Utilization Management
Medical Policy
Physical Therapy (PT) Services

Document Number: 26.41.1.3

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Medical Policy
Physical Therapy (PT) Services

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Document Approval

I have read and approved this document. My signature indicates the content accurately reflects Healthways policies.

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1. Purpose

Based upon our review of the peer-reviewed literature, acute, restorative physical therapy (PT) services have been proven to be effective when performed as clinically indicated to meet the needs of patients who suffer from a medically determinable functional physical impairment, weakness, atrophy, and/or a decreased range of motion, as determined by appropriate assessment, due to disease, trauma, congenital anomalies or prior therapeutic intervention.

2. Scope

Outpatient physical therapy is generally a covered service when skilled therapy is provided for the purpose of preventing, minimizing, or eliminating impairments, activity limitations, or participation restrictions and is not provided exclusively for the convenience of the patient/client. The services provided must require the specialized knowledge, clinical judgment, and skills of a therapist.

Application of medical policy and claims payment is determined by individual health plan policy benefits, which may vary based on product line, group, or contract. Medical necessity determinations apply only if the benefit exists and no policy contract exclusions are applicable. Individual member benefits must be verified. Patient access may be direct or require a valid referral. Prior authorization requirements are specific to each health plan.

Services may be subject to state mandates, medical necessity criteria, coverage limits, or existing contractual exclusions. Reimbursement mechanisms may vary by health plan and even within a given health plan, by product line, group, or contract.

This policy is designed to formulate medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.
3. Definitions

Habilitative Services are skilled therapy services that assist individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. Habilitative services do not include—

1) Special education related services, such as terms defined in Section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401). These types of services are available to the individual through a local educational agency;

2) Vocational rehabilitation services, which are available to the individual through a program funded under section 110 of Rehabilitation Act of 1973 (29 U.S.C. 730).

Maintenance Therapy is a continuation of care and management of an individual when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function.

Physical Therapy (PT) is a medically prescribed treatment for physical disabilities or impairments that result from disease, injury, congenital anomaly, and/or prior therapeutic intervention. PT employs the use of therapeutic exercise and other interventions that focus on locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and the functional activities of daily living. The most commonly used interventions are therapeutic exercise, manual therapy, neuromuscular reeducation, gait training, aquatic therapy, activities of daily living training, heat, cold, electrical stimulation, ultraviolet light, and ultrasound.

4. Policy Guidelines

A. Physical therapy must meet all of the following criteria:

1) address the functional needs of a patient who suffers from a physical impairment due to disease, trauma, congenital anomalies or prior therapeutic intervention;
2) achieve functional goals for a patient who has a reasonable expectation of achieving significant measurable clinical improvement in a reasonable and predictable period of time;

3) provide specific, effective, and reasonable treatment for the patient’s diagnosis and physical condition;

4) be delivered by a qualified provider of physical therapy services (a qualified provider is one who is licensed where required and performs within the scope of licensure); and

5) require the judgment, knowledge, and skills of a qualified provider of physical therapy services due to the complexity of the patient’s physical condition.

B. Habilitative Services are considered medically appropriate when one of the following are met:

1) reverse the progression of primary and secondary disabilities, and prevent further deterioration;

2) facilitate return to work in appropriate circumstances;

3) assist an individual to acquire, retain, or improve abilities and competencies needed for optimal physical functioning.

C. Documentation

Physical therapy must be provided in accordance with an ongoing, written treatment plan, and made available upon request. The treatment plan must be updated as the patient’s condition changes, and must include, at a minimum, documentation of the following:

1) The patient’s case history;

2) Findings of all examinations performed including functional limitations;

3) Condition severity (mild, moderate, or severe) as defined by the literature;

4) Physician referral and prescription for services (if required);

5) Findings of any pertinent diagnostic, evaluative, and screening studies;

6) Clinical impression, including rationale for changes in diagnosis and treatment plan;

7) Treatment plan to include long and short-term goals along with a reasonable estimation of duration (i.e., number of weeks) and frequency
of treatment (i.e., number of visits per period of time) to achieve those goals;
8) Informed consent (if required);
9) Progress notes for each date of service to follow subjective, objective, assessment, and plan format along with signature and date of the signature of provider who rendered the service(s);
10) Recording of the specific physical medicine modalities/procedures to be used in treatment, including documentation of time for constant attendance modalities and therapeutic procedures, and identification of equipment and/or techniques utilized.

