Medical Necessity Guidelines: Outpatient Physical Therapy, Occupational Therapy and Speech Therapy

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products

☐Tufts Health Plan Commercial products; Fax: 617.972.9409

☐Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*****The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

To obtain InterQual® SmartSheets™:

- **Tufts Health Plan Commercial Plan products and Tufts Health Freedom Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider website. If you are not a Tufts Health Plan provider please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888.884.2404.
- **Tufts Health Public Plans products:** InterQual SmartSheet(s) available as part of the prior authorization process.

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Physical therapy (PT): Members are covered without prior authorization for their initial evaluation and 11 visits per benefit year for outpatient PT services when referred by their primary care physician (PCP).

Occupational therapy (OT): Members are covered without prior authorization for their initial evaluation and 11 visits per benefit year for outpatient OT services when referred by their PCP.

Speech therapy (ST): Members are covered without prior authorization for their initial 30 visits per benefit year for outpatient ST services when referred by their PCP.

PT, OT and ST visits that are beyond the initial number of visits referred by their PCP require prior authorization. In order to obtain prior authorization for services(s), the appropriate InterQual SmartSheet(s), listed below, must be completed and sent to the applicable fax number listed above, according to Plan.

Tufts Health Plan requires prior authorization for outpatient PT, OT and ST, including, but not limited to:

- **Amputation, Lower Extremity: Rehabilitation (Adult/Adolescent/School age)**
- **Amputation, Upper Extremity: Rehabilitation (Adult/Adolescent/School age)**
- **Cardiac: Rehabilitation (Adult)**

- **Carpal Tunnel Syndrome (CTS): Rehabilitation (Adult)**
- **Cerebrovascular Accident (CVA): Rehabilitation (Adult)**
- **De Quervain's Tenosynovitis: Rehabilitation (Adult)**
- **Fractures, Lower Extremity: Rehabilitation (Adult/Adolescent/School age)**
- **Fractures, Upper Extremity: Rehabilitation (Adult/Adolescent/School age)**
- **General Deconditioning (Adult)**
- **Habilitation**
- **Instability / Dislocation, Shoulder: Rehabilitation (Adult)**
- **Ligamentous Injury, Ankle: Rehabilitation (Adult/Adolescent/School age)**
- **Ligamentous Injury, Knee: Rehabilitation (Adult/Adolescent/School age)**
- **Lymphedema: Rehabilitation (Adult)**
- **Maintenance Therapy: Rehabilitation (Adult)**
- **Meniscal Injury, Knee: Rehabilitation (Adult/Adolescent/School age)**
- **Multiple Sclerosis: Rehabilitation (Adult)**
- **Osteoarthritis, Hip: Rehabilitation (Adult)**
- **Osteoarthritis, Knee: Rehabilitation (Adult)**
- **Osteoarthritis, Shoulder: Rehabilitation (Adult)**
- **Pain Syndromes: Rehabilitation (Adult/Adolescent)**
- **Pediatric: Rehabilitation (Pediatric)**
- **Pelvic Floor: Rehabilitation**
- **Pulmonary: Rehabilitation (Adult)**
- **Rotator Cuff Disorders: Rehabilitation (Adult/Adolescent/School age)**
- **Soft Tissue Disorders, Elbow: Rehabilitation (Adult)**
- **Soft Tissue Disorders, Foot & Ankle: Rehabilitation (Adult/Adolescent/School age)**
- **Soft Tissue Disorders, Knee: Rehabilitation (Adult/Adolescent/School age)**
- **Spinal Disorders, Cervical: Rehabilitation (Adult)**
- **Spinal Disorders, Lumbar: Rehabilitation (Adult/Adolescent/School age)**
- **Sprain, Wrist: Rehabilitation (Adult/Adolescent/School age)**
- **Strain, Low Back: Rehabilitation (Adult/Adolescent/School age)**
- **Strain, Neck: Rehabilitation (Adult/Adolescent/School age)**
- **Tendon Injury, Hand: Rehabilitation (Adult/Adolescent/School age)**
- **Tendon Rupture, Achilles: Rehabilitation (Adult)**
- **Thoracic Outlet Syndrome: Rehabilitation (Adult/Adolescent/School age)**
- **Traumatic Brain Injury (TBI): Rehabilitation (Adult)**
- **Trigger Finger: Rehabilitation (Adult)**
- **Ulnar Neuropathy: Rehabilitation (Adult/Adolescent/School age)**

LIMITATIONS

- The services duplicative of services that are part of an individual educational plan (IEP) or an individual service plan (ISP), when applicable.

CODES

CPT/HCPCS Code	Description
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using 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.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision

CPT/HCPCS Code	Description
	making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
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.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.

CPT/HCPCS Code	Description
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.
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
97039	Unlisted modality (specify type and time if constant attendance)
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 (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, 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 (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, 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)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)

CPT/HCPCS Code	Description
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
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(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), 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
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function

APPROVAL HISTORY

August 16, 2014: Implemented by the Tufts Health Plan – Network Health Review Committee.

Subsequent endorsement date(s) and changes made:

- January 1, 2015: Instructions for Tufts Health Plan – Network Health products included in this document.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 9, 2015: Reviewed by IMPAC, renewed without changes
- July 28, 2016: Tufts Health Direct Plan products removed, effective April 1, 2016
- October 24, 2016: Reviewed at IMPAC. For effective date January 1, 2017 services duplicative of IEP/ISP added to limitations section
- December 14, 2016: Reviewed by IMPAC, renewed without changes
- January 31, 2017: CPT codes added.
- May 1, 2017: For effective date July 1, 2017 updates to prior authorization requirement language

- July 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- November 8, 2017: Reviewed by IMPAC, renewed without changes
- December 31, 2017: Coding updated. Per AMA CPT® and HCPCS Level II manual, effective December 31, 2017 the following code(s) deleted: 97532, 97762; and effective January 1, 2018 the following code(s) added: 97127, 97763, G0515
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- December 3, 2018: 2018.2 Interqual upgrade for Tufts Health Commercial products including Tufts Health Freedom Plan. Effective December 17, 2018, Interqual upgrade is effective for Tufts Health Direct and Tufts Health Together. Effective January 14, 2019, Interqual upgrade effective for Tufts Health RITogether. Additional Interqual subsets added include general deconditioning, habilitative, and pulmonary.
- December 12, 2018: Reviewed at IMPAC. For effective date April 1, 2019, IQ subset Pelvic Floor adopted to replace Medical Necessity Guidelines: Outpatient Physical Therapy for the Treatment of Pelvic Floor Dysfunction
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- December 31, 2019: Coding updated. Per AMA CPT®, effective December 31, 2019 the following code(s) deleted: 97127, G0515 and effective January 1, 2020 the following code(s) added: 97129, 97130
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 10, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.