Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospitalization

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Instructions for Use

Table of Contents **Page**

Related Policies
None

Coverage Guidelines

Outpatient cardiac rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) services may be covered when Medicare coverage criteria are met.

Cardiac Rehabilitation (CR) Exercise Programs

- As specified at 42 CFR 410.49 (c), Medicare covers cardiac rehabilitation items and services for patients who have experienced one or more of the following:
  - Effective on or after January 1, 2010:
    - An acute myocardial infarction (MI) within the preceding 12 months.
    - A coronary artery bypass surgery.
    - Current stable angina pectoris.
    - Heart valve repair replacement.
    - Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
    - A heart or heart lung transplant.
    - Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal medical therapy for at least 6 weeks, on or after February 18, 2014 for CR and on or after February 9, 2018 for ICR; or
    - Other cardiac conditions as specified through a national coverage determination (NCD). The NCD process may also be used to specify non-coverage of a cardiac condition for ICR if coverage is not supported by clinical evidence.

- CR programs must include the following components (effective for services furnished on or after January 1, 2010):
  - The physician-prescribed exercise.
  - Cardiac risk factor modification.
  - Psychosocial assessment.
  - Outcomes assessment.
  - An individualized treatment plan.

Notes:
- CR items and services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for the direct supervision for physician office services as specified at 42 CFR 410.26 and for hospital outpatient therapeutic services as specified at 42 CFR 410.27.
- As specified at 42 CFR 410.49(f)(1), CR program sessions are limited to a maximum of 2 one-hour sessions per day for up to 36 sessions over up to 36 weeks, with the option for an additional 36 sessions over an extended period if approved by the Medicare contractor under section 1862(a)(1)(A) of the Act.

Refer to:
- Medicare Claims Processing Manual, Chapter 32, §140 – Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs.
- Medicare Benefit Policy Manual, Chapter 15 § 232 – Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished On or After January 1, 2010.
- NCD for Cardiac Rehabilitation Programs for Chronic Heart Failure (20.10.1).

(Accessed March 18, 2023)

Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CPT Code 93668)

Supervised exercise therapy (SET) for members with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD) is covered is covered when criteria are met. Refer to the National Coverage Determination (NCD) for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35).
(Accessed March 18, 2023)

Medical rehabilitation (occupational therapy, physical therapy, speech-language pathology, including cognitive rehabilitation) is covered when Medicare coverage criteria are met.

Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy and Speech-Language Pathology Services)

Conditions of Coverage

Outpatient therapy services are covered in accordance with certain conditions as outlined in the Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services.

Only for use for members in AR, GA, NJ, and SC.

Notes:
- UnitedHealthcare uses the criteria below to supplement the general Medicare criteria regarding rehabilitation services at Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services in order to ensure consistency in reviewing the conditions to be met for coverage of rehabilitation services, as well as reviewing when such services may be medically necessary. Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's medical factors support rehabilitation services.

- Where the existing guidance provides insufficient clinical detail, refer to the InterQual® LOC: Outpatient Rehabilitation & Chiropractic. Click here to view the InterQual® criteria.

(Accessed November 13, 2023)

Reasonable and Necessary

To be covered, services must be skilled therapy services and be rendered under the conditions specified. Services provided by professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services. A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes 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 furnishes the service.

Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. For further information, refer to the Rehabilitative Therapy and Maintenance Program sections.

Services that do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions as therapy services. For example, services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes. Also, services not provided under a therapy plan of care, or provided by staff who are not qualified or appropriately supervised, are not payable therapy services.

To be considered reasonable and necessary, each of the following conditions must be met.

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition.

  Notes:
  - Acceptable practices for therapy services are found in:
    - Medicare manuals (such as Publications 100-2, 100-03 and 100-04),
    - Local Coverage Determinations, and
    - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.
  - When establishing the plan of care, the services must relate directly and specifically to a written treatment plan as described in §220.1.2 of Medicare Benefit Policy Manual, Chapter 15). The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated). Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.1.2 – Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services.
- The services shall be of such a level of complexity and sophistication or the condition of the member shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional. Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. For additional guidance, refer to the Maintenance Program section.
- If the Health Plan determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, the Health Plan shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing a claim, the Health Plan finds that services were not furnished under proper supervision, the claim shall be denied.
- While a member's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a member's diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel.

- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services.
(Accessed March 18, 2023)

Rehabilitative Therapy

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive objective measurements whenever possible (refer to objective measurement and other instruments for evaluation in the §220.3.C of the Medicare Benefit Policy Manual, Chapter 15). If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

For more detailed guideline, refer to the Medicare Benefit Policy Manual, Chapter 15, §220.2C – Rehabilitative Therapy.
(Accessed March 18, 2023)

Maintenance Program

Maintenance program is a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

For more detailed guidelines, refer to:
- Medicare Benefit Policy Manual, Chapter 15, §220.2D – Maintenance Programs.
- Medicare Benefit Policy Manual, Chapter 15, §220 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance, A – Definitions.

(Accessed March 18, 2023)

Documentation Requirements for Therapy Services

To be payable, the medical record and the information on the claim form must consistently and accurately report covered therapy services, as documented in the medical record. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to Medicare requirements. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all requirements applicable to Medicare claims.

For more detailed documentation requirements, refer to the Medicare Benefit Policy Manual, Chapter 15, §220.3 – Documentation Requirements for Therapy Services.
(Accessed March 18, 2023)

Covered Settings for Outpatient Rehabilitation Services

Outpatient rehabilitation services maybe covered in the following settings:

Comprehensive Outpatient Rehabilitation Facility (CORF)

CORF is defined as a facility that is primarily engaged in providing outpatient rehabilitation to the injured and disabled or to patients recovering from illness.

For more detailed guideline, refer to the Medicare Benefit Policy Manual, Chapter 12 – Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage.

Physician's Office or Therapist's Office

Refer to the:

- Medicare Benefit Policy Manual, Chapter 15, §220 – Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance.
- Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology.

Member's Place of Residence

A member's residence is wherever the member makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, home for the aged, or some other type of institution. Refer to the Medicare Benefit Policy Manual, Chapter 7, §30.1.2 – Patient's Place of Residence.
(Accessed March 18, 2023)

Therapy Caps

Although CMS implemented therapy caps effective January 1, 2006, this change does not affect the UnitedHealthcare Medicare Advantage plans.

For Medicare information regarding therapy caps, refer to the Medicare Claims Processing Manual, Chapter 5, §10.2 – The Financial Limitation Therapy Caps.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.
(Accessed March 18, 2023)

Inpatient Rehabilitation Services

Inpatient Rehabilitation Facility (IRF)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening the post-admission physician evaluation, the overall plan of care and the admission orders) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF.

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.
- The patient must generally require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.
- The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time.
- The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

- The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

For detailed guideline, refer to the Medicare Benefit Policy Manual, Chapter 1, §110 – Inpatient Rehabilitation Facility (IRF) Services.

For the list of medical conditions and facility requirements for intensive rehabilitative services, refer to the CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements.
(Accessed March 18, 2023)

Skilled Nursing Facility

Inpatient skilled nursing facility care (up to 100 days per benefit period) including room and board, skilled nursing care and other customarily provided services in a Medicare certified skilled nursing facility bed are covered when coverage factors are met.

For more detailed guideline and examples, refer to the Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care – General. (Accessed August 9, 2023)

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

Long Term Acute Care Hospitalization (LTACH)

LTACH admission is considered for members who no longer have acute inpatient hospital needs, are not appropriate for lower level-of-care setting, but who are expected to improve to lower level-of-care status in the LTACH time frame (average length of stay greater than 25 days).

UnitedHealthcare uses the criteria below to supplement the general Medicare criteria regarding inpatient hospital care services at Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A in order to ensure consistency in reviewing the complex medical factors on which a physician may reasonably base their decision, including factors such as: patient history and comorbidities; the severity of signs and symptoms; the patient's current medical needs; and the risk of an adverse event. Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's complex medical factors support long-term acute care hospitalization.

UnitedHealthcare may utilize InterQual®, an evidence-based clinical decision tool to make medical necessity determinations, if there is no NCD, applicable Local Coverage Determination (LCD)/Local Coverage Article (LCA), or Medicare manual guidance on coverage, or where the existing guidance provides insufficient clinical detail. Refer to the InterQual® LOC: Long-Term Acute Care. Click here to view the InterQual® criteria.

Also refer to the Medicare.gov Long Term Hospital Care Coverage Website and the Centers for Medicare and Medicaid Services, Medicare Learning Network, Long-Term Care Hospital Prospective Payment System (MLN6922507).

