

# Cigna Medical Coverage Policy- Therapy Services

## Physical Therapy

Effective Date: 3/15/2021

Next Review Date: 12/15/2021



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### INSTRUCTIONS FOR USE

*Cigna / ASH Medical Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these Cigna / ASH Medical Coverage Policies are based. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Cigna / ASH Medical Coverage Policy. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Determinations in each specific instance may require consideration of:*

- 1) the terms of the applicable benefit plan document in effect on the date of service*
- 2) any applicable laws/regulations*
- 3) any relevant collateral source materials including Cigna-ASH Medical Coverage Policies and*
- 4) the specific facts of the particular situation*

*Cigna / ASH Medical Coverage Policies relate exclusively to the administration of health benefit plans.*

*Cigna / ASH Medical Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines.*

*Some information in these Coverage Policies may not apply to all benefit plans administered by Cigna. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make benefit determinations. References to standard benefit plan language and benefit determinations do not apply to those clients.*

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**Under many benefit plans, coverage for outpatient physical therapy programs and physical therapy provided in the home is subject to the terms, conditions and limitations of the applicable benefit plan's Short-Term Rehabilitative Therapy benefit and schedule of copayments. Under many plans, coverage of inpatient physical therapy is subject to the terms, conditions and limitations of the Other Participating Health Care Facility/Other Health Care Facility benefit as described in the applicable plan's schedule of copayments.**

**Outpatient physical therapy is the most medically appropriate setting for these services unless the individual independently meets coverage criteria for a different level of care.**

**If covered, massage therapy is generally subject to the terms, conditions and limitations of the Short-Term Rehabilitation Therapy or Chiropractic Care Services benefits as described in the applicable plan's schedule of copayments. Many benefit plans include a maximum allowable benefit for duration of treatment or number of visits. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.**

**Coverage for physical therapy varies across plans. Refer to the customer's benefit plan document for coverage details.**

If coverage is available for physical therapy, the following conditions of coverage apply.

## **GUIDELINES**

### **Medically Necessary**

- I. **A physical therapy evaluation is considered medically necessary for the assessment of a physical impairment.**
- II. **Physical therapy services are considered medically necessary to improve, adapt or restore functions which have been impaired or permanently lost and/or to reduce pain as a result of illness, injury, loss of a body part, or congenital abnormality when ALL the following criteria are met:**
  - The individual's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
  - The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.
  - Improvement is evidenced by successive objective measurements.
  - The services are delivered by a qualified provider of physical therapy services (i.e., appropriately trained and licensed by the state to perform physical therapy services).
  - Physical therapy occurs when the judgment, knowledge, and skills of a qualified provider of physical therapy services (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service due to the complexity and sophistication of the plan of care and the medical condition of the individual, with the goal of improvement of an impairment or functional limitation.

### **Not Medically Necessary**

- I. **PT services are considered not medically necessary if any of the following is determined:**
  - The individual's condition does not have the potential to improve or is not improving in response to therapy; or would be insignificant relative to the extent and duration of therapy required; and there is an expectation that further improvement is NOT attainable.
  - Improvement or restoration of function could reasonably be expected as the individual gradually resumes normal activities without the provision of skilled therapy services. For example:
    - An individual suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities;
    - A fully functional individual who develops temporary weakness from a brief period of bed rest following abdominal surgery.
  - Therapy services that do not require the skills of a qualified provider of PT services. Examples include but not limited to:
    - Activities for the general good and welfare of patients
      - General exercises (basic aerobic, strength, flexibility or aquatic programs) to promote overall fitness/conditioning
      - Services/programs for the primary purpose of enhancing or returning to athletic or recreational sports.
      - Massages and whirlpools for relaxation
      - General public education/instruction sessions
    - Repetitive gait or other activities and services that an individual can practice independently and can be self-administered safely and effectively.
      - Activities that require only routine supervision and NOT the skilled services of a physical therapy provider

- When a home exercise program is sufficient and can be utilized to continue therapy (examples of exceptions include but would not be limited to the following: if patient has poor exercise technique that requires cueing and feedback, lack of support at home if necessary for exercise program completion, and/or cognitive impairment that doesn't allow the patient to complete the exercise program)
- Documentation fails to objectively verify subjective, objective and functional progress over a reasonable and predictable period of time.
- The physical modalities are not preparatory to other skilled treatment procedures.
- Modalities that have been deemed to provide minimal to no clinical value independently or within a comprehensive treatment for any condition and/or not considered the current standard of care within a treatment program
  - Infrared light therapy
  - Vasopneumatic device
- Treatments are not supported in peer-reviewed literature.

**II. The following treatments are considered not medically necessary because they are nonmedical, educational or training in nature. In addition, these treatments/programs are specifically excluded under many benefit plans:**

- back school
- vocational rehabilitation programs and any program with the primary goal of returning an individual to work
- work hardening programs

**III. Duplicative or redundant services expected to achieve the same therapeutic goal are considered not medically necessary. For example:**

- Multiple modalities procedures that have similar or overlapping physiologic effects (e.g., multiple forms of superficial or deep heating modalities)
- Same or similar rehabilitative services provided as part of an authorized therapy program through another therapy discipline.
  - When individuals receive physical, occupational, or speech therapy, the therapists should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals. When individuals receive manual therapy services from a physical therapist and chiropractic or osteopathic manipulation, the services must be documented as separate and distinct, performed on different body parts, and must be justified and non-duplicative.

