National Imaging Associates, Inc.	
Clinical guidelines **OUTPATIENT HABILITATIVE PHYSICAL AND OCCUPATIONAL THERAPY**	**Original Date: November 2015** **Page 1 of 8**
Physical Medicine – Clinical Decision Making	**Last Revised Date: July 2019**
Guideline Number: NIA_CG_603	**Implementation Date: January 2020**

Policy Statement

Habilitative physical and occupational therapy services may or may not be covered by all clients of this organization. If the service is covered it may or may not require prior authorization. These guidelines apply to all markets and populations contracted with this organization through the corresponding state health plans unless a market specific health plan has been developed. Services may be covered when provided for the end result of achieving age appropriate growth/development, correcting or improving a physical condition, or helping a patient acquire, maintain or regain functional skills for successful participation in everyday activities. These services must be provided by a skilled and licensed therapy practitioner and in a manner that is in accordance with accepted standards of practice for discipline-specific therapies. It must also be clinically appropriate in amount, duration and scope to achieve their purpose and considered effective treatment for the current injury, illness or condition.

Habilitative physical and occupational therapy should meet the definitions at the end of this document, be provided in a clinic, office, home, or in an outpatient setting. and be ordered by either a primary care practitioner or specialist.

Indications

Physical and/or occupational therapy evaluation and treatment services are considered medically necessary when the following criteria are met:

- Must have written referral from primary care practitioner or other non-physician practitioner (NPP) as permitted by state guidelines.
- Physical and occupational therapy initial evaluations and re-evaluations that include patient history such as recent illness, injury or disability along with diagnosis and date of onset and/or exacerbation of the condition. Prior and current level of function as well as identification of any underlying factors that have impacted current functional performance must also be noted (AJOT 2015, AJOT 2017, APTA 2009).
- Formal testing must be age appropriate, norm-referenced, standardized and specific to the therapy provided. Test scores should meet the following criteria to establish presence of delay:
    - At or below the 10th percentile of with standardized scores greater than or equal to 1.5 standard deviations below the mean in at least one subtest area for the patient's age (Andersson 2004).
    - Functional delays may be established by 25% or greater deficit in age equivalency as indicated by established general guidelines of functional assessments or specific criterion-referenced tests or profiles.
    - While providers may include age equivalents, percent delay or scaled scores in their evaluation summaries, they will not necessarily be accepted as a measure of developmental delay. Standard deviations gathered from standardized testing are preferred. Raw scores are not sufficient to interpret the measure of standard deviation from the mean on formal assessments.

    - While standardized testing is preferred, scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention. Test information must be linked to difficulty with or inability to perform everyday tasks (Herzinger 2007).
    - In the absence of standardized testing, the report must include detailed clinical observations of current skill sets, parent interview/questionnaire and/or informal assessment supporting functional mobility/ADL deficits and the medical need for skilled services. The documentation must clearly state the reason formal testing could not be completed.
    - In the case of feeding difficulties, the notes must clearly indicate a functional feeding delay as a result of underlying impairments. This may include gagging/choking, oral motor or upper extremity coordination deficits or maladaptive behaviors due to a food intolerance/aversion preventing adequate oral intake that contribute to malnutrition or decreased body mass index. Fine motor and/or sensory testing as well as detailed clinical observations of oral motor skills should also be included in the documentation if functional feeding delays are a result of these component parts of the overall task. Parent report of limited food choices is not adequate to support the medical need for feeding therapy. There must also be evidence of ongoing progress and a consistent home regimen to facilitate carry-over of target feeding skills, strategies and education of patient, family, and caregiver. Therapy for picky eaters who can eat and swallow normally meeting growth and developmental milestones, and eat at least one food from all major food groups (protein, grains, fruits, etc.) is not medically necessary.
    - Re-evaluations must be performed annually to support ongoing delays and medical necessity for continued services.
- When skilled services are also being provided by other community service agencies and/or school systems, the notes must show how the requested services are working in coordination with these agencies and not duplicating services. The extent or lack of these additional services must be indicated in the documentation.
- Treatment goals must be realistic and measurable in order to identify the functional levels related to appropriate maintenance or maximum therapeutic benefit. Goals of intervention should target the functional deficits identified by the skilled therapist during the assessment and promote attainment of age appropriate developmental milestones, functional mobility and/or ADL skills appropriate to the patient's age and circumstances (Houtrow 2019). Although identified as component parts of participation, underlying factors, performance skills, client factors or the environment should not be the targeted outcome of long term goals. In like manner, underlying factors such as strength, range of motion or cognition should not be the sole focus of short term goals (Amini 2018). When documenting interventions, an explicit connection must be made to what participation outcome the intervention will target.
- Intervention selections must be evidence-based, chosen to address the targeted goals and representative of the best practices outlined by the corresponding national organizations (AJOT 2015, AJOT 2017).
- The plan of care must include goals detailing type, amount, duration, and frequency of therapy services required to achieve targeted outcomes. The frequency and duration must also be commensurate with the patient's level of disability, medical and skilled therapy needs as well as accepted standards of practice while reflecting clinical reasoning and current evidence (Bailes 2008).
- Frequency and duration of skilled services must also be in accordance with the following:

    - Intense frequencies (3x/week or more) will require additional documentation and testing supporting a medical need to achieve an identified new skill or recover function with specific, achievable goals within the requested intensive period (Bailes 2008). Details on why a higher frequency is more beneficial than a moderate or low frequency must be included. Higher frequencies may be considered when delays are classified as severe as indicated by corresponding testing guidelines used in the evaluation. More intensive frequencies may be necessary in the acute phase, however, progressive decline in frequency is expected within a reasonable time frame.
    - Moderate frequency (2x/week) should be consistent with moderate delays as established in the general guidelines of formal assessments used in the evaluation.
    - Low frequency (1x/week or every other week) may be considered when testing guidelines indicate mild delays.
    - Additional factors may be considered on a case-by-case basis.
- Documentation should clearly reflect why the skills of a therapist are needed. There must be evidence as to whether the services are considered reasonable, effective treatments requiring the skills of a therapist or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.
- Progress notes/updated plans of care that cover the patient's specific overall functional progress toward their goals will be required every 60-90 days or per state requirements. Documentation should include:
    - The patient's current level of function, any conditions that are impacting his/her ability to benefit from skilled intervention.
    - Objective measures of the patient's overall functional progress relative to each treatment goal as well as a comparison to the previous progress report.
    - Skilled treatment techniques that are being utilized in therapy as well as the patient's response to therapy and why there may be a lack thereof.
    - An explanation of any significant changes in the plan of care and clinical rationale for why the ongoing skills of a PT/OT are medically necessary.
    - In the case of maintenance programs, clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided. The notes must also clearly demonstrate that the specialized judgment, knowledge and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.
- If the patient is not progressing, then documentation of a revised treatment plan is necessary. Discontinuation of therapy will be expected when the maximum therapeutic value of a treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition ceases to be of therapeutic value.
- It is expected that a discharge plan, with the expected treatment frequency and duration, must be included in the plan of care. The discharge plan must indicate the plan to wean services once the patient has attained their goals, if no measurable functional improvement has been demonstrated or if the program can be carried out by caregivers or other non-skilled personnel.
- Development of an age-appropriate home regimen to facilitate carry-over of targeted skills and strategies as well as patient, family, and caregiver education in home exercises and self-monitoring should be evident in the documentation.

- For patients no longer showing functional improvement, a weaning process of one to two months should occur. If the patient shows signs of regression in function, the need for skilled physical or occupational therapy can be re-evaluated at that time. Periodic episodes of care may be needed over a lifetime to address specific needs or changes in condition resulting in functional decline.

Background

Definitions

Habilitative Physical or Occupational Therapy

Treatment provided by a state-regulated physical or occupational therapist designed to help a person learn, obtain, maintain, prevent deterioration or improve age appropriate skills and functioning for daily living (Amini 2018, APTA 2009). These skills may have never been present, lost or impaired due to a congenital, genetic or early acquired condition. There must be measurable improvement and progress towards functional goals within an anticipated timeframe toward a patient's maximum potential. Treatment may also be appropriate in an individual with a progressive disorder when it has the potential to prevent the loss of a functional skill or enhance the adaptation to such functional loss. Ongoing treatment is not appropriate when a steady state of sensorimotor functioning has yielded no measurable functional progress.

Rehabilitative Physical or Occupational Therapy

Treatment provided by a state-regulated physical or occupational therapist designed to help a person recover from an acute injury or exacerbation of a chronic condition that has resulted in a decline in functional performance. The specific impact of injury or exacerbation on the patient's ability to perform in their everyday environment must be supported by appropriate tests and measures in addition to clinical observations. Services must be provided within a reasonable time frame (frequency/duration) to restore lost function or to teach compensatory techniques if full recovery of function is not possible.

Maintenance Program

A program established by a licensed therapist that consists of activities and/or mechanisms that will assist the patient in optimizing or maintaining the progress he or she has made during therapy or to prevent or slow further deteriorations due to a diseases or illness.

Medical Necessity

Reasonable or necessary, physician-prescribed services that require the specific training, skills and knowledge of a physical or occupational therapist in order to diagnose, correct or significantly improve/optimize as well as prevent deterioration or development of additional physical and mental health conditions. These services require a complexity of care that can only be safely and effectively performed by or under the general supervision of a skilled therapist. Services shall not be considered reasonable and medically necessary if they can be omitted without adversely affecting the member's condition or the quality of medical care. A service is also not considered a skilled therapy service merely

because it is furnished by a therapist or by a therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively carried out by an unskilled person, without the direct supervision of a therapist, as applicable, then the service cannot be regarded as a skilled therapy service even though a therapist actually rendered the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist renders the service.

Activities of Daily Living (ADLs)

Essential activities oriented toward taking care of one's own body (also referred to as basic and/or personal activities of daily living). Such activities are fundamental to living in a social world as well as enabling basic survival and well-being. Specific examples include bathing/showering, toileting, dressing, swallowing/eating, feeding, functional mobility, personal device care, personal hygiene/grooming and the functional mobility necessary to perform these activities. The initial evaluation and corresponding plan of care should document baseline impairments as they relate to ADL performance deficits with targeted functional outcomes/goals that are measurable, sustainable and time-specific. Subsequent plans should clearly document functional progress toward attainment of these goals in perspective to the patient's potential ability as well as skilled interventions used to target functional outcomes (AJOAT 2015, AJOT 2017.

Functional Mobility Skills

They are considered necessary activities of daily life such as ambulation, transfers, and fine motor skills. The initial plan of care documents baseline impairments as they relate to functional skills with specific goals developed that are measurable, sustainable, and time-specific. Subsequent plans of care document progress toward attainment of these goals in perspective to the patients' potential ability.

Sensory Integration Disorder

Sensory integration involves perceiving, modulating, organizing, and interpreting internal sensations from within the body as well as external sensations from the surrounding environment to optimize occupational performance and participation. Deficits in sensory integration can pose challenges in performing activities of daily living, in addition to development, learning, playing, working, socializing and exhibiting appropriate behavior. Differences in interpretation of stimuli can impact motor skills and coordination, further limiting engagement and participation. Sensory processing difficulties can occur across the lifespan. Sensory integrative therapy and evidence-based interventions provide neuroscience-based, cognitive and/or behavioral approaches that support successful adaptive responses (Kinnealey 2015).

POLICY HISTORY:

Review Date: July 30, 2019

Review Summary:

- Definitions were moved to the background so pertinent information was readily available at the beginning of the document.
- Existing definitions were revised to include greater detail with new definitions for *rehabilitative therapy* (for comparative purposes), *medical necessity* and *maintenance program* included.
- Criteria for delay was revised to include clearer and more detailed specifications for functional delays, preferred scoring, and what is required in the absence of standardized testing.
- Criteria for feeding delays were added.
- Additional specifications included for linking testing to the treatment goals, inclusion of functional treatment goals, utilizing appropriate dosing of therapy and specifying skilled interventions.

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