National Imaging Associates, Inc.	
Clinical guidelines THERAPY AND REHABILITATION SERVICES (PT, OT)	Original Date: October 2015 Page 1 of 34 "FOR CMS (MEDICARE) MEMBERS ONLY"
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"FOR CMS (MEDICARE) MEMBERS ONLY

Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

This LCD provides guidelines for many physical medicine and rehabilitation services. However, this LCD does not address all services, including BUT NOT LIMITED TO:

- Speech-language pathology services for communication disorders (see LCD L35070)
- Services related to wound care (see applicable LCD)
- Services related to swallowing problems or dysphagia, including VitalStim therapy (see LCD L34891)
- Services primarily addressed by CMS National Coverage Determinations (NCDs), including BUT NOT LIMITED TO: Cardiac Rehabilitation Programs (NCD 20.10), Manipulation (NCD 150.1), Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (NCD 150.8), Treatment of Psoriasis (NCD 250.1), NCD for Neuromuscular Electrical Stimulator (NMES) (NCD 160.12).

DEFINITIONS

(Note for a complete list of definitions that are applicable to this LCD, refer to IOM, Pub. 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220, A.)

ACTIVE PARTICIPATION of the clinician in treatment means that the clinician personally furnishes in its entirety at least one billable service on at least one day of treatment.

ASSESSMENT is separate from evaluation and is included in services or procedures (it is not separately reimbursable).

INTERVAL of certified treatment (certification interval) consists of 90 calendar days or less, based on an individual's needs. A physician/non-physician practitioner (NPP) may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is not the same as a Progress Report period.

MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities or mechanisms that will assist a patient in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

THERAPY SERVICES are those skilled services furnished according to the standards and conditions in CMS manuals, (e.g., in IOM, Pub. 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220, A. and in IOM, Pub. 100-04, *Medicare Claims Processing Manual,* Chapter 5), within their scope of practice by qualified professionals or qualified personnel.

TREATMENT DAY means a single calendar day on which treatment, evaluation or reevaluation is provided. There could be multiple visits, treatment sessions/encounters on a treatment day.

COMPLEXITIES refer to complicating factors that may influence treatment, e.g., they may influence the type, frequency or duration of treatment, may be represented by diagnoses (see IOM, Pub. 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220); by patient factors such as age, severity, acuity, multiple conditions, co-morbidities, and motivation; or by the patient's social circumstances, such as the support of a significant other or the availability of transportation to therapy.

GENERAL PHYSICAL MEDICINE & REHABILITATION (PM&R) GUIDELINES

This LCD applies to the therapy services coded with the 97XXX series of CPT codes and canalith repositioning therapy. Per CMS definitions, therapy services include these services with a few exceptions. Please refer to the documents found at https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html for the complete listing of CPT codes that are "always" considered therapy services and those that are "sometimes" considered therapy services for coverage, requirement for plan of care, and coding purposes.

Physical medicine and rehabilitative services are designed to improve, restore, or compensate for loss of physical functioning following disease, injury or loss of a body part. Clinicians use the clinical history, systems review, physical examination, and a variety of evaluations to determine the impairments, functional limitations, and disabilities of the individual patient. Impairments, functional limitations, and disabilities thus identified are

then addressed by the design and implementation of a plan of care tailored to the specific needs of the individual patient. Specific interventions are selected, applied, or modified based on the examination data, the evaluation, the diagnosis and prognosis, and the anticipated goals and expected outcomes.

The patient must have a potential for restoration or improvement of lost functions, and must require the services of a skilled therapist. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable. Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning – is not covered. For example, a person would generally be eligible for, and may be provided, rehabilitation services under self-care/home management training, (i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).

PM&R services in patients' homes, qualified professionals' offices, Skilled Nursing Facilities (SNFs), outpatient hospital clinics, Outpatient Rehabilitation Facilities (ORFs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs) are covered when reasonable and medically necessary for the treatment of the patient's condition (signs and symptoms).

For payment by Medicare, direct supervision is required for private practice licensed PTA services along with all other criteria for licensed physical therapy assistants (PTA) services, unless state practice requirements are more stringent, in which case state or local requirements must be followed. General supervision is required for all other settings for licensed PTA services. For example, in clinics, rehabilitation agencies, and public health agencies, 42 CFR 485.713 indicates that when a PTA provides services, either on or off the organization's premises, those services are supervised by a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days or more frequently if required by state or local laws or regulation. The services of a PTA shall not be billed as services incident to a physician/non-physician provider (NPP)'s service, because they do not meet the qualifications of a therapist.

Intervention with PM&R modalities and procedures is indicated when:

- an assessment by a physician, NPP or therapist supports utilization of the intervention,
- there is documentation of objective physical and functional limitations (signs and symptoms), and
- the written plan of care incorporates those treatment elements that require services of a skilled therapist for a reasonable and generally predictable period of time.

Medicare covers therapy services **personally** performed **only** by one of the following:

- Licensed therapy professionals: licensed physical therapists and occupational therapists.

- Licensed PTA with appropriate supervision by a licensed physical therapist.
- Licensed occupational therapy assistants (OTA) with appropriate supervision by a licensed occupational therapist.
- Medical Doctors (MDs) and Doctors of Osteopathy (DOs).
- Doctors of Optometry (ODs) and Podiatric Medicine (DPMs) when performing services within their licenses' scope of practice and their training and competency.
- Qualified NPPs, including Advanced Nurse Practitioners (ANPs), Physician Assistants (PAs) or Clinical Nurse Specialists (CNSs) when performing services within their licenses' scope of practice and their training and competency (ANP, PA, CNS).
- "Qualified" personnel when appropriately supervised by a physician (MD, DO, OD, DPM) or qualified NPP, and when all conditions of billing services "incident to" a physician have been met. Qualified personnel providing physical therapy (PT) or occupational therapy (OT) services "incident to" the services of a physician/NPP must have met the educational and degree requirements of a licensed therapy professional (PT, OT) from an accredited PT/OT curriculum, but are not required to be licensed. **Please note that unless these therapy services are performed by a "qualified" person, the services are not covered and must not be reported for Medicare payment.**

Covered Therapy services under Medicare must:

- Qualify as skilled therapy services;
- Be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition;
- Be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a qualified therapist; and
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

Therefore, therapy services are covered when they are rendered:

- under written treatment plan developed by the individual's physician, non-physician practitioners, optometrist, or therapist;
- to address specific therapeutic goals for which modalities and procedures are planned out specifically in terms of type, frequency and duration; and the patient's functional limitations are documented in terms that are objective and measurable.

Other specific requirements include the following:

- Medicare covers therapy services that require the skill of a trained and licensed practitioner to perform or supervise. Medicare does not cover therapy services that do not require the skill of a trained and licensed practitioner to perform **even when** one of the persons in the list above performs them.

- If canalith repositioning is performed by therapy personnel under a therapy plan of care, Medicare expects a physical therapist to perform the service.

A written plan of care, consisting of diagnoses (long-term treatment goals and type, amount, duration and frequency of therapy services), must be established by the physician, NPP, or therapist providing the services before the services are begun. The plan is established when it is developed (e.g., written or dictated).

- The plan must be periodically reviewed by the physician or NPP.
- A therapist may not significantly alter a plan of care established or certified by the physician or NPP without their documented written or verbal approval.
- The plan must be certified and recertified periodically (see "Documentation Requirement" for details) by the physician or NPP. New or significantly modified plan(s) of care must be certified within 30 calendar days after the initial treatment under that plan, unless delayed certification criteria are met.
- If certification is obtained verbally, it must be followed by a signature within 14 days to be timely.
- Recertification must be obtained within the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.
- Services provided concurrently by a physician, physical therapist and occupational therapist may be covered if separate and distinct goals are documented in the treatment plan(s).
- The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed.
- The frequency refers to the number of times in a week the type of treatment is provided. Where frequency is not specific, one treatment is assumed. If a scheduled holiday occurs on a treatment day that is part of the plan, it is appropriate to omit that treatment day unless the clinician who is responsible for writing progress reports determines that a brief, temporary pause in the delivery of therapy services would adversely affect the patient's condition.
- The duration is the number of weeks, or the number of treatment sessions, for **this plan** of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.
- The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals.

For all PM&R modalities and therapeutic procedures on a given day, it is usually not medically necessary to have more than one treatment session per discipline. Treatment times per session vary based upon the patient's medical needs and progress toward established goals. Treatment times per session typically will not exceed 45–60 minutes. Additional time is sometimes required for more complex or slow-to-respond patients.

However, documentation of the exceptional circumstances must be maintained in the patient's medical record and be made available upon request.

General Guidelines for Therapeutic Procedures

CPT Codes: 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97545, 97546:

- Therapeutic procedures are procedures that attempt to reduce impairment and improve function through the application of clinical skills or services.
- Per CPT guidelines, use of these procedures requires that the practitioner have direct (one-on-one) patient contact. (Please see the group therapy section below for further clarification.)
- A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist.
- If the service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision of a therapist, the service cannot be regarded as a skilled therapy service even when a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.
- Codes for therapeutic exercises, neuromuscular re-education, aquatic therapy/exercises, and therapeutic activities describe several different types of therapeutic interventions. The expected goals documented in the treatment plan, affected by the use of each of these procedures, will help define whether these procedures are reasonable and medically necessary. Therefore, since any one or a combination of more than one, of therapeutic exercises, neuromuscular re-education, aquatic therapy/exercises and therapeutic activities may be used in a treatment plan, the documentation must support the use of each code as it relates to specific therapeutic goal(s).
- Documentation supporting the medical necessity for continued treatment must be made available to Medicare upon request.

The following clinical guidelines pertain to the **specific listed therapeutic procedures.**

Per Change Request 2083

In accordance with established conditions, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare Physician and implemented by approved Medicare qualified professionals (physical therapists or occupational therapists) or as "incident to" physician services. Some of the following rehabilitation programs/services for beneficiaries with vision impairment may include Medicare covered therapeutic services.

- Mobility.

- Activities of daily living.
- Other medically necessary services, including low-vision services.

REHABILITATIVE THERAPY

The cornerstones of rehabilitative therapy are mobilization, education and therapeutic exercise. The goal of rehabilitative medicine is discernible, functional progress toward the restoration or maximization of impaired neuromuscular and musculoskeletal function. To that end, the dynamic components of therapy, mobilization, and patient education should predominate. Passive modalities should be used in the "warm-up" phase of the patient encounter as preparation for or as an adjunct to therapeutic procedures, and in the "cool-down" phase for reduction of pain, swelling and other post-treatment syndromes. Though passive modalities may predominate in the earlier phases of rehabilitation where the patient's ability to participate in therapeutic exercise is restricted, Medicare expects these modalities to never be the sole or predominant constituent of a therapy plan of care. Further, Medicare expects the patient's record to clearly reflect medical necessity for passive modalities, especially those that exceed 25 percent of the cumulative service hours of rehabilitative therapy provided for any beneficiary under a plan of care.

In more refractory cases, the practitioner will support the need for continued care with documentation that clearly outlines the factors that require continued skilled care. The contractor recognizes variability in strength, recovery time and the ability to be educated, and allows for a recertification for additional therapy, as long as adequate medical documentation by the supervising physician or therapist is recorded in the medical record and the patient continues to require the services of a skilled caregiver.

In all cases, whether the duration and intensity of rehabilitative services recommended or rendered are limited or extensive for passive or active services, Medicare expects the patient's medical record to clearly demonstrate medical reasonableness and necessity for all therapy services. When a service is provided beyond a patient's Medicare benefit and it is determined to be not medically necessary, it is denied by Medicare as a benefit category denial.

Therapeutic exercise and activities are essential for rehabilitation. The use of modalities as stand-alone treatment is not indicated as a sole approach to rehabilitation. Therefore, an overall course of rehabilitative treatment is expected to consist predominantly of therapeutic procedures (such as therapeutic exercises, neuromuscular re-education, gait training therapy, or therapeutic activities), with adjunctive use of modalities. Although passive modalities may play a larger role in the early stages of rehabilitation and in treating exacerbations it is expected that modalities will comprise a small portion of the total therapy service time involved during the course of rehabilitative therapy. Further, it is expected that the record will demonstrate both the patient's clinical progress and concomitant appropriate increasingly active therapeutic treatment.

MAINTENANCE THERAPY

A maintenance program consists of activities that preserve the patient's present level of function or prevent regression of that function. During the last visits for rehabilitative treatment, it may be reasonable and medically necessary for the clinician to develop a maintenance program, and instruct the patient, family member(s) or caregiver(s) in carrying out the maintenance program.

It is not medically necessary for a qualified professional to perform or supervise maintenance programs that do not require the professional skills of a qualified professional. These situations include:

- Services related to activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility).
- Repetitive exercises to maintain gait or maintain strength and endurance, and assisted walking such as that provided in support for feeble or unstable patients.
- Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are useful in maintaining range of motion (for example: in paralyzed extremities).
- Maintenance therapies after the patient has achieved therapeutic goals or for patients who exhibit no potential for progress and should become patient or caregiver-directed.

Coverage for maintenance therapy services is provided when the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers. Documentation, either with objective evidence or a clinically supportable statement of expectation, must be available that supports the necessity of the skilled services provided. Further, patients with long term, chronic conditions may occasionally need skilled input to update or revise their home maintenance program; and to assess the need for new, or changes to existing, assistive or adaptive equipment. Periodic evaluations of the patient's condition and response to treatment may be covered when medically necessary if the judgment and skills of a qualified professional are required. Examples include:

- Design of a maintenance regimen required to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease.
- Instructing the patient, family member(s) or caregiver(s) in carrying out the maintenance program.
- Infrequent re-evaluations required to assess the patient's condition and adjust the program.

If a maintenance program is not established until after the therapy program has been completed (and the skills of a therapist are not necessary), development of a maintenance program is not considered reasonable and necessary for the patient's condition.

General Modality Guidelines

(CPT Codes: 97012, 97018, 97022, 97024, 97028, 97032, 97033, 97034, 97035, 97036, 97039)

- Modality codes for mechanical traction vasopneumatic device, paraffin bath therapy, whirlpool therapy, diathermy, and ultraviolet therapy, require supervision by the qualified professional.
- Modality codes for electrical stimulation, contrast bath therapy, ultrasound therapy, hydrotherapy, and physical therapy treatment unlisted require direct (one-on-one) contact with the patient by the qualified professional.
- Generally, adjunctive use of services billed with mechanical traction and paraffin bath therapy is coverable only if they enhance the therapeutic procedures. Documentation supporting the medical necessity and clinical justification for the continued use of these services must be made available to Medicare upon request.
- Generally, only one heating modality per day of therapy is reasonable and necessary. Medicare would not expect to see multiple heating modalities billed routinely on the same day. Exceptions could include musculoskeletal pathology/injuries in which both superficial and deep structures are impaired. Documentation containing clinical justification supporting the medical necessity for multiple heating modalities such as paraffin bath therapy, diathermy, and ultrasound therapy on the same day is essential.
- Generally, only one hydrotherapy modality is coverable per day when the sole purpose is to relieve muscle spasm, inflammation or edema. Documentation must be available supporting the use of multiple modalities as contributing to the patient's progress and restoration of function. Because some of the modalities are considered components of other modalities and procedures, they are not separately reimbursed. Please refer to the Correct Coding Initiative.

Specific Modality Guidelines

The following clinical guidelines pertain to the specific modalities listed.

Electrical Stimulation for the Treatment of Wounds (CPT/HCPCS Codes G0281-G0282)

Medicare provides limited coverage of electrical stimulation for the treatment of wounds. Please refer to the National Coverage Determination (NCD) 270.1 Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds for complete coverage details.

Electrical Stimulation for Indications Other Than Wound Care (CPT/HCPCS Code G0283)

Electrical stimulation for indications other than wound care is considered medically necessary when performed as an integral part of the therapy plan of care.

CPT/HCPCS G0283 – This modality includes the following types of electrical stimulation:

- Transcutaneous Electrical Nerve Stimulation (TENS).

- Microamperage E-Stimulation (MENS).
- Percutaneous Electrical Nerve Stimulation (PENS).
- Electrogalvanic stimulation (high voltage pulsed current).
- Functional electrical stimulation.
- Interferential current/medium current.

These types of electrical stimulation may be necessary during the initial phase of treatment, but there must be an expectation of improvement in function. Electrical stimulation must be utilized with appropriate therapeutic procedures (e.g., CPT Code 97110) to effect continued improvement.

Electrical stimulation is typically used in conjunction with therapeutic exercises. It is expected this modality will be used in a clearly adjunctive role and not as a major component of the therapeutic encounter.

When electrical stimulation is used for muscle strengthening or retraining, the nerve supply to the muscle must be intact. It is not medically necessary for completely denervated motor nerve disorders in which there is no potential for recovery or restoration of function.

Medicare covers pelvic floor electrical stimulation with a non-implantable stimulator for the treatment of stress or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. See CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, section 230.8 for information on Non-Implantable Pelvic Floor Electrical Stimulation.

This modality does not require direct (on-on-one) patient contact by the provider.

Please refer to LCD L36434, Microvascular Therapy (MVT), for information regarding these services.

CPT code 97012 (mechanical traction)

This modality, when provided by physicians or independent physical therapists, is typically used in conjunction with therapeutic procedures, not as an isolated treatment; however, it may be used in weaning an acute patient to a self-administered home program. **Equipment and tables utilizing roller systems are not considered true mechanical traction. Services using this type of equipment are non-covered.**

When modality codes for mechanical traction and paraffin bath therapy are used alone (absent therapeutic procedures and not as a precursor to active treatment) and solely to promote healing, relieve muscle spasm, reduce inflammation and edema, or as analgesia, a limited number of visits (e.g., 1–2 visits) may be medically necessary to determine the effectiveness of treatment and for patient education. It is usually not medically reasonable and necessary to continue modality-only treatment by the qualified professional.

Documentation should support the medical necessity of continued traction treatment in the clinic for greater than 12 visits. For cervical conditions, treatment beyond one month can usually be accomplished by self-administered mechanical traction in the home. The time devoted to patient education related to the use of home traction should be billed under mechanical traction.

Only 1 unit of mechanical traction is generally covered per date of service.

CPT code 97016 (vasopneumatic device therapy)

The use of vasopneumatic devices may be considered medically necessary for the application of pressure to an extremity for the purpose of reducing edema.

Specific indications for the use of vasopneumatic devices include:

- reduction of edema after acute injury;
- lymphedema of an extremity; or
- education on the use of a lymphedema pump for home use.

Note: Further treatment of lymphedema by a provider after the educational visits is generally not medically necessary.

Education for the home use of a lymphedema pump is sometimes provided by the lymphedema pump supplier. If the supplier does not provide this education, limited therapy professional visits for such purposes are allowable. Education on the use of a lymphedema pump for home use can typically be completed in no more than three (3) visits. Medicare does not expect to be routinely billed for repeated lymphedema treatments. **The use of vasopneumatic devices would not be covered as a temporary treatment while awaiting receipt of ordered compression stockings.** Medicare expects that documentation in the physician's medical record must support the necessity of repeated services.

CPT code 97018 (paraffin bath therapy)

Also known as hot wax treatment, paraffin bath therapy is primarily used for pain relief in chronic joint problems of the wrists, hands or feet. Paraffin bath treatments typically do not require the unique skills of a therapist. However, the skills, knowledge and judgment of a therapist might be required in the provision of such treatment or baths in a complicated case. Only in cases with complicated conditions will paraffin be covered, and then coverage is generally limited to educating the patient/caregiver in home use. Paraffin is contraindicated for open wounds or areas with documented desensitization.

Once a trial of monitored paraffin treatment has been done in the clinic over 1-2 visits and the patient has had a favorable response, the patient can usually be taught to use a paraffin unit in 1-2 visits. Consequently, it is inappropriate for a patient to continue paraffin treatment in the clinic setting.

Only 1 unit of paraffin bath therapy is generally covered per date of service.

CPT code 97022 (whirlpool therapy) and CPT code 97036 (hydrotherapy)

These modalities involve the use of agitated water to relieve muscle spasms, improve circulation or promote the healing of wounds (e.g., ulcers, exfoliative skin conditions). Whirlpool bath treatments typically do not require the unique skills of a therapist.

Physician or therapist supervision of the whirlpool modality must be medically necessary for the following indications:

- The patient's condition is complicated by:
    - Circulatory deficiency.
    - Areas of desensitization.
    - Impaired mobility or limitations in the positioning of the patient.
    - Concerns about safety, if left unsupervised.
- If greater than 8 visits are needed for whirlpool treatments that require the skills of a therapist, the documentation should support the medical necessity of the continued treatment. Documentation supporting the medical necessity for additional sessions must be made available to Medicare upon request.
- It is not medically necessary to have more than one form of hydrotherapy during a treatment session.
- It would not be considered reasonable and necessary for a patient to have whirlpool services on the same date of service as a debridement service (CPT codes 97597-97598) performed on the same body part.

Fluidotherapy (Billable as CPT code 97022)

Fluidotherapy is a superficial dry heat modality consisting of a whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having the properties of a liquid. Medicare allows the use of fluidized therapy dry heat as an acceptable alternative to other heat therapy modalities in the treatment of acute or sub-acute traumatic or non-traumatic musculoskeletal disorders of the extremities. See CMS IOM, Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Section 150.8.

