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Subject: Physical Therapy (PT) and Occupational Therapy (OT)

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Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions	Related Guidelines
Other	References	Updates			

DESCRIPTION:

Physical therapy (PT) is a prescribed program of treatment consisting of specific therapeutic exercises and other interventions designed to restore or improve posture, ambulation, strength, endurance, balance, coordination, joint mobility, flexibility and ability to perform functional activities of daily living, and on alleviating pain. Treatment involves the use of the therapeutic properties of exercise, heat, cold, electricity, ultraviolet, and/or massage.

Occupational therapy (OT) is a prescribed program of treatment consisting of specific therapeutic and goal-directed activities to restore or improve skills needed to perform activities of daily living. Individual programs are designed to restore or improve the ability to conduct basic activities such as dressing, eating, personal hygiene, and mobility/transfers. OT is generally focused on therapeutic activities intended to restore or improve function to the shoulder, elbow, wrist or hand.

Therapeutic intervention may be passive or active. Passive intervention is defined as motion imparted to the body by another person or outside force, such as a joint being moved without using the muscles that ordinarily control the joint. Active intervention is defined as motion imparted to the body through voluntary participant contraction and relaxation of the controlling muscles. Passive interventions are often used during the acute phase of treatment, when the focus is on reducing pain and swelling. Active interventions are usually begun as pain and swelling subsides, when the focus is on restoring range of motion and function.

PT and OT services may be considered rehabilitative or habilitative:

- Rehabilitative services refers to PT and/or OT services that help an individual regain or improve skills and functioning for daily living that have been lost or impaired because a person had an illness, injury, or surgery.
- Habilitative services refers to PT and/or OT services that help an individual keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking at the expected age.

Summary and Analysis of Evidence: An UpToDate review “Approach to the management of chronic non-cancer pain in adults” (Tauben et al, 2024) suggests an individualized physical or occupational therapy program tailored to patient-specific functional limitations for those with chronic pain, particularly when they are severely deactivated. Improved physical function is a key treatment goal. It is important to recognize that PT provided for chronic pain be carefully paced and that fitness activities progress in a graded fashion, to avoid exacerbating pain, worsening function, and reducing patient willingness to continue. PT includes specific exercise training that addresses both fear avoidance and severe deconditioning commonly seen in those with chronic pain. An UpToDate review, “Treatment of acute low back pain” (Knight et al, 2024) recommends that patients with acute low back pain not be referred immediately for exercise or physical therapy. Instead, referral should be considered for patients with risk factors for developing chronic low back pain (eg, poor functional or health status, psychiatric comorbidities), who may benefit from immediate education by a physical therapist on how to avoid recurrences, appropriate levels of activity, and exercises to begin after the acute phase. An UpToDate review “Overview of geriatric rehabilitation: Patient assessment and common indications for rehabilitation” (Hoenig et al, 2024) states early intervention soon after an acute precipitating event may prevent or ameliorate the development of disability. Several retrospective cohort studies in a general adult population found that early physical therapy (PT) for outpatient musculoskeletal disorders was associated with decreased risk of advanced imaging, clinician visits, surgery, injections and opioid medications. Rehabilitation for acute spinal cord injury resulting in paralysis would involve physical therapy (PT) and occupational therapy (OT). Comprehensive rehabilitation and a multidisciplinary team are needed to address problems with weakness, mobility, self-care, and potential complex physiologic effects of the injury.