## **Experimental, Investigational, Unproven**

**I. Physical therapy for the treatment of ANY of the following conditions is considered experimental, investigational or unproven:**

- sexual dysfunction unrelated to a musculoskeletal or orthopedic condition
- scoliosis curvature correction (e.g., Schroth Method)

**II. Use of any of the following treatments is considered experimental, investigational or unproven:**

- Intensive Model of constraint-induced movement therapy(CIMT)
- Intensive Model of Therapy (IMOT) programs
- Dry hydrotherapy/aquamassage/hydromassage

- Non-invasive Interactive Neurostimulation (e.g., InterX®)
- Microcurrent Electrical Nerve Stimulation (MENS)
- H-WAVE ®
- Spinal manipulation for the treatment of non-musculoskeletal conditions and related disorders
- Equestrian therapy (e.g., hippotherapy)
- MEDEK Therapy
- The Interactive Metronome Program
- Dry needling
- Elastic therapeutic tape/taping (e.g., Kinesio™ tape, KT TAPE/KT TAPE PRO™, Spidertech™ tape)
- Low-level laser therapy (LLLT) and high-power Class IV therapeutic laser light therapy
- Vertebral axial decompression therapy and devices (e.g., VAX-D, DRX, DRX2000, DRX3000, DRX5000, DRX9000, DRS, Dynapro™ DX2, Accu-SPINA™ System, IDD Therapy® [Intervertebral Differential Dynamics Therapy], Tru Tac 401, Lordex Power Traction device, Spinerx LDM)

## **Massage Therapy**

**Massage therapy is considered not medically necessary when provided in the absence of covered physical therapy, occupational therapy or chiropractic modalities.**

**Note: Massage therapy may be provided by several types of providers. To qualify for coverage, the provider must meet the definition of provider contained in the benefit plan. Please refer to the applicable plan language to determine benefit coverage for the rendering provider.**

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Physical therapy (PT) services are skilled services which may be delivered by a physical therapist or other health care professional acting within the scope of a professional license. 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 a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though 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. Services that do not require the professional skills of a therapist to perform or supervise are not medically necessary, even if they are performed or supervised by a therapist, physician or NPP. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self-management program, restorative nursing program or caregiver assisted program, physical therapy services are not indicated or medically necessary.

PT services are intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time. If no improvement is documented after two weeks of treatment, an alternative treatment plan should be attempted. If no significant improvement is documented after a total of four weeks, re-evaluation by the referring provider may be indicated. Treatment is no longer medically necessary when the individual stops progressing toward established goals.

The Guide to Physical Therapist Practice, published by the APTA (2014), supports this guideline in all areas of physical therapy practice.

### **GENERAL BACKGROUND**

Physical therapists provide services to patients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes. Medically necessary physical therapy services must relate to a written treatment plan of care and be of a level of complexity that requires the judgment, knowledge and skills of a physical therapist to perform and/or supervise the services. The plan of care for medically necessary physical therapy services is established by a licensed

physical therapist. The amount, frequency and duration of the physical therapy services must be reasonable (within regional norms and commonly accepted practice patterns); the services must be considered appropriate and needed for the treatment of the condition and must not be palliative in nature. Thus, once therapeutic benefit has been achieved, or a home exercise program could be used for further gains without the need for skilled physical therapy, continuing supervised physical therapy is not considered medically necessary. If measurable improvement is made, then the progress towards identified goals should be clearly documented and the treatment plan updated accordingly.

## **PHYSICAL THERAPY TREATMENT SESSIONS**

A physical therapy intervention is the purposeful interaction of the physical therapist with the patient and, when appropriate, with other individuals involved in patient care, using various physical therapy procedures and techniques to produce changes in the condition that are consistent with the diagnosis and prognosis. Physical therapy interventions consist of coordination, communication, and documentation; patient-related and family/caregiver instruction; and procedural interventions. Physical therapists aim to alleviate impairment and functional limitation by designing, implementing, and modifying therapeutic interventions. A physical therapy session can vary from fifteen minutes to four hours per day; however, treatment sessions lasting more than one hour per day are infrequent in outpatient settings. Treatment sessions for more than one hour per day may be medically appropriate for inpatient acute settings, day treatment programs, and select outpatient situations, but must be supported in the plan of care and based on a patient's medical condition. Physical therapy can also be performed in a group setting. Patients with total joint replacement, low back pain, and urinary incontinence present with favorable outcomes in a group setting.

A physical therapy session may include:

- Evaluation or reevaluation;
- Therapeutic exercise, including neuromuscular reeducation, strengthening, coordination, and balance;
- Functional training in self-care and home management including activities of daily living (ADL) and instrumental activities of daily living (IADL);
- Functional training in and modification of environments (home, work, school, or community), including body mechanics and ergonomics;
- Manual therapy techniques, including soft tissue mobilization, joint mobilization, and manual lymphatic drainage;
- Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices;
- Training in the use of prosthetic devices;
- Integumentary and wound care and protection techniques;
- Electrotherapeutic modalities;
- Physical agents and mechanical modalities;
- Community functional reintegration;
- Training of the patient, caregivers, and family/parents in home exercise and activity programs;
- Skilled reassessment of the individual's problems, plan, and goals as part of the treatment session

## **MODALITIES AND PROCEDURES**

The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy" (AMA, 2018). Modalities may be supervised, which means that the application of the modality doesn't require direct one-on-one patient contact by the practitioner. This means that set-up and application of the modality needs to be supervised by a physical therapist, but they do not need to perform the modality. Modalities may also involve constant attendance, which indicates that the modality requires direct one-on-one patient contact by the practitioner.

Examples of supervised modalities include application of:

- Hot or cold packs
- Mechanical traction
- Unattended electrical stimulation (i.e., for pain relief)
- Vasopneumatic devices
- Whirlpool

- Paraffin bath
- Diathermy

Examples of modalities that require constant attendance include:

- Contrast baths
- Ultrasound
- Attended electrical stimulation (i.e., NMES)
- Iontophoresis

Passive modalities are most effective during the acute phase of treatment, since they are typically directed at reducing pain, inflammation, and swelling. They may also be utilized during the acute phase of the exacerbation of a chronic condition. Passive modalities are rarely beneficial alone and are most effective when performed as part of a comprehensive treatment approach. Some improvement with the use of passive modalities should be seen within three visits. If passive therapy is not contributing to improvement, passive therapy should be discontinued and other evidence supported interventions implemented. After one or two weeks, the clinical effectiveness of passive modalities begins to decline significantly. In some situations, passive modalities may be indicated for up to one or two months as part of comprehensive physical therapy program. The need for passive modalities beyond two weeks should be objectively documented in the clinical record.

The AMA CPT manual defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function" (AMA, 2018). Examples of therapeutic procedures include therapeutic exercise to develop strength and endurance, range of motion and flexibility; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; aquatic therapy with therapeutic exercises; gait training (including stairs); and manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction); or therapeutic activities using dynamic activities to improve functional performance (direct one-on-one patient contact by the practitioner).

Transition from passive physiotherapy modalities to active treatment procedures should be timely and evidenced in the medical record, including instructions on self/home care. And in most cases, active treatment should be initiated in addition to modality use at a level that is appropriate for the patient.

