Therapy Services

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Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

This policy outlines the intentions, guidelines and provider reimbursement regarding Medical Therapy services that are performed to the HHO population.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus LTSS (DSHP Plus LTSS) members.

Occupational Therapy (OT) – A form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life.

Physical Therapy (PT) – The treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery.

Speech Therapy (ST) – The treatment of communication impairment and swallowing disorders. Speech therapy services involve the use of special techniques to facilitate the development and maintenance of human verbal communication and swallowing through assessment, diagnosis, and rehabilitation.

Unit – One Unit represents 15 minutes of therapy.

Visit – A session of a particular activity. Visits equal up to 4 units.

POLICY POSITION

Prior authorization is always required for the initial 12 therapy visits. Once the first 12 visits have been exhausted, prior authorization is required for any additional visits.

The procedure codes listed for this service are only those that require prior authorization and do not represent an exhaustive list of billable procedure codes.

SPEECH THERAPY

Adult Speech Therapy

Speech therapy services may be considered medically necessary when ordered by a physician, physician assistant, or nurse practitioner and performed by a licensed speech pathologist/therapist. Speech therapy services must be directed to the active treatment of at least ONE of the following disorders:

- Apraxia; or
- Dysathria; or
- Aphasia; or
- Dysphagia

AND

The disorder is related to at least ONE of the following medical conditions:

- Dementia; or
- Right hemisphere brain injury; or
- Traumatic brain Injury; or
- Stroke; or
- Brain tumor; or
- Progressive neuromuscular disease (e.g., amyotrophic lateral sclerosis, Huntington's disease, multiple sclerosis, or muscular dystrophy) (This is not an all-inclusive list)

Voice therapy may be considered medically necessary for ANY of the following conditions (this is not an all-inclusive list):

- Closed head trauma; or
- Laryngeal trauma and trauma related dysphonia's; or
- Polyps; or
- Vocal cord lesions; or
- Vocal cord paralysis or paresis; or
- Vocal cysts; or
- Vocal nodules

NOTE: Voice therapy provided prior to surgery is not a covered service.

Speech therapy services must achieve a specific diagnosis-related goal for an individual who has a reasonable expectation of achieving measurable improvement in a predictable period of time. These services must also provide specific, and effective treatment for the individual's diagnosis and physical condition.

Speech therapy should be provided in accordance with an ongoing, written therapy plan.

NOTE: Neuromuscular electrical stimulation where a small current is passed through external electrodes placed on the neck to stimulate inactive or atrophied swallowing muscles may be considered medically necessary as an adjunct to treatment techniques and exercises.

Pediatric Speech Therapy

Speech therapy for children may be considered medically necessary when ordered by a physician, physician assistant, or nurse practitioner and performed by a licensed speech pathologist/therapist. Speech therapy services must be directed to the active treatment of at least ONE of the following disorders:

- Dysarthria; or
- Speech sound disorders (articulation disorder, phonological disorder); or
- Language disorders or delays (expressive language disorder, mixed receptive/expressive language disorder)

AND

The disorder is related to ONE of the following medical conditions or developmental disorders:

- Structural anomalies (e.g., cleft lip/palate, macroglossia, or velopharyngeal insufficiency. (This is not an all-inclusive list); or
- Intellectual disability resulting from a genetic disorder (e.g., trisomy 21 or fragile X syndrome), autism or an unknown cause. (This is not an all-inclusive list); or
- Neonatal disorders such as prematurity (32 weeks EGA or less), hypoxic-ischemic encephalopathy, intraventricular hemorrhage, or intrauterine/neonatal stroke. (This is not an all-inclusive list); or
- Sensory disorders such as hearing loss; or
- Developmental speech or language disorders that are moderate-to-severe (>1 SD below the mean for age) and ONE or more of the following:
  - Documented to have a significant impact of the child's ability to communicate; or
  - Persist beyond eight years of age

NOTE: Chronic ear infections must be of such documented severity and duration that the development of speech/language skills can be shown to be impaired. Generally, a bilateral hearing loss of 40dB of sufficient length (generally three months) during the speech/language formative period (prior to the age of four) is adequate for the coverage of these services.

