REHABILITATION SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY)

Policy Number: BIP148.H
Effective Date: April 1, 2018

Covered benefits are listed in three (3) Sections – A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member’s EOC/SOB, the member’s EOC/SOB provision will govern.

Essential Health Benefits for Individual and Small Group
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.
A. FEDERAL/STATE MANDATED REGULATIONS

1. Oklahoma Department of Insurance 365:40-5-30 (4): Short-term inpatient rehabilitation services are covered when member is expected to have significant improvement in condition within two (2) months.


B. STATE MARKET PLAN ENHANCEMENTS

None

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Note: For member specific coverage and limitations for Physical, Occupational and Speech Therapy as Habilitative Services, refer to the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB) or Speech Therapy Amendment, or contact the Customer Service Department.

Note: For Habilitative Services: Please refer to the Definition Section below, and the Habilitative Services BIP

1. Therapy services are covered in the following settings:
   a. **Acute Inpatient Rehabilitation**: Inpatient Acute Rehabilitation provides an intense Multidisciplinary Service to restore or enhance function, post injury or illness. Inpatient Acute Rehabilitation is medically necessary when **ALL** of the following criteria are met:
      i. The patient requires treatment from a multidisciplinary team consisting of at least two therapies (e.g., Physical Therapy, Occupational Therapy, Speech Therapy).
      ii. The patient is stable enough medically and is capable and willing to participate in intensive therapy for a minimum of three hours per day, at least five days per week.
      iii. The Rehabilitation Program is expected to result in significant therapeutic improvement over a clearly defined period of time.
      iv. The Rehabilitation Program is individualized, and documentation outlines quantifiable, attainable treatment goals.
      v. Rehabilitation is required in an inpatient rehabilitation facility rather than a less intense setting. Rehabilitative care services are determined by the patient's functional needs, and the availability of resources. Documentation provided in the patient's medical record must support medical necessity and should include relevant medical history, including the patient’s rehabilitation potential and prior level of function, physical examination, and results of pertinent diagnostic test or procedures. In addition, the documentation must reflect the ongoing assessment and necessary adjustments to the plan of care. Current functional status and measurable goals individualized to the needs and abilities of the patient should be part of the plan of care. The patient's progress toward established goals should be reviewed at least weekly and should include objective measurements (e.g., FIM scores) as well as a clinical narrative which demonstrates functional improvement and progress towards attainable treatment goals as a result of the therapy provided.
   
   b. **Outpatient Physical and Occupational Therapy**
      - Physician’s office only when done by a licensed therapist and performed in a participating/contracting physician’s office
      - Therapist’s office
      - Member’s place of Residence
i. Physical, and Occupational Therapy services must meet all of the following criteria:
   (a) Therapy services must be such that only a qualified therapist or a person supervised by a qualified therapist can safely perform the services.
   (b) Therapy services must be provided with the expectation that the member’s condition will improve or that the service is necessary to establish a safe and effective maintenance program.
   - Physical limitations and goals must be documented and progress recorded.
   (c) Amount, frequency and duration of the therapy services must be reasonable.
   (d) Services must relate directly and specifically to a written treatment plan established by a physician after consulting with the qualified therapist (Physical and/or Occupational) and/or Speech pathologist or audiologist.

ii. Speech Therapy:
   (a) Speech Therapy evaluation when ordered by a plan physician after a face to face evaluation which documents some type of deficit and or speech/language concern
   (b) Speech Therapy must be medically necessary (see MCG™ Care Guidelines, 22nd edition, 2018):
      - Acquired Apraxia of Speech Rehabilitation ACG: A-0555 (AC)
      - Dysarthria Rehabilitation ACG: A-0556 (AC)
      - Voice Disorders Rehabilitation ACG: A-0559 (AC)
      - Developmental Speech Disorders Rehabilitation ACG: A-0560 (AC)
      - Developmental Language Disorders Rehabilitation ACG: A-0561 (AC)
      and
   1) Ordered by a plan physician after a face to face evaluation including documentation of the patient’s abilities to speak, swallow and/or communicate; if a referral(s) is done copies should accompany the request:
      (i) Speech and language evaluation (face to face) by a speech and language pathologist (speech therapist); OR
      (ii) Other appropriate evaluation(s) by a healthcare professional (developmental pediatrician, neurologist; occupational therapist; psychologist or psychiatrists)
   2) A plan of care with goals and expected length of time must be submitted by the physician based on the speech and language therapist’s evaluation or other evaluations; and
   3) Periodic re-evaluation of the progress toward the goals must be done, no less than every 90 days.

Please Note:
Patients with stuttering; lisping; or articulation disorders need to be evaluated for medical necessity. See MCG™ Care Guidelines, 22nd edition, 2018:
- Developmental Speech Disorders Rehabilitation ACG: A-0560 (AC)
- Developmental Language Disorders Rehabilitation ACG: A-0561 (AC)
- Dysarthria Rehabilitation ACG: A-0556 (AC)
(c) Physical and Occupational Therapies include, but are not limited to:
1) Ultrasound, shortwave, and microwave diathermy treatments
2) Range of motion tests
3) Gait training
4) Therapeutic exercises
5) Aqua/pool therapy, only as part of an authorized treatment plan conducted by a licensed physical therapist with the therapist in attendance
6) Fluidized Therapy (Fluidotherapy) as a part of an authorized physical therapy treatment plan for the treatment of acute or subacute, traumatic or nontraumatic, musculoskeletal disorders of the extremities
(d) Circumstances under which therapy services are covered include, but are not limited to:
1) A terminally ill member who begins to exhibit self-care, mobility and/or safety dependence
2) A member who has an unhealed, unstable fracture of the leg which requires regular exercise until the fracture heals in order to maintain function of the leg.

