

## Physical Medicine

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| <b>Policy ID:</b>               | HHO-DE-MP-1154                              |
| <b>Approved By:</b>             | Highmark Health Options – Market Leadership |
| <b>Provider Notice Date:</b>    | 12/15/2021; 03/01/2023                      |
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| <b>Products:</b>                | Medicaid                                    |
| <b>Application:</b>             | All participating hospitals and providers   |
| <b>Page Number(s):</b>          | 1 of 10                                     |

### 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

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary physical medicine.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

### 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 members.

**Physical Medicine and Rehabilitation** – A medical specialty concerned with diagnosis, evaluation, and management of persons with physical impairment and disability. This specialty involves diagnosis and treatment of individuals with painful or functionally limiting conditions, the management of comorbidities and co-impairments.

### PROCEDURES

1. A prior authorization is required.

Physical medicine and rehabilitation is a medical specialty concerned with diagnosis, evaluation, and management of persons with physical impairment and disability. This specialty a diagnosis and treatment of patients with painful or functionally limiting conditions, the management of comorbidities and co-impairments.

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 (1) 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.

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

- Up to four (4) codes/units in any combination per date of service per performing provider.
- Payment will be based on the highest submitted and allowed physical medicine procedures.
  - Modalities- 97012-97039, G0283, S8950
  - Therapeutic procedures- 97110-97542
  - Tests and measurements 97750
  - Muscle range of motion (ROM) testing- 95831-95852
  - Orthotic management and prosthetic management- 97760- 97763

Services exceeding the limitation will be considered not medically necessary.

Duplicate therapy is not considered medically necessary.

## 2. 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 E&M service is reported in conjunction with a physical medicine evaluation the services must 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.

## 3. Maintenance therapy

Physical medicine services performed repetitively to maintain a level of function are not eligible for reimbursement unless the member has Habilitative services benefits.

A maintenance program consists of activities that preserve the individual's present level of function and prevent regression of that function. These services 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, and no additional functional progress is apparent or expected to occur.

#### 4. Habilitative therapy

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.

Habilitative therapy is not eligible for payment unless the member has a habilitative benefit.

\*Spinal manipulation is not considered an habilitative service.

#### 5. Supervised modalities

Supervised modalities do not require direct one-on-one contact by the provider. These are not time-based codes.

#### 6. Vasopneumatic compression

Vasopneumatic compression is considered medically necessary for the following conditions:

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

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

Vasopneumatic compression service 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.

#### 7. Infrared therapy

The use of infrared and near-infrared light and heat, including monochromatic infrared energy, when used as a physical medicine modality for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy and wounds and/or ulcers of the skin and/or subcutaneous tissues is considered not medically necessary.

8. Constant attendance modalities

Constant attendance modalities require direct one-on-one contact with the individual by the provider. Documentation must include the amount of time spent in providing all aspects of this service.

When two (2) constant attendance modalities are performed at the same time, using one (1) device, the code representing the primary modality can be reported.

9. 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 considered to be 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.

10. Gait training

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

- Foot drop resulting from stroke.
- Herniated disc(s).
- Ankle, knee, and/or hip replacement.
- 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.

11. 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);
- Mixed peripheral and central vestibular disorders; ot

- 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.

#### 12. Noncovered Services

- Equestrian/Hippotherapy
- Low-level Laser Therapy (Cold Laser Therapy)

Note: This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

#### 13. Post-payment audit statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

#### 14. Place of service: inpatient/outpatient

Physical medicine is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances including, but not limited to the presence of a comorbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

### CODING REQUIREMENTS

| CPT code | Description  |
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| 95852    | Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side.   |
| 95992    | Canalith repositioning procedure(s) (e.g., Epley Maneuver, Semont Maneuver) per day.   |
| 96125    | Standardized Cognitive Performance Testing (e.g., Ross Information Processing Assessment) Per Hour of A Qualified Health Care Professional's Time Both Face-to-face Time Administrating Tests To The Patient And Time Interpreting These Test Results And Preparing The Report |
| 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 (e.g., microwave).   |
| 97026    | Application of a modality to 1 or more areas; infrared.  |
| 97028    | Application of a modality to 1 or more areas; ultraviolet.   |

