



# Prism Health Networks (PHN)

## Clinical Guidelines for Physical and Occupational Therapy

**Important Note:** This information is provided to assist you (a current Member or potential Member) in understanding your physical and occupational therapy benefits and health care coverage through Prism Health Networks (PHN). PHN may change these guidelines from time-to-time as clinical information changes. Keep in mind that each Member's health benefit plan defines services that are covered, limited, and excluded. Therefore, Members and their providers are encouraged to consult their benefit plan and Member handbook to determine whether any specific limitations or exclusions for these services apply. Please also note that even though a service or supply is authorized or found to be medically necessary, it does not mean that the service or supply will be paid for or covered.

PHN has reached the conclusions, standards, guidelines, and/or criteria set forth in this document based on a review of currently available information (such as scientific journals, guidelines that are generally accepted by the bulk of the physical therapy and occupational therapy professions, and through agreement by licensed practitioners serving on PHN committees).

Physical therapy and occupational therapy means skilled therapy provided on an outpatient basis for covered conditions.

### Coverage and Medical Necessity

**How do I qualify for coverage?** In order to qualify for physical or occupational therapy coverage, a Member must have a covered condition that is not life-threatening. Further, any proposed services or procedures must not be inappropriate for your condition or outside of your provider's clinical scope of practice.

**What is required to obtain services?** A written referral from a qualified provider is typically required in order to be eligible for physical or occupational therapy coverage. "Qualified" providers are defined by state and/or federal law, and may also be specified by your health benefit plan. Since a written referral is typically required for insurance coverage, you should obtain it *prior* to seeing the therapist. Often times the referral has an expiration date. If the referral expires, you may be required to obtain a new one.

Once you arrive for your initial appointment, your treating therapist will be required to gather, analyze, and carefully document specific information about your condition to determine what type of care or treatment you need. Your treating therapist will then advise you whether the treatment is expected to help your condition or whether you should be referred to another type of health care professional. If treatment is appropriate, your practitioner will need to provide accurate, essential, and detailed clinical documentation about your individual case so that the medical record clearly explains your condition, as well as your response to the care being provided.

**What is the purpose of physical and/or occupational therapy treatments?** The purpose of physical or occupational therapy is to provide necessary services for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status.

Such treatment shall be rendered pursuant to a medical referral and in accordance with a covered diagnosis. Not all symptoms or conditions that a physical or occupational therapist treats may be covered. Not all services provided by a physical or occupational therapist may be covered under your insurance plan.

**What conditions are covered for physical or occupational therapy care?** Treatment of most outpatient conditions affecting the nerves, muscles, and bones (i.e., neuromusculoskeletal conditions) typically qualifies for coverage. Certain health plans or policy benefits may allow even broader coverage. Members should refer to their insurance policy and/or benefit plan to determine what is covered.

**What conditions typically do NOT qualify for coverage?** Most neuromusculoskeletal conditions that are not life-threatening and relate to the nerves, muscles, ligaments, and bones will qualify for coverage. However, all requests for physical or occupational therapy services are subject to review. Once you are evaluated, your treating therapist should provide a submission with your medical diagnosis so that medical necessity can be verified as soon as possible. PHN may also ask your treating physical or occupational therapist to submit additional information about your case in order to determine whether you qualify for benefits and coverage. The following situations typically do not qualify for physical or occupational therapy coverage:

- Services that are determined not medically necessary
- Conditions, diseases, or services that are not within the therapist's scope of practice
- Conditions or diseases that have not been scientifically shown to be helped by physical or occupational therapy
- Conditions or diseases for which therapy services are investigational and experimental
- Conditions or diseases where therapy is considered contraindicated.

**What type of information will be gathered about my condition?** Your treating therapist will begin by collecting a history about your chief complaint, how and when the symptoms began, and information about your past medical and family history. Specific examinations and tests will be performed to determine the cause of your symptoms. The information gathered will be used to prepare an appropriate plan of treatment for your diagnosis. If physical or occupational therapy treatment is proposed, your practitioner will submit the information to PHN for review of your eligibility and certification of coverage. Your treating therapist will also have you complete various forms asking about your ability to carry out daily activities.

