

## Medical Necessity Guidelines: Rehabilitative Services: Physical Therapy

Effective: October 21, 2020

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
<p><b>Applies to:</b>  <b>COMMERCIAL Products</b></p> <p><input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409  <input type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409</p> <ul style="list-style-type: none"> <li>CareLink<sup>SM</sup> – Refer to <a href="#">CareLink Procedures, Services and Items Requiring Prior Authorization</a></li> </ul> <p><b>TUFTS HEALTH PUBLIC PLANS Products</b></p> <p><input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055  <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055  <input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404  <input type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304            *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p><b>SENIOR Products</b></p> <ul style="list-style-type: none"> <li>Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the <a href="#">Tufts Health Plan SCO Prior Authorization List</a></li> <li>Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the <a href="#">Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</a></li> </ul>	

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

### OVERVIEW

The Tufts Health Plan Rehabilitative Services Physical Therapy (PT) Authorization Program is a program designed to review rehabilitative physical therapy treatment requests that are beyond the allowed number of visits referred by their primary care physician (PCP).

**Tufts Health Plan Commercial** Members are covered without prior authorization for an initial evaluation and up to 8 outpatient rehabilitative PT visits (per calendar or plan year) when referred by their PCP.

**Tufts Health Direct** Members are covered without prior authorization for their initial evaluation and 11 visits per benefit year for outpatient rehabilitative PT services when referred by their PCP.

Additional rehabilitative outpatient PT beyond the initial visits may be authorized if the criteria listed here is met. To initiate an authorization request beyond the initial number of PT visits, complete the [Rehabilitative Services: Physical Therapy Authorization Form](#).

**Note:** The Member's rehabilitative PT visit **benefit limit** may vary depending on the terms of the plan benefit document.

### CLINICAL COVERAGE CRITERIA

Physical therapy providers are expected to address the specific clinical and functional restrictions by applying skilled physical therapy techniques and utilizing appropriate physical therapy modalities, therapeutic exercise, manipulative techniques and soft tissue care with concurrent initiation of a progressive exercise and stabilization program. Additionally, emphasis of treatment is expected to be self-symptom management and an independent home or community-based exercise program.

From the initial evaluation through the entire course of treatment, **all** of the following must be met:

- There is reasonable medical expectation of significant functional improvement within sixty (60) days of the initial therapy visits

- The services are **not** duplicative of services that are part of an individual educational plan (IEP) or an individual service plan (ISP) when applicable
- Demonstration of measurable, objective, and functional progress as a direct result of treatment
- A treatment plan that requires the services of a skilled physical therapist
- An expectation that treatment will result in measurable improvement in a reasonable and predictable period of time for the particular diagnosis and phase of recovery
- Rehabilitative physical therapy treatment is medically necessary

### LIMITATIONS

Tufts Health Plan will not authorize the coverage of rehabilitative physical therapy for the following indications, as they are not considered medically necessary:

- Maintenance therapy
- Plan benefit exclusions, per individual member’s plan document, including services that are primarily educational in nature and services that are vocationally and/or recreationally based, **and may include services that are developmental in nature.**
- Services that are not medically necessary
- Sensory integration therapy\* for any diagnosis other than autism spectrum disorder(s). Refer to the [Autism Services: Physical, Occupational and Speech Therapy for Members with Autism Spectrum Disorders Medical Necessity Guidelines](#).
- Personal training, life coaching
- Treatment that is investigational or unproven, including, but not limited to facilitated communication, auditory integration therapy (AIT), holding therapy, Higashi (Daily Life Therapy)
- Custodial care (for the purposes of this guideline custodial care is “care, administered by trained personnel, to which the Member shows no beneficial response despite extended and/or repeated treatment trials”)
- Any service, program, supply, or procedure performed in a non-conventional setting (this includes, but is not limited to, spas/resorts; educational, vocational, or recreational settings; Outward Bound or wilderness, camp or ranch programs). This is the case even if the services are performed by a licensed provider (including, but not limited to, mental health professionals, nutritionists, nurses or physicians).

**Note:** If requesting **habilitative PT/OT/ST services**, please refer to the [Habilitative Services: Physical, Occupational and Speech Therapy Medical Necessity Guidelines](#).

**Note:** If requesting **autism services for PT, OT and/or ST**, please refer to the [Autism Services: Physical Therapy, Occupational Therapy and Speech Therapy for Autism Spectrum Disorders Medical Necessity Guidelines](#).

