n05674

Physical and Occupational Therapy Services

Values

Accountability Integrity Innovation ServiceExcellence Collaboration

Abstract Purpose :

This policy provides guidance for the utilization management team of Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC (NHP/NHIC/NHAS) with review of requests for the coverage of outpatient physical and occupational therapy.

Policy Detail :

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, Individual and Family Policy to determine eligibility and coverage because employer group and government contracts may vary. Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services LLC follows Medicare's National/Local (Wisconsin area) Coverage Determinations for its Medicare Advantage membership.

I. Description
   a. Physical therapy is used for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by disease, injury or disability that utilizes therapeutic exercise, physical modalities, assistive devices, patient education and training.
   b. Occupational therapy is therapy based on engagement in meaningful activities of daily life (such as self-care skills, education, work, or social interactions) specially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.
   c. Habilitation Services**:** health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking at the expected age. These services may include physical and occupational therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

II. Medical Indications:
   a. Network Health considers physical and/or occupational therapy medically necessary when the care is prescribed by a chiropractor, DO, MD, nurse practitioner, podiatrist, or other health professional and is used to significantly improve, develop, or restore physical function lost or impaired due to disease, injury, or surgical procedure and the following criteria are met:
      1. The individual’s condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predicable period of time: **AND**
      2. The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals; **AND**
      3. Improvement is evidenced by successive objective measurements; **AND**
      4. The services are delivered by a qualified provider of physical or occupational therapy services; **AND**
      5. Physical or Occupational therapy occurs when the judgement, knowledge, and skills of a qualified provider of physical therapy services are necessary to safely and effectively furnish a recognized therapy service due to the complexity and sophistication of the plane of care.

III. Coverage:

a. Physical and/or Occupational therapy is a covered benefit deemed medically necessary per the criteria listed above.
b. NHP/NHIC/NHAS follows the criteria with the policy for application to its Medicare Advantage membership. Local Coverage Determination L33631 is referenced for outpatient physical or occupational therapy services.
c. This policy does not apply to mandated benefits for autism spectrum disorders under Wis. Stat. 632.895 (12m) therapies.
d. For dates of service 06/01/2021 and after, eviCore physical and occupational therapy guidelines are utilized for medical necessity determinations.

IV. Limitations/Exclusions:

a. Therapy maybe contractually limited or excluded for some plans. Please refer to the individual's coverage document for details. The coverage document takes precedence over clinical policy and must be considered first in determining coverage eligibility.
b. Physical or occupational therapy in asymptomatic members or members without an identifiable clinical condition is considered not medically necessary.
c. The condition does not have the potential to improve or is not improving in response to therapy, or there is an expectation that further improvement is not attainable.
d. Once therapeutic benefit has been achieved, or a home exercise program could be used for further gains, continuing supervised physical therapy is not considered medically necessary.
e. The ordering physician must review the plan of treatment and the clinical records every 60 days. The member's limits and goals of therapy must be included in the documentation.
f. Services that are custodial/maintenance, or investigational/experimental are not covered.
g. Therapists must be registered and must not live in the patient's home or be a family member.
h. The following services are considered experimental or investigational due to lack of medical literature supporting effectiveness:
    1. Dry hydrotherapy massage (e.g., aqua massage, hydromassage, or water massage)
    2. Dry Needling
    3. Frequency Specific Microcurrent
    4. Iontophoresis **EXCEPT** with the diagnosis of palmar hyperhidrosis, plantar hyperhidrosis, or both.
    5. Light beam generator therapy
    6. Pelvic Floor Dysfunction (not including incontinence)
        a. Due to the lack of peer reviewed evidence concerning the effect on patient health outcomes, skilled therapy interventions (e.g., ultrasound, electrical stimulation, soft tissue mobilization, and therapeutic exercise) for the treatment of the following conditions is considered investigational and thus non-covered.
            i. pelvic floor congestion
            ii. pelvic floor pain not of spinal origin
            iii. hypersensitive clitoris
            iv. prostatitis
            v. cystourethrocele
            vi. enterocele
            vii. rectocele
            viii. vulvodynia
            ix. vulvar vestibulitis syndrome (VVS)
    7. Phonophoresis
a. The following services are non-covered as skilled therapy services and considered not medically necessary:
    1. Anodyne
    2. Athletic training
    3. Behavioral training
    4. Biofeedback **EXCEPT** provided by a physical therapist for treatment of headaches, spastic torticollis and urinary incontinence.