Diathermy (CPT code 97024)

Short wave diathermy is an effective modality for heating skeletal muscle. Because heating is accomplished without physical contact between the modality and the skin, it can be used even if skin is abraded, as long as there is no significant edema. The use of diathermy is considered medically necessary for the delivery of heat to deep tissues such as skeletal muscle and joints for the reduction of pain, joint stiffness, and muscle spasms.

Specific indications for the use of diathermy include:

- the patient has osteoarthritis, rheumatoid arthritis, or traumatic arthritis;
- the patient has sustained a strain or sprain;
- the patient has acute or chronic bursitis;
- the patient has sustained a traumatic injury to muscle, ligament, or tendon resulting in functional loss;
- the patient has a joint dislocation or subluxation;
- the patient requires treatment for a post-surgical functional loss;
- the patient has an adhesive capsulitis; or
- the patient has a joint contracture.

Diathermy is not considered medically necessary for the treatment of asthma, bronchitis, or any other pulmonary condition.

High energy pulsed wave diathermy machines (diathermy/diapulse) have been determined to produce the same therapeutic benefit as standard diathermy. Therefore, any reimbursement for diathermy will be made at the same level as standard diathermy.

Ultraviolet Therapy (CPT code 97028)

Photons in the ultraviolet (UV) spectrum are more energetic than those in the visible or infrared regions. Their interaction with tissue and bacteria can produce non-thermal photochemical reactions, the effects of which provide the rationale for ultraviolet treatment. Ultraviolet light is highly bacteriocidal to motile bacteria, and it increases vascularization at the margins of the wounds.

The application of ultraviolet therapy is considered medically necessary for the patient requiring the application of a drying heat when prescribed by the attending physician. The specific indications for this therapy are:

- A patient having an open wound. Minimal erythema dosage must be documented and made available to Medicare upon request.
- Severe psoriasis limiting range of motion.

Only 1 unit of ultraviolet therapy is covered per date of service.

Supportive Documentation Requirements (required at least every 10 visits) for Ultraviolet Therapy:

- Area(s) being treated
- Objective clinical findings/measurements to support the need for ultraviolet therapy
- Minimal erythema dosage

CPT code 97032 (electrical stimulation) - See procedure code G0283 for pelvic floor electrical stimulators.

Non-wound care electrical stimulation treatment provided in therapy is commonly billed as procedure code G0283 as it is often provided in a supervised manner (after skilled application by the qualified professional/auxiliary personnel) without constant, direct contact required throughout the treatment.

Electrical stimulation modality requires direct (one-on-one) manual patient contact by the qualified professional/auxiliary personnel. Documentation should clearly describe the type of electrical stimulation provided, as well as the medical necessity of the constant contact to justify billing electrical stimulation. Devices delivering high voltage stimulation may require one-on-one patient contact.

Types of electrical stimulation that may require constant contact include the following examples:

- Direct motor point stimulation delivered via a probe
- Instructing a patient in the use of a home TENS unit
    - Once a trial of TENS has been done in the clinic over 1-2 visits and the patient has had a favorable response, the patient can usually be taught to use a TENS unit for pain control in 1-2 visits. Consequently, it is inappropriate for a patient to continue treatment for pain with a TENS unit in the clinic setting.
- Use for Walking in Patients with Spinal Cord Injury (SCI). The type of neuromuscular electrical stimulation (NMES) that is used to enhance the ability to walk for spinal cord injury (SCI) patients is commonly referred to as functional electrical stimulation (FES). See CMS IOM, Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, section 160.12 for information on coverage for this use of NMES.

Note: Coverage for this indication is limited to those patients where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse are causing the atrophy (e.g., post-casting or splinting of a limb, and contracture due to soft tissue scarring).

Some patients can be trained in the use of a home muscle stimulator for retraining weak muscles. Only 1-2 visits should be necessary to complete the training. Once training is completed, this procedure should not be billed as a treatment modality in a facility.

Supportive Documentation Requirements (required at least every 10 visits) for Electrical Stimulation:

- Type of electrical stimulation used (do not limit the description to “manual” or “attended”)
- Area(s) being treated
- If used for muscle weakness, objective rating of strength and functional deficits
- If used for pain include pain rating, location of pain, effect of pain on function

CPT code 97033 - (Iontophoresis - to one or more areas)

Iontophoresis is the introduction into the tissues, by means of an electric current, of the ions of a chosen medication. This modality is used to reduce pain and edema caused by a local inflammatory process in soft tissue, e.g., tendonitis, bursitis.

The evidence from published, peer-reviewed literature is insufficient to conclude that the iontophoretic delivery of non-steroidal anti-inflammatory drugs (NSAIDs) or corticosteroids is superior to placebo when used for the treatment of musculoskeletal disorders. Therefore, iontophoresis will not be covered for these indications.

Iontophoresis will be allowed for treatment of intractable, disabling primary focal hyperhidrosis (See Group 1 Diagnoses Codes) that has not been responsive to recognized standard therapy. In those allowable situations, the procedure is reportable for the time putting it on or removing or for providing instruction for use at home. Good hygiene measures, extra-strength antiperspirants (for axillary hyperhidrosis), and topical aluminum chloride should initially be tried.

CPT code 97034 (contrast bath therapy)

Contrast baths are a form of therapeutic heat and cold applied to distal extremities in an alternating pattern. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold.

Hot and cold baths ordinarily do not require the skills of a therapist. However, the skills, knowledge and judgment of a therapist might be required in the provision of such treatments in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fracture or other complication. Documentation must indicate the presence of these complicating factors for reimbursement of this code. If there are no complicating factors requiring the skills of a therapist, this modality is non-covered.

Contrast bath therapy is not covered when the services provided are hot and cold packs.

It is considered reasonable and necessary for contrast bath therapy to be used in conjunction with therapeutic procedures and not as an isolated treatment. Contrast bath therapy is a constant attendance code requiring direct, one-on-one patient contact by the provider. Only the actual time of the provider's direct contact with the patient is to be billed.

No more than 2 visits will generally be covered to educate the patient or caregiver in home use, and to evaluate effectiveness. Documentation must support the medical necessity of continued use of contrast bath therapy for greater than 2 visits.

Supportive Documentation Requirements (required at least every 10 visits) for Contrast Bath Therapy:

- Rationale requiring the unique skills of a therapist to apply, including the complicating factors
- Area(s) being treated
- Subjective findings to include pain ratings, pain location, effect on function

CPT code 97035 (ultrasound therapy)

Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 MHz. In the human body ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone may receive as much as 30% greater dosage of ultrasound than tissue not adjacent to bone. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where tissue may receive a more intense irradiation, ultrasound is an ideal modality for increasing mobility in those tissues.

It is considered reasonable and necessary that ultrasound may be pulsed or continuous width; and for it to be used in conjunction with therapeutic procedures, not as an isolated treatment.

Specific indications for the use of ultrasound application include but are not limited to:

- limited joint motion that requires an increase in extensibility
- symptomatic soft tissue calcification
- neuromas

Phonophoresis (the use of ultrasound to enhance the delivery of topically applied drugs) will be reimbursed as ultrasound therapy. Separate payment will not be made for the contact medium or drugs.

If no objective or subjective improvement is noted after 6 treatments, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of ultrasound. Documentation must clearly support the need for ultrasound more than 12 visits.