D. Evaluations
Physical therapy evaluations and re-evaluations are reported using CPT codes 97001 and 97002, respectively. Muscle testing (CPT codes 95831-95834), range of motion testing (CPT codes 95851-95852), health behavior assessments (CPT 96150-96151), and physical performance testing (CPT 97750) are considered components of a physical therapy evaluation or re-evaluation (CPT codes 97001-97002), and are not reported separately and not eligible for separate payment when billed on the same date of service. Modifier “-59” may be reported with a to identify it as distinct or independent from, and not integral (related) to other services performed on the same day. When modifier “-59” is reported, the patient’s medical record must support its use in accordance with CPT guidelines.

E. Treatment
Physical therapy treatment may include active and passive modalities using a variety of means and techniques based upon biomechanical and neuropsychological principles. Treatments provided as part of a physical therapy session may include:
1) Therapeutic exercise programs, including coordination and resistive exercises to increase strength and endurance;
2) Thermotherapy;
3) Cryotherapy;
4) Acoustic, light, mechanical, or electric energy modalities;
5) Hydrotherapy/Aquatic Therapy (water-based interventions, usually performed in a pool); and/or
6) Massage, traction, or mobilization techniques.
F. Physical Medicine Modalities and Therapeutic Procedures

Physical medicine modalities vary according to whether supervised or direct (one-on-one) patient contact is required for treatment.

1) Supervised Modalities comprise those described by the CPT code range from 97010-97028 and do not require direct one-on-one patient contact by the provider. These are not time-based codes. Therefore, it is not appropriate to report multiple units of services with CPT codes 97010-97028. Report these codes only once during a patient encounter (visit), regardless of the amount of time spent supervising the modality or the number of body areas treated.

a) Hot/Cold Packs (CPT code 97010)

This modality should be reported only one time for the use of both hot and cold packs during the same treatment session (date of service or visit).

b) Vasopneumatic Compression Devices (CPT code 97016)

Intermittent compression therapy is used to reduce edema and lymphedema of the extremities. This treatment is warranted for the following conditions:

- Edema of the extremities
- Hematoma of the leg
- Lymphedema of the arm
- Lymphedema of the leg
- Venous insufficiency or venous stasis disorder

Conditions other than those listed above, or those which indicate that an infection is present, may be denied as not medically necessary. Documentation to support the application of a compression device must include the type, amount, and location of the edema, as well as the circumferential measurements of the extremity to be treated, before and after treatment.

This service is considered a "supervised" modality and is not considered “time-based.” It can be reported only once per
treatment session, regardless of the number of areas treated or the length of time required to complete treatment. Services provided by devices that provide both vasopneumatic compression and cold therapy simultaneously, must be reported with CPT code 97016. It is not appropriate to report cold therapy (CPT code 97010) with vasopneumatic compression (CPT code 97016) when services are provided simultaneously with the same device.

c) Infrared Therapy (CPT code 97026)
The use of infrared and near-infrared light and heat, including monochromatic infrared energy, is not considered medically necessary when used as a physical medicine modality for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy and wounds and/or ulcers of the skin and/or subcutaneous tissues.

2) Constant attendance modalities represented by those in the CPT code range 97032-97039, require direct one-on-one patient contact by the provider. These are time-based codes that include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Documentation must include the amount of time spent in providing all aspects of the service.

When two constant attendance modalities are performed at the same time, using one device, the CPT code representing the primary modality should be reported. For example, when ultrasound and electrical stimulation are performed together using a device such as the Sonicator, report the ultrasound code. It is not appropriate to report both modalities for the same 15-minute period of time.

3) Therapeutic Procedures represented by those in the CPT code range 97110-97542 require direct one-on-one patient contact. These are time-based codes that include the time required to perform all aspects of the service, including pre-, intra-, and post-service work.
Documentation must include the amount of time spent in providing all aspects of the service.

a) Aquatic Therapy with Therapeutic Exercises (CPT code 97113)

Aquatic therapy must be performed with the expectation of restoring a patient's level of function that has been lost or reduced by injury or illness. Aquatic therapy performed to maintain a level of function is considered to be a maintenance program and is not eligible for payment consideration.

A provider must have direct (one-to-one) patient contact when reporting aquatic therapy. Supervising multiple patients in a pool at one time and billing for each of these patients per 15 minutes of therapy time must not be done.

Before beginning an aquatic therapy program, the provider must prepare a treatment plan that includes short-term and long-term goals that the patient can be reasonably expected to accomplish through the aquatic therapy program and the specific methods chosen. Proper documentation must include:

- Documentation indicating whether the patient was in shallow or deep water. An aquatic therapy program undertaken for upper extremity exercises must take place in a depth of water that allows the patient's upper extremities to be submerged. Water depth must be at a level that provides the best postural position for exercise therapy.
- For resistance and strengthening exercises, the provider must document the number of repetitions, the number of sets, the type(s) of equipment, which body area(s) and the specific type(s) of exercise performed by the patient for each therapy session. NOTE: If a provider cannot substantiate increased resistance experienced as the patient exercises in water, the session will be considered as endurance or conditioning rather than progressive resistance exercises (PRE) to strengthen.
- Specific documented goals regarding decreasing inflammation, decreasing pain, increasing circulation,
increasing strength, etc., and the means by which the specific goals will be achieved.

- Periodic re-evaluation documenting the number of times the patient has had rehabilitative aquatic therapy, the patient's pain level before beginning the program, the current pain level, and future goals for the patient's care.
- Indication of pool water temperature for each session.

It is not considered medically necessary to have more than one form of hydrotherapy during a patient encounter (visit). Separate payment will not be made for CPT codes 97022 or 97036 in addition to 97113 for a single patient encounter. Modifier “-59” may be reported to identify it as distinct or independent from other services performed on the same day. When modifier “-59” is reported, the patient’s records must support its use in accordance with CPT guidelines.

b) Gait Training (CPT code 97116)

Gait training is a technique that restores a patient's normal stance, swing, speed, balance, and sequence of muscle contractions for walking. Examples of accepted indications for gait training include:

- Foot drop resulting from stroke
- Herniated disc(s)
- Ankle, knee and/or hip replacement
- Traumatic amputations of the toe(s)

Documentation for gait training must demonstrate that the patient’s gait was improved either by lengthening the gait or increasing the frequency of cadence lower-extremity.

Procedure code 97116 must not be used to report orthotics or prosthetics training. Orthotics training must be reported using procedure codes 97760 and 97762. Prosthetics training must be reported using procedure codes 97761 and 97762.
G. Therapy Sessions

A typical session usually consists of up to one hour of rehabilitative therapy or testing, or up to four physical medicine modalities/procedures and/or units performed on the same date of service.

Reimbursement for PT visits involving any of the physical medicine CPT codes (modalities, therapeutic procedures, active wound care management, tests and measurements, orthotic management and prosthetic management) are generally limited as follows: up to four codes/units in any combination per date of service.

Examples of billing for covered services rendered within a visit wherein up to four codes/units are reimbursed:

- CPT codes 97010 + 97014 + 97035 + 97140
- CPT codes 97140 + 97010 + 97110 + 97110 (2 units)
- CPT codes 97113 + 97113 + 97113 + 97113 (4 units)
- CPT codes 97110 + 97110 (2 units) + 97530 + 97530 (2 units)

Reimbursement for visits involving Osteopathic Manipulative Treatment (CPT codes 98925-98929) or Chiropractic Manipulative Treatment (CPT codes 98940-98943) and any of the physical medicine CPT codes (modalities, therapeutic procedures, tests and measurements, orthotic management) are generally limited as follows: up to three codes/units in any combination per date of service.

Examples of billing for covered services rendered within a visit wherein up to three codes/units are reimbursed:

- CPT codes 98925 + 97035 + 97112
- CPT codes 98940 + 98943-51 + 97014
- CPT codes 98926 + 97012 + 97110
- CPT codes 98941 + 97110 + 97110 (2 units)
According to the Centers for Medicare & Medicaid Services (CMS), the total number of reported units is constrained by the total treatment time of all "timed" procedures provided on a given day. Utilize the "8 Minute Rule" chart below to determine the total number of units to apply.

For any single CPT code, bill a single 15-minute unit as follows:

1 unit: ≥ 8 minutes through 22 minutes
2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes

The above chart is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any time prior to the eighth minute should be excluded from the total count, as the timing of active treatment counted includes all time.

H. Duplicate Therapy

Duplicate therapy rendered by two different providers is considered not medically necessary and, therefore, not covered. When a patient receives both PT and OT services, the therapies must provide different types of treatment, with separate and distinct treatment plans and goals. For example, if an individual is receiving therapy services from two different providers who are treating the same condition, the components of the treatment sessions must be different (e.g., OT must focus on the self-care/home management/adaptive equipment use, while PT must focus on strength and range of motion).

I. Vestibular Rehabilitation Therapy

Vestibular rehabilitation therapy generally refers to an individualized rehabilitation program for the treatment of patients with vertigo and disequilibrium. The therapy is designed to address the patient's specific complaints and functional deficits and may include specific exercises, gait training, balance retraining, and patient education and instructions for a home exercise program designed to decrease dizziness, improve balance function, and increase general activity levels. A vestibular rehabilitation program
typically last 45 minutes per session and is prescribed 1-2 times per week. In general, patients remain in the program 4-8 weeks.

A vestibular rehabilitation program may be considered medically necessary for patients with vertigo, disequilibrium, and balance deficits related to the following conditions:

- peripheral vestibular disorders (e.g., labyrinthitis, neuritis, benign paroxysmal positional vertigo, post vestibular surgical symptoms, and bilateral vestibular loss);
- mixed peripheral and central vestibular disorders; and
- central causes of vertigo (e.g., CVA, multiple sclerosis, and mild traumatic brain injury).