**Note:** If requesting **ABA (Applied Behavioral Analysis) Therapy and Habilitative Services for Autism Spectrum Disorders**, please refer to the applicable Medical Necessity Guidelines:

- [ABA \(Applied Behavioral Analysis\) Therapy and Habilitative Services for Autism Spectrum Disorders: Massachusetts Products](#)
- [ABA \(Applied Behavioral Analysis\) Therapy for Autism Spectrum Disorders: Rhode Island Products](#)

### CODES

**Table 1: CPT Code(s)**

CPT/HCPCS Code	Description
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

CPT/HCPCS Code	Description
	following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (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
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

<b>CPT/HCPCS Code</b>	<b>Description</b>
	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	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)
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 use of assistive technology devices/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(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

#### **REFERENCES**

None

#### **APPROVAL HISTORY**

February 10, 2006: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:

- February 28, 2007: Reviewed and renewed, no changes made
- February 27, 2008: Reviewed and renewed, no changes made
- October 8, 2008: Special Information box added to format. Rhode Island benefit limit added
- March 24, 2009: Reviewed by Medical Affairs Medical Policy; no changes
- January 1, 2010: Benefit limit of thirty (30) visits per calendar year added
- May 1, 2010: Clarification of short term (sixty days) language added
- April 2011: Reviewed by MSPAC, no changes
- July 2011: Hyperlink to NC codes updated
- April 11, 2012: Reviewed and renewed at Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes. ICD-10 codes will be added prior to the next IMPAC approval.

- August 17, 2012: Autism codes clarified and language added with a link to the specific Autism Services: Physical, Occupational and Speech Therapy for Members with Autism Spectrum Disorders.
- June 1, 2013: Noncovered codes for short term PT and OT therapy updated
- September 11, 2013: Reviewed by IMPAC, renewed without changes.
- November 3, 2014: Addition of sensory integration therapy without Autism Spectrum Disorder diagnosis to Limitations for clarification of coverage.
- December 10, 2014: Reviewed by IMPAC, renewed without changes
- May 13, 2015: Reviewed by IMPAC. For effective date October 1, 2015, ICD-9 diagnosis code 781.3 and ICD-10 diagnosis codes R27.0, R27.8 and R27.9 added to "Non Covered Diagnosis Code Reference Tool for Short Term Physical and Occupational Therapy".
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 9, 2015: Reviewed by IMPAC, renewed without changes
- June 8, 2016: Reviewed by IMPAC. Clarification to physical therapy visit benefit limit
- July 28, 2016: Tufts Health Direct Plan products added, effective April 1, 2016
- September 14, 2016: Reviewed at IMPAC for effective date January 1, 2017. Changes to MNG language and ICD-10 coding made to define rehabilitative physical therapy services.
- October 24, 2016: Reviewed by IMPAC for effective date January 1, 2017. Criteria updated for consistency across all therapy guidelines. Criteria added to indicate services will not be authorized when duplicative of services which are part of member's IEP or ISP. Language in the Limitations sections updated
- October 28, 2016: Tufts Health Freedom Plan removed effective November 1, 2016.
- November 23, 2016: Language added to clarify prior authorization requirements may vary by plan, including Tufts Health Direct. Link added to Tufts Health Direct Outpatient Therapy Services Payment Policy
- December 14, 2016: Physical Therapy MNG reviewed by IMPAC, renewed without changes
- December 31, 2016: Coding updated. Per AMA CPT®, effective December 31, 2016 the following code(s) deleted: 97001, 97002; and effective January 1, 2017 the following code(s) added: 97161, 97162, 97163, 97164
- May 1, 2017: For effective date July 1, 2017 updates to prior authorization requirement language
- July 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- November 8, 2017: Reviewed by IMPAC, renewed without changes
- December 31, 2017: Coding updated. Per AMA CPT® and HCPCS Level II manual, effective December 31, 2017 the following code(s) deleted: 97532, 97762; and effective January 1, 2018 the following code(s) added: 97127, 97763, G0515.
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- December 31, 2019: Coding updated. Per AMA CPT®, effective December 31, 2019 the following code(s) deleted: 97127, G0515 and effective January 1, 2020 the following code(s) added: 97129, 97130
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 10, 2020: Fax number for Unify updated

#### **BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic