits (or in excess of 80 15-minute treatment units) per member per benefit/Plan year rendered by an OT provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing occupational therapist/OT provider rendering OT to a Plan member must be certified in rendering OT, as defined by license, scope of practice, and certification. Untimed OT is typically billed as one (1) unit per modality, and timed modalities are billed in 15-minute treatment units.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. The Plan Medical Director will evaluate the member's individual needs and circumstances, including the factors in items 1 through 12 (when applicable) to determine the medical necessity of therapeutic services:

1. Chronological age; AND

2. Symptoms specific to the member's deficits; AND

3. How the member's deficits are impacting the member's quality of life; AND

4. How therapeutic interventions would benefit the member (based on a formal treatment plan with objective and measurable goals specific to the member's deficit); AND

5. Expected duration of therapy to meet the member's therapeutic treatment goals (with the duration consistent and reasonable when compared to professionally recognized standards of practice for the applicable therapeutic services); AND

6. Review of past therapy, the member's progress with treatment, and an evaluation of results; AND

7. Complications; AND

8. Progression of the member's condition, illness, or injury; AND

9. Comorbidities and relevant medical behavioral health/pharmacotherapy history; AND

10. Psychosocial circumstances; AND

11. Home environment; AND

12. Other applicable environmental factors.

Limitations and Exclusions

The following occupational therapy provided in the outpatient setting is NOT considered medically necessary:

1. Maintenance therapy provided in the outpatient setting; these services involve non-diagnostic, non-therapeutic, routine, and/or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed occupational therapist.

2. Therapy that is intended to restore or improve function after a temporary loss or reduction of function that could be reasonable expected to improve without such therapy when the individual resumes activities.

3. The therapy replicates services that are provided concurrently by any other type of therapy such as physical therapy and/or speech and language therapy, which should provide different treatment goals, plans, and therapeutic modalities.

4. The therapy documentation does not objectively verify progressive functional improvement over the specific time frames and therefore does not support the need for therapeutic services or continuing therapy.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, LCD L34427 includes medically necessary indications for occupational therapy. Verify CMS guidelines in in effect on the date of the prior authorization request. When there is no guidance from CMS on the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions: Codes Covered When Medically Necessary
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes

97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes by provider, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

References

American Occupational Therapy Association (AOTA). Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services. Am J Occup Ther. 2020 Nov-Dec;7413410020. doi: 10.5014/ajot.2020.74S3004.

American Occupational Therapy Association (AOTA). Occupational Therapy Using a Sensory Integration-Based Approach with Adult Populations.

American Occupational Therapy Association (AOTA). Official Documents: Accreditation, Concept Papers, Ethics, Guidelines, Specialized Knowledge and Skills, Position Papers, Standards, Statements, Societal Statements.

American Occupational Therapy Association (AOTA). Practice Guidelines.

American Occupational Therapy Association (AOTA). Scope of Practice: Questions & Answers.

Centers for Medicare & Medicaid Services (CMS). Local Coverage Article (LCA). Billing and Coding: Outpatient Physical and Occupational Therapy Services A56566. 2019 Dec 19. Revision Effective Date 2020 Oct 1. National Government Services, Inc.

Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD). Outpatient Physical and Occupational Therapy Services L33631. 2015 Oct 1. Revision Effective Date 2020 Jan 1. National Government Services, Inc.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-03. Medicare National Coverage Determinations (NCD) Manual.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 259 CMR 3.00. Occupational Therapists. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Policies, Regulations, and Statutes (Allied Health).

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 08.

Hayes. Health Technology Assessment. Occupational Therapy for Attention-Deficit/Hyperactivity Disorder (ADHD). Dallas, TX: Hayes; 2017 Mar 16. Annual Review 2021 May 12.

Massachusetts Association for Occupational Health Nurses (MaAOHN).

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 04/19/23: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	06/01/23 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC

* MA SCO product included in the *Occupational Therapy in the Outpatient Setting* medical policy, OCA 3.53, from 01/01/16 to 05/31/23.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
08/24/23	Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section.	10/28/23 Version 2	08/24/23: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual® Criteria

Physical Therapy in the Outpatient Setting

Policy Number: OCA 3.54
Version Number: 31
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers physical therapy (PT) provided in the outpatient setting to be medically necessary, including for habilitative services and/or rehabilitative services, when InterQual® criteria are met for services requested for an adult or pediatric member or are required EPSDT services for a member age 20 or younger on the date of service (when applicable). Physical therapy must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements. PT must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary.

Prior authorization is required according to the guidelines listed below:

1. Prior authorization is NOT required for any service listed in items a through c:

    a. For a member age 20 or younger on the date of service (DOS), all outpatient PT, including initial evaluations, re-evaluations, and all treatment visits, when services are rendered by a participating PT provider; OR

    b. For a member age 21 or older, an initial evaluation for outpatient PT when rendered by a participating physical therapist; OR

c. For a member age 21 or older on the DOS, outpatient PT provided in the first 20 treatment visits (and within 80 15-minute treatment units) per member per benefit/Plan year when rendered by a participating PT provider for an established plan of care and each DOS is billed on a separate claim (or prior authorization is necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

   a. All outpatient PT requested or rendered by a physical therapist/PT provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; this applies to PT for adult and pediatric members; OR

   b. All outpatient PT requested or rendered by a provider who is NOT certified or licensed as a PT provider, as defined by scope of practice, license, and certification; this applies to PT for adult and pediatric members and includes all initial evaluations, re-evaluations, and treatments; OR

   c. For an adult member age 21 or older on the DOS, any re-evaluation of the established plan of care for outpatient PT rendered, including re-evaluations conducted by a participating physical therapist; OR

   d. For an adult member age 21 or older on the DOS, outpatient PT beyond 20 treatment visits (or in excess of 80 15-minute treatment units) per member per benefit/Plan year rendered by any PT provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing physical therapist/PT provider rendering PT to a Plan member must be certified in rendering PT, as defined by license, scope of practice, and certification. Untimed PT is typically billed as one (1) unit per modality, and timed modalities are billed in 15-minute treatment units.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. The Plan Medical Director will evaluate the member's individual needs and circumstances, including the factors in items 1 through 11 (when applicable) to determine the medical necessity of therapeutic services:

1. Symptoms specific to the member's deficits; AND

2. How the member's deficits are impacting the member's quality of life; AND

3. How therapeutic interventions would benefit the member (based on a formal treatment plan with objective and measurable goals specific to the member's deficit); AND

4. Expected duration of therapy to meet the member's therapeutic treatment goals (with the duration consistent and reasonable when compared to professionally recognized standards of practice for the applicable therapeutic services); AND

5. Review of past therapy, the member's progress with treatment, and an evaluation of results; AND

6. Complications; AND

7. Progression of the member's condition, illness, or injury; AND

8. Comorbidities and relevant medical behavioral health/pharmacotherapy history; AND

9. Psychosocial circumstances; AND

10. Home environment; AND

11. Other applicable environmental factors.

Limitations and Exclusions

Any of the following physical therapy provided in the outpatient setting is NOT considered medically necessary:

1. Maintenance therapy provided in the outpatient setting; these services involve non-diagnostic, non-therapeutic, routine, and/or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed therapist.

2. The treatment constitutes non-therapeutic services, such as general exercise programs to promote overall fitness and endurance, for diversion, or for general motivation.

3. The therapy replicates services that are provided concurrently by any other type of therapy such as occupational therapy and/or speech and language therapy, which should provide different treatment goals, plans, and therapeutic modalities.

4. The therapy documentation does not objectively verify progressive functional improvement over the specific time frames and therefore does not support the need for therapeutic services or continuing therapy.

5. There is no objective clinical benefit to the use of more than four (4) modalities per PT session, therefore more than four (4) modalities per session are considered not medically necessary.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes

97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

References

American Academy of Pediatrics (AAP). Richerson JE, Abularrage JJ, Almendarez JE, Arauz Boudreau AD, Berhane AM, Cantrell PE, Hackell JM, Kafer LM, Warner R, Haga Jr JF, KemperAR, Shaw JS. 2020 Recommendations for Preventive Pediatric Health Care. Committee on Practice and Ambulatory Medicine and Bright Futures Periodicity Schedule Workgroup. Pediatrics. 2020 Mar;145(3):e20200013. doi: 10.1542/ peds.2020-0013.

American Association of Acupuncture and Oriental Medicine (AAAOM). AAAOM Position Statement on Trigger Point Dry Needling (TPDN) and Intramuscular Manual Therapy (IMT).

American College of Physicians (ACP), American Pain Society (APS). Chou R, Qaseem A, Snow V, Casey D, Cross JT Jr, Shekelle P, Owens DK; Clinical Efficacy Assessment Subcommittee of the ACP; ACP; APS Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the ACP and the APS. Ann Intern Med. 2007 Oct 2;147(7):478-91. Erratum in: Ann Intern Med. 2008 Feb 5;148(3):247-8. PMID: 17909209.