3) A member who requires Physical, Occupational, and/or Speech therapy for brain injury, when deemed medically necessary by UnitedHealthcare’s medical director.

Note:

- There must be a documented need to continue therapy and an estimate of how long the services may be needed. The physician must review the plan of treatment and the clinical records every 30 days. The member’s limits and goals of therapy must be included in the documentation.
- Rehabilitation benefit is administered based on treatment episode. Benefit can be renewed within the calendar year if there is a change in the original condition that warrants additional days of rehabilitation.
- Eligible therapy services received in the home from a Home Health Agency is covered under the Home Health Care benefit.
- Eligible therapy services received in the home from an independent physical or occupational therapist, not affiliated with the Home Health Agency, is covered under the rehabilitation benefit.

D. NOT COVERED

1. Therapy when member has either attained therapy treatment plan goals or is unable to attain the treatment plan goals.
2. General exercises that promote overall fitness and flexibility and/or solely to improve general physical condition.
3. Massage therapy unless mandated by State or Federal law and/or Market Plan Enhancements (Refer to Sections A and B).
4. Recreational therapy.
5. Maintenance Therapy.
6. Vocational, prevocational and educational assessment and training related solely to specific employment opportunities, work skills or work settings.
7. Percutaneous Neuromodulation Therapy (PNT), also referred to as Percutaneous Electrical Nerve Stimulation (PENS), for the treatment of pain, as part of physical therapy or in the doctor’s office.
8. Sensory Integration Therapy.
9. Coordination Therapy
   a. Attention deficit hyperactivity disorder
   b. Dyslexia.
10. Inpatient rehabilitation solely for the purpose of providing cognitive rehabilitation therapy when treatment of the member’s medical condition does not otherwise meet criteria for inpatient intensive skilled rehabilitation nursing care, Physical therapy, Occupational Therapy, or Speech Therapy services.
11. Services that are considered by UnitedHealthCare to be investigational or Experimental.
12. Services that are considered to be Custodial.
14. Programs that do not require the supervision of a physician and/or licensed therapy provider.
15. Gym and fitness club memberships, and fees, health club fees, exercise equipment or supplies.
16. Coverage is excluded for physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. An example includes, but is not limited to, the same day combined use of hot packs, ultrasound and iontophoresis in the treatment of strain.

E. DEFINITIONS

1. Acute Rehabilitation Program: A relatively intense rehabilitation program necessitating a Multidisciplinary coordinated team approach to upgrade the member’s ability to function as independently as possible. A program of this scope usually includes intensive skilled
rehabilitation nursing care, Physical Therapy, Occupational Therapy, and, if needed, Speech Therapy.

2. **Custodial Care**: Services that are any of the following:
   - Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
   - Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
   - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

3. **Fluidized Therapy (Fluidotherapy)**: High intensity heat modality consisting of a dry whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having the properties of a liquid.

4. **Habilitative Services**: Medically Necessary healthcare services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment. Examples of health care services that are not Habilitative Services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, Custodial Care, or education services of any kind, including, but not limited to, vocational training. Habilitative Services shall be covered under the same terms and conditions applied to Rehabilitative and Habilitative Services under the plan contract.

5. **Maintenance Therapy**: Therapy with the goal to maintain the functional status or to prevent decline in function.

6. **Multidisciplinary Team Approach**: Usually includes a physician specializing in rehabilitation, rehabilitation nurse, social worker and/or psychologist, and those therapies (physical, occupational, and/or speech) involved in the member’s care. At a minimum, a team must include a physician, rehabilitation nurse and one therapist.

7. **Occupational Therapy**: Non-surgical treatment necessary for the identification and alleviation of mental and/or physical conditions that limit an individual’s ability to perform the activities of daily living. Treatment focuses on increasing independence and minimizing recurrence through education and the use of therapeutic exercise and physical activity at home or at work.

8. **Outpatient Medical Rehabilitation Therapy**: Services for the treatment of an illness, including Severe Mental Illness and Serious Emotional Disturbances of a Child, or injury are covered when provided by a Participating Provider who is a registered physical, speech or occupational therapist, or a healthcare professional under the direct supervision of a licensed physical therapist acting within the scope of his or her license under California law. (For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this Combined Evidence of Coverage and Disclosure Form.).

9. **Physical Therapy**: Non-surgical treatment necessary for the identification, restoration, and improvement of functions that have been impaired by illness, disease, surgery, trauma or injury. Treatment includes, but is not limited to, therapeutic exercise, physical activity, and training in the activities of daily living.

10. **Place of Residence**: Wherever the member makes their home. This may be their own dwelling, an apartment, a relative’s home, home for the aged, or some other type of institution other than an acute hospital or licensed skilled nursing facility.
11. **Work Hardening**: An interdisciplinary program consisting of physical therapy, occupational therapy and counseling professionals for injured workers or other adults whose injuries or disease processes interfere with their ability to work. It provides structured treatment designed to progressively improve physical function as a transition between acute care and return to work.

**F. REFERENCES**

MCG™ Care Guidelines, 22nd edition, 2018

**G. POLICY HISTORY/REVISION INFORMATION**

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<td>Updated policy header to reflect the most current UnitedHealthcare West branding</td>
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