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Clinical Policy Document: Occupational Therapy and Physical Therapy	**Replaces Effective Clinical Policy Dated:** 11/26/24
Reference #: MC/N003	**Page:** 1 of 12

PURPOSE:

The intent of this clinical policy is to ensure services are medically necessary.

Please refer to the member's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the member's benefit plan or certificate of coverage, the terms of the member's benefit plan document will govern.

POLICY:
Benefits must be available for health care services. Health care services must be ordered by a provider. Health care services must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

GUIDELINES:
Medical Necessity Criteria – Must satisfy any of the following: I – VIII

I. Fully insured/self-funded non-ERISA groups – For members diagnosed with *autism spectrum disorder (ASD)*, no medical necessity reviews required when requesting occupational therapy (does not apply to requests for physical therapy); or

II. ETF Health Plan (Wisconsin Department of Employee Trust Funds) – For members diagnosed with *ASD*, proceed with medical necessity review, but occupational therapy and physical therapy visit limits do not apply to this benefit; or

III. All other plans/groups regardless of *ASD* diagnosis or members of the groups mentioned in I. or II. above not diagnosed with *ASD* - Initial request (following the evaluation) for physical or occupational therapy services – *Rehabilitative* services must satisfy all of the following: A - E; *Habilitative* services must satisfy all of the following: A - F

[Note: For Sensory Integration therapy requests, see III or IV]

A. Member has any of the following: 1 - 2
   1. A documented medical condition, *sickness*, *injury*, or *developmental delay* that is causing a *functional defect/ physical impairment* impacting *ADLs*; or

   2. A documented *sickness or injury* that is causing a loss of function (eg, post orthopedic or neurologic surgery that may not impact *ADLs*).

B. Documentation supports that there is an expectation that improvement is anticipated in a clinically reasonable time frame; and

C. Documentation includes previous and current therapy treatment plans provided by other providers for the purpose of coordinating care and avoiding duplication of services; and

D. Proposed treatment plan is initiated by a licensed physical therapist or occupational therapist and includes measurable, functional goals; and

E. Proposed treatment plan has projected time frames for care and clear criteria for discharge from rehabilitation services; and

F. For *habilitative* therapy, standardized test scores shows a delay in function - must satisfy any of the following: 1 - 3
   1. Norm-based test score below the 5th percentile for age (see Attachment A); or

   2. Norm-based test scores ~~than~~ fall at least 2 standard deviations from the mean (see Attachment A); or

   3. Criterion-based test score demonstrates moderate-to-severe delay for age.

IV. All other plans/groups regardless of *ASD* diagnosis or for members of the groups mentioned in I. or II. above not diagnosed with *ASD* - Initial request (following the evaluation) for physical therapy (provided by an occupational or physical therapist) for congenital muscular torticollis, positional brachycephaly or positional plagiocephaly - must satisfy any of the following: A or B

A. Congenital muscular torticollis (CMT) - allow up to 15 visits for neck passive range of motion (PROM); neck and trunk active range of motion (AROM); development of symmetrical movement; environmental adaptations; parent/caregiver education and follow-up after discontinuation of direct services.

B. Positional brachycephaly or positional plagiocephaly - allow up to 10 visits for teaching of passive stretching exercises and repositioning techniques.

V. All other plans/groups regardless of *ASD* diagnosis or for members of the groups mentioned in I. or II. above not diagnosed with *ASD* - Initial request (following the evaluation) for occupational therapy using a *Sensory Integration Therapy* approach – must satisfy all of the following: A - D

A. *Sensory integration therapy* is a covered benefit; and

B. The member is a child aged 12 and under; and

C. Therapy is part of a *habilitative* therapy plan; and

D. Standardized test scores shows a delay in function - must satisfy any of the following: 1 - 3
   1. Norm-based test score below the 5th percentile for age (see Attachment A); or

   2. Norm-based test scores fall at least 2 standard deviations from the mean (see Attachment A); or

   3. Criterion-based test score demonstrates moderate-to-severe delay for age.

VI. All other plans/groups regardless of *ASD* diagnosis or for members of the groups mentioned in I. or II. above not diagnosed with *ASD* - Initial request (following the evaluation) for occupational therapy using *Sensory Integration Therapy for feeding disorders* – must satisfy all of the following: A - E

A. *Sensory integration therapy* is a covered benefit; and

B. The member has an eating or feeding disturbance (eg, apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) associated with at least one of the following: 1 - 3
   1. Significant weight loss, failure to achieve expected weight or faltering growth; or
   2. Significant nutritional deficiency; or
   3. Receiving enteral feeding or prescribed oral nutritional supplements.