**Who reviews my case and what are their qualifications?** PHN employs Case Reviewers who hold unrestricted licenses and registrations to actively practice physical or occupational therapy. Each Case Reviewer ("CR") has a minimum of five (5) years experience and has been appropriately trained in the principles, procedures, and standards of PHN. The discipline-specific CR evaluates all of the clinical information submitted by your treating therapist in order to determine whether the proposed services will qualify for coverage under your particular health benefit plan. PHN's CRs are available to speak with your practitioner during regular business hours to discuss the facts of your case. In addition, if an urgent situation exists regarding your treatment, PHN clinical staff can be reached 24 hours per day, 7 days per week.

**What is medical necessity and how is it determined?** Medical Necessity is defined as the most appropriate level of care indicated for the diagnosis and treatment of your condition, disease, ailment or injury. The care must be in accordance with standards of good practice, and not solely for the convenience of you, your doctors, or your treating therapist.

**What are the indications and limitations of treatment?** Physical or occupational therapy intervention in the licensed therapist's office may be indicated when:

- a. the diagnosis established by the referring physician supports the medical need for the services;
- b. there is documentation of objective physical and functional limitations requiring intervention by a licensed physical or occupational therapist; and
- c. the plan of care includes those treatment elements that are expected to result in improvement of these limitations in a reasonable and generally predictable period of time. If care fails to produce significant improvement within a reasonable time period, PHN may determine that services are not reasonable or necessary. In addition, if the patient's expected restoration potential would be insignificant in relation to the extent and duration of physical or occupational therapy services required to achieve such potential, the therapy would not be considered reasonable or necessary.
- d. the services proposed are considered reasonable and necessary for the treatment of a patient's covered condition as determined by PHN and/or the patient's health benefit. The type, frequency, and duration of services must be medically necessary for the patient's condition under accepted medical, physical therapy, and/or occupational therapy practice standards, and relate directly to a written plan of care or treatment. The written plan of care must be established before treatment is begun. The plan of care is established when it is developed (e.g., written or dictated).
- e. the services require the skills of a licensed physical or occupational therapist to perform or supervise them. Services must be able to proceed safely and effectively in a therapist's office for a covered condition to be eligible for coverage. Services that do not require the skills of a licensed therapist, or services that are considered maintenance in nature, are not considered medically necessary and are not covered.

**Who determines medical necessity for PHN and how much care I can receive?** The PHN Case Review team is made up of practitioners who are actively registered and hold unrestricted licenses. The Case Reviewers are responsible for making fair, impartial, and consistent medical necessity decisions for all members. The review team makes these decisions by reviewing written and verbal information submitted by you and your treating practitioners. When information is received about your case, a Case Reviewer (CR) follows a step-by-step review process in accordance with specific policies, procedures, and clinical guidelines. In order to provide an accurate assessment of your case, the CPR takes various clinical factors into consideration that were obtained from your physical or occupational therapy visit, including but not limited to:

- Your current history of symptoms
- How and when your symptoms began (injury, accident, illness, etc.)
- Your past medical history
- Your current examination findings (muscle spasm, nerve pressure, disc findings, etc.)

- Previous examination findings (if any)
- Limitations on your daily activities
- Results of any diagnostic tests or reports
- Information from your medical physician
- Questionnaires or pain drawings you complete in the therapist's office
- Other factors that might delay your expected recovery time

Based on all information available, the CR will determine how many visits you will need to start care and how long the treatment period will last until the next time you are evaluated.

**What is required in order for me to continue receiving coverage for physical or occupational therapy services?** Your physical and occupational therapy benefit covers Active Treatment to help restore your condition. "Active Treatment" is aimed at relieving or resolving your current ailment. In some cases, your insurance plan may have limitations on the amount of visits or days that will qualify for physical or occupational therapy coverage each year. Your insurance plan may also require you to obtain a new or updated referral (or written prescription) from a "qualified" provider to be eligible for additional coverage.

**How does my insurance company know when I've reached Maximum Medical (Clinical) Improvement (MMI) from treatment?** PHN Case Reviewers may decide that you have reached a point of Maximum Medical Improvement (MMI) if one of the following is demonstrated:

- 1) During the course of care, your condition gets progressively worse, instead of better.
- 2) During a period of days, weeks, or months you routinely feel good one time and not the next.
- 3) Your condition is no longer measurably improving.
- 4) During an extended period, your visits are scheduled farther apart, yet your condition fails to show significant progress and/or the clinical potential for additional sustained improvement in your case is remote.

