Physical Therapy (PT) and Occupational Therapy (OT)

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Last Review: 10/09/2018

PARAMOUNT

ADVANTAGE | ELITE | HMO
INDIVIDUAL MARKETPLACE |
PROMEDICA MEDICARE
PLAN | PPO

GUIDELINES

This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

SCOPE

X Professional
_ Facility

DESCRIPTION

Physical therapy (PT) is the treatment of disorders or injuries using physical methods or modalities. A PT modality is often defined as any physical agent applied to produce therapeutic changes to biologic tissues. Modalities that are generally accepted for use include exercises, thermal, cold, ultrasonic or electric energy devices. Due to the passive nature of therapeutic modalities, they are generally used to enable the patient to take part in active aspects of therapy.

PT may be indicated for treatment of muscle weakness, limitations in the range of motion, neuromuscular conditions, musculoskeletal conditions, lymphedema and for selected training of patients in specific techniques and exercises for their own continued use at home.

Therapeutic procedures are intended as a means of effecting change using clinical skills and/or techniques and/or services whose goal is the improvement of function. PT procedures in general include therapeutic exercises and joint mobilization. These have generally been shown to be one set of effective means of treating aspects of many musculoskeletal conditions.

Medically necessary PT services must be restorative in nature or for the specific purposes of designing and teaching a maintenance program for the patient to carry out at home. The services must also relate to a written treatment plan and be of the level of complexity that requires the judgment, knowledge and skills of a physical therapist (or medical doctor/doctor of osteopathy) to perform and/or directly supervise.

The amount, frequency and duration of PT services must be seen as medically appropriate for the specific treatment regimen and be performed by a physical therapist. The services must not be of a palliative nature or provided for maintenance of the patient's status.

A qualified physical therapist for benefit coverage purposes is a person who is licensed as a physical therapist by the state in which he or she is practicing. A physical therapy assistant (PTA) is a person who is licensed as a PTA, if applicable, by the state in which he or she is practicing. The services of a PTA must be supervised by a licensed physical therapist at a level of supervision determined by state law or regulation. The services of a PTA cannot be provided incidental to a physician/appropriately licensed other practitioner as they are not specifically qualified as licensed physical therapists.

Occupational therapy (OT) is a form of rehabilitation therapy involving the treatment of neuromuscular and other dysfunction through the use of specific tasks or goal-directed activities to improve an individual's functional performance. This is intended to help a patient regain performance skills lost through injury or illness. Individual

patient programs are designed to improve quality of life through the recovery of specific competences, maximizing independence and the prevention of specific illness or disability.

OT includes helping patients learn or relearn specific daily living skills (eg, basic activities of daily living or ADLs) such as dressing, eating, personal hygiene, self-care and mobility/transfers. OT also includes specific task oriented therapeutic activities designed to restore physical function of the shoulder, elbow, wrist and/or hand that has been lost as a result of illness or injury. Occupational therapy can include the design, fabrication and fitting/maintenance of orthotics and related self-help devices including the fitting/fabrication of splints for the upper extremity.

Medically necessary OT services must be restorative in nature or for the specific purposes of designing and teaching a maintenance program for the patient to carry out at home. The services must also relate to a written treatment plan and be of the level of complexity that requires the judgment, knowledge and skills of an occupational therapist (or medical doctor/doctor of osteopathy) to perform and/or directly supervise these services. The amount, frequency and duration of occupational therapy services must be medically appropriate for the specific treatment regimen and be performed by an occupational therapist. These services must not be of a palliative nature or provided for maintenance of the patient's status.

A qualified occupational therapist for benefit coverage purposes is a person who is licensed as an occupational therapist by the state in which he or she is practicing. An occupational therapy assistant (OTA) is a person who is licensed as an OTA, if applicable, by the state in which he or she is practicing. The services of an OTA must be supervised by a licensed occupational therapist at a level of supervision determined by state law or regulation. The services of an OTA cannot be provided incidental to a physician/appropriately licensed other practitioner as they are not specifically qualified as licensed occupational therapists.

POLICY

Refer to CODING/BILLING INFORMATION below for complete coverage determination.

Procedure 97014 is non-covered for Elite/ProMedica Medicare Plan. HCPCS code G0283 should be used for unattended electrical stimulation, to one or more areas for indications other than wound care, in place CPT code 97014 for Elite/ProMedica Medicare Plan.