C. The member is a child aged 12 and under; and

D. Therapy is part of a *habilitative* therapy plan; and

E. Standardized test scores shows a delay in function (eg, PediEAT) - must satisfy any of the following: 1 - 3
   1. Norm-based test score below the 5th percentile for age (see Attachment A); or
   2. Norm-based test scores fall at least 2 standard deviations from the mean (see Attachment A); or
   3. Criterion-based test score demonstrates moderate-to-severe delay for age.

VII. All other plans/groups regardless of *ASD* diagnosis or for members of the groups mentioned in I. or II. above not diagnosed with *ASD* - Continuation of treatment – must satisfy any of the following: A - C

A. Adults and adolescents aged 13 and above – must satisfy all of the following: 1 - 5
   1. Demonstration of sustained improvement and progress toward stated goals through periodic summaries from providers within 2 weeks to 3 months demonstrating improvement in the targeted abnormal findings, symptoms and/or behaviors of concern. Sustained improvement continues to be demonstrated for continuation of treatment in subsequent reviews; and
   2. A need for requiring continued treatment at this level of care – must satisfy either of the following: a or b
      a. Persistent *functional defect/ physical impairment* impacting *ADLs*; or
      b. Persistent loss of function eg, post orthopedic or neurologic surgery that may not impact *ADLs*).
   3. Appropriate modifications to treatment plan implemented; and
   4. Documented plan for transition to home programming and training plans; and
   5. Documented plan for tapering and discontinuation of service.

B. Children aged 12 and under – *Rehabilitative* services must satisfy all of the following: 1-5; *Habilitative* services must satisfy all of the following: 1 - 6
   1. Demonstration of sustained improvement and progress toward stated goals through periodic summaries from providers within 3 – 6 months demonstrating improvement in the targeted abnormal findings, symptoms and /or behaviors of concern. Sustained improvement continues to be demonstrated for continuation of treatment in subsequent reviews; and

2. A full re-assessment of the child, either on an annual basis or more often if requested, utilizing the same testing that was initially used to qualify the child; and

3. Appropriate modifications to treatment plan and goals implemented; and

4. Documented summary of the child's caregiver-based home program be included on a six-month basis, and transition planning to all caregiver/school/private-based services be included; and

5. Documented plans for tapering and discontinuation of services; and

6. For *habilitative* therapy, test scores demonstrate a continued significant delay in function despite continued improvement toward goals – must satisfy any of the following: a – c

   a. Norm-based test scores fall below the 10th percentile (see Attachment A); or

   b. Norm-based test scores fall at least 1.3 standard deviations from the mean (see Attachment A); or

   c. Criterion-based test scores (eg, Rossetti Infant-Toddler Language Scale) demonstrate moderate-to-severe delay for age.

C. Congenital muscular torticollis (CMT) – additional visits may be allowed when documentation supports any of the following: 1 - 4
   1. Passive range of motion (PROM) on the affected side is greater than 5 degrees difference when compared to the non-affected side; or

   2. Asymmetrical active move patterns continue; or

   3. Lack of age-appropriate motor development; or

   4. Visible head tilt remains.

VIII. All other plans/groups regardless of *ASD* diagnosis or for members of the groups mentioned in I. or II. above not diagnosed with *ASD* - Discharge Criteria – any of the following: A - E

A. Ongoing treatment is primarily custodial or maintenance in nature and/or does not require the services of a licensed provider; or

B. Member is unable to tolerate or participate in treatment because of a serious medical, psychological, or other condition; or

C. Member demonstrates behavior that interferes with improvement or participation in treatment (eg, noncompliance, malingering) providing that efforts to address the interfering behavior have been unsuccessful; or

D. Insufficient progress being made to justify further treatment; or

E. Member has met the treatment plan goals.

EXCLUSIONS (not limited to):
Refer to member's Certificate of Coverage or Summary Plan Description

Cognitive Rehabilitation is considered investigative for ASD (see Investigative List)

DEFINITIONS:
Activities of Daily Living (ADL):
Activities related to personal self-care and independent living, which include eating, bathing, dressing, transferring, walking/mobility, and toileting/continence.