Active therapeutic procedures are typically started as swelling, pain, and inflammation are reduced. The need for stabilization and support is replaced by the need for increased range of motion and restoration of function. Active care elements include increasing range of motion, strengthening primary and secondary stabilizers of a given region, and increasing the endurance capability of the muscles. Care focuses on active participation of the patient in their exercise program. Gait training, muscle strengthening, and progressive resistive exercises are considered active procedures. Many active procedures may be performed independently and safely by the patient in a non-medically supervised setting. In general, patients should progress from active procedures to a home exercise program that is progressed throughout treatment.

Below is a description and medical necessity criteria, as applicable, for different treatment interventions, including specific modalities and therapeutic procedures associated with physical therapy. This material is for informational purposes only and is not indicative of coverage, nor is it an exhaustive list of services provided.

### **Hydrotherapy/Whirlpool/Hubbard Tank**

These modalities involve supervised use of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds e.g., ulcers, skin conditions. More specifically, Hubbard tank involves a full-body immersion tank for treating severely burned, debilitated and/or neurologically impaired individuals. Hydrotherapy is considered medically necessary for pain relief, muscle relaxation and improvement of movement for persons with musculoskeletal conditions. It is also considered medically necessary for wound care (cleansing and debridement). It is not appropriate to utilize more than one hydrotherapy modality on the same day.

### **Fluidotherapy®**

This modality is used specifically for acute and subacute conditions of the extremities. Fluidotherapy® is a dry superficial thermal modality that transfers heat to soft tissues by agitation of heated air and Cellux particles. The indications for this modality are similar to paraffin baths and whirlpool and it is an acceptable alternative to other

heat modalities for reducing pain, edema, and muscle spasm from acute or subacute traumatic or non-traumatic musculoskeletal disorders of the extremities, including complex regional pain syndrome (CRPS). A benefit of Fluidotherapy® is that patients can perform active range of motion (AROM) while undergoing treatment.

## **Vasopneumatic Devices**

These special devices apply pressure for swelling/edema reduction, either after an acute injury, following a surgical procedure, due to lymphedema, or due to pathology such as venous insufficiency. Units that provide cold therapy with compression are not examples of vasopneumatic devices. Vasopneumatic devices are considered not medically necessary for any condition given the state of evidence relative to lymphedema. Standard of care for lymphedema is complex lymphedema therapy, which includes skin and nail care, manual drainage techniques, compression bandaging, and therapeutic exercise.

## **Hot/Cold Packs**

Hot packs increase blood flow, relieve pain and increase movement; cold packs decrease blood flow to an area for pain and swelling reduction and are typically used in the acute phase of injury or in the acute phase of an exacerbation. They are considered medically necessary for painful musculoskeletal conditions and acute injury.

## **Paraffin Bath**

This modality uses hot wax for application of heat. It is indicated for use to relieve pain and increase range of motion of extremities (typically wrists and hands) due to chronic joint problems or post-surgical scenarios.

## **Mechanical Traction**

This device provides a mechanical pull on the spine (cervical or lumbar) to relieve pain, spasm, and nerve root compression.

## **Infrared Light Therapy**

Originally, this dry heat lamp was used to increase circulation to relieve muscle spasm. Other heating modalities are considered superior to infrared lamps. Given this, infrared light therapy is considered not medically necessary for any condition. More recently, infrared or near infrared energy has been used therapeutically. Considered low level laser or light therapy, these devices utilize laser or LEDs to treat damaged tissues; however utilization of this specific CPT code is not designated for low level laser. This also does not refer to Anodyne® Therapy System.

## **Electrical Stimulation**

Electrical stimulation is used in different variations to relieve pain, reduce swelling, heal wounds, and improve muscle function. Functional electric stimulation is considered medically necessary for muscle re-education (to improve muscle contraction) in the earlier phases of rehabilitation.

## **Iontophoresis**

Electric current used to transfer certain chemicals (medications) into body tissues. Use to treat inflammatory conditions, such as plantar fasciitis and lateral epicondylitis.

## **Contrast Baths**

This modality is the application of alternative hot and cold baths and is typically used to treat extremities with subacute swelling or CRPS. Contrast baths assist with hypersensitivity reduction and swelling reduction.

## **Ultrasound**

This modality provides deep heating through high frequency sound wave application. Non-thermal applications are also possible using the pulsed option. Ultrasound is commonly used to treat many soft tissue conditions that require deep heating or micromassage to a localized area to relieve pain and improve healing.

## **Diathermy (i.e., shortwave)**

This modality utilizes high frequency magnetic and electrical current to provide deep heating to larger joints and soft tissue structures for pain relief, increased healing, and muscle spasm reduction. Microwave diathermy presents a negative benefit:risk ratio and is not recommended.

## **Therapeutic Exercises**

This procedure includes instruction, feedback, and supervision of a person in an exercise program for their condition. The purpose is to increase/maintain flexibility and muscle strength. Therapeutic exercise is performed with a patient either actively, active-assisted, or passively. It is considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury. Note: Exercising done subsequently by the member without a physician or therapist present and supervising would not be covered.

## **Neuromuscular Reeducation**

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who has reduced balance, strength, functional capacity or mobility which has resulted from disease, injury, or surgery. The goal is to develop conscious control of individual muscles and awareness of position of extremities. The procedure may be considered medically necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident and systemic neurological disease.

## **Aquatic Therapy**

Pool therapy (aquatic therapy) is provided individually, in a pool, to debilitated or neurologically impaired individuals. (The term is not intended to refer to relatively normal functioning individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.) The goal is to develop and/or maintain muscle strength and range of motion by reducing forces of gravity through total or partial body immersion (except for head).

## **Gait Training**

This procedure involves teaching individuals with neurological or musculoskeletal disorders how to ambulate given their disability or to ambulate with an assistive device. Assessment of muscle function and joint position during ambulation is considered a necessary component of this procedure, including direct visual observation and may include video, various measurements, and progressive training in ambulation and stairs. Gait training is considered medically necessary for training individuals whose walking abilities have been impaired by neurological, integumentary, muscular or skeletal abnormalities, surgery, or trauma. This also includes crutch/cane ambulation training and re-education.