Procedure 97010 is bundled and not eligible for separate reimbursement for all product lines.

Kinesio taping is non-covered for all product lines.

Refer to PG0036 Vertebral Axial Decompression Therapy for coverage determination for procedure S9090.

Refer to PG0150 Chiropractic Services & Spinal Manipulation for coverage determination for procedures 98940-98943.

Refer to PG0402 Cognitive Rehabilitation for specific coverage criteria for procedure 97127.

COVERAGE CRITERIA

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage

Refer to specific contract language regarding physical and/or occupational therapy. Most contracts limit the duration or number of visits.

NOTE: The new evaluation codes for PT (97161, 97162, & 97163) and OT (97165, 97166, & 97167) are based on patient low, moderate or high complexity and the level of clinical decision-making. The re-evaluation codes for PT (97164) and OT (97168) are reported for an established patient's when a revised plan of care is indicated. These new codes must support the documentation requirements as outlined within the CPT parenthetical.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GO - Services delivered under an outpatient occupational therapy plan of care; or,
- GP - Services delivered under an outpatient physical therapy plan of care.

Physical therapy (PT)
Paramount covers a physical therapy evaluation as medically necessary for the assessment of a physical impairment.

Paramount covers a prescribed course of physical therapy by an appropriate healthcare provider as medically necessary when ALL of the following criteria are met:
- The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect or surgery.
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time.
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

The use of Kinesio taping is unproven and not medically necessary due to insufficient clinical evidence of safety and/or efficacy in published peer-reviewed medical literature.

Paramount does not cover physical therapy for the treatment of ANY of the following conditions because it is considered experimental, investigational or unproven:
- constipation
- dyspareunia
- vaginismus
- vulvodynia/vulvar vestibulitis
- sexual dysfunction unrelated to musculoskeletal or orthopedic condition
- scoliosis (e.g., Schroth Method of therapy for scoliosis)

Occupational therapy (OT)
Paramount covers an occupational therapy evaluation as medically necessary for the assessment of a physical impairment.

Paramount covers a prescribed course of occupational therapy by an appropriate healthcare provider as medically necessary when ALL of the following criteria are met:
- The program is designed to improve or compensate for lost or impaired physical functions, particularly those impacting activities of daily living.
- The program is expected to result in significant therapeutic improvement over a clearly defined period of time.
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.
- For a child, the treatment plan includes active participation/involvement of a parent or guardian.

MODALITIES (97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, & G0283)
CPT codes 97012, 97016, 97018, 97022, 97024, 97026, and 97028 require supervision by the qualified professional/auxiliary personnel of the patient during the intervention.

CPT codes 97032, 97033, 97034, 97035, 97036, and 97039 require direct (one-on-one) contact with the patient by the provider (constant attendance). Coverage for these codes indicates the provider is performing the modality and cannot be performing another procedure at the same time. Only the actual time of the provider's direct contact with the patient, providing services requiring the skills of a therapist, is covered for these codes.

Modalities chosen to treat the patient's symptoms/conditions should be selected based on the most effective and efficient means of achieving the patient's functional goals. Seldom should a patient require more than one (1) or two (2) modalities to the same body part during the therapy session. Use of more than two (2) modalities on each visit date is unusual and should be carefully justified in the documentation.

The use of modalities as stand-alone treatments is rarely therapeutic, and usually not required or indicated as the sole treatment approach to a patient's condition. The use of exercise and activities has proven to be an essential part of a therapeutic program. Therefore, a treatment plan should not consist solely of modalities, but should also include therapeutic procedures. (There are exceptions, including wound care or when patient care is focused on modalities because the acute patient is unable to endure therapeutic procedures.) Use of only passive modalities that exceeds 4 visits should be very well supported in the documentation.

Multiple heating modalities should not be used on the same day. Exceptions are rare and usually involve musculoskeletal pathology/injuries in which both superficial and deep structures are impaired. Documentation must support the use of multiple modalities as contributing to the patient's progress and restoration of function. For example, it would not be medically necessary to perform both thermal ultrasound and thermal diathermy on the same area, in the same visit, as both are considered deep heat modalities.

