Medicare Outpatient Skilled Therapy (PT/OT/ST)

Optum Health Solutions Musculoskeletal (MSK) Utilization Management Policy
Policy Number: 497

Effective Date: 08/13/2025

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Policy Statement

A course of treatment for habilitation, rehabilitation, or maintenance therapies requiring the skills of a licensed physical, occupational, or speech therapist, may be considered medically necessary for a specific individual with a specific condition when services are required for one of the following indications:

- To improve an individual's current specified condition
- To prevent or slow further deterioration in an individual's current condition
- To help an individual maintain, learn, or improve skills and functioning for daily living

For medical necessity clinical coverage criteria, refer first to Medicare Coverage Database for NCD and LCD/LCAs, next Medicare Benefit Policy Coverage Manual, Chapter 15, Medicare Benefit Policy Manual (cms.gov) followed by InterQual® LOC: Outpatient Rehabilitation and Chiropractic. Click here to access InterQual® criteria.

InterQual® Outpatient Rehabilitation & Chiropractic Criteria Benefits vs. Harms

Optum uses the criteria in the InterQual® guidelines to supplement the general Medicare criteria regarding when a request for Outpatient Rehabilitation & Chiropractic services is reasonable and necessary. Use of this criteria to supplement the general provisions provides clinical benefits by helping ensure that outpatient rehabilitation and chiropractic services requested are approved in a consistent manner from a dosage standpoint for a patient's specific clinical needs and consistent with the most current best evidence. InterQual® criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from an independent panel of clinical experts. The criteria identify key concerns throughout the process to ensure the appropriate level of care is identified and that contraindicated care is not approved, for example in the event the patient had contraindications of care, that would necessitate referral for appropriate care. InterQual® Outpatient Rehabilitation & Chiropractic Criteria support decisions about the appropriateness of therapy services and chiropractic care in the outpatient setting and have been validated for use with adult patients as appropriate with age ranges specified within the criteria. Outpatient Rehabilitation & Chiropractic Criteria subsets include Rehabilitation, Habilitation, Maintenance and Chiropractic and within each subset, the pathways are organized by condition or deficit areas (e.g., musculoskeletal, neurological, pelvic floor, swallowing, cervicogenic headache, congenital disorder, activities of daily living (ADLs), respiratory dysfunction) that may be amenable to intervention or type of program (e.g., Pulmonary Rehabilitation, Cardiac Rehabilitation). The potential clinical harms of using these criteria may include inappropriately denying or limiting access to outpatient rehabilitation and chiropractic services secondary to poor and/or incomplete provider records not identifying the full clinical findings. Additionally, the lack of demonstrating the need for skilled care or medically necessary care via measurable outcome tools, pain and/or activities of daily living may result in inappropriate denial of ongoing care.

The clinical benefits of using these criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because when the provider submits complete records, the criteria is unlikely to lead to circumstances where Outpatient Rehabilitation & Chiropractic services are inappropriately denied. Further, use of the criteria should limit the circumstances where Outpatient Rehabilitation & Chiropractic services are incorrectly approved. Approving non-skilled or non-medically necessary care when it is not indicated, can lead to delay of further clinical investigation of a member's condition and consideration of appropriate alternative treatment options, and/or encourage care dependence.

Initial Course of Treatment

The initial course of treatment request must include all of the following:

- A statement of the individual's medical history and medical condition
- A comparison prior level of function to current level of function
- Description of the individual's functional impairment including its impact on their health, safety, and/or independence
- Baseline objective measurements as demonstrated by standardized assessments, including descriptions of the individual's current deficits and their severity level which include:
  - Current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores, and/or other objective information as appropriate for the individual's condition or impairment
  - Standardized assessments administered must correspond to the delays identified and relate to the long- and short-term goals
  - If the individual has a medical condition that prevents them from completing standardized assessment(s), alternative(s) might include:
    - Therapist provides in-depth objective clinical information using task analysis to describe the individual's deficit area(s) in lieu of standardized assessments
    - Therapist should include checklists, caregiver reports or interviews, and clinical observations
- Clear diagnosis including ICD-10 CM code
- Short- and long-term treatment goals that are:
  - Specific to the individual's diagnosed condition or functional or physical impairment
  - Functional, measurable, attainable, and time-based
- Treatment frequency, duration, and anticipated length or treatment session(s)
- Reasonable prognosis including the individual's potential for meaningful progress

Care Beyond the Initial Course of Treatment

If care beyond the initial course of treatment is required, the treating practitioner shall provide an updated response to the current treatment plan for review. Requests for care beyond the initial course of treatment shall provide clear documentation of the medical necessity and reasonableness for skilled care services, including:

- Progress or lack of progress
- Medical condition
- Functional losses
- Short- and long-term treatment goals that are:
  - Specific to the individual's diagnosed condition or functional or physical impairment
  - Functional, measurable, attainable, and time-based
- Treatment frequency, duration, and anticipated length of treatment session(s)

All ongoing care is reviewed by an Optum clinical specialist provider. Determinations are subject to any applicable benefit restrictions, state and federal mandates and/or regulations, and documentation of the medical necessity and reasonableness of the service requested.