There is a lack of peer-reviewed evidence regarding the clinical value of skeletal analysis systems such as the Metrecom Skeletal Analysis System. Miro et al (1996) concluded “the Metrecom Skeletal Analysis System does not provide sufficient clinical precision to substitute for the Cobb angle measured from spinal radiographic measurements in the management of adolescents with scoliosis.” Norton, Ellison (1993) concluded that while the Metrecom provides reliable length measurements on inanimate objects and that two different test modes produce consistent measurements, further study of the validity and reliability of length measurements obtained with the Metrecom on humans under applied conditions is needed before the results of this study can be generalized to applied settings. No conclusive benefits can be drawn regarding the clinical benefits of dry hydrotherapy. No published studies or regarding dry hydrotherapy devices or dry hydrotherapy treatment were identified in the peer-reviewed scientific literature. Lupowitz (2022) concluded that while overall, vibration therapy is a safe, inexpensive, and accessible form of treatment with many benefits, further studies are warranted to study the effects of different frequency, amplitude and time parameters as they relate to physiologic response of tendon and ligament conditions. Melham et al (1998) described the use of ASTM in the treatment of excessive scar tissue around an athlete's injured ankle. Following failure of surgery and several months of conventional physical therapy, ASTM was administered. It used ergonomically designed instruments that assist therapists in the rapid localization and effective treatment of areas exhibiting excessive soft tissue fibrosis; followed by a stretching and strengthening program. Upon the completion of 6 weeks of ASTM, the athlete had no pain and had regained full range of motion and function. There are few published studies of any size that support the clinical effectiveness of ASTM. Chang et al (2015) performed a systematic review comparing the effects of Kinesio taping with McConnell taping as a method of conservative management for those with patello-femoral pain syndrome (PFPS). The authors concluded there was a lack of evidence for Kinesio taping on patellar alignment correction. McConnell taping could adjust patellar alignment and tracking but did not improve proprioception and motor function for PFPS. They stated further research examining the mechanism of pain relief is needed. For Dynamic Method of Kinetic Stimulation (MEDEK therapy or Metodo Dinamico de Estimulacion Kinesica), there are no well designed studies that support clinical effectiveness. Park, Choi (2017) examined the effects of Interactive metronome (IM) on timing for children with Attention-Deficit Hyperactivity Disorder (ADHD). The subjects were 2 children diagnosed with ADHD, who were provided with IM for 40 minutes at a time, 2 times per week, for a total of 8 weeks. While the subjects showed improvement in timing, attention, working memory and processing speed, the study was a case report involving only two subjects. A follow-up study with a larger sample size would be beneficial, as well as a comparative study examining the therapeutic effects of IM training and other treatments for ADHD. Gulick (2010) examined the effectiveness of tissue

heating with a hands-free ultrasound (US) technique compared to a hand-held US transducer using the Rich-Mar AutoSound unit. The author stated “the "hands-free" device did not result in the same level of tissue heating as the manual technique. The hands-free device has the advantage of not needing a clinician present to deliver the modality but a therapeutic level of heating was not achieved at the 2-cm tissue depth. Thus, the efficacy of the "hands-free" treatment is in question.” Muñoz-Lasa et al (2019) studied whether hippotherapy is effective as a method in physical treatment of multiple sclerosis. The authors concluded that while statistically significant improvement was observed in the therapy group in spasticity, fatigue impact, and perception of heath in general, further studies with more participants, control groups and blinded research are needed to support clinical efficacy. Hausmann et al (2019) studied whether deep oscillation therapy is effective in reducing pain and swelling with acute lateral ankle sprains compared with the current standard of care of protection, rest, ice, compression, and elevation. They analyzed 3 randomized control trials, one of which demonstrated reduction in pain after 6 weeks, with the other 2 demonstrating no difference between deep oscillation therapy and standard of care. Clinical trial NCT04497129 [“ROMTECH PortableConnect Rehabilitation Device Usage Post Unilateral Total Knee Arthroplasty (TKA)”] (trial status unknown at last review date) evaluated the ROMTECH PortableConnect Rehabilitation Device only rehabilitation program following total knee arthroplasty to an active comparator group of continuous passive motion with a standard of care combination home PT and outpatient PT rehabilitation program. There is currently a lack of published studies demonstrating clinical efficacy of the device.