When the symptoms that required the use of certain modalities begin to subside and function improves, the medical record should reflect the discontinuation of those modalities, so as to determine the patient's ability to self-manage any residual symptoms. As the patient improves, the medical record should reflect a progression of the other procedures of the treatment program (therapeutic exercise, therapeutic activities, etc). In all cases, the patient and/or caregiver should be taught aspects of self-management of his/her condition from the start of therapy. Based on the CPT descriptors, these modalities apply to one or more areas treated (e.g., paraffin bath used for the left and right hand is billed as one unit).

Hot or cold packs therapy (97010)
Code 97010 is bundled. It may be bundled with any therapy code. Regardless of whether code 97010 is billed alone or in conjunction with another therapy code, this code is never paid separately. If billed alone, this code will be denied.

Mechanical traction therapy (97012)
Traction is generally limited to the cervical or lumbar spine with the expectation of relieving pain in or originating from those areas.

Specific indications for the use of mechanical traction include cervical and/or lumbar radiculopathy and back disorders such as disc herniation, lumbago, and sciatica.

This modality is typically used in conjunction with therapeutic procedures, not as an isolated treatment. Documentation should support the medical necessity of continued traction treatment in the clinic for greater than 12 visits. For cervical conditions, treatment beyond one month can usually be accomplished by self-administered mechanical traction in the home. The time devoted to patient education related to the use of home traction should be billed under 97012.

Only 1 unit of CPT code 97012 is covered per date of service.

Equipment and tables utilizing roller systems are not considered true mechanical traction. Services using this type of equipment are non-covered.

Supportive documentation should include type of traction and part of the body to which it is applied, etiology of symptoms requiring treatment.

Electrical stimulation (unattended) (G0283)
Most non-wound care electrical stimulation treatment provided in therapy should be billed as G0283 as it is often provided in a supervised manner (after skilled application by the qualified professional/auxiliary personnel) without constant, direct contact required throughout the treatment.

Code G0283 is classified as a "supervised" modality, even though it is labeled as "unattended." A supervised modality does not require direct (one-on-one) patient contact by the provider. Most electrical stimulation conducted via the application of electrodes is considered unattended electrical stimulation. Examples of unattended electrical

stimulation modalities include Interferential Current (IFC), Transcutaneous Electrical Nerve Stimulation (TENS), cyclical muscle stimulation (Russian stimulation).

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

If unattended electrical stimulation is used for control of pain and swelling, there should be documented objective and/or subjective improvement in swelling and/or pain within 6 visits. If no improvement is noted, a change in treatment plan (alternative strategies) should be implemented or documentation should support the need for continued use of this modality.

Documentation must clearly support the need for electrical stimulation more than 12 visits. Some patients can be trained in the use of a home TENS unit for pain control. Only 1-2 visits should be necessary to complete the training (which may be billed as 97032). Once training is completed, code G0283 should not be billed as a treatment modality in the clinic.

THERAPEUTIC PROCEDURES (97110, 97112, 97113, 97116, 97124, 97127, 97139, 97140, 97150, 97530, 97533, 97535, 97537, 97542, 97750, 97755, 97760, 97761, 97763 and 97799)

Therapeutic procedures attempt to reduce impairments and restore function through the application of clinical skills and/or services. Use of these procedures is expected to result in improvement of the limitations/deficits in a reasonable and generally predictable period of time.

Use of these procedures requires the qualified professional/auxiliary personnel to have direct (one-on-one) patient contact. Only the actual time of direct contact with the patient providing a service which requires the skills of a therapist is considered for coverage. Supervision of a previously taught exercise or exercise program, patients performing an exercise independently without direct contact by the qualified professional/auxiliary personnel, or use of different exercise equipment without requiring the intervention/skills of the qualified professional/ auxiliary personnel are not covered. The patient may be in the facility for a longer period of time, but only the time the qualified professional/auxiliary personnel is actually providing direct, one-on-one, patient contact which requires the skills of a therapist is considered covered time for these procedures, and only those minutes of treatment should be recorded.

Under Medicare, time spent in documentation of services (medical record production) is part of the coverage of the respective CPT code; there is no separate coverage for time spent on documentation.

CPT codes 97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, 97760, 97761, and 97763 describe different types of therapeutic interventions. The expected goals documented in the treatment plan, affected by the use of each of these procedures, will help define whether these procedures are reasonable and necessary. Therefore, since any one or a combination of these procedures may be used in a treatment plan, documentation must support the use of each procedure as it relates to a specific therapeutic goal.

