AETNA BETTER HEALTH®

Clinical Policy Bulletin: Occupational Therapy Services

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Policy

I. Aetna considers short-term occupational therapy medically necessary in selected cases when this care is prescribed by a physician, and either of the following criteria applies:

   To learn or re-learn daily living skills (e.g., bathing, dressing, and eating) or compensatory techniques to improve the level of independence in the activities of daily living; or

   To provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury.

Occupational therapy services are considered medically necessary only if there is a reasonable expectation that occupational therapy will achieve measurable improvement in the member's condition in a reasonable and predictable period of time.

II. Once maximal therapeutic benefit has been achieved, or transition to a home program could be used for further gains, continuing supervised occupational therapy is not considered medically necessary.

   Occupational therapy if it will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities.

Notes: Aetna policies typically exclude coverage for services, treatment, education testing, or training related to learning disabilities or developmental delays. When the policy has such an exclusion, occupational therapy is not covered when the primary or the only diagnosis for a member is mental retardation or a learning disability such as a perceptual handicap, brain damage not caused by accidental injury or illness, minimal brain dysfunction, dyslexia, or developmental delay.

Driver training is not considered treatment of disease because driving an automobile is not a basic activity of daily living.

In addition to use in non-chronic conditions and acute illnesses, a role for occupational therapy has been proposed in the management of certain conditions.
chronic diseases. It may be used to slow or prevent further deterioration of body function impaired by a neurological disease such as multiple sclerosis, cerebral palsy, Parkinson's disease, polio, spina bifida and amyotrophic lateral sclerosis (Lou Gehrig's disease). Most Aetna policies limit coverage of occupational therapy to non-chronic conditions and acute illnesses. Occupational therapy may require precertification in some plan designs. Subject to plan benefit descriptions, coverage of occupational therapy may be limited. In many of our HMO plans the benefit is limited to a 60-day treatment period. In these plans, the treatment period of 60 days applies to a specific condition. Once the 60-day treatment period expires, no additional occupational therapy benefits will be provided for that condition during the contract year. However, it is possible for a member to receive more than one 60-day treatment course of occupational therapy per year as treatment of separate conditions. For example, a surgical procedure causing the need for occupational therapy is considered to be the initiation of a new or separate condition in a person who previously received occupational therapy for another indication, and so qualifies the member to receive coverage for an additional course of occupational therapy as outlined above. An exacerbation or flare-up of a chronic illness is not considered to be a new incident of illness. Other HMO and PPO and Indemnity plans have different benefits for occupational therapy. In some cases the benefits are defined by a total number of sessions covered per year. In other benefit designs, occupational therapy may be covered as an unlimited benefit as long as it is documented that the member is progressing towards a goal. Consult the specific certificates of coverage for details of plan benefits.

I. Aetna considers home-based occupational therapy medically necessary in selected cases based upon the member's needs (i.e., the member must be homebound or unable to receive services outside the home). This is usually used in the transition of the member from hospital to home and is an extension of case management services.

Note: In Aetna’s HMO and QPOS plans, such home based occupational therapy accumulates towards the 60-day limit or other applicable rehabilitation benefit limits. Please check benefit plan descriptions for details.

Background

Occupational therapy is a health care service that involves the use of purposeful activities to help people regain performance skills lost through injury or illness. Individual programs are designed to improve quality of life by recovering competence, maximizing independence, and prevent injury or disability as much as possible, so that a person can cope with work, home, and social life.

According to the American Occupational Therapy Association (2002), occupational therapists work with adults and children across the lifespan who may suffer from physical, developmental or psychological impairments.
Occupational therapy services emphasize useful and purposeful activities to improve neuromusculoskeletal function and to provide training in activities of daily living (ADL), including bathing, dressing, feeding, and other self-care activities. Other occupational therapy services include the design, fabrication and use of orthoses, and guidance in the selection and use of adaptive equipment.

Occupational therapy is considered medically necessary only when provided to achieve a specific diagnosis-related goal as documented in the plan of care. Occupational therapy should: (i) meet the functional needs of a patient who suffers from physical disability; (ii) achieve a specific diagnosis-related goal for a patient who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time; (iii) be specific, effective and reasonable treatment for the patient’s diagnosis and physical condition; and (iv) be delivered by a qualified provider of occupational therapy services (i.e., one who is licensed, where required, and is performing within the scope of license).

Hoffmann and colleagues (2011) examined if occupational therapy improves functional performance of basic ADL and specific cognitive abilities in people who have cognitive impairment after stroke. In this review, randomized controlled trials (RCTs) and quasi-RCTs that evaluated an occupational therapy intervention focused on providing cognitive retraining to adults with clinically defined stroke and confirmed cognitive impairment were included. Searches up to April 2009 were conducted in: the Cochrane Stroke Group Trials Register, the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, CINAHL, PsycINFO, PsycBITE, OTseeker, and Dissertation Abstracts. The search also included a review of the reference lists of relevant studies, a hand-search of relevant occupational therapy journals, and contact with key researchers in the area. Two review authors independently examined the abstracts that might meet the inclusion criteria, assessed the methodological quality, and extracted data. Of 17 trials that appeared to be relevant and were reviewed in full text, only 1 trial (n = 33) was finally included in this review. The study was an RCT of cognitive skills remediation training and there was no difference between groups for the 2 outcomes that were relevant to this review that were measured: improvement in time judgement skills and improvement in basic ADLs on the Barthel Index. The effectiveness of occupational therapy for cognitive impairment post-stroke remains unclear. The potential benefits of cognitive re-training delivered as part of occupational therapy on improving basic daily activity function or specific cognitive abilities, or both, of people who have had a stroke can not be supported or refuted by the evidence included in this review. The authors stated that more research is required.