Supportive Documentation Requirements (required at least every 10 visits) for Ultrasound Therapy:

- Area(s) being treated
- Frequency and intensity of ultrasound
- Objective clinical findings such as measurements of range of motion and functional limitations to support the need for ultrasound
- Subjective findings to include pain ratings, pain location, effect on function

CPT code 97036 - (Hubbard Tank - to one or more areas)

This modality involves the patient's immersion in a tank of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds, ulcers, or exfoliative skin conditions.

One-on-one supervision of the patient by qualified professional/auxiliary personnel is required. Hubbard tank treatments more than 12 visits require clear documentation supporting the medical necessity of continued use of this modality and the continued necessity for the services of a skilled therapist.

It is not medically necessary to have more than one form of hydrotherapy during a visit (whirlpool therapy and Hubbard Tank therapy).

Supportive Documentation Requirements for CPT code 97036:

- Rationale requiring the unique skills of a therapist to apply, including the complicating factors and area(s) being treated.

Specific Guidelines for Therapeutic Procedures

The following clinical guidelines pertain to the **specific listed therapeutic procedures**.

CPT code 97110 (therapeutic exercises)

Therapeutic exercise is designed to develop strength and endurance, range of motion, and flexibility and may include: active, active-assisted or passive (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening) exercises. The exercise may be reasonable and medically necessary for a loss or restriction of joint motion, strength, functional capacity or mobility that has resulted from a specific disease or injury. It is considered reasonable and necessary if an exercise is taught to a patient and performed by a skilled therapist for the purpose of restoring functional strength, range of motion, endurance training, and flexibility. Documentation must show objective loss of joint motion, strength or mobility (e.g., degrees of motion, strength grades, levels of assistance). This therapeutic procedure is measured in 15-minute units with therapy sessions frequently consisting of several units.

Many therapeutic exercises may require the unique skills of a therapist to evaluate the patient's abilities, design the program, and instruct the patient or caregiver in safe completion of the special technique. However, after the teaching has been successfully completed, repetition of the exercise, and monitoring for the completion of the task, in the absence of additional skilled care, is non-covered.

CPT code 97112 (neuromuscular re-education)

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense,

posture, and proprioception (e.g., proprioceptive neuromuscular facilitation, Feldenkrais, Bobath, BAP's boards and desensitization techniques). The procedure may be reasonable and medically necessary for impairments that affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). For example, a gym ball exercise used for the purpose of improving balance should be considered as neuromuscular reeducation.

CPT code 97113 (aquatic therapy)

This procedure uses the therapeutic properties of water (e.g.: buoyancy, resistance). The procedure may be reasonable and medically necessary for a loss or restriction of joint motion, strength, mobility or function that has resulted from a specific disease or injury.

- Documentation must show objective loss of joint motion, strength or mobility (e.g.: degrees of motion, strength grades, level of assistance).
- Do not use this code for situations where no exercise is being performed in the water environment (e.g.: debridement of ulcers).
- When aquatic therapy is provided in a community pool, the provider must rent or lease at least a portion of the pool for the exclusive use of the patients.

NOTE: For requirements on furnishing therapy service in a pool, please refer to IOM, Pub 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220C for a complete discussion on renting/leasing pool space, use of the rented/leased space, and documentation required to support these requirements.

In addition, aquatic therapy may be considered medically necessary when:

- the patient cannot perform land-based exercises effectively to treat their condition without first undergoing the aquatic therapy, or
- aquatic therapy facilitates progression to land-based exercise or increased function. Documentation must be available in the record to support medical necessity.

It is not medically necessary to employ hydrotherapy and aquatic therapy during the same treatment session.

Note: Hydrotherapy refers to whirlpool therapy and Hubbard Tank therapy.

CPT code 97116 (gait training therapy)

This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

- This procedure is not reasonable and necessary if the patient does not require skilled care.

- Repetitive walk-strengthening exercises for feeble or unstable patients or to increase endurance do not require qualified professional supervision and will be denied as not reasonable and necessary.
- Generally, it would not be considered reasonable and necessary to perform gait training therapy in conjunction with orthotic management and training. An exception to this would be if orthotic management and training was performed on an upper extremity in conjunction with gait training.

CPT code 97124 (massage therapy)

This procedure may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to restore muscle function, reduce edema, improve joint motion or for relief of muscle spasm.

CPT code 97140 (manual therapy)

Manual therapy such as mobilization, manipulation, manual traction and manual lymphatic drainage.

Myofascial Release/Soft Tissue Mobilization

This procedure may be medically necessary for the treatment of restricted motion of soft tissues involving the extremities, neck or trunk. Skilled manual techniques (active or passive) are applied to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples include:

- Facilitation of fluid exchange
- Restoration of movement in acutely edematous; muscles
- Stretching of shortened connective tissue

This procedure may be medically necessary as an adjunct to other therapeutic procedures such as therapeutic exercises neuromuscular re-education, or therapeutic activities.

Joint Mobilization

This procedure may be medically necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure. Documentation supporting the medical necessity for continued treatment must be made available to Medicare upon request.

Manipulation

This procedure may be medically necessary as an adjunct to other therapeutic procedures such as therapeutic exercises, neuromuscular re-education, or therapeutic activities.

Manual Lymphatic Drainage/Complex Decongestive Therapy (MLD/CDT)

MLD/CDT is indicated for both primary and secondary lymphedema. Common causes include surgical removal of lymph nodes, fibrosis secondary to radiation, and traumatic injury to the lymphatic system. Both primary and secondary lymphedemas are chronic and progressive conditions which can be brought under long-term control with effective management. By maintaining control of the lymphedema, patients can:

- restore a normal, or near-normal, shape
- reduce the potential for complications (e.g., cellulitis, lymphangitis, deformity, injury, fibrosis, lymphangiosarcoma (rare), etc.)
- reduce functional deficits to resume activities of daily living

MLD/CDT consists of skin care, manual lymph drainage, compression wrapping, and therapeutic exercises. Coverage of MLD/CDT would only be allowed if **all** of the following conditions have been met:

- there is a physician-documented diagnosis of lymphedema (primary or secondary)
- the patient has documented signs or symptoms of lymphedema
- the patient or patient caregiver has the ability to understand and comply with the continuation of the treatment regimen at home

The goal of treatment is to reduce lymphedema of an extremity by routing the fluid to functional pathways, preventing backflow as the new routes become established, and to use the most appropriate methods to maintain such reduction of the extremity after therapy is complete. This therapy involves intensive treatment to reduce the volume by a combination of manual decongestive therapy and serial compression bandaging, followed by an exercise program. Ultimately the plan must be to transfer the responsibility of care from the therapist to management by the patient, patient's family, or patient's caregiver.

- In moderate-severe lymphedema, daily visits may be required for the first week
- Education should be provided to the patient or caregiver on the correct application of the compression bandage
- The therapeutic exercise component for MLD/CDT is covered under therapeutic exercises service

Documentation must clearly support the need for continued manual therapy treatment beyond 12-18 visits. When the patient or caregiver has been instructed in the performance of specific techniques, the performance of these same techniques should not be continued in the clinic setting and counted as minutes of skilled therapy

Massage is not covered on the same visit as a MLD/CDT service.

CPT code 97150 (group therapeutic procedures)

In the case of group therapy, Medicare expects that skilled, medically necessary services will be provided as appropriate to each patient's plan of care. Therefore, group therapy sessions (two or more patients) should be of sufficient length to address the needs of each of the patients in the group. Although group therapy services are included with the therapeutic procedures that require one-on-one patient contact, these services involve constant attendance of the qualified health care professional, but by definition do not require one-on-one patient contact by the same health care professional.

Documentation must identify the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, and the treatment goal in the individualized (patient-specific) plan. The number of persons in the group must also be documented. These records must be made available to Medicare upon request.

CPT code 97530 (therapeutic activities)

This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, catching and overhead activities) to improve functional performance.

The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the professional skills of a qualified professional and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

CPT code 97532 (cognitive skills development)

This activity focuses on cognitive skills development to improve attention, memory and problem-solving, with direct one-on-one patient contact by the qualified professional, each 15 minutes.

Cognitive skill training should be aimed towards improving or restoring specific functions which were impaired by an identified illness or injury, and expected outcomes should be reasonably attainable by the patient as specified by the plan of care. Therefore, cognitive skills training for conditions without potential for improvement or restoration, such as chronic progressive brain conditions, would not be appropriate. Evidence-based reviews indicate that cognitive rehabilitation (and specifically memory rehabilitation) is not recommended for patients with severe cognitive dysfunction.

Cognitive skills are an important component of many tasks, and the techniques used to improve cognitive functioning are integral to the broader impairment being addressed. Cognitive therapy techniques are most often covered as components of other therapeutic procedures, and typically would not be separately reported.

Activities billed as cognitive skills development include only those that require the skills of a therapist and must be provided with direct (one-on-one) contact between the patient and

the qualified professional/auxiliary personnel. These services are also reimbursable when billed by clinical psychologists; please refer to LCD, L35070, Speech-Language Pathology (SLP) Communication Disorders. Those services that a patient may engage in without a skilled therapist qualified professional/auxiliary personnel are not covered under the Medicare benefit.

CPT code 97533 (sensory integrative techniques)

This activity focuses on sensory integrative techniques to enhance sensory processing and to promote adaptive responses to environmental demands, with direct one-on-one contact by the qualified professional, each 15 minutes.

The patient must have the capacity to learn from instructions. Utilization of sensory integrative techniques should be infrequent for Medicare patients.

CPT code 97535 (self-care management training)

This procedure is medically necessary only when it requires the professional skills of a qualified professional, is designed to address specific needs of the patient and is part of an active treatment plan directed at a specific goal.

The patient or caregiver must have the capacity to learn from instructions.

Self-care management training should be used for activities of daily living (ADL) and compensatory training for ADL, safety procedures, and instructions in the use of adaptive equipment and assistive technology for use in the home environment. It would not be appropriate to report self-care management for exercise training, orthotics, gait devices, etc.

It would not be reasonable and necessary to report self-care management for home instruction.

Services provided concurrently by physicians, physical therapists and occupational therapists may be covered if separate and distinct goals are documented in the treatment plans, and an integrated treatment plan is maintained by the requesting physician. Documentation must relate the training to expected functional goals the patient can potentially attain.

CPT code 97537 (community/work reintegration training)

This training may be medically necessary when performed in conjunction with a patient's individual treatment plan aimed at improving or restoring specific functions that were impaired by an identified illness or injury, and when expected outcomes that are attainable by the patient are specified in the plan.

This training is medically necessary only when it requires the professional skills of a

qualified professional. Generally speaking, the professional skills of a qualified professional are not required to effect improvement or restoration of function when a patient suffers a temporary loss or reduction of function that could reasonably be expected to improve as the patient gradually resumes activities normal for them. General activity programs and all activities that are primarily social or diversional in nature will be denied because the professional skills of a qualified professional are not required.

CPT code 97542 (wheelchair management training)

This procedure is medically necessary only when it requires the professional skills of a qualified professional, is designed to address specific needs of the patient and is part of an active treatment plan directed at a specific goal.

The patient or caregiver must have the capacity to learn from instructions.

Documentation of medical necessity must be available on request for an unusual frequency or duration of training sessions. Typically, up to four sessions within one month is sufficient.

When billing wheelchair management training for wheelchair propulsion training, documentation must relate the training to expected functional goals the patient can potentially attain.

CPT code 97750 (physical performance test)

This testing may be medically necessary for patients with neurological or musculoskeletal conditions when such tests are needed to formulate or evaluate a specific treatment plan or to determine a patient's capacity.

Direct one-on-one patient contact is required.

There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. This report may include torque curves and other graphic reports with interpretation.

It is not reasonable and necessary for the physical performance test to be performed on a routine basis (i.e., monthly or in place of a reevaluation) or to be routinely performed on all patients treated.

It is not appropriate to report this service for patient assessments/re-assessments such as range of motion (ROM) testing or manual muscle testing completed at the start of care (as this is typically part of the examination included in the initial evaluation) or as the patient progresses through the episode of treatment.

Documentation must be submitted with the claim identifying the need for more than 30

minutes of time for physical performance testing.

CPT code 97755 (assistive technology assessment)

Assistive technology assessment to restore, augment or compensate for existing function or optimize functional tasks requires direct one-on-one contact with the qualified professional, each 15 minutes, and a written report.

Assistive technology assessment, direct one-on-one contact with written report, each 15 minutes, is intended for use on severely impaired patients requiring adaptive technology. For example, a patient with the use of only one or no limbs might require the use of high level adaptive technology.

CPT code 97760 (orthotic management and training)

The complexity of the patient's condition is to be documented to show the medical necessity of skilled therapy to assess, fit, and instruct in the use of the orthotic. An orthotic is a brace that includes rigid and semi-rigid components that are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. **Elastic stockings, garter belts, neoprene braces and similar devices do not come within the scope of the definition of a brace.** HCFA Ruling 96-1 clarifies that the "orthotics" benefit is limited to leg, arm, back, and neck braces that are used independently rather than in conjunction with, or as components of, other medical or non-medical equipment.

When consideration is made for a patient to require an orthotic, the therapist targets the problems in performance of movements or tasks, or identifies a part that requires immobilization, and selects the most appropriate orthotic device, then fits the device, and trains the patient or caregiver(s) in its use and application. The goal is either to promote indicated immobilization or to assist the patient to function at a higher level by decreasing functional limitations or the risk of further functional limitations.

It would not be considered reasonable and necessary to perform a therapy evaluation when an assessment related to determining the specific orthotic is performed.

An orthotic may be prefabricated or custom-fabricated. A prefabricated orthotic is one that is manufactured in quantity and then modified with a specific patient in mind. A prefabricated orthotic may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). An orthotic that is assembled from prefabricated components is considered prefabricated.

Orthotic training is not for prefabricated/commercial (i.e., off the shelf) components such as, but not limited to a lumbar roll, non-customized foam supports/wedges (e.g., heel cushions), or multi-podus boots. Such components do not require the skills of a therapist and are non-covered. Minor modifications to prefabricated orthotics do not constitute a customized

orthotic.