## **Massage Therapy**

Massage involves manual techniques that include applying fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands. These techniques affect the musculoskeletal, circulatory-lymphatic, nervous, and other systems of the body with the intent of improving a person's well-being or health. The most widely used forms of basic massage therapy include Swedish massage, deep-tissue massage, sports massage, neuromuscular massage, and manual lymph drainage. Massage therapy may be considered medically necessary when designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm, and determined not duplicative to other modalities/procedures.

## **Soft Tissue Mobilization**

Soft tissue mobilization techniques are more specific in nature and include, but are not limited to, myofascial release techniques, friction massage, and trigger point techniques. Specifically, myofascial release is a soft tissue manual technique that involves manipulation of the muscle, fascia, and skin. Skilled manual techniques (active and/or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue. This procedure is considered medically necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk.

## **Joint Mobilization/Manipulation**

Joint mobilization and manipulation is utilized to reduce pain and increase joint mobility. Most often mobilizations are indicated for extremity and spine conditions, while manipulation may be more generally indicated for spinal conditions.

## **Therapeutic Activities**

This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities) to improve functional performance in a progressive manner. The

activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the professional skills of a practitioner and are designed to address a specific functional need of the member. This intervention may be appropriate after a patient has completed exercises focused on strengthening and range of motion but need to be progressed to more function-based activities. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

### **Activities of Daily Living (ADL) Training**

Training of impaired individuals in essential activities of daily living and self-care activities including: bathing; feeding; preparing meals; toileting; dressing; walking; making a bed; and transferring from bed to chair, wheelchair or walker. This procedure is considered medically necessary to enable the member to perform essential activities of daily living related to the patient's health and hygiene, within or outside the home, and with minimal or no assistance from others. Services provided concurrently by physical therapists and occupational therapists may be considered medically necessary if there are separate and distinct functional goals.

### **Cognitive Skills Development**

This procedure is considered medically necessary for persons with acquired cognitive defects resulting from head trauma, or acute neurologic events including cerebrovascular accident or pediatric developmental condition. It is not appropriate for persons without potential for improvement. Occupational/speech therapists with specific training typically provide this care, however physical therapists can also provide this care through a team approach. This procedure should be aimed at improving or restoring specific functions which were impaired by an identified illness or injury.

### **Orthotic Training**

Training and re-education with braces and/or splints (orthotics).

### **Prosthetic Checkout**

These assessments are considered medically necessary when a device is newly issued or there is a modification or re-issue of the device. These assessments are considered medically necessary when a member experiences loss of function directly related to the orthotic or prosthetic device (e.g., pain, skin breakdown, or falls). This is usually completed in 1-2 sessions.

### **Prosthetic Training**

Training and re-education with prosthetics devices. Considered medically necessary for persons with a medically necessary prosthetic. Periodic return visits beyond the third month may be necessary.

### **Wheelchair Management Training**

This procedure is considered medically necessary only when it is part of an active treatment plan directed at a specific goal. The member must have the capacity to learn from instructions. Typically, three (3) sessions are adequate.

Certain physical medicine modalities and therapeutic procedures are considered duplicative in nature and it would be inappropriate to perform or bill for these services during the same session, such as:

- Functional activities and ADLs
- More than one deep heating modality
- Massage therapy and myofascial release
- Orthotics training and prosthetic training
- Whirlpool and Hubbard tank

The medical necessity of neuromuscular reeducation, therapeutic exercises, and/or therapeutic activities, performed on the same day, must be documented in the medical record.

Only one heat modality would be considered medically necessary during the same treatment session, with the exception of use of one form of superficial heat and one form of deep heat (i.e. ultrasound or diathermy and hot packs). Use of two forms of deep or superficial heat would not be acceptable.

### **Active Wound Care Management**

The AMA CPT manual defines active wound care procedures as those procedures "performed to remove devitalized tissue and/or necrotic tissue and promote healing" (AMA, 2014). The practitioner is required to have

direct one-on-one contact with the patient. Examples of active wound care management include debridement of an open wound, including topical application; use of whirlpool or other modalities; and negative pressure wound therapy.

## **Electromyography (EMG) and Nerve Conduction Velocity (NCV) Tests**

According to the AMA CPT manual "Needle electromyographic procedures include the interpretation of electrical waveforms measured by equipment that produces both visible and audible components of electrical signals recorded from the muscle(s) studied by the needle electrode" (AMA, 2014). For nerve conduction testing, "motor nerve conduction study recordings must be made from electrodes placed directly over the motor point of the specific muscle to be tested. Sensory nerve conduction study recordings must be made from electrodes placed directly over the specific nerve to be tested." Waveforms must be reviewed on site in real-time. Reports must be prepared on site by the examiner and consist of the work product of the interpretation of numerous test results. EMG and NCV testing is only covered if provided by a qualified health care professional or physician. Physical therapists who are board certified by the APTA are considered qualified health professionals. State licensure rules and regulations apply.

## **DOCUMENTATION GUIDELINES**

### **Initial Examination/Evaluation/Diagnosis/Prognosis**

The physical therapist performs an initial examination and evaluation to establish a physical therapy diagnosis, prognosis, and plan of care prior to intervention. An initial evaluation for a new condition by a Physical Therapist is defined as the evaluation of a patient:

- For which this is their first encounter with the practitioner or practitioner group
- Who presents with:
  - A new injury or new condition; or
  - The same or similar complaint after discharge from previous care.
- Choice of code is dependent upon the level of complexity.

Note: Appropriate range of motion (ROM) testing (CPT codes 95851- 95852) and/or manual muscle testing (MMT) (CPT codes 95831 – 95834), including digital wireless dynamometers and inclinometers or other such electronic device that measures strength and/or ROM using a handheld device are integral within Evaluation/Reevaluation codes. Computerized isokinetic muscle strength and endurance testing using a machine, such as a Biodex, would be considered a physical performance test or measurement using CPT code 97750 – "Physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes."

Four components are used to select the appropriate PT evaluation CPT code. These include:

- Patient history and comorbidities
- Examination and the use of standardized tests and measures
- Clinical presentation
- Clinical decision making

Relevant CPT Codes: CPT 97161, 97162, and 97163 – Physical Therapy evaluation

The physical therapist examination:

- Is documented, dated, and appropriately authenticated by the physical therapist who performed it
- Identifies the physical therapy needs of the patient
- Incorporates appropriate tests and measures to facilitate outcome measurement
- Produces data that are sufficient to allow evaluation, diagnosis, prognosis, and the establishment of a plan of care
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time.

