



Physical Therapy Authorization Program Guidelines

TOPIC: Physical Therapy Authorization Program

ORIGINATION DATE: February 10, 2006

EFFECTIVE DATE*: February 10, 2006

TYPE OF REVIEW: Clinical Review Department

The US Family Health Plan 'Physical Therapy Authorization Program' is a program designed to review Physical Therapy treatment authorization requests beyond the initial evaluation plus 8 visits authorized by the primary care physician, PCP, in a calendar or plan year.

A US Family Health Plan reviewer, either a physical therapist or Medical Director, reviews the request and the member's historical physical therapy treatments and makes a coverage determination regarding the number of additional authorized visits, utilizing InterQual® Outpatient Physical Therapy Criteria or US Family Health Plan Clinical Coverage Criteria. (These criteria can be viewed by logging on to the Tufts Health Plan Provider Website @ <https://providers.tufts-health.com/provindex.html> and following directions to the InterQual® Criteria postings. Tufts Health Plan provides administrative services for US Family Health Plan.)

Physical therapy providers are expected to address the specific clinical and functional restrictions by applying skilled physical therapy techniques and utilizing appropriate physical therapy modalities, therapeutic exercise, manipulative techniques and soft tissue care with concurrent initiation of a progressive exercise and stabilization program. Additionally, emphasis of treatment is expected to be self-symptom management and an independent home or community-based exercise program.

From the initial evaluation through the entire course of treatment, all of the following must be met:

1. Demonstration of measurable, objective, and functional progress as a direct result of treatment.
2. A treatment plan that requires the services of a skilled physical therapist.
3. An expectation that treatment will result in measurable improvement in a reasonable and predictable period of time for the particular diagnosis and phase of recovery.
4. Physical Therapy treatment is medically necessary.

LIMITATIONS

1. Physical therapy services for educational or developmental purposes.
2. Maintenance therapy, personal training, or employer-required work hardening.
3. For diagnoses not covered, listed by ICD-9 codes, see Attachments A, B, and C.

ATTACHMENTS

[Attachment A](#): ICD-9 Codes Not Covered for Physical, Occupational and Speech Therapy

[Attachment B](#): ICD-9 List of Non-specific ICD-9 Codes that are Not Covered for Physical, Occupational, and Speech Therapy

[Attachment C](#): ICD-9 Codes Determined by US Family Health Plan as Inappropriate for Physical Therapy

*CLINICAL COVERAGE GUIDELINES DOCUMENT HISTORY:

1. **ORIGINATION DATE:** July 5, 2005. This guideline replaces the Physical Therapy Targeted Diagnoses Program.
2. **SUBSEQUENT ENDORSEMENT DATE (S) AND CHANGES MADE:**
 - a. February 10, 2006: Program guidelines revised to include reference to InterQual® Outpatient Physical Therapy and US Family Health Plan Physical Therapy Clinical Coverage Criteria For Diagnoses Not Available From InterQual®



Completion Guide Physical Therapy Authorization Form

The following guide is intended to assist you in completing the *US Family Health Plan Physical Therapy Authorization Form*.

Demographics (items 1, 2, 5): Please provide the member's full name, US Family Health Plan identification number including Suffix and the member's date of birth.

Facility /Provider info (items 8, 9, 10, 11): Please provide the name, provider ID, telephone number and fax number of the treating provider. This will ensure that the Physical Therapy Reviewer can contact you if additional information is needed. Authorization numbers and dates can be faxed to your attention.

Date of illness/injury (item 3): The date of the onset of the illness, injury or surgery is helpful to the reviewing therapist in determining availability of the short-term rehab benefit.

Diagnosis (item 6, 7): All requests should include the diagnosis and ICD-9 code for the primary diagnosis being treated.

Number of visits requested (item 15): please request the number of visits you project to complete the entire treatment plan beyond the original 8 visits.

Date of start of care / Discharge Date (items 16, 17): Please fill in all applicable dates to indicate anticipated length of treatment.

Previous Rx for this diagnosis (item 12): Indicate previous treatment either at your facility or another provider.

Initial/Previous Clinical Assessment (item 18): Please report specific pertinent objective measurements for all affected areas. In the case of multiple diagnoses, applicable data for all pertinent diagnoses should be on one USFHP Physical Therapy Authorization Form.

Current Clinical Assessment (item 19): As described in item 18 above, please provide information regarding the clinical status after 8 initial visits.

Current Functional Status (item 20): Rate the member's current functional limitations using the 1-4 scale provided. Please indicate any premorbid deficits.

Current Treatment Plan (item 21): Based on the intensity and frequency of service, please include instruction for the HEP in report.

Current Clinical Goals/Functional Outcomes (items 21, 22): Based on the severity of illness, please be specific in listing goals and outcomes as they relate to Clinical and Functional Assessments reported.

Note: The Clinical Review Department cannot perform retroactive reviews, therefore any requests for authorization of visits performed more than 7 days prior to receipt of request in Clinical Review must be submitted to Provider Appeals Department for authorization. It is not necessary to submit pages of evaluation and progress notes unless we request it. We need only the *US Family Health Plan Physical Therapy Authorization Form* completed in full.

Physical Therapy Authorization Form



**Ongoing coverage beyond initial evaluation and 8 visits.
Fax to the Clinical Review Department (617-972-9409)**

1. Member Name:	2. DOB:	3. DOI	4. Date of Report:																																																																		
5. Member ID#:	6. Dx:	7. ICD-9:																																																																			
8. Facility Name:	9. Tufts Health Plan Facility ID #:	10. Facility Phone #:	11. Facility Fax #																																																																		
12. Previous Rx for this Dx? Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Any other Dx? Yes <input type="checkbox"/> No <input type="checkbox"/>	16. Start of Care	17. Est D/C Date:																																																																		
14. Total Visits Since Start of Care:	15. # of Visits Requested:																																																																				
18. INITIAL/PREVIOUS CLINICAL STATUS		19. CURRENT CLINICAL STATUS																																																																			
20. CURRENT FUNCTIONAL STATUS																																																																					
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		Please use this scale for 1-4 (1: Fully Able 75-100% 2: 50-75% 3: 25-50% 4: 0-25%) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">A. Personal Care</td> <td style="width: 5%;">1</td> <td style="width: 5%;">2</td> <td style="width: 5%;">3</td> <td style="width: 5%;">4</td> <td style="width: 15%;">N/A</td> </tr> <tr> <td>B. Household Mobility</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>C. Community Mobility</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>D. Sitting Tolerance</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>E. Stair Climbing</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>F. Driving</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>G. Household Chores</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>H. Lift Objects 1-10 lbs</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>I. Lift Objects >20 lbs.</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>J. Work Tolerance</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> <tr> <td>K. Sports/Recreation</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>N/A</td> </tr> </table>		A. Personal Care	1	2	3	4	N/A	B. Household Mobility	1	2	3	4	N/A	C. Community Mobility	1	2	3	4	N/A	D. Sitting Tolerance	1	2	3	4	N/A	E. Stair Climbing	1	2	3	4	N/A	F. Driving	1	2	3	4	N/A	G. Household Chores	1	2	3	4	N/A	H. Lift Objects 1-10 lbs	1	2	3	4	N/A	I. Lift Objects >20 lbs.	1	2	3	4	N/A	J. Work Tolerance	1	2	3	4	N/A	K. Sports/Recreation	1	2	3	4	N/A
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