Speech Therapy for children with fluency disorders may be considered medically necessary when ordered by a physician, physician assistant or nurse practitioner and performed by a licensed speech pathologist/therapist when at least ONE of the following features is present:

- Signs of tension (blocks, facial grimacing); or
- Prolongation of sounds: or
- Repeating sounds/syllables (as opposed to whole words/phrases): or
- Symptoms began at age four or above; or
- Symptoms have been present for more than six months

Speech therapy for children with swallowing disorders (dysphagia) may be considered medically necessary if the child has a diagnosis of dysphagia or confirmed aspiration that requires speech therapy to correct or mitigate.

Speech therapy for children with problems that do not involve swallowing dysfunction (e.g., sensory food aversion or avoidant/restrictive food aversion) are considered not medically necessary.

Pediatric voice therapy may be considered medically necessary for ANY of the following conditions (this is not an all-inclusive list):

- Closed head trauma; or
- Laryngeal trauma and trauma-related dysphonia; or

- Polyps; or
- Vocal cord lesions; or
- Vocal cord paralysis or paresis; or
- Vocal cysts; or
- Vocal nodules; or
- Velopharyngeal insufficiency; or
- Upper airway obstruction

NOTE: Voice therapy provided prior to surgery is not a covered service.

Speech therapy services must achieve a specific diagnosis-related goal for an individual who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period. These services must also provide specific, effective, and reasonable treatment for the individual's diagnosis and physical condition.

Speech therapy should be provided in accordance with an ongoing, written therapy plan.

NOTE: Neuromuscular electrical stimulation where a small current is passed through external electrodes placed on the neck to stimulate inactive or atrophied swallowing muscles may be considered medically necessary as an adjunct to treatment techniques and exercises.

Habilitative Therapy

Speech Therapy services ordered by a professional provider to promote the restoration, maintenance, or improvement in the level of function following disease, illness or injury. This also includes therapies to achieve functions or skills never acquired due to congenital and developmental anomalies.

The treatment plan should be maintained in the medical record and include the following:

- Specific statements of long- and short-term goals; and
- Measurable objectives; and
- A reasonable estimate of when the goals of therapy will be reached; and
- A description of the specific treatment techniques and/or exercises to be used in the treatment; and
- The frequency and duration of the treatment
- The individual should be re-evaluated at a minimum frequency of every 12 months

The following services are not covered:

- Therapy provided in an in-patient setting if speech therapy was the sole reason for the hospitalization; and
- Therapy that is considered primarily educational; and
- Services that do not require the skills of a qualified provider of speech therapy including those that can be effectively provided by the individual, family, or caregivers as well as those treatments that maintain function using routine, repetitious, and/or reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation errors); and
- Speech therapy services for dysfunctions that are self-correcting, such as language therapy for young children with natural dysfluency or developmental articulation errors that may be self-correcting; and
- Services that duplicate those provided by physical or occupational therapists (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).

Habilitative therapy services ordered by a professional provider to promote the restoration, maintenance, or improvement in the level of function following disease, illness, or injury. This includes therapies to achieve functions or skills never acquired due to congenital and developmental anomalies.

Habilitative/Rehabilitative therapy services must be reported with the 96 or 97 modifiers in conjunction with the appropriate therapy code.

*Spinal manipulation is not considered an habilitative service.

Maintenance Therapy

A maintenance program consists of activities that preserve the individual's present level of function and prevent regression of that function. These services generally would not involve complex physical medicine and rehabilitative procedures, nor would they require clinical judgment and skill for safety and effectiveness. 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. Maintenance therapy (physical or manipulative therapy performed for maintenance rather than restoration), is not eligible for payment.

Speech therapy is eligible for 12 visits per month.

PROCEDURE CODES FOR SPEECH THERAPY THAT REQUIRE AUTHORIZATION

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

Code	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder, group, 2 or more individuals.
92521	Evaluation of speech fluency (e.g., stuttering, cluttering).
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language).
92524	Behavioral and qualitative analysis of voice and resonance.
92526	Treatment of swallowing dysfunction and/or oral function for feeding.
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour.
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification.
92607	Evaluation for prescription for non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour.
92608	Evaluation for prescription for non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes.
92609	Therapeutic service(s) for use of speech-generating device, including programming and modification.
92610	Evaluation of oral and pharyngeal swallowing function.
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording.

92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes(list separately in addition to code for primary procedure).

PRIOR AUTHORIZATION IS REQUIRED FOR ALL SPEECH THERAPY CODES

OCCUPATIONAL THERAPY

Prior authorization is required.