The physical therapist's plan of care should be sufficient to determine the medical necessity of treatment, including:

- The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis
- A reasonable estimate of when the goals will be reached
- Long-term and short-term goals that are specific, quantitative and objective

- Physical therapy evaluation
- The frequency and duration of treatment
- Rehabilitation or habilitation prognosis
- The specific treatment techniques and/or exercises to be used in treatment
- Signature of the patient's physical therapist.

## **Treatment Sessions**

Documentation of treatment sessions must include:

- Date of treatment
- Specific treatment(s) provided that match the procedure codes billed
- Total treatment time
- Response to treatment
- Skilled ongoing reassessment of the individual's progress toward the goals; including objective data that can be compared across time
- Any challenges or changes to the plan of care
- Name and credentials of the treating clinician

## **Progress Reports**

In order to reflect that continued PT services are medically necessary, intermittent progress reports must demonstrate that the individual is making functional progress. Progress reports should include at a minimum:

- Start date of therapy
- Time period covered by the report
- All diagnoses
- Statement of the patient's functional level at the beginning of the progress report period and current status relative to baseline data at evaluation or previous progress report; objective measures related to goals should be included
- Changes in prognosis, plan of care, and goals; and why
- Consultations with or referrals to other professionals or coordination of services, if applicable
- Signature and title of qualified professional responsible for the therapy services

## **Reexamination/Reevaluation**

Re-evaluations are distinct from therapy assessments. There are several routine reassessments that are not considered re-evaluations. These include ongoing reassessments that are part of each skilled treatment session, progress reports, and discharge summaries. Re-evaluation provides additional objective information not included in documentation of ongoing assessments, treatment or progress notes. Assessments are considered a routine aspect of intervention and are not billed separately from the intervention. Continuous assessment of the patient's progress is a component of the ongoing therapy services and is not payable as a re-evaluation.

Re-evaluation services are considered medically necessary when all of the following conditions are met:

- Re-evaluation is not a recurring routine assessment of patient status
- The documentation of the re-evaluation includes all of the following elements:
  - An evaluation of progress toward current goals;
  - Making a professional judgment about continued care;
  - Making a professional judgment about revising goals and/or treatment or terminating services.

AND the following indication is documented:

- An exacerbation or significant change in patient/client status or condition.

A re-evaluation is indicated when there is an exacerbation or significant change in the status or condition of the patient. Re-evaluation is a more comprehensive assessment that includes all of the components of the initial evaluation, such as:

- Data collection with objective measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods;
- Making a judgment as to whether skilled care is still warranted;
- Organizing the composite of current problem areas and deciding a priority/focus of treatment;

- Identifying the appropriate intervention(s) for new or ongoing goal achievement;
- Modification of intervention(s);
- Revision in plan of care if needed;
- Correlation to meaningful change in function; and
- Deciphering effectiveness of intervention(s).

## **Discharge/Discontinuation of Intervention**

The physical therapist discharges the patient from physical therapy services when the anticipated goals or expected outcomes for the patient have been achieved. The physical therapist discontinues intervention when the patient is unable to continue to progress toward goals or when the physical therapist determines that the patient will no longer benefit from physical therapy.

The physical therapy discharge documentation:

- Includes the status of the patient at discharge and the goals and outcomes attained;
- Is dated and appropriately authenticated by the physical therapist who performed the discharge
- Includes, when a patient is discharged prior to attainment of goals and outcomes, the status of the patient and the rationale for discontinuation
- Includes initial, subsequent, and final FOM scores
- Includes proposed self-care recommendations, if applicable
- Includes referrals to other health care practitioners/referring physicians, as appropriate

## **Standardized Tests and Measures/Functional Outcome Measures (FOMs)**

Measuring outcomes is an important component of physical therapists' practice. Outcome measures are important in direct management of individual patient care and for the opportunity they provide the profession in collectively comparing care and determining effectiveness.

The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reexamination/reevaluation, provide information about whether predicted outcomes are being realized. As the patient reaches the termination of physical therapy services and the end of the episode of care, the physical therapist measures the outcomes of the physical therapy services. Standardized outcome measures provide a common language with which to evaluate the success of physical therapy interventions, thereby providing a basis for comparing outcomes related to different intervention approaches. Measuring outcomes of care within the relevant components of function (including body functions and structures), activity, and participation, among patients with the same diagnosis, is the foundation for determining which intervention approaches comprise best clinical practice.

## **LITERATURE REVIEW**

There are several guidelines, systematic reviews, meta-analyses, and randomized controlled trials (RCTs) published that examine physical therapy (a variety of interventions) for various conditions and note effectiveness of physical rehabilitation, exercise, education, manual therapies (e.g. mobilization, manipulation, soft tissue mobilization), and other various modalities (Taylor et al., 2007; Chou et al., 2016; Qaseem et al., 2017; Byström et al., 2013; Macedo et al., 2016; Oliveira et al., 2012; Saragiotto et al., 2016; Steffens et al., 2016; van Middelkoop et al., 2010; Logerstedt et al., 2010; Cibulka et al., 2009; Cibulka et al., 2017; Blanpied et al., 2017; Gay et al., 2016; Fransen et al., 2014; Babatunde et al., 2017; BiDonde et al., 2017; Pollock et al., 2014; French et al., 2005; Yousefi-Nooraie et al., 2008 ) Passive modalities, such as ultrasound, electric stimulation, traction, laser, and hot and cold packs, are often used in combination with manual therapies and exercise despite insufficient and/or inconclusive evidence for many conditions. Often methodologic flaws and heterogeneity of studies result in an inability to draw confirmatory conclusions.

**Massage Therapy:** Few clinical trials have been undertaken to assess the effect of this modality alone in the treatment of specific medical conditions. Rehabilitation programs frequently combine massage therapy with one or more other treatment interventions. While there is scant literature regarding the efficacy of this treatment when used as the sole modality, massage therapy has been a part of physical therapy or chiropractic treatment plans for the management of musculoskeletal pain. As an example, for mechanical low back pain, the greatest

effects of massage therapy are seen in short term relief of pain. The effects on function were less clear. These therapeutic effects tend to diminish in the longer term (Chou et al., 2016).