Biofeedback Therapy

Biofeedback therapy is covered only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions. Refer to the NCD for Biofeedback Therapy (30.1).
(Accessed March 18, 2023)

Cognitive Therapy

In addition to the three required core CORF services, the CORF may furnish any of the other covered and medically necessary items and services listed in §20.2 of the Medicare Benefit Policy Manual, Chapter 12. These optional services must directly

relate to, and be consistent with, the rehabilitation plan of treatment, and must be necessary to achieve the patient's rehabilitation goals. When a CORF provides occupational therapy, speech-language pathology and/or respiratory therapy services in addition to the required physical therapy services, the physical therapy services shall represent the predominate rehabilitation service provided.

For occupational therapy, services include assessment of an individual's level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities. Refer to the Medicare Benefit Policy Manual, Chapter 12 §20.2 – Optional CORF Services.

For discussion of payment rules, refer to the Medicare Benefit Policy Manual, Chapter 12 §30.1 Rules of Payment of CORF Services.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) which address the development of cognitive skills exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.
(Accessed March 18, 2023)

Rehabilitation Services for Members with Vision Impairment

Rehabilitation services are covered for members with a primary vision impairment diagnosis pursuant to a written treatment plan by the member's physician and provided by a qualified occupational or physical therapist (or a person supervised by a qualified therapist) or incident to physician services.

- Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).
- The member must have the potential for restoration or improvement of lost functions in a reasonable amount of time.
- Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning are not covered.
- A person with profound impairment in both eyes (i.e., best corrected visual acuity is less than 20/400 or visual field is 10 degrees or less) would generally be eligible for, and may be provided, rehabilitation services under HCPCS code 97535, (self-care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).

Refer to the Medicare Program Memorandum AB-02-078, Provider Education Article: Medicare Coverage of Rehabilitation Services for Beneficiaries With Vision Impairment, Change Request 2083, May 29, 2002.

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&.
(Accessed March 18, 2023)

Other Rehabilitation Therapy Services

Other examples of rehabilitation therapy services include, but are not limited to:

- Aqua/pool therapy/hydrotherapy only as part of an authorized physical therapy treatment plan conducted by a licensed physical therapist with the therapist in attendance.
  - For descriptions of aquatic therapy in a community center pool; refer to the Medicare Benefit Policy Manual, Chapter 15, §220C – General.
  - Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&.
- 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.
  - Refer to the National Coverage Determination (NCD) for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders(150.8).

- Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&.

- Treatment of Dysphagia: Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability.
  - Refer to the National Coverage Determination (NCD) for Speech Language Pathology Services for the Treatment of Dysphagia (170.3).
  - Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&.
  - For electrical stimulation for the treatment of dysphagia, refer to the Coverage Summary titled Electrical and Ultrasonic Stimulators.
- Diathermy Treatment (CPT codes 97024 and 97035).
  - High energy pulsed wave diathermy machines have been found to produce some degree of therapeutic benefit for essentially the same conditions and to the same extent as standard diathermy. Accordingly, where the contractor's medical staff has determined that the pulsed wave diathermy apparatus used is one which is considered therapeutically effective, the treatments are considered a covered service, but only for those conditions for which standard diathermy is medically indicated and only when rendered by a physician or incident to a physician's professional services. Refer to the NCD for Diathermy Treatment (150.5).
  - Heat treatment, including the use of diathermy and ultrasound for pulmonary conditions are not covered. There is no physiological rationale or valid scientific documentation of effectiveness of diathermy or ultrasound heat treatments for asthma, bronchitis, or any other pulmonary condition and for such purpose this treatment cannot be considered reasonable and necessary. Refer to the NCD for Heat Treatment, Including the Use of Diathermy and Ultra-Sound for Pulmonary Conditions (240.3).
  - Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&.
- Massage therapy, unless it is part of a multi-modality authorized treatment plan appropriate to the patient's diagnosis plan with a licensed therapist in attendance. Refer to the Medicare Benefit Policy Manual, Chapter 15, §230.5 – Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP).
- Vocational and prevocational assessment and training related solely to specific employment opportunities, work skills or work settings. Refer to the Medicare Benefit Policy Manual, Chapter 15, §230.2 – Practice of Occupational Therapy, D-Application of Medicare Guidelines to Occupational Therapy Services.
- General exercises that promote overall fitness. Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General.
- Activities that provide a diversion or general motivation. Refer to the Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General.
- Recreational Therapy. Refer to the Medicare Benefit Policy Manual, Chapter 15, §230.5 – Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners (NPP).
- Melodic Intonation Therapy. Melodic intonation therapy is covered service only for nonfluent aphasic patients unresponsive to conventional therapy, and the conditions for coverage of speech pathology services are met. Refer to the National Coverage Determination (NCD) for Melodic Intonation Therapy (170.2).
- Passive Rehabilitation Therapy for Mandibular Hypomobility. Medicare does not have a National Coverage Determination (NCD) for passive rehabilitation therapy for mandibular hypomobility. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time. For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Temporomandibular Joint Disorders.
  Note: After searching the Medicare Coverage Database, if no state LCD or LCA is found, then use the above referenced policy.