5. Canalith Repositioning Procedure **EXCEPT** for vertigo and benign paroxysmal vertigo (BPV)
6. Constraint Induced Movement Therapy (CIMT)
7. Continuous passive motion (CPM) device setup and adjustments
8. Craniosacral therapy
9. Electro-magnetic therapy, **EXCEPT** as indicated for chronic wounds
10. Functional Electrical Stimulating (FES) devices
11. Interactive metronome therapy
12. Loop reflex training
13. Low level laser treatment (LLLT)/cold laser therapy **EXCEPT** for treatment of temporomandibular joint disorders (TMD) dysfunction, rheumatoid arthritis, carpal tunnel syndrome, and lateral epicondylitis.
14. Massage chairs or roller beds
15. Repetitive walk strengthening exercise
16. Treatment and services for sensory integration and sensory defensiveness.
17. Vestibular ocular reflex training-only when billed separately
18. Whole body periodic acceleration: does not meet the benefit requirement that it requires the services of a skilled professional
19. Work-hardening programs

V. References:

a. American Physical Therapy Association Core Documents. Retrieved May 7, 2020 from http://www.apta.org/Policies/CoreDocuments/
b. CMS Local Coverage Determination (LCD) Outpatient Physical and Occupational Therapy Services L33631
c. Hand to Shoulder Center of Wisconsin
d. Hayes, Inc. Search & Summary. Dry Needling for Mechanical Neck and/or Trapezius Muscle Pain in Adults. Comparative Effectiveness Review, Published June 23, 2020.
e. Hayes, Inc. Search & Summary. Dry Needling for Indications Other than Neck or Trapezius Muscle Pain in Adults. Comparative Effectiveness Review, Published June 24, 2020.
f. MCG Hydrotherapy ACG: A-0510 (AC). 24th edition.
g. MCG Iontophoresis ACG: A-0617 (AC). 24th edition.
h. MCG Phonophoresis ACG: A-0616 (AC). 24th edition.
a. Merriam-Webster. (n.d.). Occupational therapy. In *Merriam-Webster.com dictionary*. Retrieved April 6, 2020, from https://www.merriam- webster.com/dictionary/occupational%20therapy
j. Merriam-Webster. (n.d.). Physical therapy. In *Merriam-Webster.com dictionary*. Retrieved April 6, 2020, from https://www.merriam- webster.com/dictionary/physical%20therapy

Regulatory Citations :

UM2

Related Documents :

CPT Codes:

29125	APPLY FOREARM SPLINT	
29126	APPLY FOREARM SPLINT	
29130	APPLICATION OF FINGER SPLINT	

29131	APPLICATION OF FINGER SPLINT	
29200	STRAPPING OF CHEST	Not Covered if used to report Kinesio Taping
29220	STRAPPING OF LOW BACK	Not Covered if used to report Kinesio Taping
29240	STRAPPING OF SHOULDER	Not Covered if used to report Kinesio Taping
29260	STRAPPING OF ELBOW OR WRIST	Not Covered if used to report Kinesio Taping
29280	STRAPPING OF HAND OR FINGER	Not Covered if used to report Kinesio Taping
29520	STRAPPING OF HIP	Not Covered if used to report Kinesio Taping
29530	STRAPPING OF KNEE	Not Covered if used to report Kinesio Taping
29540	STRAPPING OF ANKLE AND/OR FT	Not Covered if used to report Kinesio Taping
29550	STRAPPING OF TOES	
64550	APPL SURFACE NEUROSTIMULATOR	
92065	ORTHOPTIC/PLEOPTIC Training	Not Covered *Some plans may allow pediatirc coverage
95992	CANALITH REPOSITIONING PROC	Not covered EXCEPT for Vertigo, dizziness, giddiness Benign Paroxysmal Vertigo (BPV) and/or Benign Paroxysmal Positional Vertigo (BPPV)
97010	HOT OR COLD PACKS THERAPY	
97012	MECHANICAL TRACTION THERAPY	
97014	ELECTRIC STIMULATION THERAPY	
97016	VASOPNEUMATIC DEVICE THERAPY	
97018	PARAFFIN BATH THERAPY	
97022	DRY HYDROTHERAPY	Not Covered (E/I)
97024	DIATHERMY EG MICROWAVE	
97026	INFRARED THERAPY	
97028	ULTRAVIOLET THERAPY	
97032	ELECTRICAL STIMULATION	
97033	ELECTRIC CURRENT THERAPY	Not covered (E/I) EXCEPT with the diagnosis of palmar hyperhidrosis, plantar hyperhidrosis, or both
97034	CONTRAST BATH THERAPY	
97035	ULTRASOUND THERAPY	Not covered (E/I) if used to report phonophoresis
97036	HYDROTHERAPY/HUBBARD TANK	
97039	PHYSICAL THERAPY TREATMENT	Unlisted modality - constant attendance PM&R (Physical Medicine and Rehabilitation) - can be used for a variety of services (no reference) - MD determination if E/I or med necessary
97110	THERAPEUTIC EXERCISES	
97112	NEUROMUSCULAR REEDUCATION	
97113	AQUATIC THERAPY/EXERCISE	
97116	GAIT TRAINING THERAPY	
97139	PHYSICAL MEDICINE PROCEDURE	Unlisted code-can be used for variety of services (no reference) - MD determination if E/I or not med necessary
97140	MANUAL THERAPY 1/> REGIONS	
97150	GROUP THERAPEUTIC PROCEDURES	Not Covered
97530	THERAPEUTIC ACTIVITIES	
97532	COGNITIVE SKILLS DEVELOPMENT	
97535	SELF CARE MNGMENT TRAINING	
97537	COMMUNITY/WORK REINTEGRATION	Not Covered

97542	WHEELCHAIR MNGMENT TRAINING	
97545	WORK HARDENING	Not Covered
97546	WORK HARDENING ADD-ON	Not Covered
97750	PHYSICAL PERFORMANCE TEST	
97755	ASSISTIVE TECHNOLOGY ASSESS	
97760	ORTHOTIC MGMT&TRAINJ 1ST ENC	
97761	PROSTHETIC TRAINJ 1ST ENC	
97762	C/O FOR ORTHOTIC/PROSTH USE	
97799	PHYSICAL MEDICINE PROCEDURE	Unlisted - other services/procedures. Investigate to see what service they are billing under this CPT code
G0151	SRVC PT HOM HLTH/HOSPICE EA 15 MIN	
G0152	SRVC OT HOM HLTH/HOSPICE EA 15 MIN	
G0153	SRVC SPCH&LANG PATH HH/HOSPIC EA 15	
G0157	SRVC PT ASSIST HH/HOSPICE EA 15 MIN	
G0238	TX PROC IMPRV RESP NOT G0237 15 MIN	
G0283	E-STIM 1/>NOT WND CARE PART TX PLAN	
97001	PT EVALUATION	
97002	PT RE-EVALUATION	
97003	OT EVALUATION	
97004	OT RE-EVALUATION	
97005	ATHLETIC TRAIN EVAL	Not Covered
97006	ATHLETIC TRAIN REEVAL	Not Covered
97161	PT EVAL LOW COMPLEX 20 MIN	
97162	PT EVAL MOD COMPLEX 30 MIN	
97163	PT EVAL HIGH COMPLEX 45 MIN	
97164	PT RE-EVAL EST PLAN CARE	
97165	OT EVAL LOW COMPLEX 30 MIN	
97166	OT EVAL MOD COMPLEX 45 MIN	
97167	OT EVAL HIGH COMPLEX 60 MIN	
97168	OT RE-EVAL EST PLAN CARE	
*CPT codes are subject to change as codes are retired or new ones developed.		

Disclaimer:

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e. Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only.

Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

Origination Date:	**Approval Date:**	**Next Review Date:**
04/08/2020	01/26/2022	01/26/2023
Regulatory Body:	**Approving Committee:**	**Policy Entity:**
OTHER	Medical Policy Committee	NHAS,NHIC,NHP
Policy Owner:	**Department of Ownership:**	**Revision Number:**
Rachell Hall	Utilization Management	4
Revision Reason:		
12/16/2021 annual review (approved by e-vote by MPC Committee 12/28/2021). 1/18/2022 - consent - clarifying language was missed in CPT code table 1/26/2022 - consent - formatted the table to fit onto the policy document		