Authorization of continued physical/occupational/speech therapy after three months of treatment.

Clinical Policy ID: CCP.1457

Recent review date: 5/2020

Next review date: 9/2021

Policy contains: Physical therapy, prior authorization, occupational therapy, speech therapy.

AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.

Coverage policy

Reviews after three months of physical, occupational, or speech therapy to authorize continued rehabilitation treatment are considered necessary when all of the following are met:

- Documentation of the severity of the member's condition indicates that more therapy is required.
- Initial efficacy of therapy to treat the condition is documented.
- Improvement of the condition in a predictable time period is expected.
- The amount, frequency, and duration of the therapy meets professional standards.
- Services are effectively performed only by a therapist or supervised by a therapist.
- The review is performed in fewer than seven days before the end of the currently approved therapy period (EviCore Health Care, 2015).

Limitations

Reviews after three months of physical, occupational, or speech therapy to authorize continued treatment are not considered medically necessary when all of the following are met:

- The member is no longer functionally impaired, has returned to baseline function, and no longer requires a caregiver to assist with activities of daily living.
- The member will not benefit from additional therapy.
- The member cannot participate in the service due to medical, psychosocial, or social complications.

Alternative covered services

None.

Background

An estimated 13.2 million Americans made use of ambulatory physical or occupational therapy in 2013, a number that is rising (Sandstrom, 2017). Millions also receive speech language pathology services. Experts agree that many more require these services, but fail to use them.

Medicare reimburses physical, occupational, and speech therapists when documentation and claim forms accurately report the provision of medically necessary covered services. These include an evaluation, plan of care, and progress reports, and must be deemed reasonable and medically necessary (WebPT, 2019).

State Medicaid agencies vary in their coverage of these three types of rehabilitation. For example, in North Carolina, Medicaid beneficiaries over 21 years old are entitled to one annual therapy evaluation between physical, occupational, and speech therapy. Exceptions to this rule exist; e.g., a patient within 60 days of a musculoskeletal procedure may be entitled to one evaluation and three treatment visits. Prior approval is required by Medicaid for the initial course of any of these therapies (Carvalho, 2017).

Findings

Criteria for necessity of prior authorization reviews for physical, occupational, and speech therapy from EviCore are cited in the Coverage section of this policy.

References

On March 5, 2020, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “occupational therapy,” “physical therapy,” “prior authorization,” and “speech therapy.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

Carvalho E, Bettger JP, Goode AP. Insurance coverage, costs, and barriers to care for outpatient musculoskeletal therapy and rehabilitation Services. *N C Med J*. 2017;78(5):312–314. Doi:10.18043/ncm.78.5.312.

EviCore HealthCare: Innovative Solutions. Physical and Occupational Therapy. Provider Orientation Session for Meridian. https://www.evicore.com/-/media/files/evicore/microsites/implementation/meridian-wellcare/evicore-provider-orientation_pt-and-ot_10919.pdf. Published 2015. Accessed March 5, 2020.

PT in Motion News. Humana Lifts Prior Authorization Requirements for Physical Therapist Services. https://www.apta.org/PTinMotion/News/2017/12/29/HumanLiftsPriorAuthorization/. Published December 29, 2017. Accessed March 6, 2020.

Sandstrom R. Utilization of ambulatory physical therapy and occupational therapy by the United States population, 2009-2013. *J Allied Health*. 2017;46(4):225-231.

WebPT. Physical therapists guide to Medicare. https://www.webpt.com/medicare/. Published 2019. Accessed March 5, 2020.

Policy updates

5/2020: initial review date and clinical policy effective date: 6/2020

5/2020: No policy updates.