American College of Physicians (ACP). Qaseem A, Wilt TJ, McLean RM, Forciea MA; Clinical Guidelines Committee of the ACP. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the ACP. Ann Intern Med. 2017 Apr 4;166(7):514-30. doi: 10.7326/M16-2367. Epub 2017 Feb 14. PMID: 28192789.

American Heart Association/American Stroke Association. Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for Adult Stroke Rehabilitation and Recovery: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2016 Jun;47(6):e98-169. doi: 10.1161/STR.0000000000000098. Epub 2016 May 4. Review. Erratum in: Stroke. 2017 Feb;48(2):e78. Stroke. 2017 Dec;48(12):e369. PMID: 27145936.

American Pain Society (APS). Chou R, Atlas SJ, Stanos SP, Rosenquist RW. Nonsurgical Interventional Therapies for Low Back Pain: a Review of the Evidence for an American Pain Society Clinical Practice Guideline. Spine. 2009 May 1;34(10):1078-93. doi: 10.1097/BRS.0b013e3181a103b1. PMID: 19363456.

American Pain Society (APS). Guideline Summaries.

American Physical Therapy Association (APTA). APTA Clinical Practice Guidelines Development Manual.

American Physical Therapy Association (APTA). Balance and Falls.

American Physical Therapy Association (APTA). Clinical Practice Guidelines (CPGs) Developed by APTA.

American Physical Therapy Association (APTA). Coding and Billing.

American Physical Therapy Association (APTA). Direction and Supervision of the Physical Therapist Assistant.

American Physical Therapy Association (APTA). Dry Needling.

American Physical Therapy Association (APTA). Ethics and Professionalism. Code of Ethics for the Physical Therapist, Standards of Ethical Conduct for the PTA, Value-Based Behaviors for the PTA, Core Values for the PT and PTA, Standards of Practice for Physical Therapy.

American Physical Therapy Association (APTA). Guide to Physical Therapist Practice. Guide 3.0. 2016.

American Physical Therapy Association (APTA). Physical Therapy Documentation of Patient/Client Management.

American Physical Therapy Association (APTA). Supervision and Teamwork.

American Society of Anesthesiologists (ASA), American Society of Regional Anesthesia and Pain Medicine (ASRA). Rosenquist RW, Benzon HT, Connis RT, De Leon-Casasola OA, Glass D, Korevaar WC, Cynwyd B, Mekhail NA, Merrill DG, NIckinovich DG, Rathnmell JP, Nai-Mei Sang C, Simon DL; ASA Task Force on Chronic Pain Management. Practice guidelines for chronic pain management: an updated report by the ASA Task Force on Chronic Pain Management and the ASRA. Anesthesiology. 2010 Apr;112(4):810-33. doi: 10.1097/ALN.0b013e3181c43103. PMID: 20124882.

Centers for Medicare & Medicaid Services (CMS). Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Medicaid.gov.

Centers for Medicare & Medicaid Services (CMS). EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. 2014 Jun.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 130 CMR 440.00. Division of Medical Assistance. Early Intervention Program Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 259 CMR 5..00. Physical Therapists. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. Division of Insurance. Bulletin 2019-06. Guidelines for Pain Management Alternatives to Opiate Products. 2019 Aug 29.

Commonwealth of Massachusetts. Early Intervention Division (EI).

Commonwealth of Massachusetts. EPSDT and PPHSD Information and Resources. Mass.gov.

Commonwealth of Massachusetts. MassHealth Guidelines for Medical Necessity Determination for Physical Therapy.

Commonwealth of Massachusetts. MassHealth Provider Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Manuals.

Commonwealth of Massachusetts. MassHealth Therapist (THP) Manual.

Commonwealth of Massachusetts. MassHealth Transmittal Letters.

Commonwealth of Massachusetts. Policies, Regulations, and Statutes (Allied Health).

Cruickshank TM, Reyes AR, Ziman MR. A systematic review and meta-analysis of strength training in individuals with multiple sclerosis or Parkinson disease. Medicine (Baltimore). 2015 Jan;94(4):e411. doi: 10.1097/MD.0000000000000411. PMID: 25634170.

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 8.

Madsen M, Larsen K, Madsen IK, Søe H, Hansen TB. Late group-based rehabilitation has no advantages compared with supervised home-exercises after total knee arthroplasty. Dan Med J. 2013 Apr;60(4):A4607. PMID: 23651717.

Massachusetts Department of Public Health. Early Intervention Operational Standards. 2013 Jul.

Monticone M, Ferrante S, Rocca B, Baiardi P, Farra FD, Foti C. Effect of a long-lasting multidisciplinary program on disability and fear-avoidance behaviors in patients with chronic low back pain: results of a randomized controlled trial. Clin J Pain. 2013 Nov;29(11):929-38. doi: 10.1097/AJP.0b013e31827fef7e. PMID: 23328343.

Parikh SS, Baxi N, Padavan SA. Musculoskeletal medicine. In: Sackheim KA, editor. Rehab Clinical Pocket Guide. New York, NY: Springer; 2013:357-426.

Reid MC, Eccleston C, Pillemer K. Management of chronic pain in older adults. BMJ. 2015 Feb 13;350:h532. doi: 10.1136/bmj.h532. PMID: 25680884.

Schaufele MK, Tate JL. Lumbar degenerative disease. In: Frontera WR, Silver JK, Rizzo TD Jr, editors. Essentials of Physical Medicine and Rehabilitation: Musculoskeletal Disorders, Pain, and Rehabilitation. 3rd ed. Philadelphia, PA: Elsevier Saunders; 2015:225-32.

Stanos SP, Tybursky MD, Harden RN. Chronic pain. In: Cifu DX, et al., editors. Braddom's Physical Medicine and Rehabilitation. 5th ed. Elsevier; 2016:809-33.

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/16/05	10/16/05 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

* Effective date for MassHealth product: 10/16/05
* Effective date for MA QHP product: 01/01/12 to 05/31/23
* Effective date for MA Senior Care Options product: 01/01/16 to 05/31/23
* Effective date for NH Medicaid product: 01/01/13 to 01/10/15 (until separate medical policies were developed for NH Medicaid product effective 01/11/15, policy number OCA 3.531 and policy number OCA 3.541 for functional therapies)

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
02/07/06	Added definitions for modality and visit. Defined coverage for visits, evaluations and units billed.	Version 2	02/07/06: Q&CMC
07/06/06	Removed verbiage regarding reimbursement for evaluation and modality services.	Version 3	07/06/06: Q&CMC
03/27/07	Policy archived.	Not applicable	Not specified
10/14/08	Updated clinical criteria. Effective date of the revised policy is 12/16/08.	12/16/08 Version 4	11/10/08: MPTAC 12/16/08: Quality Improvement Committee (QIC)
09/22/09	No changes.	Version 5	09/22/09: MPCTAC 10/28/09: QIC
10/01/10	Updated template and references.	Version 6	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	Added Commercial benefit limitations. Updated coding and references.	Version 7	10/19/11: MPCTAC 11/29/11: QIC
08/01/12	Off cycle review for Well Sense Health Plan, revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory paragraph, updated code list, revised Limitations section, and revised references.	Version 8	08/13/12: MPCTAC 09/06/12: QIC

11/01/12	Review for effective date 03/01/13. Updated references. Revised Summary section. Clarified text in Medical Policy Statement section. Revised language in introductory paragraph in Applicable Coding section and updated applicable code list. Clinical criteria moved from Clinical Background and Summary sections to Medical Policy Statement section. Moved services not considered medically necessary from the Medical Policy Statement section to the Limitations section. Removed duplicate text from Clinical Background Information section. Referenced Plan reimbursement policy 4.609 for physical therapy reimbursement guidelines. Removed "Guideline" from title.	03/01/13 Version 9	11/21/12: MPCTAC 12/20/12: QIC
08/14/13 and 08/15/13	Off cycle review for Well Sense Health Plan and merged policy format. Incorporate policy revisions dated 11/01/12 (as specified above) for the NH Medicaid product; these policy revisions were approved by MPCTAC on 11/21/12 and QIC on 12/20/12 for applicable Plan products.	Version 10	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
11/01/13, 12/01/13, 01/01/14, and 02/01/14	Review for effective date 05/01/14. Updated code definitions, introductory paragraph in Applicable Coding section, and the applicable code lists for the MA products and the NH Medicaid product. Updated references. Removed prior authorization waiver for the first 32 units of PT for the NH Medicaid product. Add criterion in the Medical Policy Statement sections for the MA products and NH Medicaid product requiring an updated physician prescription and supporting clinical documentation after 20 PT visits per treatment episode. Revised Limitations sections.	05/01/14 Version 11	02/11/14: MPCTAC 02/18/14: QIC
10/01/14 and 11/19/14	Review for effective date 01/11/15. Policy reformatted to include MA products only. References updated. Revised review calendar.	01/11/15 Version 12	10/15/14: MPCTAC 11/12/14: QIC 11/19/14: MPCTAC 12/10/14: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Administrative changes made to the Medical Policy Statement section and Limitations section without changing criteria. Updated Summary and References sections.	01/01/16 Version 13	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC

	Revised language in the Applicable Coding section.		
12/01/15	Review for effective date 02/01/16. Clarified text in the Medical Policy and Limitations section without changing criteria. Updated the Summary and Definitions sections.	02/01/16 Version 14	12/16/15: MPCTAC 01/13/16: QIC
12/01/16	Review for effective date 02/01/17. Industry-wide revisions of applicable codes. Clarified existing criteria in the Medical Policy Statement section. Updated Clinical Background Information, References, and References to Applicable Laws and Regulations sections. Plan note added to the Applicable Coding section.	02/01/17 Version 15	12/21/16: MPCTAC 01/11/17: QIC
12/01/17	Review for effective 01/01/18. Industry-wide updates to codes included in the Applicable Coding section. Annual review of policy with administrative changes made to the Definitions and Reference sections.	01/01/18 Version 16	12/20/17: MPCTAC
11/01/18	Review for effective date 12/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	12/01/18 Version 17	11/21/18: MPCTAC
03/01/19	Review for effective date 06/01/19. Updated criteria in the Medical Policy Statement. Administrative changes made to the Limitations section.	06/01/19 Version 18	03/20/19: MPCTAC
07/01/19	Review for effective date 10/01/19. Updated applicable code list to be consistent with the Plan's reimbursement guidelines.	10/01/19 Version 19	07/17/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide updates to codes included in the Applicable Coding section.	01/01/20 Version 20	Not applicable because industry-wide code changes
11/01/19	Review for effective date 02/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections. Updated the applicable code list. Revised criteria in the Medical Policy Statement and Limitations sections.	02/01/20 Version 21 Renumbered to version 21 to implement industry-wide code updates effective 01/01/20 in version 20	11/20/19: MPCTAC
12/01/19	Review for effective 02/01/20. Industry-wide updates to codes included in the Applicable	02/01/20 Version 22	Not applicable because industry-wide code changes

	Coding section of the policy version effective 02/01/20.		
12/01/19	Review for effective date 03/01/20. Revised in the Medical Policy Statement section the number of units/visits of outpatient physical therapy waived for prior authorization when the service is rendered by a provider who is certified in rendering PT services defined by scope of practice and certification.	03/01/20 Version 23	12/18/19: MPCTAC
01/01/20	Review for effective date 04/01/20. Administrative changes made to the Clinical Background Information and References sections.	04/01/20 Version 24	01/15/20: MPCTAC
11/01/20	Review for effective date 12/01/20. Administrative changes made to the Medical Policy Statement, Applicable Coding, References, and Reference to Applicable Laws and Regulations sections.	12/01/20 Version 25	11/18/20: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made to the Policy Summary and References sections. Medical policy criteria retired and InterQual® criteria will continue to be used to determine medical necessity.	12/01/21 Version 26	11/17/21: MPCTAC
08/01/22	Review for effective date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Revised the prior authorization guidelines and criteria updated in the Clinical Criteria and Limitations and Exclusions sections.	11/01/22 Version 27 Version 27 NOT implemented	08/26/22: MPCTAC (electronic vote)
09/01/22	Review for effective date 12/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Revised the prior authorization guidelines and criteria updated in the Clinical Criteria and Limitations and Exclusions sections.	12/01/22 Version 28 Version 28 NOT implemented	09/23/22: MPCTAC (electronic vote)
10/24/22	Review for effective date 11/01/22. Revisions made to version 27 and version 28 will not be implemented. Medical policy guidelines effective in version 26 will remain in effect. Administrative changes made to the Clinical	11/01/22 Version 29	10/24/22: MPCTAC (electronic vote)

	Criteria and Limitations and Exclusions section for this policy's annual review.		
04/01/23	Review for effective date 06/01/23. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections. Removed the Variations section. Removed QHP and SCO as applicable products for this policy and established new policies for QHP and SCO without changing product-specific criteria and/or coding. Removed prior authorization requirement for all outpatient PT provided to a MassHealth ACO or MassHealth MCO member age 20 or younger when rendered by a licensed, appropriately qualified participating PT provider.	06/01/23 Version 30	04/19/23: MPCTAC
08/24/23	Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section. Administrative change made to the Clinical Criteria section.	10/28/23 Version 31	08/24/23: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual® Criteria

Physical Therapy in the Outpatient Setting

Policy Number: OCA 3.541
Version Number: 2
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers physical therapy (PT) provided in the outpatient setting to be medically necessary, including for habilitative services and/or rehabilitative service when InterQual® criteria are met for services requested for an adult or pediatric member. PT must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements. PT must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary.

Prior authorization is required according to the guidelines outlined below:

1. Prior authorization is NOT required for any service listed in item a or item b:

    a. An initial evaluation for outpatient PT for an adult or pediatric member when rendered by a participating physical therapist; OR

    b. Outpatient PT provided in the first 20 treatment visits (and within 80 15-minute treatment units) per member (adult or pediatric) per benefit/Plan year when rendered by a participating PT provider for an established plan of care and each DOS is billed on a separate claim (or prior

authorization is necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

    a. All outpatient PT requested or rendered by a physical therapist/PT provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; this applies to PT for adult and pediatric members; OR

    b. All outpatient PT requested or rendered by a provider who is NOT certified or licensed as a PT provider, as defined by scope of practice, license, and certification; this applies to PT for adult and pediatric members and includes all initial evaluations, re-evaluations, and treatments; OR

    c. Any re-evaluation of the established plan of care for outpatient PT for an adult or pediatric member, including re-evaluations conducted by a participating physical therapist; OR

    d. Outpatient PT beyond 20 treatment visits (or in excess of 80 15-minute treatment units) per member per benefit/Plan year for an adult or pediatric member rendered by a PT provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing physical therapist/PT provider rendering PT to a Plan member must be certified in rendering PT, as defined by license, scope of practice, and certification. Untimed PT is typically billed as one (1) unit per modality, and timed modalities are billed in 15-minute treatment units.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. The Plan Medical Director will evaluate the member's individual needs and circumstances, including the following factors in items 1 through 12 (when applicable) to determine the medical necessity of therapeutic services:

1. Chronological age; AND

2. Symptoms specific to the member's deficits; AND

3. How the member's deficits are impacting the member's quality of life; AND

4. How therapeutic interventions would benefit the member (based on a formal treatment plan with objective and measurable goals specific to the member's deficit); AND

5. Expected duration of therapy to meet the member's therapeutic treatment goals (with the duration consistent and reasonable when compared to professionally recognized standards of practice for the applicable therapeutic services); AND

6. Review of past therapy, the member's progress with treatment, and an evaluation of results; AND

7. Complications; AND

8. Progression of the member's condition, illness, or injury; AND

9. Comorbidities and relevant medical behavioral health/pharmacotherapy history; AND

10. Psychosocial circumstances; AND

11. Home environment; AND

12. Other applicable environmental factors.

Limitations and Exclusions

The following physical therapy provided in the outpatient setting is NOT considered medically necessary:

1. Maintenance therapy provided in the outpatient setting; these services involve non-diagnostic, non-therapeutic, routine, and/or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed therapist.

2. The treatment constitutes non-therapeutic services, such as general exercise programs to promote overall fitness and endurance, for diversion, or for general motivation.

3. The therapy replicates services that are provided concurrently by any other type of therapy such as occupational therapy and/or speech and language therapy, which should provide different treatment goals, plans, and therapeutic modalities.

4. The therapy documentation does not objectively verify progressive functional improvement over the specific time frames and therefore does not support the need for therapeutic services or continuing therapy.

5. There is no objective clinical benefit to the use of more than four (4) modalities per PT session, therefore more than four (4) modalities per session are considered not medically necessary.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and

do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

97150	Therapeutic procedure(s), group (2 or more individuals)
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

References

American Academy of Pediatrics (AAP). Richerson JE, Abularrage JJ, Almendarez JE, Arauz Boudreau AD, Berhane AM, Cantrell PE, Hackell JM, Kafer LM, Warner R, Haga Jr JF, KemperAR, Shaw JS. 2020 Recommendations for Preventive Pediatric Health Care. Committee on Practice and Ambulatory Medicine and Bright Futures Periodicity Schedule Workgroup. Pediatrics. 2020 Mar;145(3):e20200013. doi: 10.1542/peds.2020-0013.

American Association of Acupuncture and Oriental Medicine (AAAOM). AAAOM Position Statement on Trigger Point Dry Needling (TPDN) and Intramuscular Manual Therapy (IMT).

American College of Physicians (ACP), American Pain Society (APS). Chou R, Qaseem A, Snow V, Casey D, Cross JT Jr, Shekelle P, Owens DK; Clinical Efficacy Assessment Subcommittee of the ACP; ACP; APS Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the ACP and the APS. Ann Intern Med. 2007 Oct 2;147(7):478-91. Erratum in: Ann Intern Med. 2008 Feb 5;148(3):247-8. PMID: 17909209.

American College of Physicians (ACP). Qaseem A, Wilt TJ, McLean RM, Forciea MA; Clinical Guidelines Committee of the ACP. Noninvasive Treatments for Acute, Subacute, and Chronic Low

Back Pain: A Clinical Practice Guideline from the ACP. Ann Intern Med. 2017 Apr 4;166(7):514-30. doi: 10.7326/M16-2367. Epub 2017 Feb 14. PMID: 28192789.