Occupational therapy (OT) is the treatment of neuromusculoskeletal and psychological dysfunction, caused by disease, trauma, congenital anomaly, or prior therapeutic process, using specific tasks or goal-directed activities designed to improve functional performance of the individual. OT services emphasize useful and purposeful activities to improve neuromusculoskeletal function and to provide training in activities of daily living (ADL).

OT may be considered medically necessary for individuals who meet ALL the following criteria:

- The therapy is aimed at improving, adapting, or restoring functions of an individual who have been impaired or permanently lost because of physical disability due to illness, injury, congenital anomaly, or prior therapeutic intervention; and
- Achieve a specific diagnosis-related goal for an individual who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period based on the qualified OT assessment of the individual's restoration potential and unique medical condition; and
- Specific, effective, and reasonable treatment for the individual's diagnosis and physical condition; and
- The services are delivered by a qualified provider of OT services

A qualified provider is an individual who is licensed, where required, and performs within the scope of licensure.

A typical treatment plan consists of up to one hour sessions and up to four physical medicine procedures per date of service and includes ANY of the following:

- Modalities; or
- Therapeutic procedures; or
- Tests and measurements; or
- Muscle range of motion (ROM) testing; or
- Orthotic management and prosthetic management

Exceptions include standardized cognitive performance testing per hour and work hardening/conditioning; initial two hours. Only one of these services are eligible for reimbursement per date of service since each represents one hour or greater of OT testing or treatment. Each additional hour of work hardening/conditioning will be considered exceeding the limitation; and is considered not medically necessary. No other physical medicine procedure codes can be billed on the same date of service.

Duplicate therapy is considered not medically necessary. Example: An individual receiving therapy services from two different providers treating the same condition.

An evaluation and management (E/M) service is considered an inherent part of an OT evaluation. The E/M service is not eligible for separate reimbursement when reported on the same day as an OT evaluation.

Consequently, when an E/M service is reported in conjunction with an OT evaluation, the services may should be combined under the appropriate code for the OT evaluation.

Muscle testing, ROM testing, and physical performance testing are considered components of an OT evaluation. They are not eligible for separate reimbursement when billed with an OT evaluation.

VISIT LIMITATIONS

Occupational therapy is eligible for 12 visits per month.

PROCEDURE CODES FOR OCCUPATIONAL THERAPY THAT REQUIRE AUTHORIZATION

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

Code	Description
97530	Therapeutic activities, direct (one on one) patient contact (use of dynamic activities to improve functional performance), 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) encounter, each 15 minutes.

PHYSICAL THERAPY

Prior authorization is required.

Physical Medicine Evaluation

Evaluation and Management (E&M) service is considered an inherent part of a physical medicine evaluation. The E&M service is not eligible for separate payment when reported on the same day as a physical medicine evaluation.

When an Evaluation and Management service is reported in conjunction with a physical medicine evaluation the services should be combined under the appropriate code for the physical medicine evaluation.

Modifier "-25" may be reported with medical care (e.g., E/M visits, consultations) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier "-25" is reported, the individual's medical records must clearly document that separately identifiable medical care was rendered.

Muscle testing, ROM testing, and physical performance testing are considered components of a physical medicine evaluation and are not eligible for separate payment when billed on the same date of service as a physical medicine evaluation.

Modifier "-59" may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day.

Physical medicine is a covered service when performed with the expectation of restoring the individual's level of function that has been lost or reduced by injury or illness.

Treatment plans must be maintained in the medical record and made available upon request.

A typical session usually consists of up to one hour of rehabilitative therapy which could include up to four (4) physical medicine modalities/procedures and/or units performed on the same date of service, per performing provider.

Services exceeding the limitation will be considered not medically necessary.

Duplicate therapy is considered not medically necessary.

COVERED PROCEDURE CODES FOR PHYSICAL THERAPY THAT REQUIRE AUTHORIZATION

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

Code	Description
90912	Biofeedback training ,perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan to care.

Pulmonary Rehabilitation

Prior authorization is required.

A single course of PR in the outpatient ambulatory care setting may be considered medically necessary for ANY of the following indications:

- Treatment of chronic pulmonary disease for individuals with moderate to severe disease (see Table) who are experiencing disabling symptoms and significantly diminished QOL despite optimal medical management; or
- Pre-operative conditioning component for those considered appropriate candidates for lung volume reduction surgery or for lung transplantation; or
- Following lung transplantation.

