Policy Title	**OP Therapy Authorizations -Fifteen Visit Policy**
Policy Department	**Utilization Management**
Effective Date	**9/17/21**
Revision Date(s)	**6/29/21, 8/30/21**

Disclaimer:

Clover Utilization Management applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgement in rendering services. Providers are expected to provide care based on best practices and use their medical judgement for appropriate care.

Purpose:

Clover strives to ensure that our members receive the care they need without incurring unnecessary hurdles. Therefore, Clover has updated our prior authorization requirements around occupational therapy (OT), speech therapy (ST), physical therapy (PT), and chiropractic therapy. Effective September 1, 2021, Clover members are now eligible to receive up to 15 PT visits, 15 OT visits, 15 ST and 15 Chiropractic visits per calendar year without obtaining a pre-authorization. Once the member exceeds their 15 therapy visits for the calendar year, all additional therapy visits will require pre-authorization.

The purpose of this policy is to outline Clover Health's process for review of the quantity of OP Therapy visits per Authorization request.

Scope:

Clover follows the triple aim to ensure members receive appropriate, continuous and efficient care. Clover reviews outpatient therapy prior authorization for medical necessity and will approve up to fifteen (15) prospective visits per authorization request. If additional visits are needed, prior authorization requests can be submitted with additional medical records to support ongoing treatment needs.

Policy:

This policy covers Clover's review process of outpatient therapy prior authorization requests. The prior authorization is reviewed for medical necessity and will approve up to fifteen (15) prospective visits per authorization request.

Outpatient therapy MUST be under the care of a Physician (or treating Practitioner) , See references Definition of Physician/Practitioner and LCD- L35036 Medicare covers therapy services **personally** performed **only** by one of the following. An order (sometimes called a referral) for therapy services, documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.Recertification must be obtained within the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.

Ongoing treatment needs will be reviewed for medical necessity. If additional visits are needed, prior authorization requests can be submitted with additional medical records to support ongoing treatment care.

Definitions:

- **CPT/HCPCS:** Codes created by CMS for reporting medical procedures and services
- **Prospective Visits:** Outpatient therapy treatments requested for future dates of service

References
NJ L35036 Therapy and Rehabilitation Services (PT, OT)
NJ L34891-Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy
Medicare Benefit Policy Manual, Chapter 15
Section: 40.4 - Definition of Physician/Practitioner (Rev. 62, Issued: 12-22-06, Effective: 11-13-06, Implementation: 04-02-07)