American Heart Association/American Stroke Association. Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for Adult Stroke Rehabilitation and Recovery: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2016 Jun;47(6):e98-169. doi: 10.1161/STR.0000000000000098. Epub 2016 May 4. Review. Erratum in: Stroke. 2017 Feb;48(2):e78. Stroke. 2017 Dec;48(12):e369. PMID: 27145936.

American Pain Society (APS). Chou R, Atlas SJ, Stanos SP, Rosenquist RW. Nonsurgical Interventional Therapies for Low Back Pain: a Review of the Evidence for an American Pain Society Clinical Practice Guideline. Spine. 2009 May 1;34(10):1078-93. doi: 10.1097/BRS.0b013e3181a103b1. PMID: 19363456.

American Pain Society (APS). Guideline Summaries.

American Physical Therapy Association (APTA). APTA Clinical Practice Guidelines Development Manual.

American Physical Therapy Association (APTA). Balance and Falls.

American Physical Therapy Association (APTA). Clinical Practice Guidelines (CPGs) Developed by APTA.

American Physical Therapy Association (APTA). Coding and Billing.

American Physical Therapy Association (APTA). Direction and Supervision of the Physical Therapist Assistant.

American Physical Therapy Association (APTA). Dry Needling.

American Physical Therapy Association (APTA). Ethics and Professionalism. Code of Ethics for the Physical Therapist, Standards of Ethical Conduct for the PTA, Value-Based Behaviors for the PTA, Core Values for the PT and PTA, Standards of Practice for Physical Therapy.

American Physical Therapy Association (APTA). Guide to Physical Therapist Practice. Guide 3.0. 2016.

American Physical Therapy Association (APTA). Physical Therapy Documentation of Patient/Client Management.

American Physical Therapy Association (APTA). Supervision and Teamwork.

American Society of Anesthesiologists (ASA), American Society of Regional Anesthesia and Pain Medicine (ASRA). Rosenquist RW, Benzon HT, Connis RT, De Leon-Casasola OA, Glass D, Korevaar WC, Cynwyd B, Mekhail NA, Merrill DG, NIckinovich DG, Rathnmell JP, Nai-Mei Sang C, Simon DL; ASA Task Force on Chronic Pain Management. Practice guidelines for chronic pain management: an updated report by the ASA Task Force on Chronic Pain Management and the ASRA. Anesthesiology. 2010 Apr;112(4):810-33. doi: 10.1097/ALN.0b013e3181c43103. PMID: 20124882.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 259 CMR 5.00. Physical Therapists. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. Division of Insurance. Bulletin 2019-06. Guidelines for Pain Management Alternatives to Opiate Products. 2019 Aug 29.

Commonwealth of Massachusetts. Massachusetts General Laws (MGL). Chapter 71B. Children with Special Needs.

Commonwealth of Massachusetts. Massachusetts General Laws (MGL). Chapter 721. Early Intervention.

Cruickshank TM, Reyes AR, Ziman MR. A systematic review and meta-analysis of strength training in individuals with multiple sclerosis or Parkinson disease. Medicine (Baltimore). 2015 Jan;94(4):e411. doi: 10.1097/MD.0000000000000411. PMID: 25634170.

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 8.

Madsen M, Larsen K, Madsen IK, Søe H, Hansen TB. Late group-based rehabilitation has no advantages compared with supervised home-exercises after total knee arthroplasty. Dan Med J. 2013 Apr;60(4):A4607. PMID: 23651717.

Massachusetts Department of Public Health. Early Intervention Operational Standards. 2013 Jul.

Monticone M, Ferrante S, Rocca B, Baiardi P, Farra FD, Foti C. Effect of a long-lasting multidisciplinary program on disability and fear-avoidance behaviors in patients with chronic low back pain: results of a randomized controlled trial. Clin J Pain. 2013 Nov;29(11):929-38. doi: 10.1097/AJP.0b013e31827fef7e. PMID: 23328343.

Parikh SS, Baxi N, Padavan SA. Musculoskeletal medicine. In: Sackheim KA, editor. Rehab Clinical Pocket Guide. New York, NY: Springer; 2013:357-426.

Reid MC, Eccleston C, Pillemer K. Management of chronic pain in older adults. BMJ. 2015 Feb 13;350:h532. doi: 10.1136/bmj.h532. PMID: 25680884.

Schaufele MK, Tate JL. Lumbar degenerative disease. In: Frontera WR, Silver JK, Rizzo TD Jr, editors. Essentials of Physical Medicine and Rehabilitation: Musculoskeletal Disorders, Pain, and Rehabilitation. 3rd ed. Philadelphia, PA: Elsevier Saunders; 2015:225-32.

Stanos SP, Tybursky MD, Harden RN. Chronic pain. In: Cifu DX, et al., editors. Braddom's Physical Medicine and Rehabilitation. 5th ed. Elsevier; 2016:809-33.

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity;

utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 04/19/23: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	06/01/23 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC

* QHP product included in the *Physical Therapy in the Outpatient Setting* medical policy, OCA 3.54, from 01/01/12 to 05/31/23.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
08/24/23	Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section.	10/28/23 Version 2	08/24/23: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual® Criteria

Physical Therapy in the Outpatient Setting

Policy Number: OCA 3.545
Version Number: 2
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers physical therapy (PT) provided in the outpatient setting to be medically necessary, including for habilitative services and/or rehabilitative service when InterQual® criteria are met for services requested for a member. Physical therapy must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements. PT must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary.

Prior authorization is required according to the guidelines outlined below:

1. Prior authorization is NOT required for any service listed in item a or item b:

    a. An initial evaluation for outpatient PT for a member when rendered by a participating physical therapist; OR

    b. Outpatient PT provided in the first 20 treatment visits (and within 80 15-minute treatment units) per member per benefit/Plan year when rendered by a participating PT provider for an established plan of care and each DOS is billed on a separate claim (or prior authorization is

necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

    a. All outpatient PT requested or rendered by a physical therapist/PT provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; OR

    b. All outpatient PT requested or rendered by a provider who is NOT certified or licensed as a PT provider, as defined by scope of practice, license, and certification; this includes all initial evaluations, re-evaluations, and treatments; OR

    c. Any re-evaluation of the established plan of care for outpatient PT for a Plan member, including re-evaluations conducted by a participating physical therapist; OR

    d. Outpatient PT beyond 20 treatment visits (or in excess of 80 15-minute treatment units) per member per benefit/Plan year rendered by a PT provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing physical therapist/PT provider rendering PT to a Plan member must be certified in rendering PT, as defined by license, scope of practice, and certification. Untimed PT is typically billed as one (1) unit per modality, and timed modalities are billed in 15-minute treatment units.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. The Plan Medical Director will evaluate the member's individual needs and circumstances, including the following factors in items 1 through 12 (when applicable) to determine the medical necessity of therapeutic services:

1. Chronological age; AND

2. Symptoms specific to the member's deficits; AND

3. How the member's deficits are impacting the member's quality of life; AND

4. How therapeutic interventions would benefit the member (based on a formal treatment plan with objective and measurable goals specific to the member's deficit); AND

5. Expected duration of therapy to meet the member's therapeutic treatment goals (with the duration consistent and reasonable when compared to professionally recognized standards of practice for the applicable therapeutic services); AND

6. Review of past therapy, the member's progress with treatment, and an evaluation of results; AND

7. Complications; AND

8. Progression of the member's condition, illness, or injury; AND

9. Comorbidities and relevant medical behavioral health/pharmacotherapy history; AND

10. Psychosocial circumstances; AND

11. Home environment; AND

12. Other applicable environmental factors.

Limitations and Exclusions

The following physical therapy provided in the outpatient setting is NOT considered medically necessary:

1. Maintenance therapy provided in the outpatient setting; these services would involve non-diagnostic, non-therapeutic, routine, and/or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed therapist.

2. The treatment constitutes non-therapeutic services, such as general exercise programs to promote overall fitness and endurance, for diversion, or for general motivation.

3. The therapy replicates services that are provided concurrently by any other type of therapy such as occupational therapy and/or speech and language therapy, which should provide different treatment goals, plans, and therapeutic modalities.

4. The therapy documentation does not objectively verify progressive functional improvement over the specific time frames and therefore does not support the need for therapeutic services or continuing therapy.

5. There is no objective clinical benefit to the use of more than four (4) modalities per PT session, therefore more than four (4) modalities per session are considered not medically necessary.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO member. When there is no guidance from CMS for the requested service for the specified indication

on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and

	compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

References

American Association of Acupuncture and Oriental Medicine (AAAOM). AAAOM Position Statement on Trigger Point Dry Needling (TPDN) and Intramuscular Manual Therapy (IMT).

American College of Physicians (ACP), American Pain Society (APS). Chou R, Qaseem A, Snow V, Casey D, Cross JT Jr, Shekelle P, Owens DK; Clinical Efficacy Assessment Subcommittee of the ACP; ACP; APS Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the ACP and the APS. Ann Intern Med. 2007 Oct 2;147(7):478-91. Erratum in: Ann Intern Med. 2008 Feb 5;148(3):247-8. PMID: 17909209.