Spiliotopoulou and Atwal (2012) noted that although occupational therapists are integral to the rehabilitation process of people with amputations, the effectiveness of the occupational therapy intervention for older adults with lower limb amputations has not been investigated. These researchers examined the effectiveness of the occupational therapy interventions with older adults aged 65 years and older with lower limb amputations. A systematic search was conducted in CINAHL, PUBMED, OTSEEKER and OTDBASE from January 1985 to January 2011. The eligible papers were critiqued using a typology, which involved designation of levels of evidence and quality markers. The databases yielded
2,664 potential publications. Of these, only 2 were included in the final review. These studies suggested that the frequency of the occupational therapy sessions was found to be statistically significantly related to prosthesis use and that service users perceived positive benefits about the provision of stump boards. Both studies had limitations resulting in a need for further investigation in these areas. The authors concluded that research evidence on the occupational therapy interventions with this population is limited and scarce. They stated that occupational therapists need to take urgent action to address the identified evidence-based gaps in order to devise informed targeted rehabilitation programs for this client group. This systematic review has contributed to the understanding of the occupational therapy practice in the rehabilitation of older adults with lower limb amputations. It has highlighted gaps in evidence that occupational therapists need to address urgently in order to inform their rehabilitation programs with this client group.

In a meta-analysis, Kim and colleagues (2012) examined effects of occupational therapy based on sensory stimulation, environmental modification and functional task activity on the behavioral problems and depression of individual with dementia. These investigators performed an extensive search in database such as MEDLINE, CINAHL, ProQuest Medical Library, and Cochrane and occupational therapy-related 11 journals. Two reviewers independently identified studies, extracted data, evaluated methodological quality of the studies. Effect size was estimated using standardized mean difference with 95 % confidence intervals (CI). Significant heterogeneity and publication bias were investigated. A total of 9 studies including 751 people were selected. Sensory stimulation was effective intervention in improving behavioral problems (0.32; 95 % CI: 0.04 to 0.59). The authors concluded that this review identified that occupational therapy based on sensory stimulation was effective in improving behavioral problems. However, they stated that the number of studies included in this review was limited; more research is needed to enable evidence-based occupational therapy for dementia patients.

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Appendix

Documentation Requirements:

The following care plan is required to document the medical necessity of occupational therapy:

I. Occupational therapy must be provided in accordance with an ongoing, written plan of care. The purpose of the written plan of care is to assist in determining medical necessity.

II. The plan of care must include sufficient information to determine the medical necessity of treatment. The plan of care must be specific to the diagnosis, presenting symptoms, and findings of the occupational therapy evaluation.

III. The plan of care must be signed by the member's attending physician and occupational therapist.

IV. The plan of care should include:

   A. A reasonable estimate of when the goals will be reached;
   B. Quantitative objectives;
   C. Specific statements of long-term and short-term goals;
   D. The date of onset or exacerbation of the disorder/diagnosis;
   E. The frequency and duration of treatment; and
   F. The specific treatment techniques and/or exercises to be used in treatment.

The plan of care should be ongoing (i.e., updated as the member's condition changes) and treatment should demonstrate reasonable expectation of improvement (as defined below):

The member should be re-evaluated regularly, and there should be documentation of progress made toward the goals of occupational therapy.

The treatment goals and subsequent documentation of treatment results should specifically demonstrate that occupational therapy services are contributing to such improvement.

CPT Codes / HCPCS Codes / ICD-9 Codes

CPT codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97003</td>
<td>Occupational therapy evaluation</td>
</tr>
<tr>
<td>97004</td>
<td>Occupational therapy re-evaluation</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction, one or more regions, each 15 minutes</td>
</tr>
</tbody>
</table>
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 by provider, each 15 minutes

**HCPCS codes covered if selection criteria are met:**

G0129  Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day

G0152  Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes

G0160  Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective therapy maintenance program, each 15 minutes

S9129  Occupational therapy, in the home, per diem

**Other HCPCS codes related to the CPB:**

G0158  Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes

**ICD-9 codes covered if selection criteria are met (not all-inclusive):**

045.00 - 045.93  Acute poliomyelitis

138  Late effects of acute poliomyelitis

333.6  Genetic torsion dystonia

333.71 - 333.79  Acquired torsion dystonia

335.20  Amyotrophic lateral sclerosis

335.21  Progressive muscular atrophy

340  Multiple sclerosis

343.0 - 343.9  Infantile cerebral palsy

741.00 - 741.93  Spina bifida

**ICD-9 codes not covered for plans that exclude developmental delay:**

314.1  Hyperkinesis with developmental delay
315.00 - Specific delays in development
315.9
317 - 319 Mental retardation
781.3 Lack of coordination
783.40 Lack of normal physiological development, unspecified
783.42 Delayed milestones
784.61 Alexia and dyslexia
V40.0 Problems with learning
V40.1 Problems with communication (including speech)

The above policy is based on the following references: