UHA
HEALTH INSURANCE

Occupational Therapy

I. Policy

Occupational therapy is a form of rehabilitation therapy involving the treatment of neuromusculoskeletal function through the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual which involves cognitive, perceptual, safety, and judgment evaluations and training. These services emphasize useful and purposeful activities to improve neuromusculoskeletal functions and to provide training in activities of daily living.

University Health Alliance (UHA) will reimburse for occupational therapy when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Occupational therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) only if services meet all of the following criteria:

1. Therapy is medically necessary to treat function lost or impaired by disease or trauma/congenital anomalies (structural malformation) or prior therapeutic intervention.
2. Therapy is ordered by a practitioner acting within the scope of his/her license and who has also established the patient's diagnosis and has an intimate understanding of the disease process and therapeutic options.
3. Therapy requires the judgment, knowledge, and skills of a qualified provider of occupational therapy services due to the complexity and sophistication of the therapy and the physical condition of the patient. A qualified provider is one who is licensed where required, performs within the scope of licensure, and is recognized by UHA.
4. Therapy meets the functional needs of a patient who suffers from physical impairment due to disease, trauma, congenital anomalies, or prior therapeutic intervention and is necessary to sufficiently restore or improve neurological and/or musculoskeletal function. Neurological and/or musculoskeletal function is sufficiently restored when one of the following first occurs:
    a. Neurological and/or musculoskeletal function is the level of the average healthy person of the same age, or
    b. When improvement beyond what is expected with activities of daily living, prescribed home exercise, and passage of time, is unlikely.
5. The purpose of the therapy is to achieve a specific diagnosis-related goal for a patient who has a reasonable expectation of achieving significant improvement in a reasonable and predictable period of time.
    a. Significant is defined as a measurable and meaningful increase (as documented in the patient's record) in the patient's level of physical and functional abilities that can be attained with short-term therapy, usually within a three month period.
    b. The purpose of therapy is not to return to (or improve upon) pre-impairment level of function.
6. The therapy must include a home exercise/education program to be initiated at the first occupational therapy visit. The occupational therapist must document the patient's participation in and compliance with the home exercise/education program.

B. Therapy is used to achieve significant, functional improvement through specific diagnosis-related goals documented in an individualized, written treatment plan of care with measurable objectives that include:

   1. Useful and purposeful activities (neuromusculoskeletal)
   2. Guidance in the selection and use of orthoses
   3. Functional abilities (skills and deficits)

C. Modalities defined by CPT as requiring constant attendance or direct one-on-one patient contact, must be provided by the licensed occupational therapist using constant, direct, one-on-one patient contact.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Occupational therapy benefits are not available for the following:

   1. Leisure activities including hobbies, sports, or recreation of all types even if suggested as part of an OT treatment plan. This includes continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform activities of daily living; it is **NOT** intended to return the individual to their previous (or improved) level of sports competition or capability;
   2. Ongoing treatment solely to improve endurance and distance;
   3. General exercise programs to promote overall fitness;
   4. Programs to provide diversion or general motivation;
   5. Long term therapy;
   6. Group exercise/therapy programs: defined as the simultaneous treatment of two or more patients who may or may not be doing the same activities;
   7. Developmental delay defined as any significant lag in a child's physical, cognitive, behavioral, emotional, or social development, in comparison with norms.

B. Up to four procedures and/or modalities per visit are allowed (not to exceed one hour). Modalities and procedures must meet payment determination criteria and are subject to review.

C. Application of hot or cold packs (CPT 97010) is bundled into the payment for other services and is not separately payable.

D. Iontophoresis (CPT 97033), infrared (97026), ultraviolet modalities (97028), and laser therapy (97039) do not meet payment determination criteria as there is no evidence based on published, controlled clinical studies which demonstrate their efficacy.

E. Work hardening and community work integration programs (CPT 97545, 97546, 97537) and functional capacity assessments (CPT 97750) do not meet payment determination criteria as these services are intended for the purpose of testing or conditioning for return to work, rather than treatment for medical condition.

F. Duplicate therapy is not covered. When a patient receives both occupational and physical therapy, the therapies should provide different treatments and not duplicate the same treatment. However, total treatment session limitations are combined for physical and occupational therapy (i.e., no more than a total of 32 units). They must have separate treatment plans and goals with treatment occurring in separate treatment sessions and visits. This includes:

    1. Duplicate services available through schools and government programs. Occupational therapy may be available under a child's individualized education program (IEP). An IEP should be completed before requesting coverage through UHA.