American College of Physicians (ACP). Qaseem A, Wilt TJ, McLean RM, Forciea MA; Clinical Guidelines Committee of the ACP. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the ACP. Ann Intern Med. 2017 Apr 4;166(7):514-30. doi: 10.7326/M16-2367. Epub 2017 Feb 14. PMID: 28192789.

American Heart Association/American Stroke Association. Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for Adult Stroke Rehabilitation and Recovery: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2016 Jun;47(6):e98-169. doi: 10.1161/STR.0000000000000098. Epub 2016 May 4. Review. Erratum in: Stroke. 2017 Feb;48(2):e78. Stroke. 2017 Dec;48(12):e369. PMID: 27145936.

American Pain Society (APS). Chou R, Atlas SJ, Stanos SP, Rosenquist RW. Nonsurgical Interventional Therapies for Low Back Pain: a Review of the Evidence for an American Pain Society Clinical Practice Guideline. Spine. 2009 May 1;34(10):1078-93. doi: 10.1097/BRS.0b013e3181a103b1. PMID: 19363456.

American Pain Society (APS). Guideline Summaries.

American Physical Therapy Association (APTA). APTA Clinical Practice Guidelines Development Manual.

American Physical Therapy Association (APTA). Balance and Falls.

American Physical Therapy Association (APTA). Clinical Practice Guidelines (CPGs) Developed by APTA.

American Physical Therapy Association (APTA). Coding and Billing.

American Physical Therapy Association (APTA). Direction and Supervision of the Physical Therapist Assistant.

American Physical Therapy Association (APTA). Dry Needling.

American Physical Therapy Association (APTA). Ethics and Professionalism. Code of Ethics for the Physical Therapist, Standards of Ethical Conduct for the PTA, Value-Based Behaviors for the PTA, Core Values for the PT and PTA, Standards of Practice for Physical Therapy.

American Physical Therapy Association (APTA). Guide to Physical Therapist Practice. Guide 3.0. 2016.

American Physical Therapy Association (APTA). Physical Therapy Documentation of Patient/Client Management.

American Physical Therapy Association (APTA). Supervision and Teamwork.

American Society of Anesthesiologists (ASA), American Society of Regional Anesthesia and Pain Medicine (ASRA). Rosenquist RW, Benzon HT, Connis RT, De Leon-Casasola OA, Glass D, Korevaar WC, Cynwyd B, Mekhail NA, Merrill DG, NIckinovich DG, Rathnmell JP, Nai-Mei Sang C, Simon DL; ASA Task Force on Chronic Pain Management. Practice guidelines for chronic pain management: an updated report by the ASA Task Force on Chronic Pain Management and the ASRA. Anesthesiology. 2010 Apr;112(4):810-33. doi: 10.1097/ALN.0b013e3181c43103. PMID: 20124882.

Centers for Medicare and Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual.

Centers for Medicare and Medicaid Services (CMS). Manuals. Publication # 100-03. Medicare National Coverage Determinations (NCD) Manual.

Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) Neuromuscular Electrical Stimulation (NMES) 160.12. Version 2. 2006 Oct 1.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 259 CMR 5..00. Physical Therapists. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. Division of Insurance. Bulletin 2019-06. Guidelines for Pain Management Alternatives to Opiate Products. 2019 Aug 29.

Commonwealth of Massachusetts. Policies, Regulations, and Statutes (Allied Health).

Cruickshank TM, Reyes AR, Ziman MR. A systematic review and meta-analysis of strength training in individuals with multiple sclerosis or Parkinson disease. Medicine (Baltimore). 2015 Jan;94(4):e411. doi: 10.1097/MD.0000000000000411. PMID: 25634170.

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 8.

Madsen M, Larsen K, Madsen IK, Søe H, Hansen TB. Late group-based rehabilitation has no advantages compared with supervised home-exercises after total knee arthroplasty. Dan Med J. 2013 Apr;60(4):A4607. PMID: 23651717.

Massachusetts Department of Public Health. Early Intervention Operational Standards. 2013 Jul.

Monticone M, Ferrante S, Rocca B, Baiardi P, Farra FD, Foti C. Effect of a long-lasting multidisciplinary program on disability and fear-avoidance behaviors in patients with chronic low back pain: results of a randomized controlled trial. Clin J Pain. 2013 Nov;29(11):929-38. doi: 10.1097/AJP.0b013e31827fef7e. PMID: 23328343.

Parikh SS, Baxi N, Padavan SA. Musculoskeletal medicine. In: Sackheim KA, editor. Rehab Clinical Pocket Guide. New York, NY: Springer; 2013:357-426.

Reid MC, Eccleston C, Pillemer K. Management of chronic pain in older adults. BMJ. 2015 Feb 13;350:h532. doi: 10.1136/bmj.h532. PMID: 25680884.

Schaufele MK, Tate JL. Lumbar degenerative disease. In: Frontera WR, Silver JK, Rizzo TD Jr, editors. Essentials of Physical Medicine and Rehabilitation: Musculoskeletal Disorders, Pain, and Rehabilitation. 3rd ed. Philadelphia, PA: Elsevier Saunders; 2015:225-32.

Stanos SP, Tybursky MD, Harden RN. Chronic pain. In: Cifu DX, et al., editors. Braddom's Physical Medicine and Rehabilitation. 5th ed. Elsevier; 2016:809-33.

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 04/19/23: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	06/01/23 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC

* SCO product included in the *Physical Therapy in the Outpatient Setting* medical policy, OCA 3.54, from 01/01/16 to 05/31/23.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
08/24/23	Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section.	10/28/23 Version 2	08/24/23: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual® Criteria

Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting

Policy Number: OCA 3.551
Version Number: 31
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers speech therapy (speech and language therapy, swallowing therapy, feeding therapy, aural or auditory rehabilitation, and/or voice therapy) provided in the outpatient setting to be medically necessary, including habilitative services and/or rehabilitative services, when InterQual® criteria are met for an adult or pediatric member or are required EPSDT services for a member age 20 or younger on the date of service (when applicable). Speech therapy (ST) must be provided within the scope of practice of the treating provider and follow all applicable state licensing and supervisory requirements. ST must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary. Review the Plan's *Gender-Affirmation Services* medical policy, policy number OCA 3.11, for Plan guidelines when voice therapy is used to treat gender incongruence.

Prior authorization for ST is required according to the guidelines outlined below:

1. Prior authorization is NOT required for any service listed in items a through c:

a. For a member age 20 or younger on the date of service (DOS), all outpatient ST, including initial evaluations, re-evaluations, and all treatment visits, when services are rendered by a participating ST provider; OR

b. For a member age 21 or older, an initial evaluation for outpatient ST when rendered by a participating speech-language pathologist/speech therapist; OR

c. For a member age 21 or older on the DOS, outpatient OT provided in the first 35 treatment visits (and within 140 15-minute treatment units) per member per benefit/Plan year when rendered by a participating ST provider for an established plan of care and each DOS is billed on a separate claim (or prior authorization is necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

a. All outpatient ST requested or rendered by a speech-language therapist/ST provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; this applies to ST for adult and pediatric members; OR

b. All outpatient ST requested or rendered by a provider who is NOT certified or licensed as a ST provider, as defined by scope of practice, license, and certification; this applies to ST for adult and pediatric members and includes all initial evaluations, re-evaluations, and treatments; OR

c. For an adult member age 21 or older on the DOS, any re-evaluation of the established plan of care for outpatient ST rendered, including re-evaluations conducted by a participating speech-language pathologist/speech therapist; OR

d. For an adult member age 21 or older on the DOS, outpatient ST beyond 35 treatment visits (or in excess of 140 15-minute treatment units) per member per benefit/Plan year rendered by any ST provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing speech therapist/ST provider rendering ST to a Plan member must be certified in rendering ST, as defined by license, scope of practice, and certification.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. Individual consideration by a Medical Director includes evaluation of applicable member-specific factors that included but are not limited to the following:

1. Symptoms specific to member's deficits; OR

2. Impact on member's quality of life; OR

3. How therapeutic interventions would be beneficial (based on formal treatment plan with objective and member-specific measurable goals; OR

4. Expected duration of therapy to meet member's therapeutic treatment goals (consistent with professionally recognized standards of practice); OR

5. Review of past therapy, member's progress with treatment, and evaluation of results.

Limitations and Exclusions

Limitations include ANY service and/or indication for treatment listed in items 1 through 3:

1. Maintenance ST that can be performed safely and effectively without the skilled assistance of a qualified therapist.

2. Treatment plans that address a self-correcting dysfunction such as natural dysfluency or developmental articulation errors.

3. Therapy replicates concurrent therapeutic services the member is receiving, including but is not limited to ANY circumstance listed in item a or item b:

    a. Speech-language therapeutic services replicated/already provided to the member in a different setting or program (e.g., component of home health care services).

    b. Occupational therapy and/or any other type of service with similar treatment goals, plan of care, and therapeutic modalities for the member (e.g., component of home health care services).

