Policy Statement
Active care services have sufficient evidence to support superior outcomes when used alone or in combination with manual-based treatments and/or passive care services.

Purpose
These guidelines will assist the evidence based physical medicine provider in properly choosing the correct service/s when indicated for proper overall case management.

Scope
This policy will apply to all participating network practitioners who provide active procedures, data/claims processing, and peer reviewers.

Definition
The following services are considered “active”; meaning the patient themselves takes part in the completion of the service. This is opposed to “passive” where the patient passively receives health care services without any physical input or effort.

All services outlined in this section require the provision of skilled services and direct (one on one) provider-patient contact.

Clinical Reasoning
The current valid literature references indicate the necessity of incorporating active care measures into treatment programs. Interventions chosen to treat the patient’s symptoms or conditions should be selected based on the most effective and efficient means of achieving the patient’s functional goals.

Timing of Introduction
Acute care cases: The literature supports the introduction and management of active care procedures as soon as clinically possible once the patient has sufficient range of motion/functional ability. For the care to be considered beneficial and effective, active care services should generally be provided within the first two weeks of intervention. For the basis of these guidelines, an acute care case is when a patient is seen for treatment within seven days of the onset of the illness, injury, and/or medical intervention.

Subacute care cases: Similar to acute care cases, the literature support the introduction and management of active care procedures as soon as clinically possible once the patient has sufficient range of motion/functional ability. For the care to be considered beneficial and effective, active care services should generally be provided within the first two weeks of intervention. For the basis of these guidelines, a subacute care case is when a patient is
seen for treatment between 7 to 21 days after the onset of an illness, injury, and/or medical intervention.

**Chronic care cases** - The literature supports the introduction and management of active care procedures at the onset of intervention, either the first or second visit. For the basis of these guidelines, a chronic care case is when a patient is seen for treatment beyond 21 days after the onset of an illness, injury, and/or medical intervention. Chronic conditions that have intermittent episodes will also be considered chronic in nature for these guidelines.

**Documentation Requirements**

Documentation must support the medical necessity for the services requested and why the skills of a licensed professional are needed to render the service. The provider must outline the patient-specific rationale/need for care intervention as it relates to the patient’s condition and resultant functional limitations in activities of daily living, and mobility and safety, as identified in a comprehensive evaluation. Based on these findings, a plan of care is developed that includes specific and measurable goals that support the need for the identified interventions.

Documentation must include a timeframe for initiating, progressing and discharging the patient from skilled services. Documentation must also include specific treatment parameters to support the intervention, in addition to applicable precautions. This includes the specific type of any procedure, instruction and/or exercise performed, area of body and muscle groups treated, and time component.

**Units billing**

Magellan Healthcare follows Medicare rules for reporting timed units. Billing units are based on 15 minutes per unit for time based codes and the Medicare minimum time requirement for a service to be justifiably billed.

- 1 unit - 8 minutes to 22 minutes
- 2 units - 23 minutes to 37 minutes
- 3 units - 38 minutes to 52 minutes
- 4 units - 53 minutes to 67 minutes
- 5 units - 68 minutes to 82 minutes
- 6 units - 83 minutes to 98 minutes

NOTE: Individual states may have varying statutory guidelines for reporting timed units that supersede Magellan Healthcare requirements.

**CPT Code Definitions, Examples, and Requirements**

**97110 - Therapeutic Procedures/Exercise**

**Definition:**

Although not exclusive by definition, therapeutic exercise is any exercise planned and performed to attain a specific goal. Goals would be to increase strength, endurance, range of motion, and flexibility. Therapeutic procedures/exercise could be applied to one or more areas and billed in units as noted above.
Parameters for Use:

I. The following requirements must be documented in the medical record to support and justify the use of all therapeutic procedures/exercises:
   a. Evidence to support medical necessity
   b. Plan of care with specific and measurable goals and timeframe for initiating, progressing, and discharging the patient from skilled medical services to an independent home program.
   c. Detailed description of active care services including:
      i. What exercise(s) were provided
      ii. What area and muscle groups the exercise(s) were provided to
      iii. Amount and type of resistance, repetitions, sets and time component.
   d. Evidence to support the need for skilled services by a licensed professional in direct contact with one patient.

II. Medical research supports the initiation of appropriate therapeutic procedures/exercise as soon as the patient is reasonably able to engage in the planned activity. Therefore, the expectation is for a patient to perform therapeutic exercises and receive a home exercise program within a reasonable timeframe.

III. Based on the definition and guidelines for services that are medically necessary, the expectation is for the provision of the therapeutic procedures/exercises that are not for the convenience of the patient or health care provider or more costly than an alternative form of treatment.

IV. Guidelines regarding the Use of Fitness Machines (MedX Extension Machine, Isostation B-220 Lumbar Dynamometer, Cybex Back System etc)
   There is insufficient evidence that they are more efficacious than standard exercise equipment or that their use improves clinical outcomes to a greater extent than standard programs thus documentation must support the following:
   a. It must be clear that the intervention is medically necessary.
   b. Evidence to support number of visits that are often in excess of community standards for treatment of musculoskeletal conditions
   c. Evidence of functional improvement as a result of the increased muscle strength
   d. It must be clear skilled service is being provided (as defined in Guideline III above)
   e. Evidence for why the skills of a therapist are needed beyond progressing weights and repetitions.
   f. Evidence for why the skills of a therapist are needed beyond a few visits to establish a program
   g. Their use should be part of a comprehensive rehab program
   h. Plan of care is driven by impairments, not the intervention itself
   i. It must be clear that increasing muscle strength is the treatment of choice e.g. strength building may be detrimental in an individual with movement restrictions.

Examples

Strengthening of select muscle groups (beginning in gravity-eliminated plane, if needed) progressing to anti-gravity plane utilizing body weight with progressive
resistive exercises utilizing theraband, exercise ball, free weights etc. (Closed chain exercises are often preferable to open chain exercises in preventing shearing forces and simulating functional activities); monitored graded exercise following cardiac or pulmonary surgery or heart attack; selective stretching to increase joint ROM.

Note: The Precor Stretching Station is not considered least costly as this service must be performed in the office setting. Once a patient is educated regarding stretching and demonstrates proper form, they should be able to continue stretching in the home setting.

**Support for this service**

I. Indications must be documented for loss or restriction of joint motion, reduced strength, and functional capacity or mobility concerns. The clinical records must show objective (quantitative if possible) loss of ROM, strength, flexibility or mobility. The code is generally not reimbursable for increasing a patient’s endurance without deficits, promotion of overall fitness, weight loss, return to sports, and/or sports and aerobic conditioning.

II. Documentation must include evidence of the skilled services required to support the use of therapeutic exercise. It is considered a skilled service that would require proper licensure/credentials of the clinician. Without evidence in the documentation to support the need for skilled services, the records would suggest the patient is “working out” in the clinical setting which is generally not medically necessary and not eligible for reimbursement.

III. Most programs should only entail up to one to three units at any time to ensure competency and compliance with instructions. The clinical rationale for more than three units would need to be clearly supported by the documentation. As this service should be seen in the acute phase, the patient should not then require more than three units at any time. If more than three units are seen—this might suggest the patient is “working out” in the clinical setting, which is generally not medically necessary as the service can be performed in a less costly arena (home or health club setting).

IV. Patient non-compliance with active home instructions will not result in further in-office instruction being considered medically necessary. The patient should instead be discharged for non-compliance/acting against medical advice. Any active care program may include periodic review of the program as part of case management in regard to monitoring continued therapeutic benefit and progression in specific exercises/instructions. This ongoing case management should outline patient compliance, necessary alterations to any active home care program, progressions in specific active home care program, and anticipated term date for the need for skilled in-office services.