**What if my condition returns?** Depending on your health benefit plan, additional care directed at monitoring or stabilizing your condition might qualify for additional therapy coverage. However, some benefit plans have specific limitations on the amount of therapy you can receive, regardless of the condition you have. Once your benefit is exhausted or you are discharged from care, you may need to obtain a new referral or written prescription from a qualified provider in order to qualify for further services. However, this would only apply if you did not already reach the maximum limit of physical or occupational therapy services allowed under your benefit plan each year.

**Is coverage provided for ongoing physical or occupational therapy treatments, such as Maintenance, Preventative, or Wellness Care once my condition has reached a point of Maximum Clinical Improvement?** Not usually. Maintenance, Preventative, or Wellness Care is not generally considered medically necessary care. These types of care are utilized once your condition becomes stable or has reached Maximum Clinical Improvement. The goal of this care is maintaining your condition and/or providing optimal body function. It typically occurs after you

have reached a point where further therapy or care provides little or no measurable improvement for your condition, or when your symptoms have resolved or stabilized. Maintenance, Preventative, and/or Wellness Care is typically considered elective in nature and only paid for by health insurance companies when you have a specific benefit for this coverage.

## **GUIDELINES FOR CHART RECORD CONTENT**

Physical and occupational therapists have the legal and ethical responsibility to maintain complete, consistent, and accurate records for each patient. Documentation must be legible, relevant, and sufficient to justify the services billed. Patient files should be stored neatly and organized to facilitate tracking and retrieval, with a system in place to maintain patient confidentiality. For more information on PHN documentation requirements, refer to PHN's Standards for Medical Record Documentation, Policy Number QI-5 (previously policy MR-1). This policy may be obtained at [www.prismnetwork.com](http://www.prismnetwork.com) or by contacting our Customer Service Department.

## **REFERENCES**

**PHN used the following information, standards, and scientific references in constructing its practice guidelines:**

- American Occupational Therapy Association. Standards of Practice for Occupational Therapy. Previously published and copyrighted in 2005 by the AOTA in the *American Journal of Occupational Therapy*, 59, 663-665.
- American Physical Therapy Association. Guide to Physical Therapy Practice. Second Edition, © 2001.
- Atlas, S.J., Deyo, RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *J Gen Intern Med* 2001; 16: 120-131.
- Tunis SR, Hayward RSA, Wilson MC, Rubin HR, Bass EB, Johnston ME, Steinberg EP. Internists' attitudes about clinical practice guidelines. *Guidelines Appraisal Project*, 1997.
- Guideline Appraisal Project — Improving access to and use of evidence-based practice guidelines. McMaster University, Toronto, Canada, June 10, 1997.
- Hayward RSA, Steinberg EP, Ford DE, Roizen MF, Roach K. Preventive Care Guidelines: 1991. *Guidelines Appraisal Project*, 1997.
- Hayward RSA, Wilson MC, Tunis SR, Guyatt GH, Moore KA, Bass EB. Practice guidelines: what are Internists looking for? *Guidelines Appraisal Project*, 1997.

- Hayward RSA, Wilson MC, Tunis SR, Bass EB, Guyatt F. How to use a clinical practice guideline. Guidelines Appraisal Project, 1997.
- Hayward RSA, Wilson MC, Tunis SR, Bass EB, Rubin HR, Haynes RB. More informative abstracts of articles describing clinical practice guidelines. Guidelines Appraisal Project, 1997.
- Faculty of the Health Sciences. How to teach evidence-based medicine, '97. Guidelines Appraisal Project, 1997.
- Evidence Based Medicine. Guidelines for Evidence-based Medicine. University of Alberta, Canada, 1997.
- Introduction to Evidence-based Medicine
  - How to Use an Article about Therapy
  - How to Use an Article about a Diagnostic Test
  - How to Use an Article about Prognosis
  - How to Use an Article about Harm
  - How to Use a Clinical Practice Guideline
  - Medline Search Strategies for Articles on Therapy/Prevention
  - Medline Search Strategies for Articles on Diagnosis
  - Medline Search Strategies for Articles on Prognosis
  - Medline Search Strategies for Articles on Harm/Etiology
  - Worksheet for Using an Article about Therapy or Prevention
  - Worksheet for Using an Article about Assessing Diagnostic Tests
  - Worksheet for Using an Article about Prognosis
  - Worksheet for Using an Article about Causation or Harm
  - Worksheet for Using Clinical Practice Guidelines
- American College of Rheumatology Clinical Guidelines Committee. Guidelines for Acute Musculoskeletal Symptoms. American College of Rheumatology, 1997.
- Agency for Health Care Policy and Research — Acute Low Back Problems in Adults, December 8, 1994. These guidelines were constructed by a 23 member multidisciplinary panel over a two year period that reviewed nearly 4,000 citations in the indexed literature. On December 8, 1994, the Federal agency, Agency for Health Care Policy and Research (AHCPR) released guidelines for use by providers for use in the diagnosis and treatment of Acute Low Back Pain in Adults. The guidelines were created by a 23 member professional panel of experts, mostly physicians, an osteopath, a physical therapist, some chiropractors, and a health care consumer, who together reviewed over 3,900 research studies in preparing the guidelines.
- Clinical Standards Advisory Group on Low Back Pain — British Guidelines on Low Back Pain (similar to the AHCPR Guidelines above).