Outpatient PR for any other indication not listed above is considered not medically necessary.

Classification of Severity of Airflow Limitation in COPD a,b		
Gold 1	Mild	FEV1 ≥ 80% predicted
Gold 2	Moderate	50% ≤ FEV1 < 80% predicted
Gold 3	Severe	30% ≤ FEV1 < 50% predicted
Gold 4	Very Severe	FEV1 < 30% predicted
a – Based on post-bronchodilator FEV1		
b – In patients with FEV1/FVC < 0,70		

Comprehensive outpatient PR programs may include: team assessment, individual training, psychosocial intervention, exercise training, and follow-up. PR program length may be considered medically necessary for up to 18 sessions and is only eligible one time per three-year period, depending on program and may include the following:

- Team assessment:
  - May include input from:
    - Physician; and
    - Respiratory care practitioner; and
    - Nurse; and
    - Psychologist; and
    - Others as needed
- Individual training:
  - May include:
    - Breathing training; and
    - Bronchial hygiene; and
    - Medications; and
    - Proper nutrition
- Psychosocial intervention:
  - May address:
    - Support system; and
    - Dependency issues
- Exercise training:
  - Includes strengthening and conditioning and may utilize the following:
    - Stair climbing; or
    - Inspiratory muscle training; or
    - Treadmill walking; or
    - Cycle training (with or without ergometer); or
    - Supported and unsupported arm exercise training

NOTE: Exercise conditioning is an essential component of pulmonary rehabilitation. Education in disease management techniques without exercise conditioning does not improve health outcomes of individuals who have chronic obstructive pulmonary disease.

- Follow up:
  - May include supervised home exercise conditioning

COVERED CODES FOR PULMONARY REHABILITATION THAT REQUIRE AUTHORIZATION

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

Code	Description
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session).
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session).
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).

Cardiac Rehab

Prior authorization is required.

Cardiac rehabilitation programs, Phase II Outpatient may be considered medically necessary when individually prescribed by a physician and the following criteria are met:

- Initiated within 12 months of ANY of the following:
  - Acute myocardial infarction (MI) (heart attack); or
  - Coronary artery bypass graft (CABG) surgery; or
  - Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
  - Heart valve surgery; or
  - Heart or heart-lung transplantation; or
  - Current stable angina pectoris; or
  - Compensated heart failure; or
  - Coronary artery disease (CAD) associated with chronic; stable angina pectoris that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; and
- The individual does not have an absolute contraindication to cardiac rehabilitation (examples include: unstable angina, overt cardiac failure, dangerous arrhythmias, dissecting aneurysm, myocarditis, acute pericarditis, severe obstruction of the left ventricular outflow tract, severe hypertension, exertional hypotension or syncope, uncontrolled diabetes mellitus, severe orthopedic limitations, and recent systemic or pulmonary embolus)

Following the initial evaluation, services provided in conjunction with a phase II outpatient cardiac rehab program may be considered medically necessary for up to 36 sessions, three sessions per week, for a 12-week period. The need for supervised exercise sessions can be determined by the individual's risk stratification as follows:

- Low Risk: 6-18 exercise sessions
- Moderate Risk: 12-24 exercise sessions
- High Risk: 18-36 exercise sessions

A routine cardiac rehabilitation session usually consists of an exercise training session lasting 20-60 minutes and at least ONE of the following services:

- Continuous ECG/EKG monitoring during exercise; or
- EKG rhythm strip with interpretation and physician's revision of the exercise program; and/or
- Limited physician follow-up to adjust medication or other treatment(s) related to the program.
- Cardiac rehabilitation exercise programs beyond the initial 12-week/36 session will require individual medical review. If documentation substantiates that additional sessions are medically necessary to reach a realistic and achievable increase in work capacity, the number of services may be extended, but not exceed a maximum of 24 weeks or 72 sessions.
- Phase II cardiac rehabilitation services that do not meet the medical necessity criteria and frequency guidelines outlined on this policy will be denied as not medically necessary.
- Maintenance exercise programs undertaken by the participant after formal freestanding clinic or facility based programs are completed are not covered.
- Generally, psychotherapy and psychological testing are not considered medically necessary for all cardiac rehabilitation participants. However, if a participant has been diagnosed with a mental, psychoneurotic or personality disorder, psychotherapy performed by a psychiatrist or a psychologist it may be considered medically necessary. In addition, psychological diagnostic testing of a cardiac rehabilitation participant who exhibits symptoms of mental illness or mental problems (e.g., anxiety disorder associated with the cardiac disease) may be considered medically necessary.