**97112 - Neuromuscular reeducation**

**Definition:**
Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception (defined as the three modalities of joint position: sense, sense of
movement and sense of force.) Injuries can be seen after stroke, closed head injury, spinal cord injury, tumor, congenital disorders such as Cerebral Palsy or secondary to degenerative joint disease, musculoskeletal injury such as ankle sprain, post orthopedic surgery, or prolonged immobilization.

**Examples**
Treatment involves the stimulation of reflexes, sensation, posture, proprioception and motor activity through rocker/BAPS board, mini-trampolines, targeted exercises to spastic or rigid muscles, balance training, Proprioceptive Neuromuscular Facilitation (PNF), Feldenkrais, Bobath, Neurodevelopmental Treatment (NDT), and desensitization techniques.

**Support for this service**
Documentation must support the need for skilled services by a licensed professional in direct contact with one patient. An indication of the lesion of the neuromusculoskeletal system needs to be documented and the exact procedure must be noted. Instructions for home care should be seen within a reasonable timeframe and the service discontinued with proper education and instruction given to the patient.

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**97113 - Aquatic Therapy**

**Definition**
A therapy program utilizing therapeutic exercise techniques with the properties of water; designed and carried out in a suitably heated hydrotherapy pool by a qualified clinician specifically for an individual to improve function. Examples: TAi Chi, Aquatic PNF, the Bad Ragaz Ring Method, Fluid Moves, the Halliwick Concept, Swim Stroke Training and Modification, Task Type Training Approach and Watsu. Treatment to address improved circulation and decreased venous pooling, increased endurance facilitated through the availability of cardiovascular training with less stress on weight-bearing joints or working with enhancement of balance and coordination as a result of the buoyancy obtained from an aquatic environment.

**Support for this Service**
Documentation must support the need for skilled services by a licensed professional in direct contact with one patient. The patient would need to be immersed in a pool of water for this code to apply.

The provider must also indicate the medical necessity for the buoyancy, hydrostatic pressure, and heat properties that are present in a pool setting versus standard therapeutic exercise or activities. This is often used to transition the patient to a land based program.

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**97116 - Gait Training**

**Definition**
Training the patient in specific activities that will facilitate ambulation on varied surfaces and stair climbing with or without an assistive device. This includes training in rhythm, speed, sequencing and safety instructions.

**Examples**
Gait training can be useful for people with any condition needing to re-learn proper ambulation. Common conditions include: Amputation; Osteoarthritis; Muscular Dystrophy;
Cerebral Palsy; Stroke; Parkinson's disease; Multiple Sclerosis; Brain/Spinal Cord injuries; post surgical; sports injury; Low Back Pain.

**Support for this Service**
Documentation must support the need for skilled services by a licensed professional in direct contact with one patient as opposed to just “walking the patient.” Deficits in gait parameters including walking speed, cadence, stride length and balance, and Functional Ambulation Category scores must be documented. The provider would need to document if body-weight support (BWS) systems, unweighting devices, or assistive devices are used. The record must denote the assessment of the phases of gait to include stance phase, stride length, balance issues and what the ankle, knee, hip and low back are doing during the phases of gait cycle.

**97760 -Orthotics Management and Training**
**Definition**
Orthotic(s) management and training, including assessment and fitting when not otherwise reported as a separate L HCPCS code(L-code), fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes.

**Explanation**
This code applies to custom-fabricated orthotics and for adjustments to over-the-counter orthotics. The orthotics management portion of this code refers to time spent assessing the need for the orthotic and the type of orthotic as well as the fitting and the fabrication if the fabrication is done in the presence of the patient. The Training portion of this code includes training in the care and use of the orthotic device.

This code cannot be used if the orthotic is fabricated/formed without the patient being present Supplies and time for the actual orthotic fabrication is typically reported under L-codes. If an L-code is NOT used to report the orthotic, then the time assessing and fitting/fabricating would be reported under code 97760.