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions: Services Considered Medically Necessary

92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual Plan note: This code is used for individual treatment after the initial evaluation.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals Plan note: This code is used for group treatment after the initial evaluation.
92526	Treatment of swallowing dysfunction and/or oral function for feeding Plan note: This code is used for treatment after the initial evaluation.
92630	Auditory rehabilitation; prelingual hearing loss Plan note: This code may be used when billing for treatment after the initial evaluation.
92633	Auditory rehabilitation; postlingual hearing loss Plan note: This code may be used when billing for treatment after the initial evaluation.
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)

References

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Clinical Practice Guidelines.

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Schwartz S, Cohen S, Dailey S, Rosenfeld R, Deutsch E, Gillespie B, Granieri E, Hapner E, Kimball E, Krouse H, McMurray S, Medina S, O'Brien K, Ouellette D, Messinger-Rapport B, Stachler R, Strode S, Thompson D, Stemple J, Willging P, Cowley T, McCoy, Bernad P, Patel M. Clinical practice guideline: hoarseness (dysphonia). Otolaryngol Head Neck Surg. 2009 Sep;141(3S2):S1-31. doi: 10.1016/ j.otohns.2009.06.744. PMID: 19729111.

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Stachler RJ, Francis DO, Schwartz SR, Damask CC, Digoy GP, Krouse HJ, McCoy SJ, Ouellette DR, Patel RR, Reavis CCW, Smith LJ, Smith M, Strode SW, Woo P, Nnacheta LC. Clinical Practice Guideline:

Hoarseness (Dysphonia) (Update). Otolaryngol Head Neck Surg. 2018 Mar;158(1_suppl):S1-S42. doi: 10.1177/0194599817751030. PMID: 29494321.

American Speech-Language-Hearing Association (ASHA). Adult Speech and Language.

American Speech-Language-Hearing Association (ASHA). Cognitive-Communication. ASHA Policy Documents.

American Speech-Language-Hearing Association (ASHA). Scope of Practice in Speech-Language Pathology.

American Speech-Language-Hearing Association (ASHA). Speech-Language Pathology Medical Review Guidelines.

American Speech-Language-Hearing Association (ASHA). Stuttering.

American Speech-Language-Hearing Association (ASHA). Swallowing and Feeding Disorders.

Bahar-Fuchs A, Clare L, Woods B. Cognitive training and cognitive rehabilitation for persons with mild to moderate dementia of the Alzheimer's or vascular type: a review. Alzheimers Res Ther. 2013;5(4):35. doi: 10.1186/alzrt189. PMID: 23924584.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 130 CMR 440.00. Division of Medical Assistance. Early Intervention Program Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 260.00. Speech-Language Pathologists and Audiologists. Board of Registration in Speech-Language Pathology and Audiology. Board of Registration in Speech-Language Pathology and Audiology.

Commonwealth of Massachusetts. MassHealth Guidelines for Medical Necessity Determination for Speech and Language Therapy.

Commonwealth of Massachusetts. MassHealth Provider Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Manuals.

Commonwealth of Massachusetts. MassHealth Therapist Provider Manual. Subchapter 6 Service Codes and Descriptions.

Commonwealth of Massachusetts. MassHealth Transmittal Letters.

Commonwealth of Massachusetts. Policies, Regulations and Statutes (Speech-Language Pathology and Audiology).

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 8.

Hayes. Health Technology Assessment. Lee Silverman Voice Treatment (LSVT) LOUD for Speech and Voice Problems in Parkinson Disease. Dallas, TX: Hayes; 2020 Nov 9.

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 03/16/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 04/27/11: Quality Improvement Committee (QIC)	07/01/11 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	MPCTAC and QIC

* Effective date for MassHealth product: 07/01/11
* Effective date for MA QHP product: 01/01/12 to 05/31/23
* Effective date for MA Senior Care Options product: 01/01/16 to 05/31/22
* Effective date for NH Medicaid product: 01/01/13 to 01/10/15 (until separate medical policies were developed for the NH Medicaid product effective 01/11/15, policy number OCA 3.542, for *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member 21 Years of Age or Older in the Outpatient Setting* for NH Medicaid product)

Policy title changed from *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member Age 22 or Older in the Outpatient Setting* to the following effective 04/01/17: *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member Age 21 or Older in the Outpatient Setting.* Policy title changed to *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting* as of 02/01/22 to include adult and pediatric members.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
03/19/12	Updated references.	Version 2	03/21/12: MPCTAC 04/25/12: QIC
08/01/12	Off cycle review. Revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory paragraph, updated code list, revised Limitations, and updated references.	Version 3	08/13/12: MPCTAC 09/06/12: QIC
11/01/12	Review for effective date 03/01/13. Updated references. Revised title so policy applies to members age 22 or older (rather than members	03/01/13 Version 4	11/21/12: MPCTAC 12/20/12: QIC

	over the age of 21). Added language in Summary section to clarify text. Referenced Plan reimbursement policy 4.609 for therapy reimbursement guidelines. Reorganized clinical criteria in Medical Policy Statement section and referenced InterQual® criteria. Revised applicable code list.		
08/14/13 and 08/15/13	Off cycle review. Incorporate policy revisions dated 11/01/12 (as specified above) for the NH Medicaid product; these policy revisions were approved by MPCTAC on 11/21/12 and QIC on 12/20/12 for applicable Plan products. Additional review of policy conducted.		08/14/13: MPCTAC (via electronic vote) 08/15/13: QIC
11/01/13, 12/01/13, 01/01/14, and 02/01/14	Review for effective date 05/01/14. Revised Applicable Coding section by updating code definitions and Plan notes, introductory paragraph, and applicable codes for the MA products and the NH Medicaid product. Reformatted Limitations section without changing criteria. Updated references.	05/01/14 Version 5	02/11/14: MPCTAC 02/18/14: QIC
10/01/14 and 11/19/14	Review for effective date 01/11/15. Policy reformatted to include MA products only. References and Summary sections updated. Revised review calendar.	01/11/15 Version 6	10/15/14: MPCTAC 11/12/14: QIC 11/19/14: MPCTAC 12/10/14: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Administrative changes made to the Medical Policy Statement section and Limitations section without changing criteria. Updated Summary section. Revised language in the Applicable Coding section.	01/01/16 Version 7	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
12/01/15	Review for effective date 02/01/16. Clarified text in the Medical Policy and Limitations section without changing criteria. Updated the Summary and Definitions sections.	02/01/16 Version 8	12/16/15: MPCTAC 01/13/16: QIC
12/01/16	Review for effective date 04/01/17. Updated Summary, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Plan notes added to applicable codes. Revised title and policy guidelines to apply to members 21 years of age or older on the date of service.	04/01/17 Version 9	12/21/16: MPCTAC 01/11/17: QIC
05/01/17	Review for effective date 08/01/17. Removed CPT code 92524 from the applicable code list because it is an initial evaluation code for voice and resonance.	08/01/17 Version 10	05/17/17: MPCTAC

12/01/17	Review for effective date 01/01/18. Industry-wide updates to codes included in the Applicable Coding section. Annual review of policy with administrative changes made to the Definitions and References sections.	01/01/18 Version 11	12/20/17: MPCTAC
11/01/18	Review for effective date 02/01/19. Administrative changes made to the Limitations, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Updated the applicable code list.	02/01/19 Version 12	11/21/18: MPCTAC
07/01/19	Review for effective date 08/01/19. Updated Plan note in the Applicable Coding section to be consistent with the Plan's reimbursement guidelines.	08/01/19 Version 13	07/17/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide update to coding (as a code deletion) included in the Applicable Coding section.	01/01/20 Version 14	Not applicable because industry-wide code changes
11/01/19	Review for effective date 02/01/20. Administrative changes made to the Policy Summary, References, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections.	02/01/20 Version 15 Renumbered to version 15 to implement industry-wide code updates effective 01/01/20 included in version 14	11/20/19: MPCTAC
12/01/19	Review for effective 02/01/20. Industry-wide update to coding effective 01/01/20 included in the Applicable Coding section of the policy version 11 effective 02/01/20.	02/01/20 Version 16	Not applicable because industry-wide code changes
03/01/20	Review for effective date 06/01/20. Criteria revised in the Medical Policy Statement and Limitations sections. Administrative changes made to the Policy Summary, Description of Item or Service, and Reference to Applicable Laws and Regulations sections.	06/01/20 Version 17	03/12/20: MPCTAC (electronic vote)
09/01/20	Review for effective date 12/01/20. Administrative changes made to the Policy Summary and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections.	12/01/20 Version 18	09/16/20: MPCTAC
11/01/20	Review for effective date 02/01/21. Administrative changes made to the Policy Summary, Description of Item or Service,	02/01/21 Version 19	11/18/20: MPCTAC