## **PHYSICAL THERAPY FOR CONDITIONS CONSIDERED EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN**

### **Sexual Dysfunction (unrelated to musculoskeletal or orthopedic condition)**

Female sexual dysfunction conditions can be classified as sexual desire disorders, sexual arousal disorder, orgasmic disorder, or sexual pain disorders. Hypoactive sexual desire disorder and sexual aversion disorder comprise the sexual desire disorders.

ACOG (2011) published a clinical management guideline on female sexual dysfunction. Conditions included in this guideline include: sexual desire disorders (e.g., hypoactive sexual desire disorder and sexual aversion disorder), female sexual arousal disorder, female orgasmic disorder, and sexual pain disorders with no muscular involvement (e.g., dyspareunia, vaginismus). Physical therapy is not included in the recommendations in this guideline. The guideline includes the following for management of these conditions:

- Conclusion based on good and consistent scientific evidence (Level A):
  - Transdermal testosterone has been shown to be effective for the short-term treatment of hypoactive sexual desire disorder, with little evidence to support long-term use (longer than 6 months).
- Conclusions are based on limited or inconsistent scientific evidence (Level B) include:
  - Prospective studies constructed to address the effect of hysterectomy on postoperative sexual function have failed to show a difference in total versus subtotal hysterectomy.
  - Vaginal estrogen for the treatment of postmenopausal atrophy results in improved dyspareunia, less vaginal dryness, improved vaginal mucosal maturation indices, and reduced vaginal pH.
  - The main risks associated with androgen replacement therapy in women are hirsutism, acne, virilization, and CV complications. In addition, a possible association with breast cancer has been reported.

The European Urological Association published guidelines on male sexual dysfunction, including erectile dysfunction and premature ejaculation. Physical therapy is not included in the guidelines as a treatment for these conditions (Hatzimouratidis, et al., 2014).

### **Scoliosis**

Scoliosis, lateral curvature of the spine, is a structural alteration that occurs in a variety of conditions. Progression of the curvature during periods of rapid growth can result in significant deformity, which may be accompanied by cardiopulmonary compromise (Scherl, 2016). Options for treatment of scoliosis include observation, bracing, and surgery. Evidence is insufficient to demonstrate effectiveness of physical therapy (scoliosis-specific exercises, including the Schroth Method), chiropractic treatment, electrical stimulation, or biofeedback to correct, improve or prevent further curvature (Scherl, 2016; National Institutes of Health [NIH]/National Institute of Arthritis and Musculoskeletal and Skin Disease [NIAMS], 2015; American Academy of Orthopedic Surgeons [AAOS], 2015; Mehlman, 2015; Romana, et al., 2012).

## **PHYSICAL THERAPY TREATMENTS CONSIDERED EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN**

### **Constraint-Induced Movement Therapy (CIMT)**

Constraint-induced movement therapy (CIMT) is a multi-faceted intervention that has been proposed for neurological conditions that involve hemiparesis. CIMT is also referred to as constraint-induced therapy or forced use therapy and is primarily provided by physical therapists and occupational therapists. Several variations exist based on method and length of restraint, and type and duration of therapy (e.g. environment and provider). The therapy involves constraining the unaffected arm or hand with a sling, glove or mitt. CIMT typically involves intensive individualized therapy with up to six–eight hours of therapy provided per day. However, other forms of modified CIMT have been developed with less therapy provided, but longer periods of restraint (Wolf, 2007). Veterans Affairs/Dept of Defense (VA/DoD) published guidelines that have also been endorsed by American Heart Association/American Stroke Association (AHA/ASA)—Clinical Practice Guideline for the Management of Adult Stroke Rehabilitation Care (Bates, et al., 2005). The guidelines note that, “Use of constraint-induced therapy should be considered for a select group of patients—that is, patients with 20 degrees of wrist extension and 10 degrees of finger extension, who have no sensory and cognitive deficits.” indicating a recommendation that the intervention may be considered). The Royal College of Physicians/Intercollegiate Stroke Working Party (United Kingdom) and the Ottawa Panel (2006) agree with these recommendations.

CIMT has demonstrated inconsistent effectiveness for treatment of patients post-stroke (Pulman et al., 2013; McIntyre et al., 2012; Corbetta et al., 2010; Sirtori et al., 2009). Future randomized controlled trials need to have accurate characteristics in terms of methodological quality, larger samples, longer follow up, reliable and relevant measure and report of adverse events. Some evidence demonstrates that modified CIMT could reduce the level of disability, improve the ability to use the paretic upper extremity, and enhance spontaneity during movement time, but evidence is still limited about the effectiveness of modified CIMT in kinematic analysis (Pollack et al., 2014; Shi et al., 2011). Research suggests that modified CIMT and intensive CIMT produce similar results (Peurala et al., 2012).

CIMT has also been used for the treatment of children with cerebral palsy (CP). Research is not conclusive with regards to the effectiveness of CIMT for this population; however there appears to be modest evidence to support its use in a modified format (Taub et al., 2004; Sakzewski et al., 2009; Eliasson et al., 2005; Hoare et al., 2007). Further research using adequately powered RCTs [randomized controlled trials], rigorous methodology and valid, reliable outcome measures is essential to provide higher level support of the effectiveness of CIMT for children with hemiplegic cerebral palsy.

### **Intensive Model of Therapy (IMOT) programs**

IMOT was developed in Poland for treating children and adults with cerebral palsy and other neurologic disorders. This therapy involves performing exercises over an extended period of time — typically 5 days a week for 4 hours a day. The time in the program may be a 3 week period or longer. There is insufficient evidence to conclude that IMOT demonstrates improved long term and short term outcomes over less intensive/frequent care (Sakzewski et al., 2014; Anderson et al., 2013; Christiansen and Lange 2008; Sakzewski, Ziviani et al., 2014). Therapeutic suits such as the Adeli and NeuroSuit are also used and proposed to assist in re-training the central nervous system by allowing the child to overcome increasingly complex pathological movement and to execute and repeat previously unknown movement patterns. More studies are needed to provide evidence to support use of these suits to improve outcomes.