**Support for this Service**
The need for an orthotic requires documented support. This would include a proper examination (not just a vendor specific evaluation) along with the outline of the causal nexus to justify inclusion for any complaints other than foot based. Foot based complaints need a detailed notation as to the fault/deficit present that requires custom orthotics, versus usage of a heel lift or over-the-counter orthotic. This service should typically not be seen more than once per calendar year for one set of orthotics. Orthotic use is based on plan benefit.

Documentation must also support why the skills of licensed professional are needed for the training in care and use of the orthotic.

**97761-Prosthetic Training**
**Definition**
Functional mobility and ADL assessment, training with prosthesis, upper and/or lower extremity. This would include instruction and practice in use of prosthesis.
Support for this Service
The patient would need to be the recipient of a recent prosthetic device. Surgical records would need to be supplied in support. 97760 cannot be reported with gait training (97116).

97762-Checkout for Orthotic/Prosthetic use, established patient
Definition
Intervention that evaluates the effectiveness of an existing orthotic or prosthetic device and makes recommendations for changes.

Support for this Service
Documentation must clearly support the skilled need of licensed professional for the adjustments.

97530 -Therapeutic Activities
Definition
This code includes the use of dynamic activities in teaching and training the patient to improve functional performance in a progressive manner.

Examples
Activities that address quantifiable deficits (e.g. loss of ROM, strength or functional capacity) resulting in a deficit in functional mobility. Functional mobility may include bending, reaching, lifting, carrying, pushing, pulling, bed mobility and transfers.

Support for this Service
Documentation must support the need for skilled services by a licensed professional in direct contact with one patient.

The code is generally not reimbursable for increasing a patient’s endurance without deficits, promotion of overall fitness, weight loss, return to sports, and/or sports and aerobic conditioning.

97532 -Cognitive Skills Development
Definition
Development of cognitive skills to improve attention, memory, problem solving (including compensatory training). Cognitive skill development includes mental exercises that assist the patient in such areas as attention, memory, perception, language, reasoning, planning, problem-solving and related skills.

Examples
Individuals with inherited learning disabilities, individuals who have lost cognitive skills as a result of illness or brain injury

Support for this Service
Cognitive deficits would need to be present and quantifiably documented. Documentation must support the need for skilled services by a licensed professional in direct contact with one patient.

97533 -Sensory Integration
Definition
Treatment techniques designed to enhance sensory processing and adaptive responses to environmental demands.

The goal of sensory integration therapy is to improve the way the brain processes and adapts to sensory information as a foundation for later, more complex learning behavior.

**Examples**
Sensory integration (SI) therapy has been proposed as a treatment of developmental disorders in patients with established dysfunction of sensory processing, e.g., children with autism, attention deficit hyperactivity disorder (ADHD), fetal alcohol syndrome, and neurotransmitter disease. Sensory integration disorders may also be a result of illness or brain injury.

Therapy usually involves activities that provide vestibular, proprioceptive, and tactile, visual and auditory stimuli, which are selected to match specific sensory processing deficits of the child. For example, swings are commonly used to incorporate vestibular input, while trapeze bars and large foam pillows or mats may be used to stimulate somatosensory pathways of proprioception and deep touch. Tactile reception may be addressed through a variety of activities and surface textures involving light touch.

Sensory integration differs from 97112 as 97112 focuses on training to restore the ability to perform the particular activities.

**Support for this Service**
Sensory integration therapy is usually provided by occupational and physical therapists who are certified in sensory integration therapy.

Documentation must support the need for skilled services by a licensed professional in direct contact with one patient.

**97535 - Self-care/home management training**

**Definition**
Instructing and training the patient in self-care and home management activities (activities of daily living or ADL). This includes compensatory training, safety procedures and instruction in the use of assistive technology devices/adaptive equipment.

**Examples**
Activities that address quantifiable deficits resulting in functional limitations in activities of daily living (ADL). ADLs include toileting, continence, bathing, dressing, personal hygiene, house cleaning, eating and meal preparation.