Massage therapy (97124)

If massage therapy is not specifically excluded from coverage in the benefit plan, the following condition of coverage applies.

Massage therapy may be medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to reduce edema, improve joint motion, or relieve muscle spasm.
Massage therapy is considered a covered service ONLY when provided by a person who is recognized by Medicare as a physical therapy provider.

Massage is non-covered as an isolated treatment.

Paramount does not cover massage therapy when it is provided in the absence of other covered physical therapy, occupational therapy or chiropractic modalities because it is considered not medically necessary.

Paramount covers massage therapy ONLY when provided as one component of a medically necessary and covered comprehensive physical therapy or chiropractic treatment plan.

Massage chairs, aqua massage tables and roller beds are not considered massage and are non-covered.

CPT code 97124 is non-covered on the same visit date as CPT code 97140 (manual therapy techniques).

Do not bill 97124 for percussion for postural drainage.

Documentation must clearly support the need for continued massage beyond 6-8 visits, including instruction, as appropriate, to the patient and caregiver for continued treatment.

Supportive Documentation Recommendations for 97124:

- Area(s) being treated
- Objective clinical findings such as measurements of range of motion, description of muscle spasms and effect on function
- Subjective findings including pain ratings, pain location, effect on function

Unlisted Codes (97039, 97139, 97799)

Procedures/services that are billed with an unlisted code must meet medical necessity guidelines appropriate to the procedure/service.

Miscellaneous Services (Non-covered)

The following are non-covered as skilled therapy services (this list may not be all-inclusive):

- Iontophoresis, except as indicated for primary focal hyperhidrosis
- Anodyne
- Low level laser treatment (LLLT)/cold laser therapy
- Dry hydrotherapy massage (e.g., aquamassage, hydromassage, or water massage)
- Massage chairs or roller beds
- Interactive metronome therapy (Brain Bright Therapy)
- Loop reflex training
- Vestibular ocular reflex training
- Continuous passive motion (CPM) device setup and adjustments
- Craniosacral therapy
- Electro-magnetic therapy, except as indicated for chronic wounds
- Constraint Induced Movement Therapy (CIMT)
- Driving assessments
- Work-hardening programs
- Pelvic Floor Dysfunction (not including incontinence)
    - Due to the lack of peer reviewed evidence concerning the effect on patient health outcomes, skilled therapy interventions (e.g., ultrasound, electrical stimulation, soft tissue mobilization, and therapeutic exercise) for the treatment of the following conditions is considered investigational and thus non-covered.
        - pelvic floor congestion
        - pelvic floor pain not of spinal origin
        - hypersensitive clitoris
        - prostatitis
        - cystourethrocele
        - enterocele
        - rectocele
        - vulvodynia
        - vulvar vestibulitis syndrome (VVS)

CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES		COMMERCIAL	ADVANTAGE	ELITE
97001	Physical therapy evaluation (Deleted code effective 12/31/16)	COVER	COVER	COVER
97002	Physical therapy re-evaluation (Deleted code effective 12/31/16)	COVER	COVER	COVER
97003	Occupational therapy evaluation (Deleted code effective 12/31/16)	COVER	COVER	COVER
97004	Occupational therapy re-evaluation (Deleted code effective 12/31/16)	COVER	COVER	COVER
97010	Application of a modality to one or more areas; hot or cold packs	BUNDLE	BUNDLE	BUNDLE
97012	Application of a modality to 1 or more areas; traction, mechanical	COVER	COVER	COVER
97014	Application of a modality to one or more areas; electrical stimulation (unattended)	COVER	NC	NC
97016	Application of a modality to one or more areas; vasopneumatic devices	COVER	COVER	COVER
97018	Application of a modality to one or more areas; paraffin bath	COVER	COVER	COVER
97022	Application of a modality to one or more areas; whirlpool	COVER	COVER	COVER
97024	Application of modality to one or more areas; diathermy (e.g., microwave)	COVER	COVER	COVER
97026	Application of a modality to one or more areas; infrared	COVER	NC	NC
97028	Application of a modality to one or more areas; ultraviolet	COVER	NC	COVER
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	COVER	COVER	COVER
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes	COVER	NC	COVER
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes	COVER	COVER	COVER
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes	COVER	COVER	COVER
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes	COVER	COVER	COVER
97039	Unlisted modality (specify type and time if constant attendance)	BY REVIEW	NC	BY REVIEW
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	COVER	COVER	COVER
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture,	COVER	COVER	COVER