(Accessed March 18, 2023)

Definitions

Occupational Therapy: Services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. Medicare Benefit Policy Manual, Chapter 15, §230.2 – Practice of Occupational Therapy. (Accessed March 18, 2023)

Physical Therapy: Services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. Medicare Benefit Policy Manual, Chapter 15, §230.1 – Practice of Physical Therapy. (Accessed March 18, 2023)

Qualified Professional: A physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (refer to section 230.1 and 230.2) and may not supervise other therapy caregivers. Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology. (Accessed March 18, 2023)

Speech-Language Pathology Services: The services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia) regardless of the presence of a communications disability. Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology. (Accessed March 18, 2023)

Therapy Services: Skilled services furnished according to the standards and conditions in CMS manuals, (e.g., Medicare Benefit Policy Manual, Chapter 15 and in Medicare Claims Processing Manual, Chapter 5), within their scope of practice by qualified professionals or qualified personnel, as defined in §230 of the Medicare Benefit Policy Manual, Chapter 15. Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology. (Accessed March 18, 2023)

Policy History/Revision Information

Date	Summary of Changes

11/20/2023	**Title Change**
	• Previously titled *Rehabilitation: Cardiac and Medical*
	Template Update
	• Updated *Instructions for Use*
	Coverage Guidelines
	Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy and Speech-Language Pathology Services)
	• Added notation to indicate:
	  ○ UnitedHealthcare uses the criteria [listed in the policy] to supplement the general Medicare criteria regarding rehabilitation services at *Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services* in order to ensure consistency in reviewing the conditions to be met for coverage of rehabilitation services, as well as reviewing when such services may be medically necessary
	  ○ Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's medical factors support rehabilitation services
	  ○ Where the existing guidance provides insufficient clinical detail, refer to the InterQual® LOC: Outpatient Rehabilitation & Chiropractic

Date	Summary of Changes
	• Removed instruction to refer to the Optum Care Guidelines located at https://www.myoptumhealthphysicalhealth.com to determine maximum therapeutic benefit for therapy services ***Long Term Acute Care Hospitalization (LTACH)*** (new to policy) • Added language to indicate: ○ LTACH admission is considered for members who no longer have acute inpatient hospital needs, are not appropriate for lower level-of-care setting, but who are expected to improve to lower level-of-care status in the LTACH time frame (average length of stay greater than 25 days) ○ UnitedHealthcare uses the criteria below to supplement the general Medicare criteria regarding inpatient hospital care services at *Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A* in order to ensure consistency in reviewing the complex medical factors on which a physician may reasonably base their decision, including factors such as: ▪ Patient history and comorbidities ▪ The severity of signs and symptoms ▪ The patient's current medical needs ▪ The risk of an adverse event ○ Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's complex medical factors support long-term acute care hospitalization ○ UnitedHealthcare may utilize InterQual®, an evidence-based clinical decision tool to make medical necessity determinations, if there is no NCD, applicable Local Coverage Determination (LCD)/Local Coverage Article (LCA), or Medicare manual guidance on coverage, or where the existing guidance provides insufficient clinical detail ○ Refer to the: ▪ InterQual® LOC: Long-Term Acute Care ▪ Medicare.gov *Long Term Hospital Care Coverage* website ▪ CMS Medicare Learning Network: *Long-Term Care Hospital Prospective Payment System* (MLN6922507) **Supporting Information** • Archived previous policy version MCS079.07

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies or other guidelines referenced in this coverage summary. The

coverage criteria in these policies and guidelines was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.