**Support for this Service**
Documentation must support the need for skilled services by a licensed professional in direct contact with one patient. Documentation should relate the ADL instruction to the patient’s expected functional goals and indicate that it is part of an active treatment plan directed at a specific goal.
97537 - Community Work Reintegration – typically not a covered service

Definition
Services are instructing and training the patient in community and/or work re-integration activities. These activities could include shopping, safely accessing transportation sources, money management, avocational activities and/or work environment/ modification analysis, work task analysis, and use of assistive technology devices and/or adaptive equipment.

Example
Community reintegration is often performed in conjunction with other therapeutic procedures such as gait training and self-care/home management training. The payment for community reintegration training is often bundled into the payment for those other services. Therefore, these other services are not usually separately reimbursable.

Services provided to issue, modify, adjust, and/or educate the patient on assistive technology devices and/or adaptive equipment typically will not be covered if the adaptive equipment and/or assistive technology device(s) are not covered by the third-party payer.

Generally, services, which are related solely to specific employment opportunities, work skills, or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by Section 1862(a)(1) of the Social Security Act.

Support for this Service
Documentation would need to provide evidence to support the medical necessity and the need for skilled services provided to the patient.

97542 - Wheelchair Management and Training

Definition
Includes assessment, fitting and adjustment of the wheelchair and seating; instructing the patient and/or care-giver on how to propel and safely operate the wheelchair. 97001 and 97002 cannot be billed with this code.

Support for this Service
Documentation should include the recent event that prompted the need for a skilled wheelchair assessment; the result of any previous wheelchair assessments; most recent prior functional level; the interventions that were tried by nursing staff, caregivers or the patient to address poor seating or positioning; and any functional deficits or applicable impairments such as range of motion (ROM), strength, sitting balance, skin integrity, sensation and tone.

The documentation must correlate the training provided to the expected functional goals that are attainable by the patient and/or caregiver along with the response of the patient to the instruction or fitting.

The documentation must clearly support that the services rendered required the skills and expertise of a licensed therapist.

97545 - Work Hardening/Conditioning – initial 2 hours, use 97546 for each additional hour and used in conjunction with 97545 – typically not a covered service
**Definition**
Work hardening includes job simulation tasks and educational activities related to a safe return to work for the patient. Often, work hardening programs incorporate an interdisciplinary approach to restore physical, behavioral, and/or vocational functions. Work conditioning includes exercises directed towards safely returning the patient to work related activities or commence with vocational rehabilitation services. In general, work conditioning programs are designed to address neuromuscular functions such as flexibility, strength, endurance, and/or range of motion as well as cardiopulmonary functions.

**Example**
An work induced injury and/or impairment was present that resulted in the need for therapeutic exercises/procedures. Once the patient has completed acute medical care including chiropractic or rehabilitation treatment, the patient may require a comprehensive, intensive, and individualized program for safely returning to work activities. Subsequently, the patient may begin a work hardening and/or work conditioning program. Typically, the patient will participate in a program for at least two hours a day, three days a week to as much as eight hours a day, five days a week. The activities performed by the patient in the program may include and exercise regimen, simulation of specific or general work requirements, training and/or modifications of activities of daily living, injury prevention training, cognitive-behavioral pain management training, and/or occupational/educational training aspects.

**Support for this Service**
The documentation would need to support the patient had an injury and/or impairment within the last 12 months, has received acute rehabilitation services, and is expected to return to his/her previous employment. Furthermore, the documentation should clearly report the patient’s limitations for returning to work: the patient’s willingness to participate in the program; a highly structured, goal oriented plan of care including reference to return to work and discharge from skilled services; identified systemic neuromusculoskeletal deficits that interfere with work; documentation to support that care is at the point of resolution for the initial or principal injury so that participation in the conditioning process would not be prohibited; and, if applicable, the identification of psychosocial and/or vocation problems and evidence of a referral to the appropriate professional.
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Guidelines


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