- Physical and/or occupational therapies are considered not medically necessary in conjunction with cardiac rehabilitation services unless performed for an unrelated diagnosis (e.g., a participant who is recuperating from an acute phase of heart disease may have also had a stroke which could require physical and/or occupational therapies).
- Repeat participation in an outpatient cardiac rehabilitation program in the absence of another qualifying cardiac event is considered experimental/investigational and therefore, non-covered. Scientific evidence does not support the need for repeat cardiac rehabilitation in the absence of cardiac events.
- Educational services (e.g., lectures, counseling) that may be provided as part of a cardiac rehabilitation exercise program are not eligible for separate reimbursement.
- Phase III cardiac rehabilitation programs, or self-directed, self-controlled or monitored exercise programs are considered not medically necessary.
- Phase IV cardiac rehabilitation programs or maintenance therapy that may be safely carried out without medical supervision are considered not medically necessary.
- Cardiac rehabilitation when used in a preventive or prophylactic way, such as for angina, hypertension, or diabetes is considered not medically necessary.

Risk stratification based on the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

Cardiac rehabilitation services are contraindicated in patients with the following conditions:

- A recent significant change in the resting ECG suggesting significant ischemia, recent MI (within 2 days), or other acute cardiac event;
- Severe residual angina;
- Uncompensated heart failure;
- Uncontrolled arrhythmias;
- Symptomatic severe aortic stenosis;
- Severe ischemia, LV dysfunction, or arrhythmia during exercise testing;
- Poorly controlled hypertension;
- Acute pulmonary embolism or pulmonary infarction;
- Acute myocarditis or pericarditis;
- Suspected or known dissecting aneurysm;
- Acute systemic infection, accompanied by fever, body aches, or swollen lymph glands;
- Hypertensive or any hypotensive systolic blood pressure response to exercise

Relative contraindications to exercise include:

- Left main coronary stenosis;
- Moderate stenotic valvular heart disease;
- Electrolyte abnormalities (e.g., hypokalemia, hypomagnesemia);
- Severe arterial hypertension (i.e., systolic BP If greater than 200mm Hg and/or diastolic BP of greater than 110 mm Hg) at rest;
- Tachydysrhythmia or bradydysrhythmia;
- Hypertrophic cardiomyopathy and other forms of outflow tract obstruction;
- Neuromuscular, musculoskeletal, or rheumatoid disorders that are exacerbated by exercise;
- High-degree atrioventricular block;
- Ventricular aneurysm;
- Uncontrolled metabolic disease (e.g., diabetes, thyrotoxicosis, or myxedema);
- Chronic infectious disease (e.g., mononucleosis, hepatitis, AIDS);
- Mental or physical impairment leading to inability to exercise adequately

The participant's risk for another coronary event determines the status of the individual as a high moderate-, or low-risk. Use of early (pre-discharge) exercise testing, with or without radionuclide studies, provides the ability

to determine the probability of a proximate ischemic event. Risk stratification testing benefits all participants regardless of their level of risk.

Initially, a comprehensive evaluation may be performed to evaluate the participant and determine an appropriate exercise program.

In addition to typical program duration, an endpoint for cardiac rehabilitation services may also be determined using the participant's work capacity as measured by metabolic equivalents of task (MET). A MET is the measurement of the work required from the cardiovascular and pulmonary systems by a given activity. One MET equals approximately 3.5 ml of oxygen consumption per kilogram of body weight per minute.

Depending on variables such as age, sex, cardiac history, the existence of other complicating medical conditions, etc., work capacity usually levels out at a maximal level of five to eight METs for most cardiac rehabilitation participants. Reasonable endpoint criteria for medically supervised cardiac rehabilitation programs can include the ability of the participant to exercise at a level of eight or more.

METs without cardiac symptoms and the acquisition of the skills necessary for the self-monitoring of an unsupervised exercise program.

Since many participants with cardiac disease will not be capable of achieving this level of work capacity, the absence of improvement in capacity after three serial exercise tests can be used as an alternative endpoint indicator.