Definitions

Unless otherwise noted, the following is consistent with the Medicare Benefit Policy Manual.

Complexities: Complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity, and/or duration of treatment. Complexities may be represented by diagnoses (ICD codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the individual's social circumstances such as the support of a significant other or the availability of transportation to therapy.

Custodial care: Nonskilled personal care – such as help with activities of daily living, e.g., bathing, eating, dressing, getting in/out of bed or chair, moving around, or using the bathroom. It may also include the kind of health care most people do for themselves, e.g., using eye-drops or a hot pack.

Habilitative/Habilitation services: Habilitation refers to health care services that help an individual keep, learn, or improve skills and functioning for daily living. Habilitative services include physical therapy, occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings (U. S. Centers for Medicare and Medicaid Services. HealthCare.gov, 2023).

Maintenance program: 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.

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.

Reasonable and Necessary: The services shall be of such a level of complexity and sophistication, or the condition of the individual shall be such that the services required can only be performed safely and effectively by a qualified health care provider. Services that do not require the performance of a qualified health care provider are not skilled and are not considered reasonable or necessary.

Rehabilitative (Restorative) Services: 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 a 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. Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation.

Skilled Care Services: Services provided by a qualified health care provider that must require the expertise, knowledge, and clinical judgment/decision making abilities of a qualified health care provider that caregivers or the patient cannot provide independently.

Overview

Unless otherwise noted the following is consistent with the Medicare Benefit Policy Manual.

Skilled rehabilitative care services are part of a prescribed plan of treatment provided to improve or restore lost or impaired physical function resulting from illness, injury, neurologic disorder, congenital defect, or surgery. These skilled care services are intended to enhance rehabilitation and recovery by clarifying an individual's impairments and functional limitations and by identifying interventions, treatment goals, and precautions. Rehabilitative services may be needed, and improvement in an individual's condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. The fact that full or partial recovery is not possible does not necessarily mean that skilled services are not needed to improve the individual's condition or to maximize functional abilities. The deciding factors are always whether the services are considered reasonable, effective treatments for the individual's condition and require the skills of a qualified health care provider, or whether they can be safely and effectively carried out by nonskilled personnel.

Unlike rehabilitative care services, which aim to recover capacities lost, habilitative services help individuals acquire, maintain, or improve skills and functioning for daily living. Skilled habilitative services may be reasonable and necessary, in particular, for individuals with intellectual or physical disabilities. The services and devices used in habilitation are often the same or similar as in rehabilitation, as are the professionals who provide these services, the settings in which the services and devices are provided, the individuals receiving the services, the functional deficits being addressed, and the improvement in functional deficits. The only meaningful difference is whether the services provided involve learning something new or relearning something that has been lost or impaired (American Physical Therapy Association, 2017).

Skilled services that do not meet the criteria for rehabilitative or habilitative care may be considered medically necessary in certain circumstances under a maintenance program. Skilled maintenance therapy may be reasonable and necessary when the particular individual's special medical complications or the complexity and sophistication of the therapy procedures indicated require the skills of a qualified health care provider. The goals of a maintenance program would be, for example, to maintain functional status, or to prevent or slow further deterioration in function. Maintenance programs that are not considered skilled or do not require the skills of a qualified health care provider to render are usually carried out by the member, family or non- licensed personal.

Services related to activities for the general good and welfare of individuals, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute skilled care services. Services provided by practitioners/staff who are not qualified health care providers are not skilled intervention services. Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills or maintain function after a maintenance program has been developed. Custodial care services for daily personal activities are nonskilled.

References

American Physical Therapy Association (APTA). Standards of Practice for Physical Therapy. HOD S06-20-35-29. updated: 08/12/20. Accessed: August 23,2024. Available from: https://www.apta.org/siteassets/pdfs/policies/standards-of-practice-pt.pdf

Centers for Medicare and Medicaid Services. HealthCare.gov. Glossary. Accessed August 23,2024. Available from: Glossary | HealthCare.gov

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Review and Approval History

Date	Action
11/03/2023	New UM policy. Assigned policy number 497. Effective date: 1/1/2024.
11/03/2023	Approved by Optum Clinical Guideline Advisory Committee.
11/29/2023	Approved by Medicare Advantage Policy and Technology Assessment Committee (MAP-TAC).
04/09/2024	Added discussion concerning the benefits vs. harms of InterQual® criteria when applied to this policy and inserted a link to the InterQual® criteria. New content approved by Optum Clinical Guideline Advisory Committee.
04/17/2024	New content described above approved by Medicare Advantage Policy and Technology Assessment Committee (MAP-TAC).
10/09/2024	Annual review completed, No substantive changes. Approved by Optum Clinical Guideline Advisory Committee.
06/11/2025	Annual review and approval by Medicare Advantage Policy and Technology Assessment Committee (MAP-TAC).
08/13/2025	Interim revision to clarify documentation requirements for initial course of treatment. Approved by Medicare Advantage Policy and Technology Assessment Committee (MAP-TAC).
09/11/2025	Notified Optum Clinical Guideline Advisory Committee of interim revision clarifying documentation requirements for initial course of treatment.