Autism Spectrum Disorder:
A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early developmental period, that cause clinically significant impairment in social, occupational, or other important areas of functioning, and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Cognitive Rehabilitation:
Is a multidisciplinary treatment program designed to improve cognitive function and retrain an individual's ability to think, use judgment and make decisions. The focus of these therapeutic activities is to improve deficits in memory, attention, perception, visual processing, language, reasoning, learning, planning, judgment, and problem-solving. CR comprises tasks to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurologic systems. The goal of CR is to maximize functional independence with minimal interference from cognitive limitations.

Developmental Delay:
The child demonstrates a delay or impairment in one or more of the following areas: cognitive development, physical development, vision, hearing, communication development, social or emotional development, or adaptive development

DSM:
The most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Health Disorders.

Failure to Thrive (FTT):
FTT is a significantly prolonged cessation of appropriate weight gain compared with recognized norms for age and gender after having achieved a stable pattern (eg, weight-for-age decreasing across 2 major percentile channels from a previously established growth pattern; weight-for-length < 80% of ideal weight). This is often accompanied by normal height velocity.

Functional Defect/ Physical Impairment:
A functional defect or physical/physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing *activities of daily living*.

Habilitative Therapy:
Therapy provided to develop initial functional levels of movement, strength, daily activity or speech.

Injury:
Bodily damage other than sickness including all related conditions and recurrent symptoms.

Maintenance Care:
Care that is not *habilitative* or *rehabilitative* therapy and there is a lack of documented significant progress in functional status over a reasonable period of time; and is performed to maintain clinical status without the ability to expect further clinical improvement.

Rehabilitative Therapy:
Therapy provided to restore functional levels of movement, strength, daily activity or speech after a sickness or injury.

Sensory Integration Disorder and Sensory Integration Therapy (SIT):
The theory of sensory integration disorder or dysfunction is based upon the hypothesis that various sensory experiences (eg, vestibular, proprioceptive, gravitational, tactile, visual, and auditory) help to guide development. Within this hypothesis, aberrations in sensory integration are thought to result in disorganization of the central nervous system that manifests as developmental and behavioral abnormalities known as sensory integration dysfunction. As part of this theory, sensory integration dysfunction is treated through the introduction of intensive sensory inputs using specific equipment and techniques. Such treatment typically is provided by occupational therapists. Sensory integration therapy is often used for children with ASD because many of their behaviors are thought to be related to deficiencies in the sensory system.

Sensory Integration Therapy (SIT) for Feeding Disorders:
Sensory integration therapy (SIT) is the treatment of choice for children diagnosed with a sensory-based feeding problem (the diagnosis may be based on the child's atypical responses to stimulation in and around the mouth, such as coughing, gagging, spitting out, or refusing foods). From a sensory integration perspective, the inappropriate feeding behavior is a symptom of the child's inability to process sensory information to make an adaptive response. Intervention targets the underlying sensory processing deficits rather than the specific behaviors. The goal of therapy is to promote sensory modulation, which should result in a decreased sensory defensiveness. SIT usually involves modifying the child's sensory diet (i.e., the sensory input needed by an individual to organize sensory information effectively). Examples of sensory diets for children with sensory-based feeding problems might include rhythm and music activities, proprioceptive activities, heavy work, and sensory modulation techniques.

Sickness:
Presence of a physical or mental illness or disease.

BACKGROUND:
In cases where some parts of the treatment plan for a specific modality of care (i.e. PT or OT) are eligible for coverage and medically necessary and some parts of the treatment plan are not, the entire treatment plan needs to be reviewed to determine if the majority of requested treatments are eligible for coverage and medically necessary. Recommendations need to be for the total treatment plan, not parts of the treatment plan.