	Definitions, Applicable Coding, References, and Reference to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement section.		
05/01/21	Review for effective date 08/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, and References sections. Codes added to the Applicable Coding section.	08/21/21 Version 20	05/19/21: MPCTAC
10/01/21	Review for effective date 01/01/22 Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made to the Policy Summary, Limitations and Exclusions, and Applicable Coding sections. Added gender dysphoria as a medically necessary indication for voice therapy in the Criteria section.	01/01/22 Version 21	10/01/21: MPCTAC
11/01/21	Review for effective date 02/01/22. Administrative changes made to the Policy Summary and References section. Revised policy title because policy will apply to adult and pediatric members. Adopted InterQual criteria to determine medical necessity and retired medical policy criteria. Gender dysphoria specified as a medically necessary indication for voice therapy in the *Gender-Affirmation Services* medical policy, OCA 3.11, as of 01/01/22.	02/01/22 Version 22	11/17/21: MPCTAC
05/01/22	Review for effective date 06/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections.	06/01/22 Version 23	05/11/22: MPCTAC (electronic vote)
05/01/22	Review for effective date 08/01/22. Codes added to the Applicable Coding section.	08/01/22 Version 24	05/11/22: MPCTAC (electronic vote)
08/01/22	Review for effective date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Revised the prior authorization guidelines and criteria updated in the Clinical Criteria and Limitations and Exclusions sections.	11/01/22 Version 25 Version 25 NOT implemented	08/26/22: MPCTAC (electronic vote)
09/01/22	Review for effective date 12/01/22. Administrative changes made to the Policy	12/01/22 Version 26	09/23/22: MPCTAC (electronic vote)

	Summary and Applicable Coding sections. Revised the prior authorization guidelines and criteria updated in the Clinical Criteria and Limitations and Exclusions sections.	Version 26 NOT implemented	
10/24/22	Review for effective date 11/01/22. Revisions made to version 25 and version 26 will not be implemented. Medical policy guidelines effective in version 24 will remain in effect. No additional revisions made for this policy's annual review.	11/01/22 Version 27	10/24/22: MPCTAC (electronic vote)
01/01/23	Review for effective date 01/01/23. Administrative change made to the Policy Summary section.	01/01/23 Version 28	12/21/22: MPCTAC
04/01/23	Review for effective date 06/01/23. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections. Removed the Variations section. Removed the QHP and SCO as applicable products for this policy and established new policies for QHP and SCO without changing criteria and/or coding for those products. Removed PA requirement for all outpatient ST provided to a MassHealth ACO or MassHealth MCO member age 20 or younger when rendered by a licensed, appropriately qualified participating ST provider.	06/01/23 Version 29	04/19/23: MPCTAC
06/01/23	Review for effective date 07/01/23. Removed codes in the Applicable Coding section that are no longer applicable to this policy.	07/01/23 Version 30	06/21/23: MPCTAC
08/24/23	Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section.	10/28/23 Version 31	08/24/23: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual® Criteria

Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting

Policy Number: OCA 3.552
Version Number: 3
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers speech therapy (speech and language therapy, swallowing therapy, feeding therapy, aural or auditory rehabilitation, and/or voice therapy) provided in the outpatient setting to be medically necessary, including habilitative services and/or rehabilitative services, when InterQual® criteria are met for an adult or pediatric member. Speech therapy (ST) must be provided within the scope of practice of the treating provider and follow all applicable state licensing and supervisory requirements. ST must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary. Review the Plan's *Gender-Affirmation Services* medical policy, policy number OCA 3.11, for Plan guidelines when voice therapy is used to treat gender incongruence.

Prior authorization is required according to the guidelines outlined below:

1. Prior authorization is NOT required for any service listed in item a or item b:

    a. An initial evaluation for outpatient ST for an adult or pediatric member when rendered by a participating speech-language pathologist/speech therapist; OR

b. Outpatient ST provided in the first 35 treatment visits (and within 140 15-minute treatment units) per member (adult or pediatric) per benefit/Plan year when rendered by a participating ST provider for an established plan of care and each DOS is billed on a separate claim (or prior authorization is necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

   a. All outpatient ST requested or rendered by a speech-language pathologist/speech therapist/ST provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; this applies to ST for adult and pediatric members; OR

   b. All outpatient ST requested or rendered by a provider who is NOT certified or licensed as a ST provider, as defined by scope of practice, license, and certification; this applies to ST for adult and pediatric members and includes all initial evaluations, re-evaluations, and treatments; OR

   c. Any re-evaluation of the established plan of care for outpatient ST for an adult or pediatric member, including re-evaluations conducted by a participating speech-language pathologist/speech therapist; OR

   d. Outpatient ST beyond 35 treatment visits (or in excess of 140 15-minute treatment units) per member per benefit/Plan year for an adult or pediatric member rendered by a ST provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing speech-language pathologist/speech therapist /ST provider rendering ST to a Plan member must be certified in rendering ST, as defined by license, scope of practice, and certification.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. Individual consideration by a Medical Director includes evaluation of applicable member-specific factors that included but are not limited to the following:

1. Symptoms specific to member's deficits; OR

2. Impact on member's quality of life; OR

3. How therapeutic interventions would be beneficial (based on formal treatment plan with objective and member-specific measurable goals; OR

4. Expected duration of therapy to meet member's therapeutic treatment goals (consistent with professionally recognized standards of practice); OR

5. Review of past therapy, member's progress with treatment, and evaluation of results.

Limitations and Exclusions

Limitations include ANY service or indication for treatment listed in items 1 through 3:

1. Maintenance ST that can be performed safely and effectively without the skilled assistance of a qualified therapist.

2. Treatment plans that address a self-correcting dysfunction such as natural dysfluency or developmental articulation errors.

3. Therapy replicates concurrent therapeutic services the member is receiving, including but is not limited to ANY circumstance listed in item a or item b:

    a. Speech-language therapeutic services replicated/already provided to the member in a different setting or program (e.g., component of home health care services).

    b. Occupational therapy and/or any other type of service with similar treatment goals, plan of care, and therapeutic modalities for the member (e.g., component of home health care services).

ST is considered medically necessary for the treatment of autism spectrum disorders and the limitations related to ST do NOT apply to Qualified Health Plan and Employer Choice Direct members. Review the Plan's *Autism Spectrum Disorders (ASD) Medical Diagnosis and Treatment* medical policy, policy number OCA 3.724, for additional information.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions: Codes Covered When Medically Necessary
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual Plan note: This code is used for individual treatment after the initial evaluation.

92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals Plan note: This code is used for group treatment after the initial evaluation.
92526	Treatment of swallowing dysfunction and/or oral function for feeding Plan note: This code is used for treatment after the initial evaluation.
92630	Auditory rehabilitation; prelingual hearing loss Plan note: This code may be used when billing for treatment after the initial evaluation.
92633	Auditory rehabilitation; postlingual hearing loss Plan note: This code may be used when billing for treatment after the initial evaluation.
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)

References

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Clinical Practice Guidelines.

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Schwartz S, Cohen S, Dailey S, Rosenfeld R, Deutsch E, Gillespie B, Granieri E, Hapner E, Kimball E, Krouse H, McMurray S, Medina S, O'Brien K, Ouellette D, Messinger-Rapport B, Stachler R, Strode S, Thompson D, Stemple J, Willging P, Cowley T, McCoy, Bernad P, Patel M. Clinical practice guideline: hoarseness (dysphonia). Otolaryngol Head Neck Surg. 2009 Sep;141(3S2):S1-31. doi: 10.1016/j.otohns.2009.06.744. PMID: 19729111.

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Stachler RJ, Francis DO, Schwartz SR, Damask CC, Digoy GP, Krouse HJ, McCoy SJ, Ouellette DR, Patel RR, Reavis CCW, Smith LJ, Smith M, Strode SW, Woo P, Nnacheta LC. Clinical Practice Guideline: Hoarseness (Dysphonia) (Update). Otolaryngol Head Neck Surg. 2018 Mar;158(1_suppl):S1-S42. doi: 10.1177/0194599817751030. PMID: 29494321.

American Speech-Language-Hearing Association (ASHA). Adult Speech and Language.

American Speech-Language-Hearing Association (ASHA). Cognitive-Communication. ASHA Policy Documents.

American Speech-Language-Hearing Association (ASHA). Scope of Practice in Speech-Language Pathology.

American Speech-Language-Hearing Association (ASHA). Speech-Language Pathology Medical Review Guidelines.

American Speech-Language-Hearing Association (ASHA). Stuttering.

American Speech-Language-Hearing Association (ASHA). Swallowing and Feeding Disorders.

Bahar-Fuchs A, Clare L, Woods B. Cognitive training and cognitive rehabilitation for persons with mild to moderate dementia of the Alzheimer's or vascular type: a review. Alzheimers Res Ther. 2013;5(4):35. doi: 10.1186/alzrt189. PMID: 23924584.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 260.00. Speech-Language Pathologists and Audiologists. Board of Registration in Speech-Language Pathology and Audiology. Board of Registration in Speech-Language Pathology and Audiology.

Commonwealth of Massachusetts. Massachusetts General Laws (MGL). Chapter 71B. Children with Special Needs.

Commonwealth of Massachusetts. Massachusetts General Laws (MGL). Chapter 721. Early Intervention.