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| 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.  |
| 97039 | Unlisted modality (specify type and time if constant attendance).   |
| 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).   |
| 97129 | 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; Initial 15 Minutes   |
| 97130 | 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; Each Additional 15 Minutes (list Separately In Addition To Code For Primary Procedure)   |
| 97139 | Therapeutic procedure, 1 or more areas, each 15 minutes; unlisted therapeutic procedure (specify).  |
| 97140 | Manual therapy techniques (e.g., 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   |

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|       | 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 (i.e., 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 (e.g., 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 (i.e., 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 (e.g., 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 (i.e., 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 (e.g., 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   |

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|       | 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.   |
| 97533 | Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact, each 15 minutes.   |
| 97535 | Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in the use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.  |
| 97537 | Community/work reintegration training (e.g., 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 (e.g., assessment, fitting, training), each 15 minutes.   |
| 97750 | Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.  |
| 97755 | Assistive Technology Assessment (e.g., 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) encounter, each 15 minutes.  |
| 97799 | Unlisted physical medicine/rehabilitation service or procedure.   |
| S8948 | Application of modality (requiring constant provider attendance) to one or more areas; low-level laser, each 15 minutes.  |
| S9123 | Nursing Care, In The Home; By Registered Nurse, Per Hour (use for General Nursing Care Only, Not To Be Used When cpt Codes 99500-99602 Can Be Used)   |
| S9124 | Nursing Care, In The Home; By Licensed Practical Nurse, Per Hour  |
| S9125 | Respite Care, In The Home, Per Diem   |
| S9128 | Speech Therapy, In The Home, Per Diem   |
| S9129 | Occupational Therapy, In The Home, Per Diem   |
| S9131 | Physical Therapy; In The Home, Per Diem   |
| T1025 | Intensive, Extended Multidisciplinary Services Provided In A Clinic Setting To Children With Complex Medical, Physical, Medical And Psychosocial Impairments, Per Diem  |
| T1026 | Intensive, Extended Multidisciplinary Services Provided In A Clinic Setting To Children With Complex Medical, Physical, Medical And Psychosocial Impairments, Per Hour  |

**COVERED DIAGNOSIS CODES FOR PROCEDURE CODE 97016**

| Codes    |          |          |       |          |          |          |
|----------|----------|----------|-------|----------|----------|----------|
| I87.2    | I87.8    | I87.9    | I89.0 | I97.2    | M79.81   | M79.89   |
| Q82.0    | R60.0    | R60.1    | R60.9 | S70.10XA | S70.11XA | S70.12XA |
| S80.10XA | S80.11XA | S80.12XA |       |          |          |          |

**COVERED DIAGNOSIS CODES FOR PROCEDURE CODE 97116**

| Codes    |          |          |          |          |          |          |
|----------|----------|----------|----------|----------|----------|----------|
| M51.27   | S98.111A | S98.111D | S98.111S | S98.112A | S98.112D | S98.112S |
| S98.121A | S98.121D | S98.121S | S98.122A | S98.122D | S98.122S | S98.131A |
| S98.131D | S98.131S | S98.132A | S98.132D | S98.132S | S98.141A | S98.141D |
| S98.141S | S98.142A | S98.142D | S98.142S | S98.211A | S98.211D | S98.211S |
| S98.212A | S98.212D | S98.212S | S98.221D | S98.221S | S98.221S | S98.222A |
| S98.222D | S98.222S | Z96.641  | Z96.642  | Z96.643  | Z96.649  | Z96.651  |
| Z96.652  | Z96.653  | Z96.659  | Z96.661  | Z96.662  | Z96.669  |          |

**COVERED DIAGNOSIS CODES FOR PROCEDURE CODE S9476**

| Codes   |         |         |         |         |         |         |
|---------|---------|---------|---------|---------|---------|---------|
| G35     | H81.10  | H81.11  | H81.12  | H81.13  | H81.20  | H81.21  |
| H81.22  | H81.23  | H81.311 | H81.312 | H81.313 | H81.319 | H81.391 |
| H81.392 | H81.393 | H81.399 | H81.4   | H83.01  | H83.02  | H83.03  |
| H83.09  | I63.30  | I63.311 | I63.312 | I63.313 | I63.321 | I63.322 |
| I63.323 | I63.329 | I63.331 | I63.332 |         |         |         |

**REIMBURSEMENT**

Participating facilities will be reimbursed per their Highmark Health Options contract.

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**POLICY UPDATE HISTORY**

|            |                                      |
|------------|--------------------------------------|
| 09/28/2022 | Approved in Medical Policy Committee |
| 10/2022    | Approved in QI/UM                    |
|            |                                      |
|            |                                      |