### **Dry hydrotherapy**

Dry hydrotherapy, also referred to as aquamassage, water massage, or hydromassage, is a treatment that incorporates water with the intent of providing therapeutic massage. The treatment is generally provided in chiropractor or physical therapy offices. There are several dry hydrotherapy devices available that provide this treatment, including the following:

- Aqua Massage® (AMI Inc., Mystic, CT)
- AquaMED® (JTL Enterprises, Inc., Clearwater, FL)
- H2OMassage System™ (H2OMassage Systems, Winnipeg, MB, Canada)
- Hydrotherapy Tables (Sidmar Manufacturing, Inc., Princeton, MN)

Proponents of dry hydrotherapy maintain that it can be used in lieu of certain conventional physical medicine therapeutic modalities and procedures, such as heat packs, wet hydrotherapy, massage, and soft tissue manipulation. The assertions that have been made by manufacturers of this device at their websites have not yet been proven. No published studies or information regarding dry hydrotherapy devices or dry hydrotherapy treatment were identified in the peer-reviewed scientific literature. In the absence of peer-reviewed literature demonstrating the effectiveness of dry hydrotherapy and in the absence of comparison to currently accepted treatment modalities, no definitive conclusions can be drawn regarding the clinical benefits of this treatment.

### **Non-invasive Interactive Neurostimulation (e.g., InterX®)**

Non-invasive, Interactive Neurostimulation (NIN) (e.g. InterX®) is used for the treatment of acute and chronic pain using high amplitude, high density stimulation to the cutaneous nerves, activating the natural pain relieving mechanisms of the body (segmental and descending inhibition). There is a lack of evidence to support this form of modality.

### **Microcurrent Electrical Nerve Stimulation (MENS)**

There is insufficient evidence in the published peer-reviewed scientific literature to support the safety and effectiveness of MENS (Rajpurohit et al., 2010; Zuim et al., 2006).

### **H-WAVE®**

H-wave stimulation is a form of electrical stimulation that differs from other forms of electrical stimulation, such as transcutaneous electrical nerve stimulation (TENS), in terms of its wave form. There is insufficient evidence in the published peer reviewed scientific literature to support the safety and effectiveness of the H-WAVE® electrical stimulators (Blum et al., 2008).

### **Spinal Manipulation for the Treatment of Non-Musculoskeletal Conditions and Related Disorders**

Spinal manipulation is considered experimental, investigational, or unproven for the treatment of non-musculoskeletal conditions and related disorders including, but not limited to:

- Asthma
- ADHD
- Autism spectrum disorders
- Dysmenorrhea
- Hypertension
- Infantile colic
- Nocturnal enuresis
- Otitis media

The set of conditions above represents those non-musculoskeletal conditions which have been found in the literature relative to spinal manipulation either through RCTs, systematic reviews, or both. Evidence is insufficient to support use of spinal manipulation for treatment of these conditions (Alcantara et al., 2011; Hondras et al., 2011; Kaminsky et al., 2014; Gleberzon et al., 2012; Clar et al., 2014; Karpouzis et al., 2010; Ferrance and Miller, 2010; Proctor, et al., 2006; Bakris, 2007; Mangum et al., 2012; Dobson et al., 2012; Huang et al., 2011; Pohlman, Holton-Brown, 2012).

### **Equestrian therapy (e.g. hippotherapy)**

Equestrian therapy, also known as hippotherapy, is proposed to offer a person with a disability a means of physical activity that aids in improving balance, posture, coordination, the development of a positive attitude and a sense of accomplishment. It is proposed for treatment of several conditions including autism spectrum disorders and cerebral palsy. There is insufficient published evidence regarding the effects of this therapy on individuals with impaired physical function resulting from illness, injury, congenital defect or surgery (Bronson et al., 2010; Lee et al., 2014; O'Haire et al., 2014). The authors note that most studies were limited by methodological weaknesses. This review demonstrates that there is a need for further, more rigorous research.

### **MEDEK Therapy**

MEDEK, a form of physiotherapy, refers to Metodo Dinamico de Estimulacion Kinesica or Dynamic Method for Kinetic Stimulation. MEDEK is used for developing gross motor skills in young children with physical disabilities and movement disorders (e.g., cerebral palsy, Down's syndrome, hypotonia, muscular dystrophy, and developmental motor delay). At this time, no evidence exists of its effectiveness in the peer reviewed literature. Well-designed clinical studies are needed to determine the effectiveness of MEDEK and whether a clinically significant improvement is achieved through the use of MEDEK Therapy, as there appears to be no peer-reviewed, published literature available as noted with a thorough literature search at this time.

### **The Interactive Metronome Program**

Interactive Metronome® (IM) is purported to be an assessment and training tool that measures and improves Neurotiming, or the synchronization of neural impulses within key brain networks for cognitive, communicative, sensory and motor performance. It is designed to improve processing speed, focus, and coordination. Patients wear headphones and match a beat using a hand or foot sensor along with visual and auditory feedback. The IM program has been promoted as a treatment for children with attention-deficit hyperactivity disorder (ADHD) and for other special needs children to increase concentration, focus, and coordination. It has also been promoted to improve athletic performance, to assess and improve academic performance of normal children, and to improve children's performance in the arts (e.g., dance, music, theater, creative arts). Additionally, it has been implemented as part of a therapy program for patients with balance disorders, cerebrovascular accident, limb amputation, multiple sclerosis, Parkinson's disease, and traumatic brain injury. However, based on peer-reviewed literature, evidence is insufficient to support effectiveness of the IM program. Well-designed clinical studies are needed to determine the effectiveness of the IM program and whether a clinically significant improvement is achieved.

## **Taping/Elastic therapeutic tape (e.g., Kinesio™ tape, Spidertech™ tape)**

Elastic therapeutic tape, also known as kinesiology tape, differs from traditional white athletic tape in the sense that it is elastic and can be stretched to 140% of its original length before being applied to the skin.

Elastic tape is available in various lengths or pre-cut. There are several types of elastic therapeutic tape available including:

- Kinesio™ tape (Kinesio Taping, LLC. Albuquerque, NM)
- SpiderTech™ tape (SpiderTech Inc., Toronto, Ontario)
- KT TAPE/KT TAPE PRO™ (LUMOS INC., Lindon, UT)

The clinical value of elastic therapeutic taping (i.e., Kinesio taping) or rigid therapeutic taping (i.e., McConnell) for back pain, radicular pain syndromes, and other back-related conditions has not been established as there is insufficient evidence in the peer-reviewed literature.