Benn et al (2023) investigated the effect of a personalized, home-based, biomechanical foot-worn device on the referral rates for secondary care among patients with hip osteoarthritis (OA) who met the clinical criteria for hip replacement. One hundred fifty-seven patients were calibrated with a foot-worn biomechanical device (AposHealth®) that re-distributes loads via center of pressure manipulation, and generates perturbation to train proprioception. There were thirty-one (19.7%) referrals for secondary consultation. The mean days to referral was 310.5 days. Sixty-seven percent of all referrals occurred during the first year of treatment. The authors concluded that the results suggested a significant clinical improvement among patients who failed core therapies and who met the criteria for joint replacement, with over 80% of patients avoiding joint replacement for at least three years. The authors acknowledged that further research is needed to support the findings of this study, as well as several study limitations, including a retrospective study with no control group; the examined intervention was primarily home-based and did not monitor and verify patient compliance; and lastly, the study looked at patients with hip OA who met surgical criteria and is limited in its generalizations to the entire hip OA population. They stated future studies should look at the effect of treatment in newly diagnosed patients with hip OA. Benn et al (2023) also examined knee osteoarthritis and the referral rates to secondary care consultation and clinical outcomes in patients with severe knee OA treated with a home-based, non-surgical intervention (AposHealth®). They conducted a retrospective audit on 571 patients with knee OA who met the clinical criteria for total knee replacement (TKR) and received the service between October 2015 and March 2020. Patients were advised to use the device at home or work and continue their routine, and to return to follow-up appointments to readjust the device and treatment plan. There were 65 (11.4%) referrals for secondary consultation with an average follow-up of 3.5 years. The mean days to referral was 480.9 days. Of all referrals, 48% occurred during the first year of treatment, and 32% occurred during the second year. The rest were after more than 2 years of treatment. Significant improvements were seen in all clinical outcomes, including a reduction in pain and an improvement in function and gait patterns. The authors concluded that the AposHealth® intervention as a non-surgical option for patients with knee OA who met the clinical criteria for TKR led to a significant reduction in pain and improvement in function after 3 months that was maintained for up to 3 years. Most patients (89%) did not proceed to secondary care consultation during their time in treatment for up to 6 years. The authors again acknowledged several study limitations, including lack of confirmation on actual TKRs; it was a retrospective registry analysis with no control group, which made it difficult to determine the effectiveness of the intervention and its ability to reduce referral rates to secondary care consultations; and finally, patients were allowed to have other treatments in parallel to the examined one which might have a potential bias in interpreting the results. Drew et al (2022) examined whether the use of a home-based, noninvasive biomechanical intervention (AposHealth®) reduced the rate of progression to surgery for 237 patients with knee OA deemed eligible for TKR based on pre-established clinical selection criteria. Over the 24-month study period, 204 patients (86%) avoided surgery, with only 33 patients progressing to a TKR with an average

length of time to TKR of 324 days (ranging from 31 to 671 days). The authors compared this rate with 294 individuals who chose to proceed directly to TKA; over 2 years, 259 of them (88%) actually underwent TKA. Patients who chose to receive therapy with (AposHealth®) may differ from those who preferred TKA (e.g., less pain or less favorable opinions of surgery). The study was not randomized and did not compare therapy with AposHealth® to any other intervention.

Awad et al (2024) conducted a multi-site, prospective, interventional, 2-arm randomized controlled trial that evaluated the safety and efficacy of an autonomous neurorehabilitation system (InTandem™) designed to use auditory-motor entrainment to improve post-stroke walking. 87 individuals were randomized to 5-week walking interventions with InTandem™ or Active Control (i.e., walking without InTandem). The primary endpoints were change in walking speed and safety. InTandem™ was associated with a 2x larger increase in speed, 3x more responders, and similar safety (both groups experienced the same number of adverse events). The authors concluded that "the auditory-motor intervention autonomously delivered by InTandem™ is safe and effective in improving walking in the chronic phase of stroke." Limitations of the trial included inclusion criteria limited to individuals with chronic post-stroke hemiparesis with walking speeds between 0.50 m/s and 0.80 m/s, the trial's five-week intervention period was relatively short, and lack of follow-up period. Smayda et al (2023) conducted a study to evaluate the safety and effectiveness of a neurorehabilitation system (InTandem™) to improve walking in the chronic stroke population. A total of 15 participants in the chronic phase of stroke recovery (≥6 months after stroke) participated in this validation study. Participants were scored on 8 simulated use tasks, 4 knowledge assessments, and 7 comprehension assessments in a simulated home environment. Fourteen of fifteen participants were able to successfully complete the critical tasks associated with the simulated use of the InTandem™ system. Overall, participants were able to find and correctly interpret information in the materials in order to answer the knowledge assessment questions. No adverse events, including slips, trips, or falls, occurred in this study. The authors concluded that "people in the chronic phase of stroke recovery were able to safely and effectively use InTandem™ in the intended use environment." Limitations of the study included small size, a focus on only critical tasks involved in the use of InTandem™ (non-critical tasks were experienced but not scored), gait impairment was not included as a screening criterion, lower literacy population, and lack of racial and ethnic diversity.

POSITION STATEMENT:

NOTE: The following services are covered according to the member's/subscriber's contract benefits. Member's/subscriber's contract benefits may have limitations, exclusion, or criteria applicable to physical and occupational therapy services (see PROGRAM EXCEPTIONS).

***NOTE:** For coverage of physical and occupational therapy for **Autism Spectrum Disorders**, please refer to MCG 01-97000-08, Treatment of Autism Spectrum disorders.

Physical or occupational therapy evaluation, re-evaluation, procedures, techniques, interventions and modalities **meet the definition of medical necessity** when **ALL** the conditions below are met:

- The level of complexity or the member's condition requires that the services be performed by or under the direct supervision of a qualified physical or occupational therapist, **AND**
- The services meet accepted standards of practice, **AND**
- The services are specific and effective treatment for the member's condition, **AND**
- The services are rendered in accordance with a written treatment plan, **AND**
- For continued therapy, the plan of care should be updated as the member's condition changes

Prior to the initiation of physical or occupational therapy, a comprehensive evaluation of the member's physical and functional potential is required. The initial physical or occupational therapy evaluation should be performed by a qualified provider of physical or occupational therapy services, and should include:

- Specific statements regarding history and diagnosis, **AND**

- Specific short-term and long-term goals with measurable objectives, **AND**
- The specific techniques and/or exercises to be used in the treatment, **AND**
- The frequency and duration of the treatment

Physical and occupational therapy services **meet the definition of medical necessity** when performed to improve or restore physical functions in members who have a functional deficit that is associated with:

- An illness or condition [e.g., cerebrovascular accident (stroke)]
- An exacerbation of a chronic illness or condition
- An injury or trauma
- A surgical procedure
- A congenital defect

Massage therapy (97124) and manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, and manual traction) **(97140)** performed by a licensed massage therapist, **meets the definition of medical necessity** when the following criteria are met:

- Documentation is provided indicating 97124 **OR** 97140 are specifically prescribed by the attending physician as medically necessary, **AND**
- The attending physician's prescription specifies the number of treatments.

NOTE: Massage therapy services are subject to the contract limitations applied to all other physical therapy services.

Aquatic therapy **meets the definition of medical necessity** when all criteria for physical or occupational therapy above are met, and the aquatic therapy does not duplicate therapy provided on land.

Manual lymph drainage (97140 or S8950), also known as complex decongestive physiotherapy **OR** complex lymphedema therapy, is a method for treating lymphedema by way of massage, exercise, and compression bandaging several times a day, usually for 4 – 6 weeks, in an effort to redirect lymph fluid back into circulation and reduce swelling in the affected extremity.

Manual lymph drainage therapy **meets the definition of medical necessity** when the individual can be instructed in continuing the therapy at home or when there is a caregiver who can assist in continuing home therapy. Initiation of therapy should be limited to one course or program per lifetime.

Physical performance tests and measurements (97750), (e.g., musculoskeletal, functional capacity) **meet the definition of medical necessity** when rendered for the purpose of evaluating an individual's physical performance, determining function of one or more body areas or measuring any aspect of physical performance including functional capacity evaluations.

Comprehensive computer-based motion analysis by video-taping and 3-D kinematics (gait analysis), (96000, 96001, 96002, 96004) is the quantitative laboratory assessment of human walking, and includes videotaped observation of walking, as well as measurements of joint angles, step length, stride length, cadence, and cycle time. EMG, assessed during walking, measures timing and intensity of muscle contractions, allowing determination of whether a certain muscle's activity is normal, out of phase, continuous, or clonic. A dedicated facility-based motion analysis laboratory uses a computer-based analysis of videotaping and 3D kinematics, tracking retroreflective markers along the body.

Comprehensive motion analysis (gait analysis) services **meet the definition of medical necessity** for the preoperative or postoperative evaluation of musculoskeletal function upon gait in individuals diagnosed with cerebral palsy.

The use of computer-based motion analysis by video-taping and 3-D kinematics (gait analysis) for all other indications **does not meet the definition of medical necessity**.

Work hardening programs (97545, 97546) are physical conditioning programs for injured workers who are out of work, or who are working at less than full capacity. These programs gradually progressive, work-related activities performed with proper body mechanics. The goal is physical and psychological reconditioning in order to facilitate return to full employment.