	and/or proprioception for sitting and/or standing activities			
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	COVER	COVER	COVER
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)	COVER	COVER	COVER
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	COVER	COVER	COVER
97127	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact (New code effective 01/01/2018)	COVER	COVER	COVER
97139	Unlisted therapeutic procedure (specify)	BY REVIEW	NC	BY REVIEW
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	COVER	COVER	COVER
97150	Therapeutic procedure(s), group (2 or more individuals)	COVER	COVER	COVER
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.	COVER	COVER	COVER
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	COVER	COVER	COVER

	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.**	**COVER**	**COVER**	**COVER**
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.**	**COVER**	**COVER**	**COVER**
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.**	**COVER**	**COVER**	**COVER**

	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.**	**COVER**	**COVER**	**COVER**
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.**	**COVER**	**COVER**	**COVER**

	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.**	**COVER**	**COVER**	**COVER**
97530	**Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes**	**COVER**	**COVER**	**COVER**
97532	**Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes (Deleted code effective 12/31/17)**	**COVER**	**COVER**	**COVER**
97533	**Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes**	**COVER**	**COVER**	**COVER**
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**	**COVER**	**COVER**	**COVER**
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**	**COVER**	**COVER**	**COVER**
97542	**Wheelchair management (eg, assessment, fitting, training), each 15 minutes**	**COVER**	**NC**	**COVER**
97545	**Work hardening/conditioning; initial 2 hours**	**NC**	**NC**	**NC**
97546	**Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)**	**NC**	**NC**	**NC**
97750	**Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes**	**COVER**	**COVER**	**COVER**
97755	**Assistive technology assessment (eg, to restore, augment or compensate for**	**COVER**	**COVER**	**COVER**

	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	COVER	COVER	COVER
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	COVER	COVER	COVER
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes (Deleted code effective 12/31/17)	COVER	COVER	COVER
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 (New code effective 01/01/2018)	COVER	COVER	COVER
97799	Unlisted physical medicine/rehabilitation service or procedure	BY REVIEW	NC	BY REVIEW
HCPCS CODES		**HMO**	**ADVANTAGE**	**ELITE**
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)	NC	NC	NC
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	COVER	NC	COVER
S8940	Equestrian/hippotherapy, per session	NC	NC	NC
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	NC	NC	NC
S9117	Back school, per visit	NC	NC	NC
MODIFIERS		**HMO**	**ADVANTAGE**	**ELITE**
GO	Services delivered under an outpatient occupational therapy plan of care; or,	REQUIRED	REQUIRED	REQUIRED
GP	Services delivered under an outpatient physical therapy plan of care.	REQUIRED	REQUIRED	REQUIRED

REVISION HISTORY EXPLANATION
ORIGINAL EFFECTIVE DATE: 05/30/2008
07/12/16: Changed name from Massage therapy to Physical Therapy (PT) and Occupational Therapy (OT). Added codes 97001, 97002, 97003, 97004, 97010, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97545, 97546, 97750, 97755, 97760, 97761, 97762, 97799, G0129, G0283, S8940, S8990, S9117. Per the Medicare Tactical Team Meeting review and determination, code 97014 is non-covered for Elite per CMS guidelines. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
02/14/17: Effective 12/31/16 deleted codes 97001-97004. Added effective 01/01/17 new codes 97161-97168. Added Modifiers GO & GP. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

10/10/17: Code 97012 added as covered for all product lines with limit of 1 unit per date of service. Kinesio taping added as non-covered for all product lines. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
01/09/18: Effective 12/31/17 deleted codes 97532 & 97762. Revised effective 01/01/18 codes 97760 & 97761. Added effective 01/01/18 new codes 97127 & 97763. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
05/24/18: Added Miscellaneous Services (Non-covered) per CMS guidelines that includes Interactive metronome therapy (Brain Bright Therapy). Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG).
09/25/18: Verbiage regarding Advantage limits removed per administrative direction.
10/09/18: Manual therapy (97140) no longer requires prior authorization for children 0-3 years of age for all product lines. Policy reviewed and updated to reflect most current clinical evidence per The Technology Assessment Working Group (TAWG).
12/15/2020: Medical policy placed on the new Paramount Medical Policy Format.

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid
American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.