- Ad Hoc Committee on Diagnostic and Therapeutic Procedures of the North American Spine Society (NASS). Common Diagnostic and Therapeutic Procedures of the Lumbosacral Spine. (See: Lee CK, et al. Common diagnostic and therapeutic procedures of the lumbosacral spine. *Spine* 1991;16(10):1161-1167. According to the NASS, these procedures "should provide a rationale for the clinician with which properly to order diagnostic examinations and prescribe treatments that maximize the quality and efficiency of patient care." The NASS rated each procedure based on a six point procedural rating scale from "I. Generally accepted, well established, and widely used." to "VI. Of no proven value." Among the procedures NASS rated as Category I, "generally accepted, well established and widely used," included a classification called *manual therapy* which was defined as:
  - "Joint manipulation, soft tissue and joint mobilization, therapeutic massage, and chiropractic adjustments are modalities included in this category. Mechanical adjustments are performed by applying external pressure, or from trunk movements the patient performs.
    - a. Minimum time for treatment response: 1 or 2 treatments.
    - b. Treatment frequency: 2-5 supervised treatments per week for the first 2 weeks, decreasing to 1-2 treatments per week.
    - c. Optimum treatment duration: 1 month
    - d. Maximum treatment duration: 2-4 months."
- CMA. Implementing Clinical Practice Guidelines: A Handbook for Practitioners. Developed at the 1966 Canadian Medical Association Workshop — Guideline implementation: making it happen.
- Guidelines for the Initial Evaluation of the Adult Patient with Acute Musculoskeletal Symptoms.
- Hochberg MC, Altman, RD, Brandt KD, Clark BM, Dieppe PA, Griffin MR, et al. Guidelines for the Medical Management of Osteoarthritis. Guidelines for Management of Hip Osteoarthritis. *Arthritis and Rheumatism* 1995 (Nov); 38(11): 1535-1540.
- Hochberg MC, Altman RD, Brandt KD, Clark BM, Dieppe PA, Griffin MR, et al. Guidelines for the Medical Management of Osteoarthritis. Guidelines for the Management of Knee Osteoarthritis. *Arthritis and Rheumatism* 1995 (Nov); 38(11): 1541-1546.
- ACR Ad Hoc Committee on Clinical Guidelines. Guidelines for Rheumatoid Arthritis Management. *Arthritis and Rheumatism* 1996 (May); 39(5): 713-722.
- ACR Ad Hoc Committee on Clinical Guidelines. Guidelines for Monitoring Rheumatoid Arthritis Drug Therapy. *Arthritis and Rheumatism* 1996 (May); 39(5): 723-731.
- DHHS. Guide to Clinical Preventive Services, Second Edition. Report of the U.S. Preventive Services Task Force. April 1989.

- Introduction
  - Methodology
  - The Periodic Health Examination: Age-Specific Charts
  - Patient Education and Counseling for Prevention
  - Cost-Effectiveness and Clinical Preventive Services
  - Screening for Postmenopausal Osteoporosis
  - Screening for Adolescent Idiopathic Scoliosis
  - Counseling to Prevent Low Back Pain
  - Task Force Ratings
- 
- And other studies selected for their content:
  
  - Medicare Benefit Policy Manual. Chapter 15 – Covered Medical and Other Health Services. Rev. 48, 03-24-06. 220-240.

F:\Users\BDunevitz\Clinical Criteria\2008\PT - OT\PT Prism Clinical Criteria Response Revised PT - OT Final 7-7-2008.doc