Work hardening programs **do not meet the definition of medical necessity**.

The following physical therapy services **do not meet the definition of medical necessity:**

- **Non-skilled services:** treatments that do not require the skills of a qualified provider, such as passive range of motion exercise which is not related to development, restoration or improvement of a specific function.
- **Duplicate therapy:** if member receives both physical and occupational therapy, the therapies should provide different treatments and not duplicate the same treatment. They must also have separate treatment plans and goals.
- **Maintenance programs:** activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent **OR** expected to occur.

The following services are considered **experimental or investigational** due to the lack of scientific evidence of effects on health outcomes:

- **Skeletal analysis systems** (e.g., Metrecom Skeletal Analysis System to measure angular positions of bony structures)
- **Dry Hydrotherapy**, performed unattended on a table or chair that contains an electrically powered massager device with rotating hydro-jets and the pressure of the water against the barrier provides the massage (also known as hydromassage, aquamassage, and water massage) (examples include Aqua Massage®, AquaMED®, H2OMassage System™, Hydrotherapy Tables)
- **Unattended vibromassage therapy**, performed unattended on a table or chair that uses low frequency vibrations to stimulate body cells into therapeutic states of relaxation and healing.
- **Augmented Soft-tissue Mobilization (ASTM),** a non-invasive mobilization technique that uses hand-held tools (bone, stone, metal) along with a lubricant on the skin to scrape and mobilize fibrotic (scar) tissue resulting from chronic musculoskeletal disorders.
- **Kinesio taping**, a method of taping which uses a fabric tape that is air permeable and water resistant and applies a constant pulling force to the skin over which it is applied; often used immediately following injury and during the rehabilitation process.
- **Dynamic Method of Kinetic Stimulation [MEDEK therapy or Metodo Dinamico de Estimulacion Kinesica],** a mode of physical therapy used to develop gross motor skills in infants and children with movement disorders due to neurological dysfunction; it uses the principle of anti-gravity extension.
- **Interactive metronome program,** a therapy designed to improve concentration, focus and coordination, in which participants wear headphones and hear a fixed, repeating reference beat. They respond by pressing a hand or foot sensor to try to match the beat, while receiving visual and auditory feedback.

- **Hands-free ultrasound (low frequency sound, or infrasound)**, an ultrasound unit that allows the clinician to choose the mode of ultrasound delivery, using either a hand-held (manual) transducer or a hands-free device that pulses the ultrasound beam through the transducer.
- **Equestrian therapy (S8940)**, also known as horseback riding, equine therapy, or hippotherapy, is an exercise thought 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 often proposed for the treatment of autism spectrum disorders, multiple sclerosis, and cerebral palsy.
- **Hivamat therapy (deep oscillation therapy)**, which utilizes an intermittent electrostatic field via a Hivamat machine; the theory is that electrostatic waves create a kneading effect deep within the damaged tissues (deeper than manual methods), restoring flexibility and blood supply to the affected area, and allowing previously untreatable injuries to be manipulated with a minimum of physical pressure.
- **ROMTech PortableConnect®; ROMTech AccuAngle®** (ROM Technologies, INC.), a multi-purpose rehabilitation telemedicine system with physiological & musculoskeletal monitoring functionality used for home-based orthopedic rehabilitation or home-based cardiac rehabilitation.
- **Apos®** (AposTherapy®**,** AposHealth®), a home-use device designed to treat chronic knee, hip, or back pain. The device looks similar to a shoe and has adjustable pods built into the soles. It is intended to be used by trained physical therapists for adjusting the distribution of weight/force(s) that is being applied to a lower limb.
- **InTandem**™ (MedRhythms, Inc.), a neurorehabilitation system based on the principles of Rhythmic Auditory Stimulation (RAS), an intervention that utilizes the mechanism of action of auditory-motor entrainment. Entrainment occurs when the motor and auditory systems in the brain unconsciously synchronize to an external cue, such as music. InTandem™ is a home-use device that includes shoe-worn sensors, a headset, and a touchscreen device preloaded with the InTandem™ software.

BILLING/CODING INFORMATION:

CPT Coding:

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)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
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)
97026	Application of a modality to 1 or more areas; infrared (**Investigational**)
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.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy

	records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 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

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
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours (**Non-covered**)
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure) (**Non-covered**)
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, 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 trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

HCPCS Coding:

E3200	Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only (eg, InTandem) (**Investigational**)
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
S8940	Equestrian/hippotherapy, per session (**Investigational**)
S8950	Complex lymphedema therapy, each 15 minutes

REIMBURSEMENT INFORMATION:

***NOTE:** Refer to member's/subscriber's contract benefits. Member's/subscriber's contract benefits may have limitations, exclusion, or criteria applicable to physical therapy services (see program exceptions). Services may be subject to medical review of documentation (e.g., physician history and physical, physician progress notes, plan of treatment (narrative), physical therapy treatment plan, plan of treatment, progress note and attainment of goals, reason to continue and justification) for determination of medical necessity. The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes, plan of treatment (narrative), physical therapy treatment plan, plan of treatment, progress note and attainment of goals, reason to continue and justification.

****NOTE**: Physical therapy (PT) and occupational therapy (OT) evaluation codes should not be included in the member contract outpatient therapy limit or the PT/OT modalities per day limit.

LOINC Codes:

DOCUMENTATION TABLE	LOINC CODES	LOINC TIME FRAME MODIFIER CODE	LOINC TIME FRAME MODIFIER CODES NARRATIVE
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made

			six months or fewer before starting date of service for the claim.
Attending physician progress note	18741-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physical therapy initial assessment	18735-1	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physical therapy progress note	11508-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Treatment plan, Plan of treatment	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage Products:

The following National Coverage Determinations (NCD) were reviewed on the last guideline reviewed date: Diathermy Treatment (150.5), and Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders (150.8) located at cms.gov.

Coverage mandated by Florida statute: refer to member's/subscriber's contract benefits.

627.6686, Florida Statutes, Coverage for individuals with autism spectrum disorder required; exception.

641.31098, Florida Statutes, Coverage for individuals with developmental disabilities.

"Eligible individual" means an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.

"Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer which includes the state group insurance program provided under s. 110.123. The term does not include any health insurance plan offered in the individual market, any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer.

A health insurance plan issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

Treatment of autism spectrum disorder and down syndrome through speech therapy, occupational therapy, physical therapy, and applied behavior analysis.

393.063, Florida Statutes, Developmental Disabilities.

"Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely."

486.021, Florida Statutes, Physical Therapy Practice, section 11(a): A physical therapist may implement a plan of treatment developed by the physical therapist for a patient or provided for a patient

by a practitioner of record or by an advanced registered nurse practitioner licensed under s. 464.012. The physical therapist shall refer the patient to or consult with a practitioner of record if the patient's condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 30 days for a condition not previously assessed by a practitioner of record, the physical therapist shall have a practitioner of record review and sign the plan. The requirement that a physical therapist have a practitioner of record review and sign a plan of treatment does not apply when a patient has been physically examined by a physician licensed in another state, the patient has been diagnosed by the physician as having a condition for which physical therapy is required, and the physical therapist is treating the condition. For purposes of this paragraph a health care practitioner licensed under chapter 458 (Medical Doctors and Physician Assistants), chapter 459 (Osteopathic Physicians), chapter 460 (Chiropractors), chapter 461 (Podiatrists), chapter 466 (Dentistry) and engaged in active practice is eligible to serve as a practitioner of record.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

Aquatic therapy: therapeutic physical therapy exercises which takes place in or on water, most likely in a swimming pool. This involves the therapist doing manipulation, mobilization or manual stretching and strengthening in the water instead of on land. This type of therapy is often prescribed following intra-articular and ligament reconstruction in the knee, as well as for walking reeducation, strengthening leg muscles, enhancing joint range of motion, and rheumatic disease.

Condition: a disease, illness, ailment, injury, or pregnancy.

Habilitative services: health care services that are short-term and help a person to acquire or attain an age-appropriate bodily function necessary to participate in activities of daily living.

Rehabilitative services: health care services rendered for the purpose of restoring function lost due to illness, injury or surgical procedures.

RELATED GUIDELINES:

Home Health Care, 01-99500-01

Infrared Energy Therapy and Low Level Laser Therapy, 09-E0000-44

Pelvic Floor Stimulation as a Treatment of Incontinence, 01-97000-06

Treatment of Autism Spectrum Disorders, 01-97000-08

OTHER:

None applicable.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 02/26/26.