Commonwealth of Massachusetts. Policies, Regulations and Statutes (Speech-Language Pathology and Audiology).

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 8.

Hayes. Health Technology Assessment. Lee Silverman Voice Treatment (LSVT) LOUD for Speech and Voice Problems in Parkinson Disease. Dallas, TX: Hayes; 2020 Nov 9.

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 04/19/23: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	06/01/23 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC

* QHP product included in the *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting* medical policy, OCA 3.551, from 01/01/12 to 05/31/23.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
06/01/23	Review for effective date 07/01/23. Removed codes in the Applicable Coding section that are no longer applicable to the policy.	07/01/23 Version 2	06/21/23: MPCTAC
08/24/23	Review for effective date 10/28/23. Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section.	10/28/23 Version 3	08/24/23: MPCTAC

Medical Policy – Policy with InterQual® Criteria

Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting

Policy Number: OCA 3.553
Version Number: 2
Version Effective Date: 10/28/23

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☐ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers speech therapy (speech and language therapy, swallowing therapy, feeding therapy, aural or auditory rehabilitation, and/or voice therapy) provided in the outpatient setting to be medically necessary, including habilitative services and/or rehabilitative services, when InterQual® criteria are met. Speech therapy (ST) must be provided within the scope of practice of the treating provider and follow all applicable state licensing and supervisory requirements. ST must be ordered by a physician or a licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) for the Plan to consider therapy medically necessary. Review the Plan's *Gender-Affirmation Services* medical policy, policy number OCA 3.11, for Plan guidelines when voice therapy is used to treat gender incongruence.

Prior authorization is required for ST according to the guidelines outlined below:

1. Prior authorization is NOT required for any service listed in item a or item b:

    a. An initial evaluation for outpatient ST for a member when rendered by a participating speech-language pathologist/speech therapist; OR

b. Outpatient ST provided in the first 35 treatment visits (and within 140 15-minute treatment units) per member (adult or pediatric) per benefit/Plan year when rendered by a participating ST provider for an established plan of care and each DOS is billed on a separate claim (or prior authorization is necessary for these services); the total number of treatment visits/units includes therapy from all providers.

2. Prior authorization is required for any service listed below in items a through d:

   a. All outpatient ST requested or rendered by a speech-language pathologist/speech therapist/ST provider who is NOT a Plan participating provider, including all initial evaluations, re-evaluations, and treatments; this applies to ST for adult and pediatric members; OR

   b. All outpatient ST requested or rendered by a provider who is NOT certified or licensed as a ST provider, as defined by scope of practice, license, and certification; this applies to ST for adult and pediatric members and includes all initial evaluations, re-evaluations, and treatments; OR

   c. Any re-evaluation of the established plan of care for outpatient ST for an adult or pediatric member, including re-evaluations conducted by a participating speech-language pathologist/speech therapist; OR

   d. Outpatient ST beyond 35 treatment visits (or in excess of 140 15-minute treatment units) per member per benefit/Plan year for an adult or pediatric member rendered by a ST provider; the total number of treatment visits/units includes therapy from all providers.

Note: The servicing speech-language pathologist/speech therapist /ST provider rendering ST to a Plan member must be certified in rendering ST, as defined by license, scope of practice, and certification.

Clinical Criteria

Plan Medical Director review is required when medical necessity criteria are NOT met and prior authorization is required. Individual consideration by a Medical Director includes evaluation of applicable member-specific factors that included but are not limited to the following:

1. Symptoms specific to member's deficits; OR

2. Impact on member's quality of life; OR

3. How therapeutic interventions would be beneficial (based on formal treatment plan with objective and member-specific measurable goals; OR

4. Expected duration of therapy to meet member's therapeutic treatment goals (consistent with professionally recognized standards of practice); OR

5. Review of past therapy, member's progress with treatment, and evaluation of results.

Limitations and Exclusions

Limitations include ANY service or indication for treatment listed in items 1 through 3:

1. Maintenance ST that can be performed safely and effectively without the skilled assistance of a qualified therapist.

2. Treatment plans that address a self-correcting dysfunction such as natural dysfluency or developmental articulation errors.

3. Therapy replicates concurrent therapeutic services the member is receiving, including but is not limited to ANY circumstance listed in item a or item b:

    a. Speech-language therapeutic services replicated/already provided to the member in a different setting or program (e.g., component of home health care services).

    b. Occupational therapy and/or any other type of service with similar treatment goals, plan of care, and therapeutic modalities for the member (e.g., component of home health care services).

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 170.3 includes guidelines for the treatment of dysphagia, LCD L33580 includes coverage guidance for speech-language pathology, and LCA A52866 includes billing and coding guidelines for speech therapy. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section.

Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions: Codes Covered When Medically Necessary
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual Plan note: This code is used for individual treatment after the initial evaluation.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals Plan note: This code is used for group treatment after the initial evaluation.
92526	Treatment of swallowing dysfunction and/or oral function for feeding Plan note: This code is used for treatment after the initial evaluation.
92606	Therapeutic services for use of non-speech-generating device with programming
92609	Therapeutic services for use of speech-generating device with programming
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)

References

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Clinical Practice Guidelines.

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Schwartz S, Cohen S, Dailey S, Rosenfeld R, Deutsch E, Gillespie B, Granieri E, Hapner E, Kimball E, Krouse H, McMurray S, Medina S, O'Brien K, Ouellette D, Messinger-Rapport B, Stachler R, Strode S, Thompson D, Stemple J, Willging P, Cowley T, McCoy, Bernad P, Patel M. Clinical practice guideline: hoarseness (dysphonia). Otolaryngol Head Neck Surg. 2009 Sep;141(3S2):S1-31. doi: 10.1016/ j.otohns.2009.06.744. PMID: 19729111.

American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF). Stachler RJ, Francis DO, Schwartz SR, Damask CC, Digoy GP, Krouse HJ, McCoy SJ, Ouellette DR, Patel RR, Reavis CCW, Smith LJ, Smith M, Strode SW, Woo P, Nnacheta LC. Clinical Practice Guideline: Hoarseness (Dysphonia) (Update). Otolaryngol Head Neck Surg. 2018 Mar;158(1_suppl):S1-S42. doi: 10.1177/0194599817751030. PMID: 29494321.

American Speech-Language-Hearing Association (ASHA). Adult Speech and Language.

American Speech-Language-Hearing Association (ASHA). Cognitive-Communication. ASHA Policy Documents.

American Speech-Language-Hearing Association (ASHA). Scope of Practice in Speech-Language Pathology.

American Speech-Language-Hearing Association (ASHA). Speech-Language Pathology Medical Review Guidelines.

American Speech-Language-Hearing Association (ASHA). Stuttering.

American Speech-Language-Hearing Association (ASHA). Swallowing and Feeding Disorders.

Bahar-Fuchs A, Clare L, Woods B. Cognitive training and cognitive rehabilitation for persons with mild to moderate dementia of the Alzheimer's or vascular type: a review. Alzheimers Res Ther. 2013;5(4):35. doi: 10.1186/alzrt189. PMID: 23924584.

Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD) L33580. Speech-Language Pathology. 2015 Oct 1. National Governmental Services, Inc. 2015 Dec 19. Revision Effective Date 2019 Dec 19.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-03. Medicare National Coverage Determinations (NCD) Manual.

Centers for Medicare & Medicaid Services (CMS). Medicare Coverage Database (MCD).

Centers for Medicare & Medicaid Services (CMS). Local Coverage Article (LCA) A52866. Billing and Coding: Speech Language Pathology. National Government Services, Inc. 2015 Oct 1. Revision Effective Date 2021 Oct 1.

Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD) L33580. Speech-Language Pathology. National Government Services. 2015 Oct 1. Revision Effective Date 2019 Dec 19.

Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) 170.3. Speech-Language Pathology Services for the Treatment of Dysphagia. 2006 Oct 1.

Centers for Medicare & Medicaid Services (CMS). Transmittals.

Commonwealth of Massachusetts. Allied Health Professions Licensing.

Commonwealth of Massachusetts. Board of Allied Health Professionals.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 114.3 CMR 39.00. Rehabilitation Center Services, Audiological Services, Restorative Services.

Commonwealth of Massachusetts. Code of Massachusetts Regulations (CMR). 260.00. Speech-Language Pathologists and Audiologists. Board of Registration in Speech-Language Pathology and Audiology.

Commonwealth of Massachusetts. Policies, Regulations and Statutes (Speech-Language Pathology and Audiology).

Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 8.

Hayes. Health Technology Assessment. Lee Silverman Voice Treatment (LSVT) LOUD for Speech and Voice Problems in Parkinson Disease. Dallas, TX: Hayes; 2020 Nov 9.

Next Review Date

11/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 04/19/23: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	06/01/23 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC

* SCO product included in the *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting* medical policy, OCA 3.551, from 01/01/16 to 05/31/23.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
08/24/23	Review for effective date 10/28/23. Review for effective date 10/28/23. Prior authorization guidelines revised in the Policy Summary section.	10/28/23 Version 2	08/24/23: MPCTAC (electronic vote)