BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy and InterQual® Criteria

Occupational Therapy in the Outpatient Setting

Policy Number: OCA 3.53
Version Number: 24
Version Effective Date: 12/01/21

Product Applicability	☐ **All Plan⁺ Products**
WellSense Health Plan ☐ NH Medicaid ☐ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ 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 or are required **EPSDT services** for a member age 20 or younger on the date of service (when applicable). 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. Prior authorization is required according to the guidelines outlined below.

A. Prior authorization is NOT required for the services listed in item 1 or item 2 when rendered by a Plan participating provider:

   1. An **initial evaluation** for OT does NOT require Plan prior authorization when rendered by a servicing OT provider‡; OR

   2. Prior authorization is NOT required for services when ALL criteria in items a through c are met:

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.

a. Outpatient OT provided in the **first 12 treatment visits *per member per occupational therapist servicing provider*‡ *per benefit/Plan year*** for an established plan of care; AND

b. Outpatient OT (up to the first 12 visits) **does NOT exceed a total of 48 treatment units *per member per servicing OT provider*‡ *per benefit/Plan year*** to account for OT billed in 15-minute intervals (when services are billed in 15-minute intervals according to industry-standard coding); AND

c. When outpatient OT meets the Plan's waived prior authorization requirement specified above, each date of service must be billed on a separate claim (or prior authorization is necessary for these services).

B. Prior authorization is REQUIRED for ANY of the services listed in items 1 through 5:

1. A re-evaluation of the established plan of care; OR

2. Outpatient OT BEYOND 12 treatment visits *per member per servicing OT provider*‡ *per benefit/Plan year*; OR

3. Outpatient OT (even when provided in the first 12 visits) when treatment EXCEEDS 48 treatment units in total *per member per servicing OT provider*‡ *per benefit/Plan year* to account for OT billed in 15-minute intervals according to industry-standard coding); OR

4. All outpatient OT rendered by a non-participating provider (including initial evaluation and all other services waived for prior authorization when rendered by a servicing OT participating provider); OR

5. All outpatient OT provided by a provider who is NOT certified as an occupational therapist, as defined by scope of practice and certification.

‡ Note: The servicing OT provider refers to a Plan participating provider who is certified in rendering OT, as defined by scope of practice and certification. Untimed OT is typically billed as 1 unit per modality, and timed modalities are billed in 15-minute treatment units.

Clinical Criteria

Occupational therapy provided in the outpatient setting is considered medically necessary 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).

Limitations and Exclusions

A. Occupational therapy provided in the outpatient setting is NOT considered medically necessary when ANY of the criteria in items 1 through 4 are met:

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

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; OR

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; OR

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.

B. Plan requires Medical Director review is required when medical necessity criteria are NOT met. 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.

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 uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents for BMC HealthNet Plan members are available at www.bmchp.org and posted at www.SeniorsGetMore.org for Senior Care Options members.

CPT Codes	Description: 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 Plan Note: Code is NOT payable for the Senior Care options plans.
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 Plan note: Code is ONLY payable for the Senior Care Options products.
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours Plan note: Code is ONLY payable for the Senior Care Options products.
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure) Plan Note: Code is ONLY payable for the Senior Care Options products.
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 Plan note: Code is ONLY payable for the Senior Care Options products.
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

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Policy History

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

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the Senior Care Options Product: 01/01/16

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 WellSense New Hampshire 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	03/01/13 Version 9	11/21/12: MPCTAC 12/20/12: QIC

Policy Revisions History			
	Guidelines Statement section. 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 WellSense New Hampshire Medicaid product and merged policy format. Incorporate policy revisions dated 11/01/12 (as specified above) for the WellSense New Hampshire 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 BMC HealthNet Plan products and the WellSense New Hampshire Medicaid product. Updated references. Removed prior authorization waiver for the first 32 units of OT for the WellSense New Hampshire Medicaid product. Add criterion in the Medical Policy Statement sections for the BMC HealthNet Plan products WellSense New Hampshire 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 BMC HealthNet Plan 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

Policy Revisions History			
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	03/01/20 Version 22	12/18/19: MPCTAC

Policy Revisions History			
	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.		
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

Next Review Date

11/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

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.