Habilitative Services

I. Policy

University Health Alliance (UHA) will reimburse for Habilitative services when treatment is based upon the best available research, evidence, and practice experience, and it is determined to be medically necessary.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes § 432E-1.4), generally accepted standards of medical practice, and review of medical literature. UHA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with UHA's determination as to medical necessity in each case, the physician may request that UHA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

II. Background

Habilitative services are medically necessary health care services that assist an individual in partially or fully acquiring skills and functions of daily living. Habilitation is the process of evaluation, treatment, and education for the purpose of developing, improving, and maintaining skills and functions which the individual has not previously possessed. Habilitative services may include, but are not limited to, physical therapy, occupational therapy, speech/swallowing therapy, medical equipment, orthotics, and prosthetics.

Activities of daily living (ADLs) refer to such activities as bathing, getting dressed, using toilet facilities, eating, transferring (getting into and out of a bed or chair) and ambulating (walking). Health professionals may gauge the functional status of an individual by their ability to perform ADLs.

III. Criteria/Guidelines

A. Habilitative services are covered (subject to Limitations/Exclusions and Administrative Guidelines) only if services meet ALL of the following criteria:

1. Treatment must be initiated upon the referral of a medical provider (physician, physician's assistant, or advanced practice registered nurse, qualified under regulatory and licensure guidelines) within the following criteria:
    a. Ordering provider must have an intimate knowledge of the patient's preexisting disability/disease and all comorbidities; and
    b. Must understand the likelihood of effectiveness of Habilitative services ordered; and
    c. Must follow and document the progress of therapy.
2. Services must be necessary to assist patients in acquiring (versus restoring) a necessary skill or function due to a disabling condition which impairs ADLs.
3. Services must address the functional needs (ADLs) of a patient who suffers from physical impairment due to congenital anomalies or preexisting conditions and be necessary to acquire neurological and/or musculoskeletal function. Neurological and/or musculoskeletal function is sufficiently restored or acquired when one of the following first occurs:
    a. Neurological and/or musculoskeletal function is the level of the average healthy person of the same age, or

b. When improvement beyond what is expected with activities of daily living, prescribed home exercise, and passage of time, is unlikely.

4. The purpose of the service is to achieve a specific functional goal for a patient who has a reasonable expectation of achieving significant improvement. Significant is defined as a measurable and meaningful increase (as documented in the patient's record) in the patient's level of physical and functional abilities (ADLs) that can be attained with short-term therapy, usually within a three-month period.
5. The treatment plan must include an appropriate home exercise/education program to be initiated at the first visit. Training must be provided to the patient, family and/or caregiver(s) to facilitate their participation in and assumption of therapy for continued improvement and maintenance. The therapist must document the patient's participation in and compliance with the home exercise/education program.
6. Services must not duplicate services provided by any other therapy.
7. Services require the judgment, knowledge and skills of a qualified provider of therapy services due to the complexity and sophistication of the therapy and the physical condition of the patient. A qualified provider is one who is licensed and performs within the scope of licensure.
8. The frequency of visits should be appropriate according to the patient's physical condition, level of functioning and ability to benefit from therapy.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation

I. Limitations/Exclusions

A. Only services that meet the medical necessity criteria under Hawaii's Patient' Bill of Rights and Responsibilities Act (Hawaii Revised Statues 432E-1.4) are covered.

B. Habilitative Services benefits are not available for the following:

1. Leisure activities including hobbies, sports or recreation of all types even if suggested as part of a treatment plan. This includes continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform activities of daily living;
2. Ongoing treatment solely to improve endurance and distance;
3. General exercise programs to promote overall fitness;
4. Programs to provide diversion or general motivation;
5. Long term therapy;
6. Services available through schools and government programs.

C. The following services are not covered:

1. Non-skilled services which do not require the intervention of a qualified provider of physical therapy services are not covered, such as:
    a. Any of the following treatments: hydrocollator; whirlpool baths; paraffin baths; Hubbard tank; and contrast baths.
    b. Procedures that may be carried out effectively by the patient, family or caregivers.
    c. Services which do not require one-to-one intervention (such as stationary bike riding without any intervention) do not generally require the skills of a licensed provider of therapy services.
2. Services provided by students, aides, assistants or other non-qualified/non-licensed professionals are not covered.
3. For applied behavioral analysis (ABA) services see UHA's ABA payment policy.
4. Sensory and auditory integration therapies are not covered.
5. Routine vision services are not covered.
6. Duplicate therapies should provide different treatments and not duplicate the same treatment. They must include separate treatment plans and goals with treatment occurring in separate treatment sessions and visits. This includes:
    a. When patients receive occupational, speech, and/or physical therapy that duplicates the prescribed habilitative therapy.
    b. Duplicate services available through schools and government programs. Services may be available under a child's individualized education program (IEP). An IEP should be completed before requesting coverage through UHA.

II. Administrative Guidelines

A. Prior authorization is required.
    1. Please also refer to the UHA payment policies for Physical Therapy, Occupational Therapy, and Speech Therapy as applicable to treatment plan.
    2. To request prior authorization, please submit via UHA's online portal. If login has not been established, you may contact UHA at 808-532-4000 to establish one.

B. Documentation submitted must include an individualized, written treatment plan appropriate for the diagnosis, symptoms, and findings of the habilitative services evaluation, which clearly documents the medical necessity of the treatment. This documentation should include the following:
    1. Specific statements of goals including a transition from one-to-one supervision to a patient, family member or caregiver upon discharge to a home maintenance program.
    2. Measurable objectives intended to facilitate meaningful functional improvement;
    3. A reasonable estimate of when the goals will be reached;
    4. The specific procedures and/or modalities to be used in treatment including those for use in a home maintenance program.
    5. The frequency and duration of the treatment.

C. The treatment plan should be appropriately revised as the patient's condition changes.

D. The frequency of visits should be appropriate according to the patient's physical condition, level of functioning and ability to benefit from therapy.

E. Requests for speech therapy must include an age-appropriate evaluation and applicable standardized tests which document the condition to be treated.

III. Policy History

Policy Number: MPP-0110-150101

Current Effective Date: 08/01/2022

Original Document Effective Date: 01/01/2015

Previous Revision Dates: 01/01/2017, 09/19/2018

PAC Approved Date: 01/01/2015