A custom fabricated orthotic is one that is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth, from the patient's individualized measurements. A molded-to-patient model orthotic is a particular type of custom fabricated orthotic in which an impression of the specific body part is made and the impression is then used to make a positive model. The orthotic is molded from the patient-specific model.

It is unusual to require more than 30 minutes of static orthotics training. In some cases, dynamic training may require additional time.

Documentation supporting the medical necessity for additional time must be made available to Medicare upon request.

Generally, it would not be reasonable and necessary to perform gait training at the same time as orthotic management and training. An exception to this would be if orthotic management training was performed on an upper extremity at the same time that gait training was also performed.

Payment for prosthetics and orthotics is made on the basis of a fee schedule whether it is billed to the DME MAC or the Part A MAC.

The Medicare coverage for orthotics includes the following items.

- Assessment of the patient regarding the orthotic
- Measurement or fitting
- Supplies to fabricate or modify the orthotic
- Time associated with making the orthotic

Orthotic training may include teaching the patient regarding a wearing schedule, placing and removing the orthosis, skin care and performing tasks while wearing the device. It would not be appropriate to include the time spent assessing, measuring or fitting, fabricating or modifying, or making the orthotic in the time spent providing orthotic training. Only the time spent actually training the patient should be included in the orthotic training service.

The documentation for orthotic management and training must support the need for a skilled qualified professional/auxiliary personnel to train the patient in the use and care of the orthotic. When the management of the orthotic can be turned over to the patient, the caregiver or nursing staff, the services of the therapist will no longer be covered.

An orthotic provided for positioning or increasing range of motion in a non-functional extremity must include documentation that the unique skills of a therapist are required to fit and manage the orthotic and that the orthotic is medically necessary for the patient's

condition.

For **uncomplicated** conditions, the following services would not be considered reasonable and necessary as they would not require the unique skills of a therapist.

- Issuing off-the-shelf splints for foot drop or wrist drop
- Issuing off-the-shelf foot or elbow cradles for routine pressure relief (these are not considered orthotics)
- Issuing "carrots" (i.e., cylindrical, cone-shaped forms) or towel rolls for hand contractures for hygiene purposes
- Bed positioning (e.g., pillows, wedges, rolls, foot cradles to relieve potential pressure areas)

With chronic conditions, repetitive range of motion prior to placing an orthotic/positioner to maintain the range of motion is not considered reasonable and necessary except when all criteria above for maintenance programs are met.

Ongoing therapy visits, to increase length of time an orthotic is worn, are generally not reasonable and necessary when patient problems related to the orthotic have not been observed.

Ongoing visits by the qualified professional/auxiliary personnel to apply the device would be considered monitoring. Once the initial fit is established, any further visits should be used for specific documented problems and modifications that require skilled therapy. It is reasonable and necessary to require 1-3 visits to fit and educate the patient or caregiver. The medical necessity of any further visits must be supported by documentation in the medical record.

It is not appropriate to bill orthotic training for measurements taken to obtain custom fitted burn or pressure garments. These garments do not fit the definition of an orthotic.

Supportive Documentation Requirements for orthotic management and training:

- A description of the patient's condition (including applicable impairments and functional limitations) that necessitates an orthotic
- Any complicating factors
- The specific orthotic provided and the date issued
- A description of the skilled training provided
- Response of the patient to the orthotic

CPT code 97761 (prosthetic training)

The medical record should document the distinct goal(s) and service(s) rendered when prosthetic training for a lower extremity is performed during the same treatment session as gait training or self-care/home-management training.

It is unusual to require more than 30 minutes of prosthetic training per day. Documentation supporting the medical necessity for additional time must be made available to Medicare upon request.

CPT code 97762 (check-out for orthotic use)

These assessments may be medically necessary when a device is newly issued or there is a modification or reissue of the device.

These assessments may be medically necessary when patients experience loss of function directly related to the orthotic or prosthetic device (e.g., pain, skin breakdown or falls).

It is unusual to require more than 30 minutes of checkout for orthotic/prosthetic use for an established patient. Documentation supporting the medical necessity for additional time must be made available to Medicare upon request.

LIMITATIONS

Services not relating to a written treatment plan are not medically necessary.

Services that do not require the professional skills of a physician or NPP to perform or supervise are not medically necessary.

Claims submitted by anyone other than a therapist enrolled as a Medicare provider are not covered.

PT and OT evaluation or re-evaluation claims submitted with an evaluation and management code performed on the same day are not considered reasonable and necessary.

Services not performed by or under the appropriate supervision of the therapist are not covered. Direct supervision is required for private practice but general supervision is required for all other settings for PTA services. All other criteria for PTA services must be met for payment by Medicare. PTA services cannot be billed by a PTA but must be billed by the supervising PT. The services of a PTA shall not be billed as services incident to a physician/NPP's service, because they do not meet the qualifications of a therapist.

Services performed by people who are not employees of, or supervised by, the therapist are not covered.

Services not furnished in the therapist's office or in the patient's home are not covered.

PT services that do not require the professional skills of a qualified physical therapist to perform or supervise are not medically necessary.

OT services that do not require the professional skills of a qualified occupational therapist to perform or supervise are not medically necessary.

Ultrasound application (CPT code 97035) is not considered reasonable and necessary for the treatment of:

- asthma, bronchitis, or any other pulmonary condition;
- conditions for which the ultrasound can be applied by the patient without the need for a therapist or other professional to administer, or for extended period of time (e.g., devices such as PainShield MD); wounds.

Electrical stimulation used in the treatment of facial nerve paralysis, commonly known as Bell's Palsy, is considered investigational. (CMS IOM, Manual 100-03, *Medicare National Coverage Determinations (NCD) Manual*, section 160.15)

Electrical stimulation used to treat motor function disorders, such as multiple sclerosis, is considered investigational. (CMS IOM, Manual 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, section 160.2).

Electrical Stimulation when it is the only intervention utilized purely for strengthening of a muscle with at least Fair graded strength. Most muscle strengthening is more efficiently accomplished through a treatment program that includes active procedures such as therapeutic exercises and therapeutic activities.

Billing an electrical stimulation service for constant attendance while providing an electrical stimulation modality that is typically considered supervised (such as electrical stimulation for indications other than wound care) to a patient requiring constant attendance for safety reasons due to cognitive deficits, is non-covered. This type of monitoring may be done by non-skilled personnel.

Non-Surgical Spinal Decompression is performed for symptomatic relief of pain associated with lumbar disk problems. The treatment combines pelvic or cervical traction connected to a special table that permits the traction application. There is insufficient scientific data to support the benefits of this technique. Refer to NCD 160.16. Examples of this type of non-covered procedure include, but are not limited to, VAX-D™, DRX-3000, DRX9000, Decompression Reduction Stabilization (DRS) System, IDD, MedX., Spina System, Accua-Spina System, SpineMED Decompression Table, Lordex Traction Unit, Triton DTS, and Z-Grav.

Dry hydrotherapy massage (also known as aqua-massage, hydro-massage, or water massage) is considered investigational and is non-covered.

Diathermy/Microwave services are considered as not reasonable and necessary due to insufficient evidence from published, controlled clinical studies demonstrating the efficacy of this modality.

Per Centers for Medicare and Medicaid Service CR 9252, infrared application (CPT code 97026) is considered a non-covered service. See CMS IOM Pub. 100-03, *National Coverage Determination (NCD) Manual,* Chapter 1, Section 270.6 for further coverage guidelines.