If none of these conditions are reported, a vestibular rehabilitation program is considered not medically necessary, and therefore, not covered.

A vestibular rehabilitation program may include the following physical medicine or occupational therapy procedures:

- Physical medicine evaluation and re-evaluation (CPT codes 97001, 97002);
- Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility (CPT 97110);
- Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (CPT 97112);
- Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing) (CPT 97116); and
- Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes (CPT 97530).
5. **Procedure Codes**

The following codes represent commonly performed services that may be billed by physical therapists:

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6. **Non-Covered Services**

The following services are considered experimental/investigational or not medically necessary and therefore, not covered:

A. **Low-Level Laser Therapy (Cold Laser Therapy) (HCPCS code S8948)**

   Low-level laser therapy is the non-invasive application of red or cold (sub thermal) laser light to injuries or wounds to improve soft tissue healing and relieve both acute and chronic pain (e.g., wound healing, carpal tunnel syndrome, and pain management). Low-level laser therapy is considered experimental/investigational. This service is still being performed in a clinical trial setting with no long-term outcomes available. Further studies are needed to determine the long-term efficacy of this modality.

B. **Dry Hydro Massage (Unlisted physical medicine/rehabilitation service or procedure, CPT code 97799)**

   Hydrotherapy refers to the use of water in the treatment of disease or trauma. The patient lies back, completely clothed, on the surface of a hydrotherapy table. Under the surface is a mattress filled with heated water. A pump propels the water toward the patient through hydro-jets. The pressure of the water against the patient’s body provides the massage. A primary wave and a lighter secondary wave combine to produce a deep tissue massage to all areas of the spine simultaneously. The therapy can be applied to nearly every body part by changing the individual’s position on the table. This is an unattended hands-free massage. The Profiler and Aqua PT
are considered forms of dry hydro massage. Dry hydro massage is considered not medically necessary.

C. Low-Intensity Pulsed Ultrasound (Hands-Free Ultrasound) (Unlisted physical medicine/rehabilitation service or procedure, CPT code 97799)
Hands-free ultrasound is used as an alternative to traditional manual ultrasound. The lower intensity, pulsed treatment allows for a longer treatment time. In traditional ultrasound, the therapist manually moves the sound head over the treatment area, whereas the stationary sound head used in this method of ultrasound therapy does not require that the therapist remain with the patient during the duration of the treatment. Hands-free ultrasound therapy is considered investigational. There is a lack of clinical studies showing that lower intensity ultrasound therapy is as effective as traditional ultrasound.

D. Equestrian/Hippotherapy (HCPCS code S8940)
Hippotherapy (Equestrian therapy) is a treatment modality that utilizes the movement of a horse as a tool to improve the patient’s neuromuscular function. Hippotherapy is used for patients with compromised neuromuscular function (e.g., cerebral palsy). The horse’s walk provides sensory stimulation through its rhythmic, repetitive movement. The goals of hippotherapy are to combine this treatment modality with other therapeutic modalities to improve balance, posture, mobility, and function. Hippotherapy is considered experimental/investigational. Scientific evidence does not demonstrate the efficacy of this service.

E. Electromagnetic Stimulation (Unlisted physical medicine/rehabilitation service or procedure, CPT code 97799)
Electromagnetic therapy devices create a magnetic field that penetrates the body creating nerve impulses that innervate smooth and striated muscles. This type of therapy is used for the treatment of bulk muscle excitation, relaxation of muscle spasms, maintaining or increasing range of motion, prevention, or retardation of disuse atrophy, muscle reeducation, increasing local blood circulation, and immediate post-surgical stimulation of the calf muscles to prevent venous thrombosis. Because the effectiveness of electromagnetic stimulation has not been established, this service is considered experimental/investigational.
F. Vibromyography (VMG) (Unlisted neurological or neuromuscular diagnostic procedure, CPT code 95999)
Vibromyography is proposed as a means of measuring muscle effort and detecting imbalance. VMG is performed utilizing a device, such as the Myowave (Sonostics, Inc), to non-invasively capture skin surface vibrations from the muscle through a sensor. The muscle vibration readings are then analyzed to provide information on the peak effort for each muscle assessed, the time required for each muscle to reach peak effort, and muscle balance ratios. A search of the peer-reviewed published literature addressing vibromyography identified few studies that have been recently published. Identified studies generally include very small study populations and include several limitations. The efficacy of vibromyography has not been medically proven to be effective or to improve health outcomes.

7. References
Please refer to the “HWHN UM Clinical Reference Sources for PT-OT Services” document.