GUIDELINE UPDATE INFORMATION:

07/15/99	Medical Coverage Guideline developed.
04/01/02	HCPCS coding update; S8945 added.
01/01/03	HCPCS coding update; E0761 added.
02/15/03	Review of guideline; no change in coverage statement.
04/01/03	HCPCS coding update; S8945 deleted.
04/15/03	Revision of guideline; G0283 added.
08/15/03	Revision of guideline consisting of addition of information on infrared and low level laser, addition of G0281 and addition of cross-reference for diathermy and ultrasound for wound healing.
01/01/04	Annual HCPCS coding update.
03/15/04	Review and revision of guideline; consisting of updated references and addition of cross-references for pelvic floor stimulation, TMJ dysfunction and electrical stimulation for wound healing.

07/01/04	2nd quarter HCPCS update; consisting of the addition of S8948.
03/15/05	Review and revision of guideline; consisting of updated references.
01/01/06	Annual HCPCS coding update consisting of the deletion of 97020, 97505 and 97520.
03/15/06	Review and revision of guideline consisting of updated references.
06/15/06	Revision of guideline consisting of the addition of investigational statements for DRS therapy and dry hydrotherapy.
10/15/07	Review and revision of guideline consisting of updated references and reformatted guideline.
09/15/08	Scheduled review; no change in position statement. Update references. Update related guidelines.
04/01/09	Unscheduled review; update position statement and reimbursement section. Add program exception for Florida Statute 627.6686 and Medicare program exception for Comprehensive Motion Analysis (Gait Analysis).
09/15/09	Update exception section for treatment of autism.
04/15/10	Annual review; no change in position statement. Updated description for physical tests and measurements CPT code 97750. References updated.
04/15/11	Revision; added ICD-9 & ICD-10 diagnosis codes related to massage therapy.
07/15/11	Revision; formatting changes.
08/15/11	Revision; added a statement to the Position Statement that the treatment plan must be recertified by the physician at least every 60 days.
07/15/12	Scheduled review. Revised MCG title, description section and position statement. Updated references.
07/15/13	Scheduled review. Added coverage statement for Interactive Metronome Program (E/I). Revised ICD9 and ICD10 coding sections. Updated Medicare Advantage program exception. Updated references.
04/15/14	Revised ICD9 and ICD10 coding for massage therapy.
08/15/14	Scheduled review. Revised position statement and definitions section. Updated references.
10/01/15	Revision; updated ICD10 coding section.
11/01/15	Revision: ICD-9 Codes deleted.
07/15/16	Revision: Updated Program Exceptions section and references.
09/15/16	Revision: updated Positon Statement section and Definitions section.
09/15/17	Revision: deleted “physician directed” in reference to a treatment plan. Revised Program Exceptions section.
01/01/18	Revision: updated Reimbursement Information section.
10/01/18	ICD10 coding update: deleted M79.1.
03/15/20	Scheduled review. Revised position statement. Added CPT and HCPCS coding. Revised program exceptions and related guidelines. Updated references.
03/15/21	Revision: added definition for “eligible individual” and “health insurance plan” as described in Florida statutes 627.6686 and 641.31098. Added definition of “developmental disability” as described in Florida statute 393.063.
10/01/21	Quarterly CPT/HCPCS coding update: added codes M35.0A; M35.0B; M35.0C, revised M35.00-M35.09 code range descriptor.
03/15/22	Scheduled review. Maintained position statement and updated references.
07/15/22	Revision. Updated position statement regarding ROMTech rehabilitation device. Added clarifying language for habilitative versus rehabilitative therapy. Updated references.
05/22/23	Update to Program Exceptions section.
10/01/23	ICD10 coding update: added G20.A1, G20.A2, G20.B1, G20.B2, G20.C. Deleted G20.
03/15/24	Scheduled review. Revised description, deleted references to electrodynography and infrared laser therapy, and updated references.
09/15/24	Revision. Revised description, added coverage statement for AposTherapy®, and updated references.
10/01/24	Quarterly CPT/HCPCS coding update. Added code E3200. Revised description and position statement, and updated references.

01/01/25	Annual CPT/HCPCS coding update. Deleted 96003.
03/15/25	Scheduled review. Maintained position statement and updated references.
03/15/25	Scheduled review. Maintained position statements; deleted ICD10 coding and updated references.