Congenital Muscular Torticollis and Plagiocephaly/Brachycephaly

Torticollis in infancy is generally related to positioning in utero, difficult delivery, multiple gestations, fetal positioning low in the pelvis in the last trimester, or rarely, birth trauma causing true muscular torticollis or fibrosis of sternocleidomastoid muscle. The contracture or muscle tightness causes the head to rotate so that the face is turned to the opposite side of tightness and the head to tilt toward the side of tightness so that the ear is closer to the shoulder on the side of tightness.

Positional plagiocephaly results from the skull being exposed to external pressure, which causes the skull to be misshapen. It can be directly related to torticollis as the tightness on one side causes the infant to turn their head position to the unaffected side, sheering forces cause a flatness on that side, pushing the face and ear forward. Another increasingly common reason for positional plagiocephaly is that they spend a lot of time on their backs. Starting in the early 1990s, parents were told to put their babies to sleep on their back to reduce the risk of Sudden Infant Death Syndrome (SIDS). While this advice may have saved thousands of babies' lives, experts have also noted a fivefold increase in the incidence of misshapen heads since then.

Physical therapy is usually effective in treating most cases of torticollis, especially if instituted in the first two months of life. Botulinum toxin has also recently been shown to be an effective intermediate method of treatment for more resistant cases of torticollis in older children and adults but is not used extensively in infants. Surgery may also be an option.

Treatment for positional brachycephaly/plagiocephaly is based on the age of the infant and severity of the deformity. If the infant is less than or equal to 6 months of age, a trial of physical and positional therapy for about 2-3 months is usually initiated. Infants who have failed physical and positional therapy or who are greater than 6 months of age when diagnosed of positional plagiocephaly may require the use of orthosis for active reshaping of the skull.

Feeding Disorders

A child with a feeding disorder does not consume enough food (or liquid or a broad enough variety of food) to gain weight and grow normally. General feeding difficulties are relatively common among most children. For example, a child may be a picky eater and consume a limited number of foods, but the foods eaten span all the food groups and provide a well-balanced diet. A child with a feeding disorder, on the other hand, may only eat a few foods, completely avoiding entire food groups, textures or liquids necessary for proper development. As a result, children diagnosed with feeding disorders are at greater risk for compromised physical and cognitive development. Children with feeding disorders may also develop slower, experience behavioral problems and even fail to thrive. Severe feeding disorders can cause children to feel socially isolated and often put financial strains on families.

There are many different types of feeding disorders, and they can take on one or more of the following forms:

- Trouble accepting and swallowing different food textures
- Throwing tantrums at mealtimes
- Refusing to eat certain food groups
- Refusing to eat any solids or liquids
- Choking, gagging or vomiting when eating
- Oral motor and sensory problems
- Gastrostomy (g-tube) or naso-gastric (ng-tube) dependence

Feeding disorders typically develop for several reasons, including medical conditions (food allergies), anatomical or structural abnormalities (e.g., cleft palate), and reinforcement of inappropriate behavior. In

most cases, no single factor accounts for a child's feeding difficulties. Rather, several factors interact to produce them.

While a wide spectrum of factors can contribute to feeding disorders, certain medical and psychological conditions may accompany them, including one or more of the following:

- Gastroesophageal reflux disease
- Gastrointestinal motility disorders
- Palate defects
- Failure to thrive
- Prematurity
- Oral Motor Dysfunction (dysfunctional swallow, dysphagia, oral motor dysphagia)
- Esophagitis/Gastritis/Duodenitis
- Food allergies
- Delayed exposure to a variety of foods
- Behavior management issues
- Short Gut Syndrome

Prior Authorization: Yes, per network provider agreement.