G. Non-skilled services which do not require the intervention of a qualified provider of occupational therapy services are not covered, such as:

    1. Services that include any of the following treatments given alone or to patient who presents no complications: hydrocollator; whirlpool baths; paraffin baths; Hubbard tank; and contrast baths.
    2. Procedures that may be carried out effectively by the patient, family, or caregivers.

H. Certain types of therapy (e.g., passive range of motion treatment not related to restoration of a specific loss of function by using routine, repetitive, and reinforced procedures such as daily feeding programs once the adaptive procedures are in place) do not generally require the skills of a qualified provider of OT services and are therefore not covered.

I. Electrical stimulation (E-stim/NMES) for swallowing/feeding disorders is not covered as it is not known to improve health outcomes.

J. Maintenance programs are not covered. Maintenance programs are defined as activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent.

K. Services provided by students, OT aides, or other non-qualified professionals are not covered.

L. If the patient requires skilled therapy for multiple body sites (e.g. shoulder and knee, bilateral shoulders, etc.) a visit should include all treatment necessary.

M. Occupational therapy benefits are not available to treat conditions which are otherwise excluded from coverage under the member's plan.

N. For any single timed CPT code used on the same day and measured in 15 minute units, providers must bill a single 15-minute unit for treatment for greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 4 units are as follows:

    1. 1 unit: $\geq$ 8 minutes through 22 minutes
    2. 2 units: $\geq$ 23 minutes through 37 minutes
    3. 3 units: $\geq$ 38 minutes through 52 minutes
    4. 4 units: $\geq$ 53 minutes through 67 minutes

IV. Administrative Guidelines

A. Prior authorization is required after 8 visits or 32 units combined OT and PT per calendar year. All prior authorizations submitted will be reviewed for medical necessity.

B. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

C. Providers of occupational therapy services must confirm whether the patient has previously received services for occupational therapy from another OT/PT provider.

D. Documentation submitted must include an individualized, written treatment plan appropriate for the diagnosis, symptoms, and findings of the occupational therapy evaluation which clearly documents the medical necessity of the treatment.

    1. Specific statements of goals including a transition from one-to-one supervision to a patient, family member, or caregiver upon discharge to a home maintenance program.
    2. Measurable objectives intended to facilitate meaningful functional improvement.
    3. A reasonable estimate of when the goals will be reached.
    4. The specific procedures and/or modalities to be used in treatment including those for use in a home maintenance program.
    5. The frequency and duration of the treatment.
    6. A treatment plan should be appropriately revised as the patient's condition changes.

E. The frequency of visits should be appropriate according to the patient's physical condition and stage of healing.

F. Definitions:

    1. Activities of daily living: Normal activities of daily living such as toileting, feeding, dressing, grooming, bathing, etc.
    2. Assessment: Assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). For example, assessment determines changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on this assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or reevaluation is indicated. Assessment is included in services/procedures and is not separately payable (as distinguished from CPT codes that specify assessment).
    3. Evaluation: Evaluation is a comprehensive service that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. For example, an evaluation is warranted for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to developing a plan of care, with goals and interventions. The time spent performing an evaluation does not also count as treatment time. Evaluation services are separately payable.
    4. Reevaluation: Revaluation requires the same professional skills as an evaluation and is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline, or change in a patient's condition or physical status. A reevaluation is focused on evaluating progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. The reevaluation CPT code can only be used under the following circumstances: a significant change in the patient's condition requiring a new treatment plan; the patient is not responding to the current treatment plan; or new findings will significantly affect the current treatment plan. The reevaluation CPT code is not a covered code when used: for periodic reassessments; when creating a progress summary note for a physician; and for routine pre-

and post-service assessments. These services are not separately reimbursable as reevaluations and should be included in the time rendered for the procedure.

CPT Code	Description
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)
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), 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)
97139	Unlisted therapeutic procedure (specify)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
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 (i.e., 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 (e.g., 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 (i.e., 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 (e.g., 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 (i.e., 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 (e.g., 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.
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
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
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

HCPCS Code	Description
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
S8950	Complex lymphedema therapy, each 15 minutes

V. Policy History

Policy Number: MPP-0077-120301

Current Effective Date: 08/08/2019

Original Document Effective Date: 03/01/2012

Previous Revision Dates: 09/10/2015, 10/01/2015, 12/01/2017, 01/29/2019

PAC Approved Date: 03/01/2012