Once a participant’s maximal work capacity has leveled out, ongoing exercise is considered maintenance. Additional cardiac rehabilitation services are eligible based on the clinical criteria defined in this policy when the individual has a repeat occurrence of the covered conditions, e.g., another cardiovascular surgery, a new MI, etc.

COVERED PROCEDURE CODES FOR CARDIAC REHAB THAT REQUIRE AUTHORIZATION

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

Code	Description
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation without continuous ECG monitoring (per session).
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation with continuous ECG monitoring (per session).

Vasopneumatic Compression

Vasopneumatic compression is considered medically necessary for the following conditions:

- Edema of the extremities; or
- Hematoma of the leg; or
- Lymphedema of the arm; or
- Lymphedema of the leg; or
- Venous insufficiency or venous stasis disorder; or

Vasopneumatic compression not meeting the criteria as indicated in this policy is considered not medically necessary.

Vasopneumatic compression is considered a supervised modality and is not considered time-based. It should be reported only once per treatment session, regardless of the number of areas treated or the length of time required to complete treatment.

Vestibular Rehabilitation Therapy

A vestibular rehabilitation program typically last 45 minutes per session and is prescribed 1-2 times per week. In general, individuals remain in the program 4-8 weeks.

A vestibular rehabilitation program may be considered medically necessary for individuals with vertigo, disequilibrium, and balance deficits related to the following conditions:

- Peripheral vestibular disorders (e.g., labyrinthitis, neuritis, benign paroxysmal positional vertigo, post vestibular surgical symptoms, and bilateral vestibular loss); or
- Mixed {peripheral and central vestibular disorders; or
- Central causes of vertigo (e.g., CVA, multiple sclerosis, and mild traumatic brain injury).

A vestibular rehabilitation program not meeting the criteria as indicated in this policy is considered not medically necessary.

Gait Training

Gait training may be considered medically necessary for the following indications:

- Foot drop resulting from stroke; or
- Herniated disc(s); or
- Ankle, knee and/or hip replacement; or
- Traumatic amputations of the toe(s)

Documentation for gait training must demonstrate that the individual's gait was improved either by lengthening the gait or increasing the frequency of cadence lower extremity.

Gait training not meeting the criteria as indicated in this policy is considered not medically necessary.

COVERED PROCEDURE CODES THAT REQUIRE AUTHORIZATION

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

Code	Description
94680	Oxygen uptake, expired gas analysis; rest and exercise, direct, simple.
96001	Comprehensive computer-based motion analysis by videotaping and 3-D kinematics; with dynamic plantar pressure measurements during walking.
96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles.
96004	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire.
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.

99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, requiring a minimum of 30 minutes of time.

Aquatic Therapy

Aquatic therapy must be performed with the expectation of restoring an individual's level of function that has been lost or reduced by injury or illness. Aquatic therapy performed to maintain a level of function is a maintenance program and is not eligible for reimbursement.

A provider must have direct (one to one) contact with the individual when reporting aquatic therapy.
Before beginning an aquatic therapy program, the provider must prepare a treatment plan that includes short-term and long-term goals that the individual can be reasonably expected to accomplish through the aquatic therapy program and the specific methods chosen.

Separate reimbursement will not be made for whirlpool or Hubbard tank in addition to aquatic therapy with therapeutic exercise for a single individual encounter.

VISITATION LIMITATIONS

Outpatient Therapy Services have a combined $70 limitation per day. There are exclusions to this limit which would include Nursing Homes and Skilled Nursing Facilities (SNF).

Reimbursement for physical therapy (PT) occupational therapy (OT) services involving any physical medicine procedures are limited as follows:

- Services exceeding the limitation will be considered not medically necessary.

The attached spreadsheet is a list of procedure codes that clarify if there is a $70 limitation:

$70 per day limit grid (PDF)

MODIFIER(S) FOR ALL PROCEDURE CODES

Modifier	Description
25	Used to report an Evaluation and Management (E/M) service on a day when another service was provided to the patient by the same physician or other qualified health care professional.
59	Used to identify procedures/services, other than E/M services, that are not normally reported together.
96	Used to identify habilitative services or procedures that could be considered either habilitative or rehabilitative.
97	Used to identify rehabilitative services that could otherwise be considered either habilitative or rehabilitative .

References

MSA
CMS.gov

POLICY UPDATE HISTORY

11/3/2022	Approved in Reimbursement Policy Committee
12/19/2022	Approved in Governance