CODING:
CPT® or HCPCs
Evaluation – prior authorization is not required for the evaluation
97161 Physical therapy evaluation: low complexity
97162 Physical therapy evaluation: moderate complexity
97163 Physical therapy evaluation: high complexity
97164 Re-evaluation of physical therapy established plan of care
97165 Occupational therapy evaluation: low complexity
97166 Occupational therapy evaluation: moderate complexity
94167 Occupational therapy evaluation: high complexity
97168 Re-evaluation of occupational therapy established plan of care
Modalities – Supervised
97012 Application of a modality to 1 or more areas; traction, mechanical
97014 Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016 Application of a modality to 1 or more areas; vasopneumatic devices
97018 Application of a modality to 1 or more areas; paraffin bath
97022 Application of a modality to 1 or more areas; whirlpool
97024 Application of a modality to 1 or more areas; diathermy (eg, microwave)
97026 Application of a modality to 1 or more areas; infrared
97028 Application of a modality to 1 or more areas; ultraviolet
Modalities - Constant Attendance
97032 Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033 Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034 Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035 Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036 Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97039 Unlisted modality (specify type and time if constant attendance)
Therapeutic Procedures
97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112 Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113 Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116 Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124 Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, pertrissage and/or tapotement (striking, compression, percussion)
97129 Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiative, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
+97130 Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiative, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes
97140 Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

97150 Therapeutic procedure(s), group (2 or more individuals)
97530 Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance, (each 15 minutes)
97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535 Self-care/home management training (eg, activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct (one-on-one) patient contact, each 15 minutes
97542 Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported) upper extremity(s), lower extremity(s) and/or trunk, each15 minutes
97761 Prosthetics training upper and/or lower extremity(s), each15 minutes
97762 Checkout for orthotic/prosthetic use, established patient, each15 minutes
97763 Orthotic(s)/prosthetic(s) management and/or training upper and/or lower extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each15 minutes
97799 Unlisted physical medicine/rehabilitation service or procedure
G0151 Services performed by a qualified physical therapist in the home health or hospice setting, ea 15 minutes
G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, ea 15 minutes
S9129 Occupational therapy in the home, per diem
S9131 Physical therapy in the home, per diem

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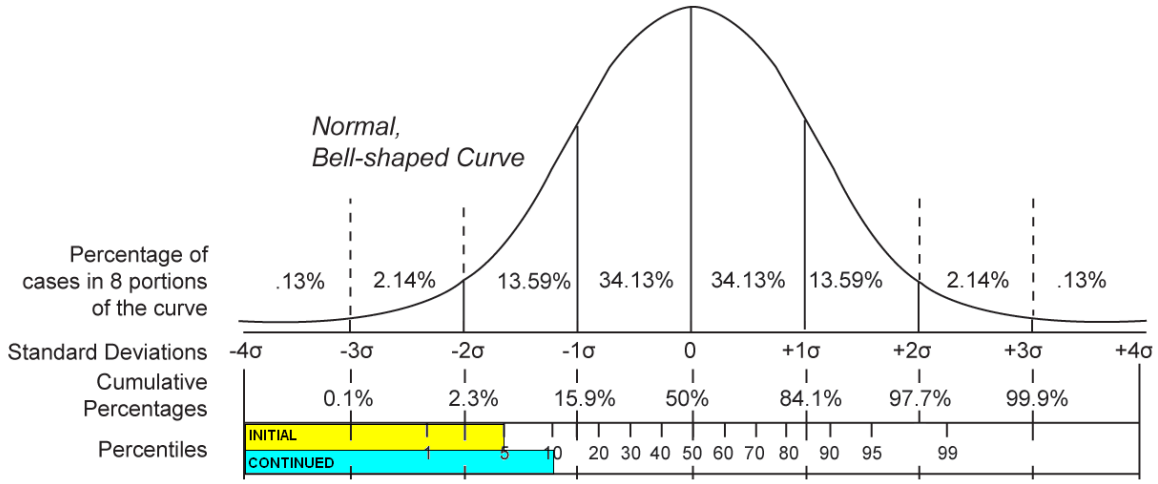
Attachment A



Source: http://psychology.wikia.com/wiki/File:Normal_distribution_and_scales.gif

PreferredOne Community Health Plan Nondiscrimination Notice

PreferredOne Community Health Plan ("PCHP") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PCHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PCHP:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PCHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Community Health Plan
PO Box 59052
Minneapolis, MN 55459-0052
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

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ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው: 763.847.4013).

ဟသျှဉ်ဟသး– နမ့်ကတိ၊ ကညီ ကျိာ်အယိ, နမၤန့် ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့၊ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

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주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

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Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
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Grievance Specialist
PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

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