Manual Lymphatic Drainage/Complex Decongestive Therapy (MLD/CDT) is not covered for:

- conditions reversible by exercise or elevation of the affected area;
- dependent edema related to congestive heart failure or other cardiomyopathies;
- patients who do not have the physical and cognitive abilities, or support systems, to accomplish self-management in a reasonable time;
- continuing treatment for a patient non-compliant with a program for self-management.

Medicare considers the following as non-covered for group therapy CPT code (97150):

- Groups directed by a student, therapy aide, rehabilitation technician, nursing aide, recreational therapist, exercise physiologist, or athletic trainer
- Routine (i.e., supportive) groups that are part of a maintenance program, nursing rehabilitation program, or recreational therapy program
- Groups using biofeedback for relaxation
- Viewing videotapes; listening to audiotapes
- Group treatment that does not require the unique skills of a therapist

Supervision of a previously taught exercise program or supervising patients who are exercising independently is not a skilled service and is not covered as group therapy or as any other therapeutic procedure. Supervision of patients exercising on machines or exercise equipment, in the absence of the delivery of skilled care, is not a skilled service and is not covered as group therapy or as any other therapeutic procedure.

Services that are related **solely** to specific employment opportunities, work skills or work settings (CPT codes 97545 and 97546) 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.

The services of work hardening and work hardening add-on are related solely to specific work skills and are not considered medically reasonable and necessary for the diagnosis or treatment of an illness or injury.

Notice: Services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS National Coverage Determinations, and all Medicare payment rules.

For frequency limitations, please refer to the Utilization Guidelines section below.

Notice: This LCD imposes frequency limitations as well as diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

As published in CMS IOM, 100-08, *Medicare Program Integrity Manual,* Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
    - Furnished in a setting appropriate to the patient's medical needs and condition.
    - Ordered and furnished by qualified personnel.
    - One that meets, but does not exceed, the patient's medical needs.
    - At least as beneficial as an existing and available medically appropriate alternative.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements of this LCD.

Group 1 Paragraph: Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

Group 1 Codes:

95992 Canalith repositioning proc

97012 Mechanical traction therapy

97016 Vasopneumatic device therapy

97018 Paraffin bath therapy

97022 Whirlpool therapy

97024 Diathermy eg microwave
97028 Ultraviolet therapy
97032 Electrical stimulation
97033 Electric current therapy
97034 Contrast bath therapy
97035 Ultrasound therapy
97036 Hydrotherapy
97039 Physical therapy treatment
97110 Therapeutic exercises
97112 Neuromuscular reeducation
97113 Aquatic therapy/exercises
97116 Gait training therapy
97124 Massage therapy
97139 Physical medicine procedure
97140 Manual therapy 1/> regions
97150 Group therapeutic procedures
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
97530 Therapeutic activities
97532 Cognitive skills development
97533 Sensory integration
97535 Self care mngment training
97537 Community/work reintegration
97542 Wheelchair mngment training
97750 Physical performance test
97755 Assistive technology assess
97760 Orthotic mgmt and training

97761 Prosthetic training

97762 C/o for orthotic/prosth use

97799 Physical medicine procedure

G0283 Elec stim other than wound

Please refer to the CMS website for the ICD-10 Codes that Support Medical Necessity.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
   Note: Please refer to the various therapy procedures in the body of the policy for required documentation requirements.
5. Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.
6. Documentation should establish through objective measurements that the patient is making progress toward goals. Results of one of the following three measurements are recommended:
   a. Patient Inquiry by Focus on Therapeutic Outcomes, Inc. (FOTO).
   b. Activity Measure - Post Acute Care (AM-PAC).
   c. OPTIMAL by Cedaron through the American Physical Therapy Association.

   Note: If results of one of the three instruments listed above are not recorded, the medical record shall contain that information outlined in IOM, Pub. 100-02, *Medicare Benefit Policy Manual,* Chapter 15, Section 220.3.
7. The medical record must identify the physician responsible for the general medical care.
8. Therapy services must be furnished according to a written treatment plan determined by the physician or by the therapist who will provide the treatment after an appropriate assessment of the condition (illness or injury). All qualified professionals rendering therapy must document the appropriate history, examination, diagnosis, functional assessment, type of treatment including rationale for each specific treatment, the body areas to be treated, the date therapy was initiated, and expected frequency and number of treatments.
9. Outpatient therapy **MUST** be under the care of a Physician/NPP. An order (sometimes called a referral) for therapy services, documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician.

Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.

10. Certification is the physician's/NPP's approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. A certification is timely when it is obtained within 30 calendar days of the initial treatment under that plan of care.
11. Recertifications must be obtained within the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.
12. For CMS recommendations regarding progress reports and modifications to the plan of care, refer to the IOM, Pub. 100-02, *Medicare Benefit Policy Manual,* Chapter 15.
13. When a verbal order is used to certify the plan of care, a dated notation should be made in the patient's medical record.
14. Evidence considered necessary to justify delayed certification should be maintained by the supplier of services.
15. Signature and professional identity of the person who established the plan and the date it was established must be recorded with the plan.
16. Documentation for rehabilitative services should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time or the need to establish a safe and effective maintenance program. Evaluation, re-evaluation and assessment documented in Progress Notes should describe objective measurements that, when compared, show improvement in function or decrease in severity or rationalization for an optimistic outlook to justify continued treatment.
17. Documentation supporting the medical necessity for multiple heating modalities on the same date of service must be available for review and show that all were needed toward the restoration of function.
18. For any timed services, the total number of treatment minutes must be documented in the medical record. It is recommended but not required that the time for each timed service be noted in rounded minutes to show consistency with and support the treatment provided. Total treatment time in minutes must also be recorded in the medical record. Total treatment time is comprised of the minutes for timed code treatment and untimed code treatment. Services that are not billable (e.g., rest periods) are not included in the total treatment time and are recommended to show consistency with and support the treatment provided.

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Medicare covers the following number of therapy services without routinely requiring medical review of records to determine medical necessity:

- Five (15 minutes each) timed PT services per patient per day.

- Five (15 minutes each) timed OT services per patient per day.
- Sixty (15 minutes each) PT services per patient per month.
- Sixty (15 minutes each) OT services per patient per month.

Providers of PT/OT services must be aware, however, that any service reported to Medicare, even when reported at a frequency within the following stated covered guidelines, may be denied if done so in association with medical review of the patient's record that demonstrates no medical necessity for the services. Similarly, services in addition to the above limits may be payable when done so in association with medical review of the patient's record that demonstrates medical necessity for additional services.

Medicare allows the following units of service for providers of PT/OT services, as long as each service is medically reasonable and necessary for the specific patient and his condition. Additionally, Medicare expects that the patient's medical record will clearly demonstrate that medical necessity. Further, Medicare does not expect that maximum allowable services will be routinely necessary, necessary for multiple-week periods, or necessary for the entirety of the patient's course of treatment.

Any federally established financial limitations on outpatient therapy services' coverage and coding rules will apply.

Notice: This LCD imposes utilization guideline limitations. Despite Medicare's allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

Reviewed/Approved by Michael Pentecost MD Michael Pentecost, MD, Chief Medical Officer