The effectiveness of elastic therapeutic taping (i.e. Kinesio taping) or rigid therapeutic taping (i.e., McConnell) for all conditions such as lower extremity spasticity, meralgia paresthetica, post-operative subacromial decompression, wrist injury, performance enhancement and prevention of ankle sprains has not been established as the evidence is insufficient in the peer-reviewed literature.

The following uses of therapeutic taping are professionally recognized and safe; however, additional studies are needed before the clinical effectiveness can be established. Use of elastic or rigid taping techniques as part of comprehensive treatment program may be clinically appropriate for the following:

- Elastic therapeutic tape (e.g., Kinesio tape, Spidertech tape) in the treatment or management of lymphedema
- Rigid therapeutic taping for pain reduction in patellofemoral pain syndrome
- Rigid therapeutic taping of the shoulder in patients with hemiplegia

The use of rigid taping or elastic taping for rehabilitation of orthopedic or neurologic conditions is not intended as a sole treatment or as a separately billable procedure, but rather is part of a broad treatment program that includes exercise, manual therapy and/or neuromuscular re-education (NMR) and is inclusive in these procedures. Strapping codes are not allowed for application of therapeutic taping.

## **Dry Needling**

Research suggests that dry needling may improve pain control, reduce muscle tension, normalize biochemical and electrical dysfunction of motor endplates, and may facilitate an accelerated return to active rehabilitation [American Association of Orthopaedic Manual Physical Therapists (AAOMPT) position statement, 2010; APTA Resource Paper, 2012]. However further high quality research is needed to confirm findings for specific conditions and to relate improvements in pain and muscle quality to objective functional measures (Boyles et al., 2015; Cerezo-Téllez et al., 2016; Cotchett et al., 2010; Dommerholt et al., 2016; Dıraçoğlu et al., 2012; Gerber et al., 2016; Kalichman et al., 2010; Kietrys et al., 2013; Lui et al., 2015; Rodríguez-Mansilla et al., 2016; Tekin et al., 2014; Tough et al., 2009; Gattie et al., 2017; Espí-López et al., 2017; Lui et al., 2017).

## **Low-level laser therapy (LLLT)**

Although the use of LLLT appears to be safe for the treatment of carpal tunnel syndrome, lateral epicondylitis, rheumatoid arthritis, and other musculoskeletal pain syndromes, the literature is insufficient to conclude that the use of LLLT is either clinically effective or ineffective in the treatment of these conditions due to inconsistent results, methodologic weaknesses and heterogeneity of studies. (Valdes and Marik, 2010; Brosseau et al. 2007; Pereira Alfredo et al., 2011; Huang et al., 2015; Youssef et al., 2016; Khesie et al., 2014; Kim et al., 2016; Dong et al., 2015; Bekhet et al., 2017; Franke et al., 2017; Chou et al., 2016; Wong et al., 2016; Butts et al., 2017; Yu et al., 2016; Dion et al., 2017; Doyle et al., 2016; Clijisen et al., (2017). Additional clinical trials are required to determine the effectiveness of LLLT for the treatment of these conditions for individual patients in order to determine its benefit:risk profile. There is a paucity of peer reviewed literature on high power laser light therapy (Class IV).

## **Vertebral Axial Decompression Therapy and Devices**

Vertebral axial decompression therapy, also referred to as mechanized spinal distraction therapy, has been proposed as a nonsurgical treatment for back pain. Vertebral axial decompression devices are typically used in

a clinic or rehabilitation setting and include the VAX-D (VAX-D Medical Technologies LLC, Oldsmar, FL), DRS system (Professional Distribution Systems, Inc., Boca Raton, FL), DRX2000 (Axiom Worldwide, Inc., Tampa, FL) and other FDA-approved devices.

The published scientific data is insufficient to validate improved clinical outcomes (e.g., reduction of back pain, improved functioning) associated with vertebral axial decompression therapy. While several technology assessments have been published, effectiveness of the various devices have not been proven when compared to standard equipment or testing (Macario and Pergolizzi 2006, 2008; Daniel 2007; Beattie et al., 2008; Schimmel et al., 2009; Apfel et al., 2010).

### **Providers of Physical Therapy Services**

Physical therapists are licensed health care professionals. Qualification for licensure includes passing the National Physical Therapy Exam (NPTE), administered by the Federation of State Boards of Physical Therapy. Another important qualification for licensure is graduation from a physical therapy education program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) or a program that is deemed substantially equivalent to a CAPTE accredited program. Physical therapist assistants working under the supervision and direction of a PT are also considered qualified providers of PT services.

## **Coding/Billing Information**

**Note:** 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Considered Medically Necessary when criteria in the applicable policy statements listed above are met:**

<b>CPT®*</b> <b>Codes</b>	<b>Description</b>
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)

97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or truck, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

HCPCS Codes	Description
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
S9131	Physical therapy; in the home, per diem

**Considered Not Medically Necessary:**

<b>CPT®*</b> <b>Codes</b>	<b>Description</b>
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97026	Application of a modality to 1 or more areas; infrared

**Considered Training in Nature/Not Medically Necessary:**

<b>CPT®*</b> <b>Codes</b>	<b>Description</b>
97169	Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family
97170	Athletic training evaluation, moderate complexity, requiring these components: A medical history and physical activity profile with 1-2 comorbidities that affect physical activity. An examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97171	Athletic training evaluation, high complexity, requiring these components: A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; Clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97172	Re-evaluation of athletic training established plan of care requiring these components: An assessment of patient's current functional status when there is a documented change, and A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)

<b>HCPCS</b> <b>Codes</b>	<b>Description</b>
S8990	Physical or manipulative therapy performed for maintenance rather than restoration
S9117	Back school, per visit

**Considered Experimental, Investigational, Unproven:**

<b>CPT®* Codes</b>	<b>Description</b>
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles

<b>HCPCS Codes</b>	<b>Description</b>
S8940	Equestrian/hippotherapy, per session
S8948	Application of a modality (requiring constant provider attendance) to one or more areas, low-level laser; each 15 minutes
S9090	Vertebral axial decompression, per session

**Considered Experimental/Investigational/Unproven when used to report any other treatment listed as EIU in the policy statement that does not have an assigned code:**

<b>CPT®* Codes</b>	<b>Description</b>
97039	Unlisted modality (specify type and time if constant attendance)
97799	Unlisted physical medicine/rehabilitation service or procedure

**\*Current Procedural Terminology (CPT®) ©2019 American Medical Association: Chicago, IL.**

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